SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, JUNE 22, 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, 5.25.16	*Hirsch*	Action
4. SOUND PHYSICIANS JOINT OPERATING COMMITTEE	*Verducci*	Inform
5. PATIENT CARE SERVICES REPORT	*Kobe*	Inform
6. POLICY & PROCEDURES ✓ Lab Multiple Policies April 2016 ✓ Patient Safety and Grievance Policies May 2016	*Lovejoy*	Action
7. QUALITY REPORT JUNE 2016	*Lovejoy*	Inform/Action
8. CLOSING COMMENTS/ANNOUNCEMENTS	*Hirsch*	
9. ADJOURN	*Hirsch*	
10. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*	
11. CLOSED SESSION: ✓ Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report ✓ CIHQ Patient Grievance Discussion	*Sebastian/ Lovejoy*	Action
12. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
13. ADJOURN	*Hirsch*	

3.

CONSENT

+

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
MINUTES
Wednesday, May 25, 2016
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch Michael Mainardi Ingrid Sheets Kelsey Woodward Susan Idell Joshua Rymer	Brian Sebastian, M.D. (by phone) Howard Eisenstark Cathy Webber	Carol Snyder	Leslie Lovejoy Mark Kobe Gigi Betta

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	The meeting was called to order at 5:00p.	
2. PUBLIC COMMENT	*Hirsch*	
	No public comment.	
3. CONSENT CALENDAR	*Hirsch*	Action
QC Minutes, 04.27.16		**MOTION** by Idell to approve Consent and 2nd by Mainardi
4. POLICY & PROCEDURES		
Materials Management Multiple, April 2016	*Lovejoy*	Action **MOTION** by Idell to approve Consent and 2nd by Mainardi
5. QUALITY REPORT	*Lovejoy*	
• Quality & Resource Management Report, May 2016 • Annual Review QA/PI Program	May priorities included plan of correction for the CDPH survey, Hospital Quality Survey Participation and CALHEN oversight meeting. The Quality Dept. 2015 Performance Review included purpose, scope, availability, findings, assessments and infrastructure goals, reportable outcome measures and objectives for next performance period.	Inform/Action **MOTION** by Mainardi to approve Annual Report and 2nd by Eisenstark. All in favor.

9. CLOSING COMMENTS	*Hirsch*	
10. ADJOURN	*Hirsch*	
11. UPON ADJOURNMENT OF REGULAR SESSION	*Hirsch*	
12. CLOSED SESSION		Action
✓ Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report		
13. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
14. ADJOURN	*Hirsch*	
	Meeting adjourned at 5:55pm	

4.

SOUND PHYSICIANS JOINT OPERATING COMMITTEE

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

SOUND PHYSICIANS

Joint Operating Committee

Sonoma Valley Hospital

May 26, 2016

Agenda

- Sound Physician Team
- Dashboard Review
- Volumes
- Performance
- CPOE
- TCS

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Sound Physician Team

- Fully-Staffed
- W-2s
  - Dennis Verducci, Chief
  - Matthew Gilmartin
  - David Streeter
  - James Horodyski – Started Feb
  - Xavier Perez – Started Feb

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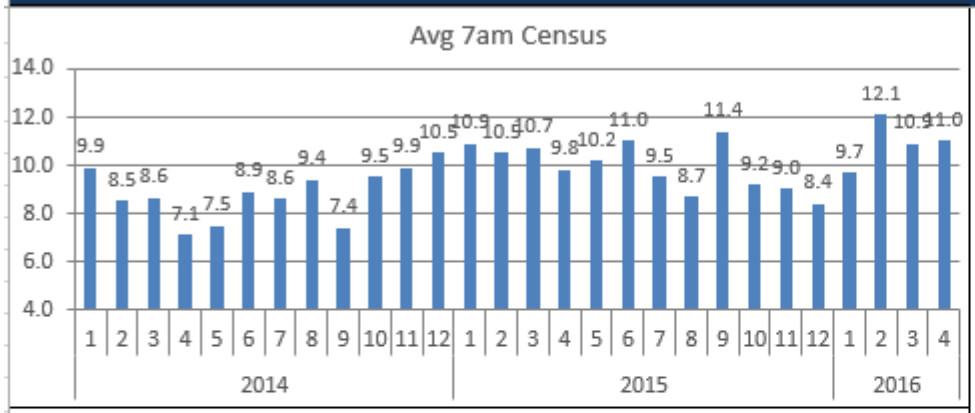
Dashboard

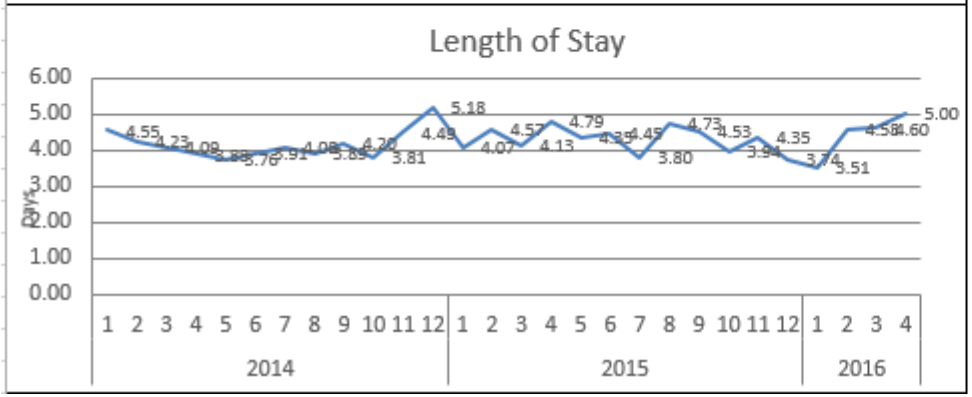
Sonoma Valley Hospital Dashboard

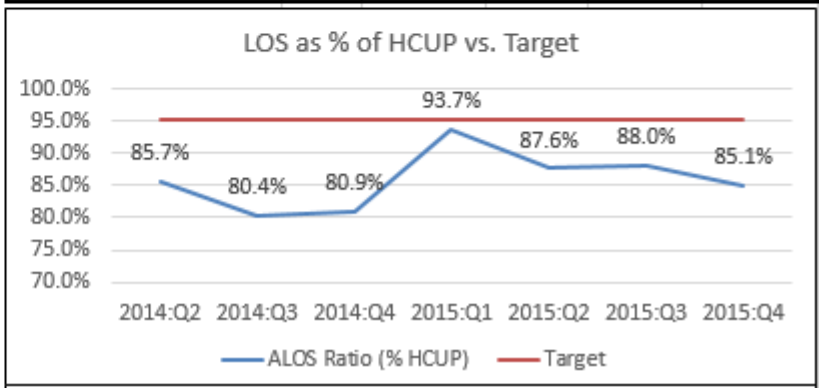


SVH - Total Encounters per Shift (Billable and Unbillable)

include Hospital and SNF patients

Physician	Dec	Jan	Feb	Mar	Apr
Burchet, Larry	11.6	-			
Gilmartin, Matthew	14.0	16.2			
Liu, Yong (1099)	12.0	19.0			
Streeter, David	17.8	17.3			
Verducci, Dennis	13.0	16.3			
Urcuyo (1099)	10.5	15.5			
Campbell, Douglas	9.0	8.0			
Dolan, James	-	8.0			
Total	**14.2**	**16.3**			





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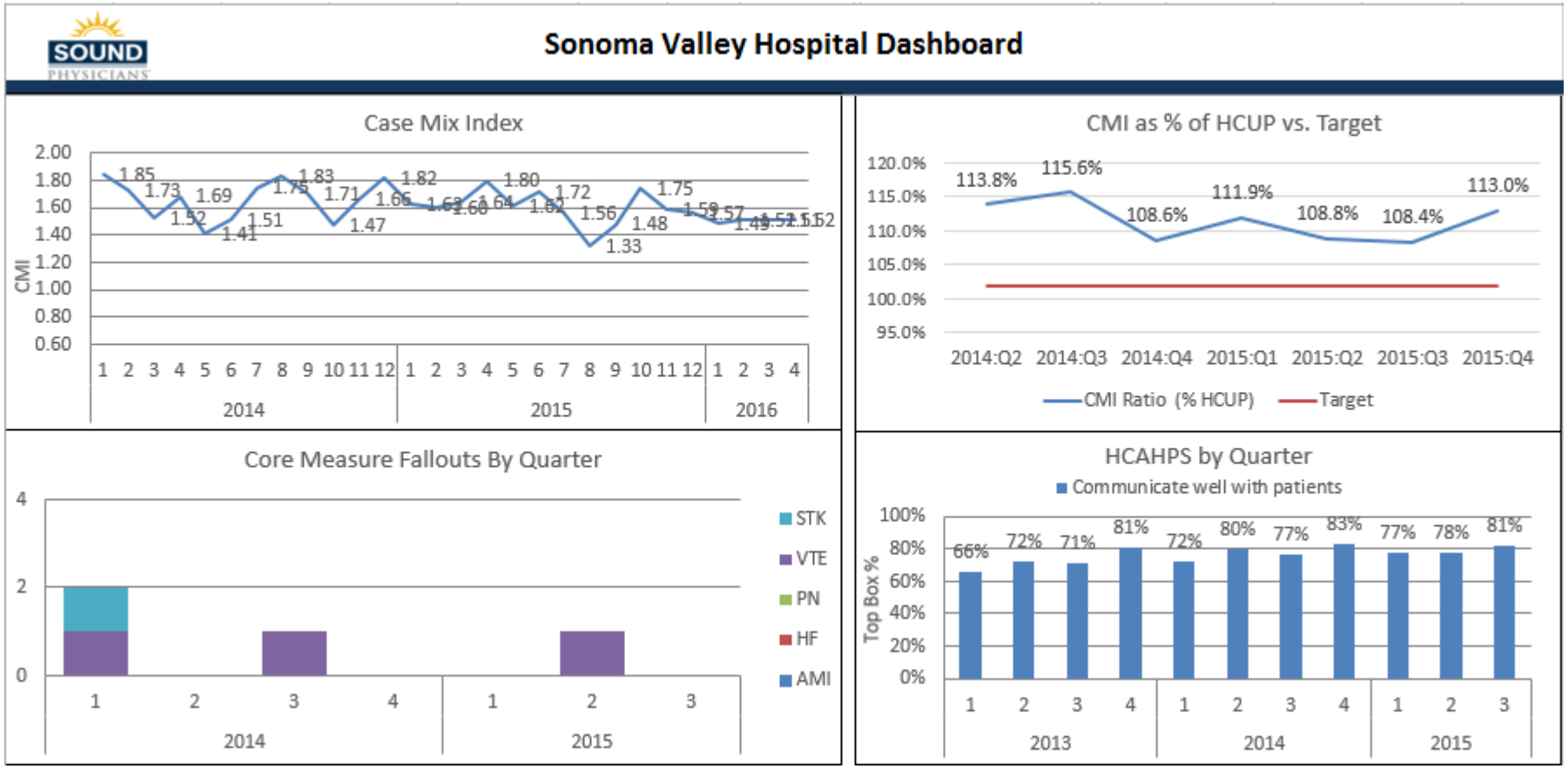
Dashboard



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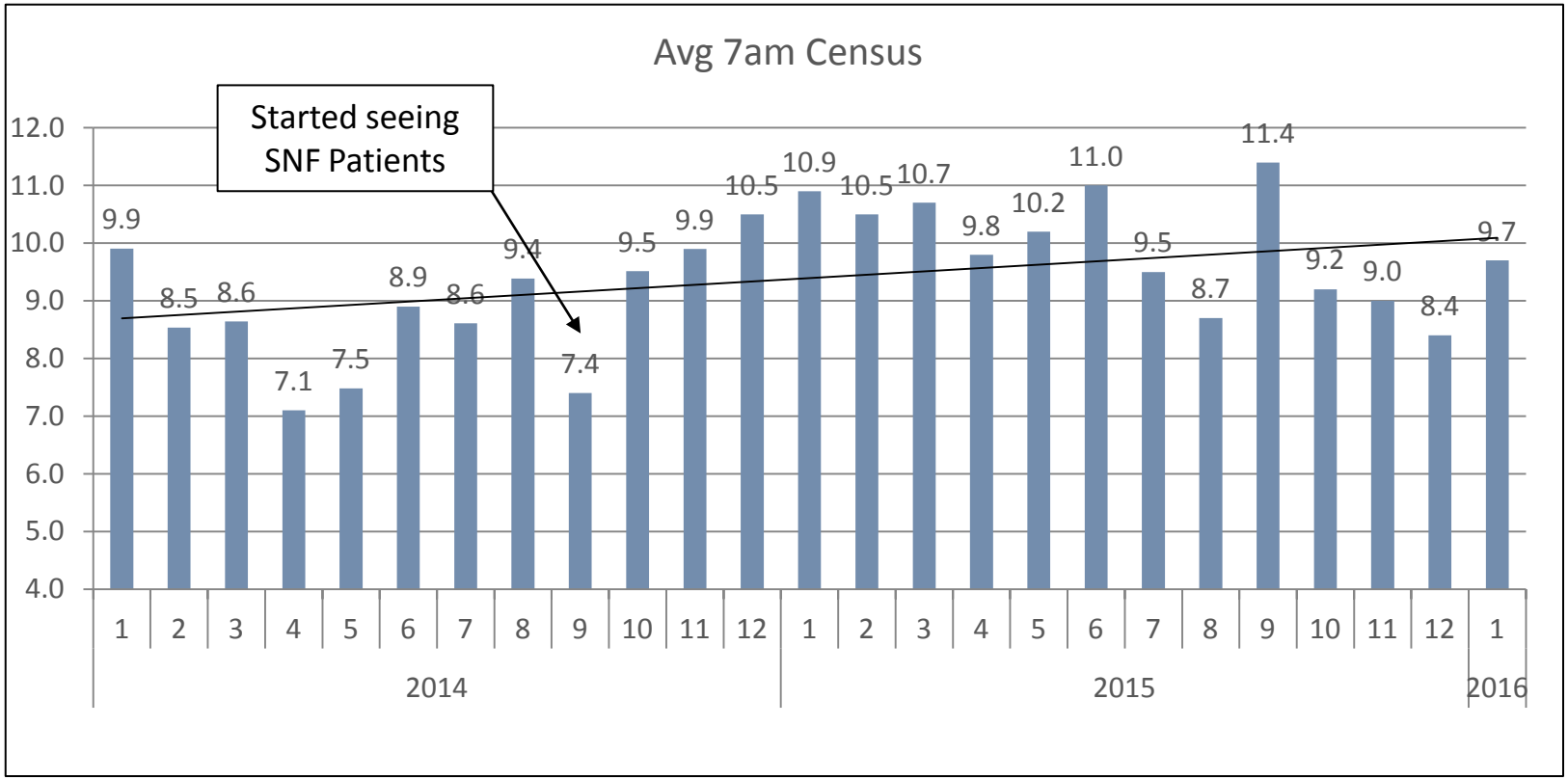
Volumes – 7am Census

Team has been seeing increases in volumes in 2015:

- 2014 average volumes = 8.8 pts/day
- 2015 average volumes = 9.9 pts/day



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Performance - 2015 Quality Objectives

METRIC	DESCRIPTION	GOAL for 100%	PAYOUT	Quarterly Payout	Q1 2015 RESULTS	Q2 2015 RESULTS	Q3 2015 RESULTS	Q4 2015 RESULTS	FULL YEAR PAYOUT
Patient Satisfaction	Physician Communication Press Ganey Top Box	80% or greater	$10,000	$2,500	77%	73%	80%	81%	$5,000
Discharge Orders by Noon	Each day for patients who are ready for AM discharges	60% or greater	$10,000	$2,500	77%	73%	77%	76%	$10,000
Core Measures	AMI HF STK PN VTE	No Fallouts	$10,000	$2,500	100%	98%	100%	100%	$7,500
Admission Orders	Written within 60 minutes of arrival on floor from ED	60% fo admission	$10,000	$2,500	100%	100%	100%	100%	$10,000
			$40,000	$10,000	$7,500	$5,000	$10,000	$10,000	**$32,500**

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SOUND PHYSICIANS

Performance - 2016 Quality Objectives

PERFORMANCE ASSESSMENT CRITERIA

	Performance Assessment Criteria	Measurement Method	Compliance Target
1	Patient Satisfaction: MD communication	NRC Rolling 12-month SVH Total Top Box Mean Score	≥ 68 = 100% < 66 = 50% < 64 = 0%
2	Admit Decision Time to ED Departure for Admitted Patients	Most recent SVH data (CMS benchmark 2nd Qtr 2015 = 118") (SVH 2015 avg. =124")	≤ 120 = 100% >120 = 50% >130 = 0%
3	Severe Sepsis & Septic Shock: **6-hour bundle compliance (all-or-none)	% of septic shock patients fully compliant with 6-hour bundle as per chart review by SVH Quality Department	Evidence of all Criteria =100% Missing criteria = 0%
4	80% of Hospitalist orders are entered by MD (CPOE)	Most recent SVH EHR compliance data	≥ 80% orders = 100% < 80% orders = 0%
5	Documentation of medical necessity includes a LOS statement inclusive of 2 midnights 95% of the time	Random selection of inpatient records across all hospitalists quarterly	≥ 95% group score = 100% < 95% group score = 0%

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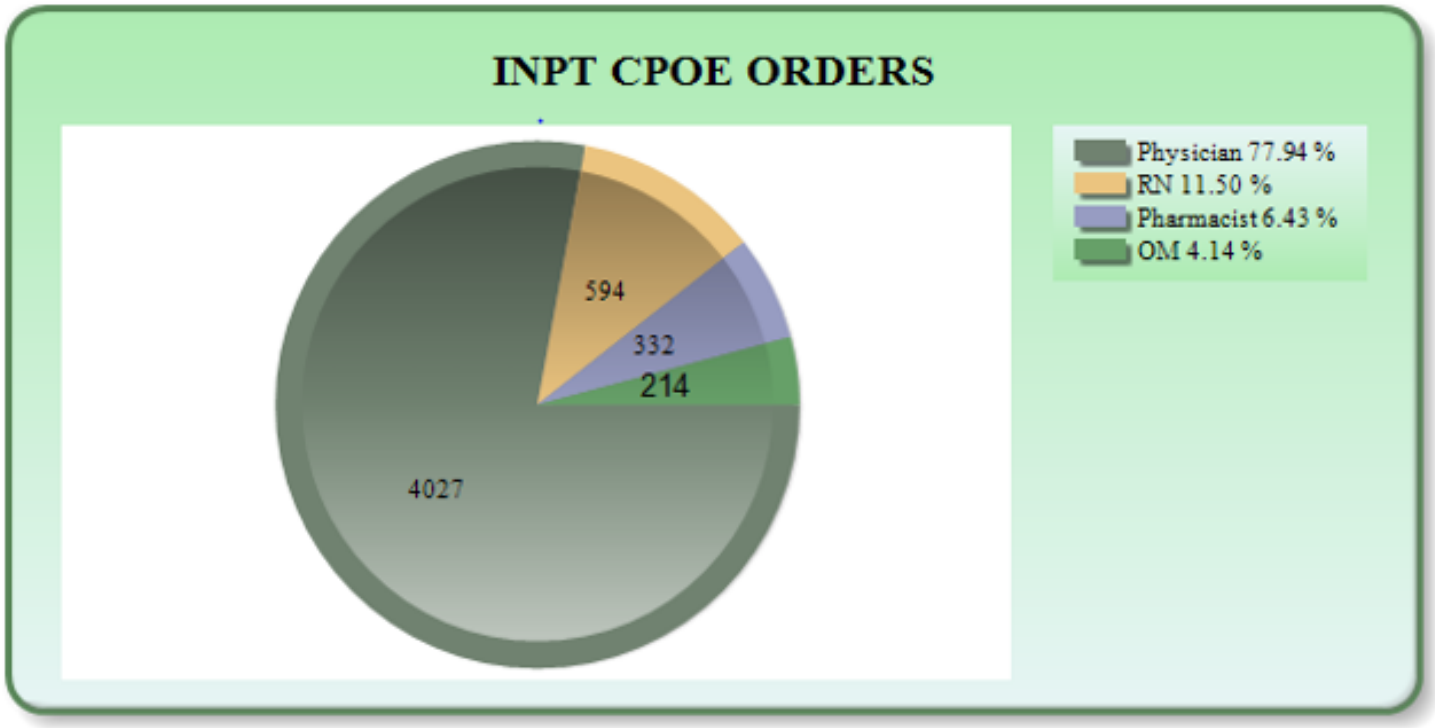
SOUND PHYSICIANS

CPOE

Friday, April 01, 2016 Through **Saturday, April 30, 2016**

Total number of **CPOE** generated orders by **INPT Physicians**: 4,027
Total number of **Verbal Order** entry generated orders by **INPT RNs**: 594
Total number of **Verbal Order** entry generated orders by **Pharmacist**: 332



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SOUND PHYSICIANS

TCS

- Nikki - Sound TCS NP working every Monday at Sonoma SNF
- Rounding on SNF patients
- Off loading workload from Sound physicians
- Credentialing in process

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5.

PATIENT CARE SERVICES REPORT

Patient Care Services

Annual Report 2016

SONOMA

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AGENDA

I. Patient Care Services Education and Certification
II. Patient Care Services Competency
III. Patient Experience of Care
IV. Patient Care Services Challenges

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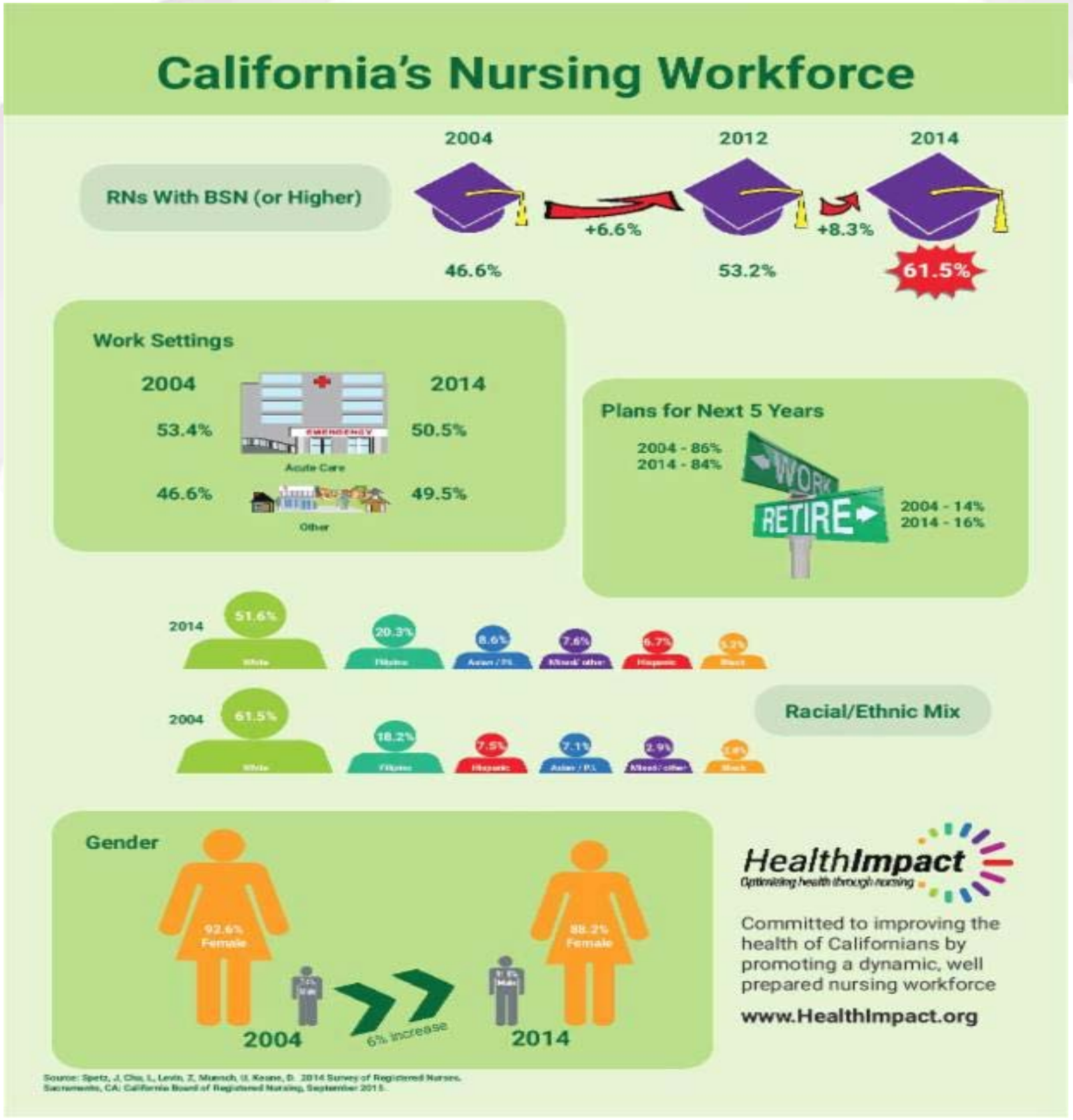
EDUCATION AND CERTIFICATION



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EDUCATION AND CERTIFICATION

SVH RN Certification & Education	2015-16				
	CERTIFICATION		HIGHER EDUCATION		
Patient Care Service	SVH	Goal	Undergraduate (Baccalaureate)	Graduate (Masters)	Postgraduate (PhD)
Emergency (CEN) (n=22)	0	1	3 (14%)		
ICU (CCRN) (n=17)	2	3	5 (31%)	1((6%)	
The Birthplace (Lactation) (n=15)	1	2	10 (67%)	3 (19%)	
Med Surg (MSRN) (n=18) (2 working toward MSRN cert; 1 working on BSN)	1	2	8 (44%)	1 (6%)	
Surgery (AORN, ASPAN) (n=16)	0	1	10 (63%)		
SNF (Gerontology, Palliative care, Long-term care, Resident Assessment Coordinator) (n=16) (1 RN currently working on MSN)	11	12	8 (50%)	1 (7%)	1 (7%)
Case Management (n=8)	3	4	1 (13%)		1 (13%)
Healing at Home (n=17)	2	3	9 (50%)	2(11%)	
42% of SVH RNs have a Baccalaureate Degree. 49% of SVH RNs have a Baccalaureate Degree or Higher					

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COMPETENCY

How do we know they are and what they need?

Mandated by Regulation or Policy	High risk, high or low volume, problem prone
Restraints	Rhythm Recognition (Telemetry)
Workplace Violence	Med Admin & Electronic Health Record
Safe Patient Lifting (equipment)	Pediatric Assessment
Waived Testing	Fetal Heart Monitoring
EMTALA	Therapeutic Hypothermia
Hyperthermia	Central Lines, PICC, Ports, epidurals
BCLS, ACLS, PALS, NRP Infection Control	Crash C-Section, Mock Code Blue, Pink/Purple drills
Blood Transfusion	Sterile Fields
Elder Abuse	Moderate Sedation
HIPAA	Wound Care
Developmentally Appropriate Care	Patient education

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COMPETENCY

What else?

- Annual needs assessment by staff
- Identified Quality issues
- New regulatory requirements
- New equipment/technology
- Evidence-based practice changes
- Public reporting agency requirements

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COMPETENCY

SKILLS LAB 2015

Competency	Assessment Criteria
1. AED (ED, ICU, SNF, M/S, SCU, OR, Birthplace, UR, Ind. Med, Wound, Nsg Admin) Observer Signature: _____ Date: _____ **Transcutaneous Pacing/Defib/Synch Cardioversion (ED. ICU, PACU Nsg. Admin)** Observer Signature: _____ Date: _____	P F
2. Pediatric Code Blue (ED, ICU, M/S, SCU, OR, Birthplace, Nsg. Admin) Observer Signature: _____ Date: _____	P F
3. Restraints (ED, ICU, SNF, M/S, SCU, Birthplace, UR, Wound, Nsg. Admin) Observer Signature: _____ Date: _____	P F
4. IV Admixture (ED, ICU, SNF, M/S, SCU, OR, Birthplace, Nsg. Admin) Observer Signature: _____ Date: _____	P F
5.PICC/PORT-Access/Flush (ED, ICU, SNF, M/S, SCU, Birthplace, Nsg. Admin) Observer Signature: _____ Date: _____	P F
6. Wound Care (ED, ICU, SNF, M/S, Birthplace) Observer Signature: _____ Date: _____	P F
7. Constavac (ICU, SNF, M/S, SCU, OR, Nsg. Admin) Observer Signature: _____ Date: _____	P F
8. Accu-Chek (ED, ICU, SNF, M/S, SCU, OR, Birthplace, Nsg. Admin) Observer Signature: _____ Date: _____	P F
9. Neonatal Mock Code (Birthplace, Nsg. Admin) Observer Signature: _____ Date: _____	P F

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COMPETENCY

Sonoma Valley Hospital Presents

Skills Lab 2016

Friday, September 30
or
Tuesday, October 25
or
Friday, November 18

8:00am-12:00pm

Third Floor

Mandatory Training for Nursing and Cardiopulmonary Departments

Time needed to complete stations vary by position and department

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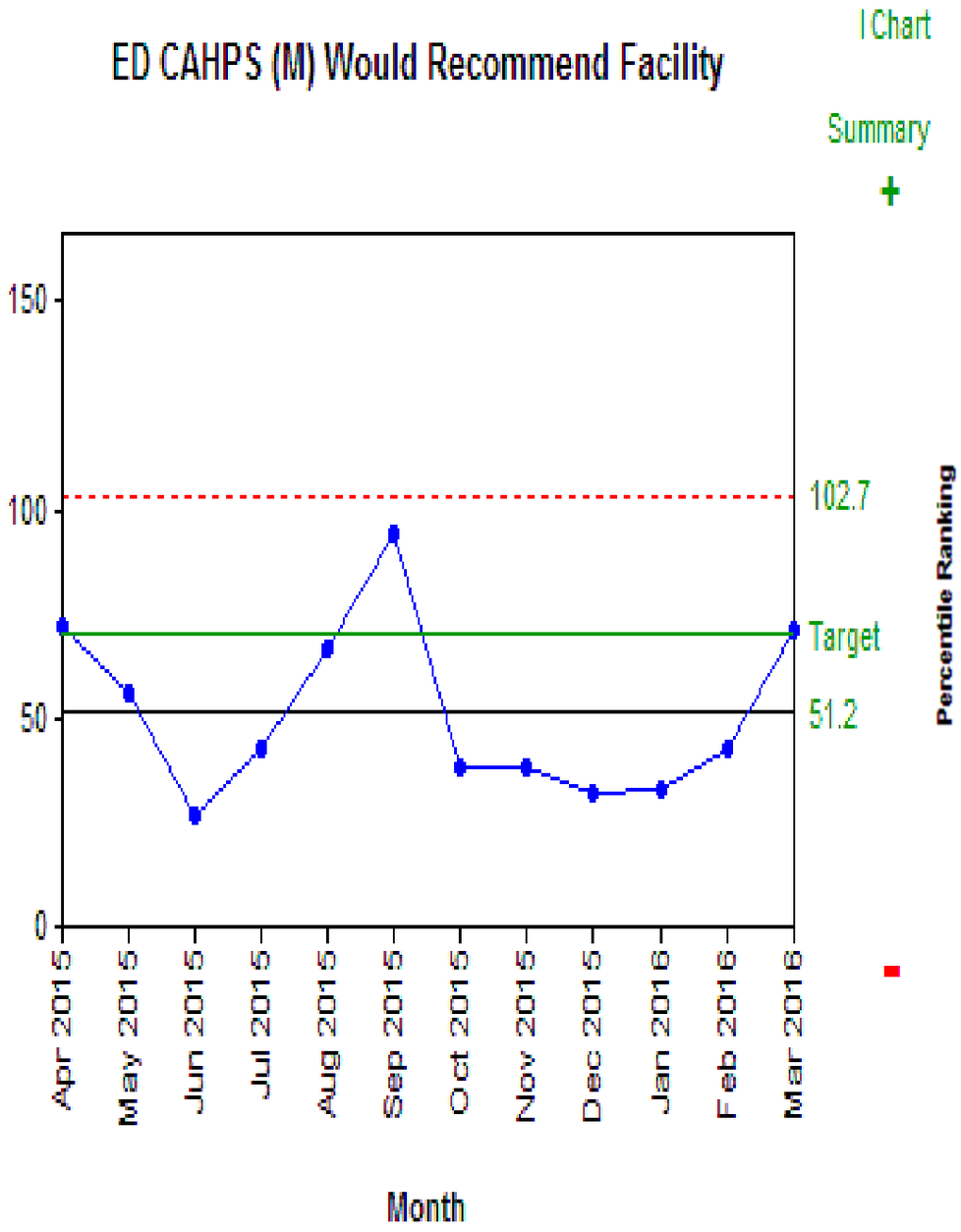
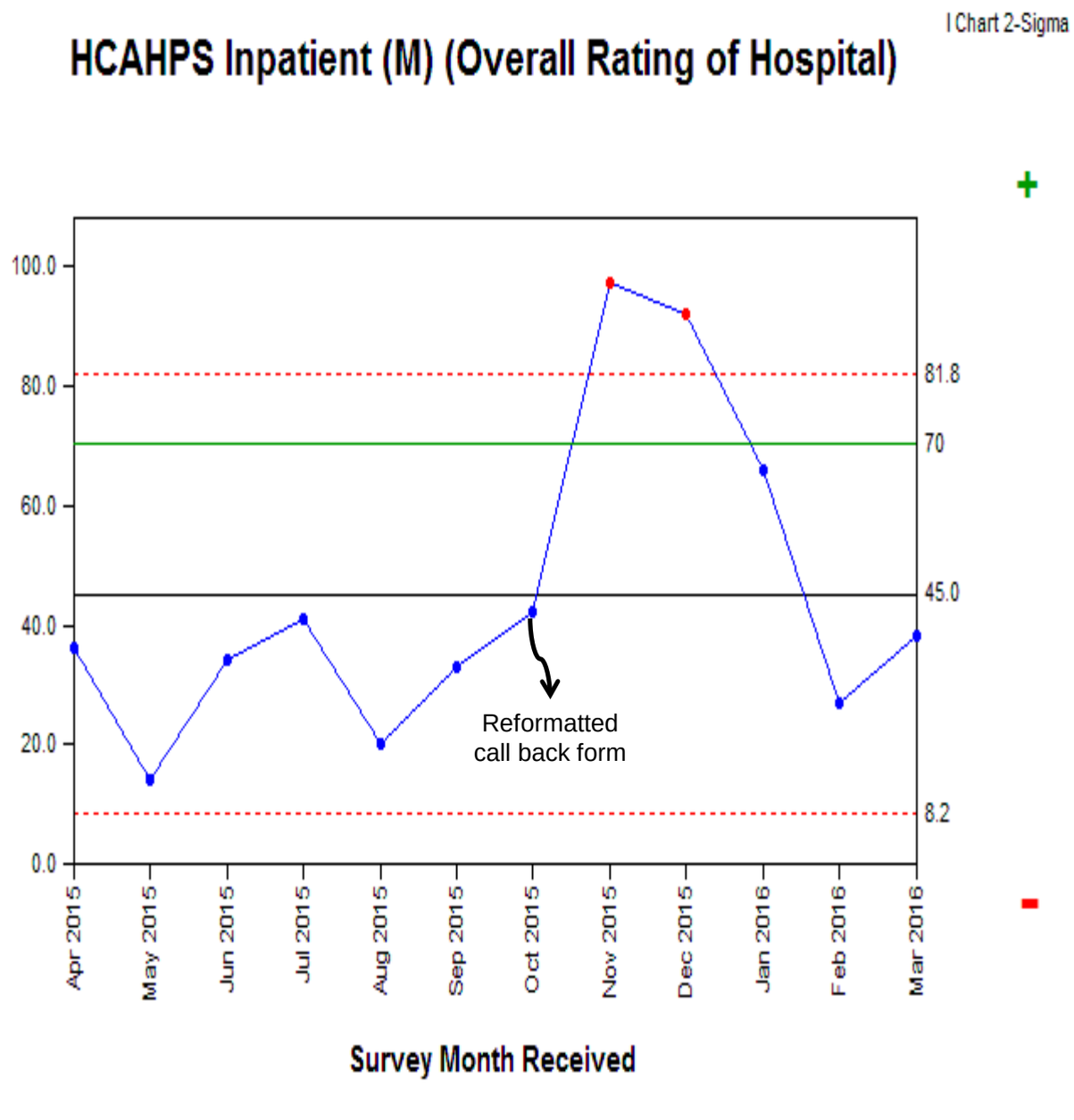
Experience of Care





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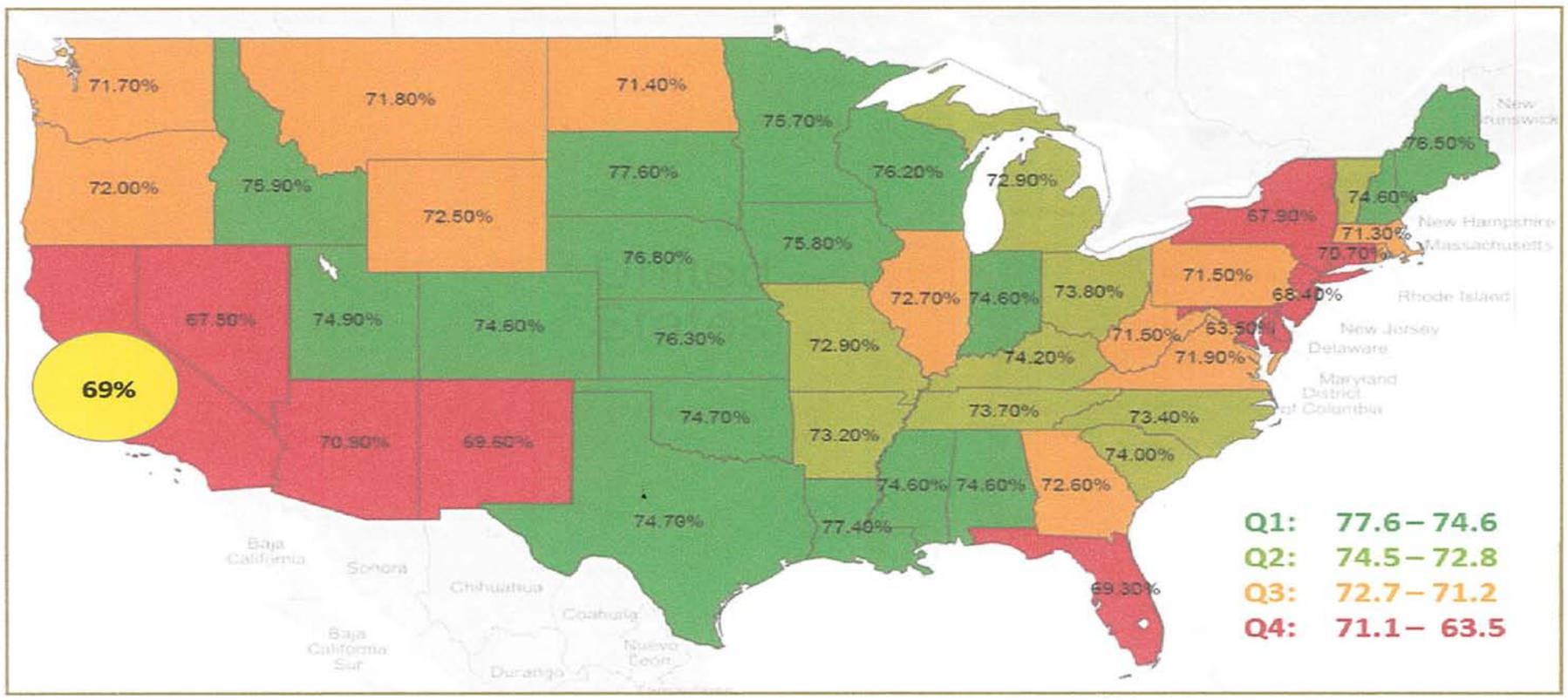
Experience of Care

California's HCAHPS Performance

Discharges between July 1, 2013 – June 30, 2014



Hospital Quality Institute

PERCENTAGES LISTED HERE ARE ACTUALLY MEAN SCORES.
SONOMA VALLEY'S 12 MONTH ROLLING MEAN SCORE = 78.9% (NRC Data: Jul 2014)
12 MONTH ROLLING MEAN SCORE = 69.5% (NRC Data March 2016)

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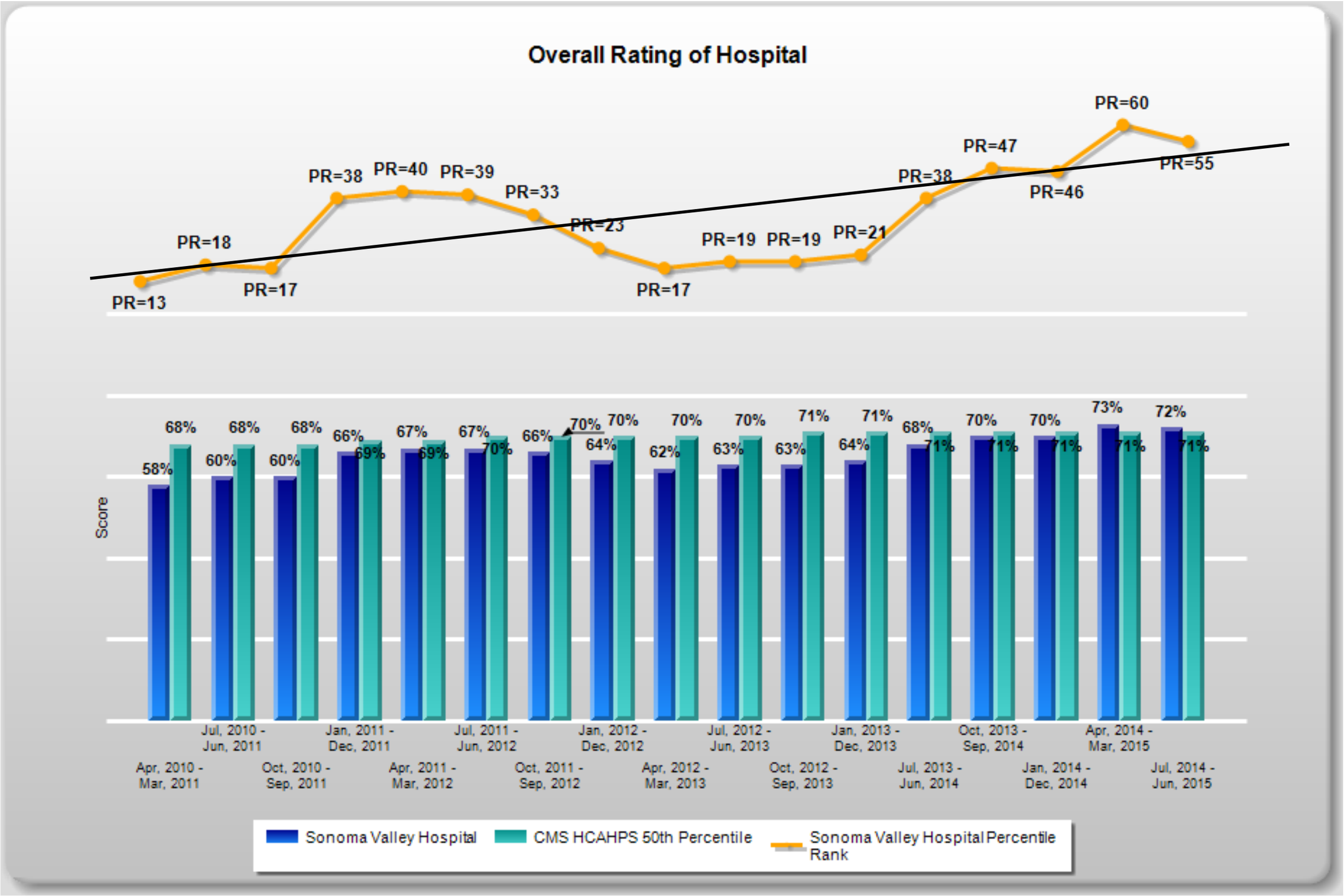
Experience of Care



Experience of Care

Report Run Date: 05/06/2016

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital CAHPS (HCAHPS) Survey

Reporting Period for HCAHPS Measures: Fourth Quarter 2014 through Third Quarter 2015 Discharges

Reporting Period for HCAHPS Star Ratings: Fourth Quarter 2014 through Third Quarter 2015 Discharges

050090 - SONOMA VALLEY HOSPITAL

Address: 347 ANDRIEUX ST
City, State, ZIP: SONOMA, CA 95476
Phone Number: (707) 935-5000
County Name: SONOMA

Type of Facility: Short-term
Type of Ownership: Government - Hospital District or Authority
Emergency Service Provided: Yes

HCAHPS Survey Completion, Response Rate and Summary Star Rating	
Number of Completed Surveys	244
Survey Response Rate	31
HCAHPS Summary Star Rating	3 stars

HCAHPS Composites and Individual Items

HCAHPS Composites		HCAHPS Star Rating		Your Hospital's Adjusted Score			State Average			National Average		
		Star Rating (Out of 5)	Linear Score (0-100)	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always
Composite 1 (Q1 to Q3)	Communication with Nurses	4	92	4	17	79	6	19	75	4	16	80
Composite 2 (Q5 to Q7)	Communication with Doctors	3	92	6	12	82	6	16	78	4	14	82
Composite 3 (Q4 & Q11)	Responsiveness of Hospital Staff	3	85	9	27	64	12	26	62	9	23	68
Composite 4 (Q13 & Q14)	Pain Management	3	88	5	24	71	8	24	68	7	22	71
Composite 5 (Q16 & Q17)	Communication about Medicines	3	79	16	23	61	20	19	61	18	17	65
Hospital Environment Items		**Star Rating (Out of 5)**	**Linear Score (0-100)**	**% Sometimes to Never**	**% Usually**	**% Always**	**% Sometimes to Never**	**% Usually**	**% Always**	**% Sometimes to Never**	**% Usually**	**% Always**

Footnote Legend
1 . The number of cases/patients is too few to report.
3 . Results are based on a shorter time period than required.
5 . Results are not available for this reporting period.
6 . Fewer than 100 patients completed the HCAHPS survey. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.
10 . Very few patients were eligible for the HCAHPS survey. The scores shown reflect fewer than 50 completed surveys. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.
11 . There were discrepancies in the data collection process.
15 . The number of cases/patients is too few to report a star rating.

Star Ratings Legend
More stars are better
"For additional Information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org."

Experience of Care

Report Run Date: 05/06/2016

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital CAHPS (HCAHPS) Survey

Reporting Period for HCAHPS Measures: Fourth Quarter 2014 through Third Quarter 2015 Discharges

Reporting Period for HCAHPS Star Ratings: Fourth Quarter 2014 through Third Quarter 2015 Discharges

050090 - SONOMA VALLEY HOSPITAL

Q8	Cleanliness of Hospital Environment	2	86	9	19	72	10	20	70	8	18	74
Q9	Quietness of Hospital Environment	2	78	14	35	51	16	33	51	9	29	62

Discharge Information Composite		Star Rating (Out of 5)	Linear Score (0-100)	% Yes	%No	% Yes	%No	% Yes	%No
Composite 6 (Q19 & Q20)	Discharge Information	4	90	90	10	85	15	87	13

Care Transition Composite		Star Rating (Out of 5)	Linear Score (0-100)	% Disagree to Strongly Disagree	% Agree	% Strongly Agree	% Disagree or Strongly Disagree	% Agree	% Strongly Agree	% Disagree or Strongly Disagree	% Agree	% Strongly Agree
Composite 7 (Q23 to Q25)	Care Transition	2	81	5	45	50	7	45	48	5	43	52

HCAHPS Global Items												
		HCAHPS Star Rating		Your Hospital's Adjusted Score			State Average			National Average		
Q21	Overall Rating of Hospital	Star Rating (Out of 5)	Linear Score (0-100)	% 0 to 6 rating	% 7 or 8 rating	% 9 or 10 rating	% 0 to 6 rating	% 7 or 8 rating	% 9 or 10 rating	% 0 to 6 rating	% 7 or 8 rating	% 9 or 10 rating
Overall Rating of Hospital (0= Worst Hospital 10= Best Hospital)		3	89	7	18	75	10	22	68	8	20	72
		HCAHPS Star Rating		Your Hospital's Adjusted Score			State Average			National Average		
Q22	Willingness to Recommend this Hospital	Star Rating (Out of 5)	Linear Score (0-100)	%No: Definitely or Probably Not Recommend	%Yes: Probably Recommend	%Yes: Definitely Recommend	%No: Definitely or Probably Not Recommend	%Yes: Probably Recommend	%Yes: Definitely Recommend	%No: Definitely or Probably Not Recommend	%Yes: Probably Recommend	%Yes: Definitely Recommend
Willingness to Recommend this Hospital		4	90	4	20	76	7	24	69	5	24	71

Footnote Legend
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Star Ratings Legend
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Experience of Care

Patient Experience is everyone's responsibility in an organization, from the moment a patient, family member or visitor enters the building. Every contact, every encounter has the potential to greatly influence that person's perception of us and ultimately, the outcomes of our survey responses. Patient Satisfaction is not a nursing initiative: it belongs to everyone working at SVH as a unified team.

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What's the Plan?

STAY CALM AND FOCUSED

ACTIONS:

- Perform AIDET competency all staff; clinical and non-clinical
- Validate White Board utilization; nursing and ancillary staff
- Follow-up phone calls (Questioning relating to CAPHS dimensions)
- Hourly Rounding by clinical staff
- Daily Rounding by Clinical Dept management; validation of staff performing #1-4 and rounding on patients using open-ended questions targeting low scoring dimensions
- Rounding by all Ancillary management: Scheduled 1-2 days/week.
- Validation rounding by CNO and Ancillary Lead
- Daily multi-disciplinary rounds with Patient Experience daily agenda item (CNO)
- Rounding by OR team 2 days/week on postoperative patients
- Daily rounding by Nursing Supervisors
- Efforts to increase survey response rate: posters in patient rooms reminding patients/families of surveys (add ICU and ED). Include reminders to patients/families during rounding

- Include 1-2 patient/family advisors as members of Patient Care Experience Team
- Patient Care Experience team members will conduct random AIDET validations on all SVH staff

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Patient Care Service Challenges

1. Staffing/recruitment

- Turnover; train and transfer, core staffing
- Salary; hard to hire, hard to retain

2. Electronic Health Record

- Software user-friendly/intuitive
- Connectivity
- Med reconciliation
- Verbal Order entry

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Patient Care Service Challenges

3. Physician/Staff Collaboration

- 3-15% rate ‘unfavorable to neutral’ on Staff Satisfaction Survey 2016

4. Pt. Satisfaction Survey Returns

- March 2015-March 2016 response rate 31% (~21/month)
- Problem is monthly ‘n’ is 9-20. 30 is statistically valid

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Questions?

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6.

POLICY AND PROCEDURES

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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/Department: Laboratory Policies	
APPROVED BY: Lois Valenzuela	DATE: **04-19-16**
Director's/Manager's Signature	Printed Name **Lois Valenzuela**

Douglas S Campbell, MD
Chair Medicine Committee — 6/3/16 Date

Michael Brown, MD
Chair Surgery Committee — 6/6/16 Date

Keith J. Chamberlin, MD MBA
President of Medical Staff — 6/2/16 Date

Kelly Mather
Chief Executive Officer — Date

Jane Hirsch
Chair, Board of Directors — Date

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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Policy Submission Summary Sheet

Title of Document: **Multiple Policies – April 2016**

New Document or Revision written by:

Date of Document: **4-19-16**

Type:	**Regulatory:**
❑ **Revision** X **New Policy**	❑ **CIHQ** X **CDPH** X **CMS** ❑ **Other:**
Organizational: X **Clinical** X **Non-Clinical**	X **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)

Organizational Policy:

QS8610- Critical Values Chart- Revised; added Lactate chemistry value

Lab Department Policies:

7500-25 Kit Draws – New policy; to provide the service of drawing, processing, labeling and packing blood specimens for kits provided by patients.

7500-58 Reflex Testing Policy- now for CBC test; unfractionated Heparin changed to APTT test

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	03/15/2016	Yes	
Surgery Committee	5/11/2016	Yes	Rescheduled from 5/04; Lois to present
Medicine Committee	05/12/2016	Yes	Lois to present
P.I. or P. T. Committee	n/a		
Medical Executive Committee	05/19/2016	Yes	
Board Quality	06/22/2016		
Board of Directors	07/07/2016		

SONOMA VALLEY HOSPITAL
CRITICAL LABORATORY VALUES

Test	Critical value		Units	Special Instructions
HEMATOLOGY				
WBC	<2,000	>30,000	x $10^3/\mu L$	**DO NOT CALL: OutPatient <2,000; >30,000 If "Consistent with previous"**
HEMATOCRIT	<21.0	>60.0	%	
HEMOGLOBIN	<7.0	>20.0	g/dL	
PLATELETS	<40,000	>999,000	x $10^3/\mu L$	**DO NOT CALL: OutPatient <40,000; > 999,000 If "Consistent with previous"**
EOSINOPHILS		>20	%	**Call next business day**
CHEMISTRY				
BILIRUBIN, TOTAL	Pediatric patient only >16.0		mg/dL	
CALCIUM		>13.0	mg/dL	
CREATININE		>5.0	mg/dL	**Do not call Nephrology patients**
DIGOXIN		>3.0	ng/mL	
DILANTIN		>20	ug/ml	
GLUCOSE	<50	>500	mg/dL	
POTASSIUM	<2.8	>6.2	mmol/L	
SODIUM	<120	>160	mmol/L	
LACTATE		>4	mmol/L	
TROPONIN		>0.040	ng/mL	
MICROBIOLOGY				
MRSA		**POSITIVE**		**Call Inpatient only**
SALMONELLA		**POSITIVE**		**new cases only**
SHIGELLA		**POSITIVE**		**new cases only**
ESBL		**POSITIVE**		**Call Inpatient only**
VRE		**POSITIVE**		**New cases only**
BLOOD CX		**POSITIVE**		
CSF CX		**POSITIVE**		
CSF GM STAIN		**POSITIVE**		
JOINT FLUID CX		**POSITIVE**		
GROUP B STREP		**POSITIVE**		**ON LABOR & DELIVERY PATIENTS ONLY**
CHLAMYDIA/GC		**POSITIVE**		**Call next business day**
ANTIBIOTIC LEVELS				
GENTA PEAK		>10	ug/mL	**CALL TO PHARMACIST**
GENTA TROUGH		>2	ug/mL	**CALL TO PHARMACIST**
VANCO PEAK		>40	ug/mL	**CALL TO PHARMACIST**
VANCO TROUGH		>20	ug/mL	**CALL TO PHARMACIST**
COAGULATION				
Anti -Xa (Lovenox & Heparin Inject)		>1.0	IU/mL	**Sent to SRMH 3 hr TAT, Call to Pharmacist**
PROTIME-INR		>4.0		**Inpatient call to Pharmacist, Outpatient call to Coumadin Clinic or physician**
PTT		>106	Seconds	**Therapeutic patient**
PTT		>68	Seconds	**Non-anticoagulated patient**

BLOOD BANK				
ATYPICAL ANTIBODIES		Present		
TRANSFUSION RX		Positive Result		
BLOOD GAS				
pCO2	<20	>80	mm/L[Hg]	**Notify Cardio or call to physician or nursing station**
pH	<7.2	>7.6		
pO2	<50		mm/[Hg]	
REFERENCE LAB				
PERTUSSIS		**POSITIVE**		**Call to ER or Physician AND place copy of report in Infection Control**
				Revised 09/2015

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SUBJECT: Kit Draws	POLICY # 7500-25
	PAGE 1 OF 1
DEPARTMENT: Laboratory Department	EFFECTIVE: 3/16
APPROVED BY: Director of Laboratory	REVIEW/REVISED:

Policy:
It is the policy of Sonoma Valley Hospital Laboratory to provide the service of drawing, processing, labeling and packing blood specimens for kits provided by patients.

Procedure:
- The lab will draw, process, label & pack the blood specimen(s) according to the instructions accompanying the kit
- The kit is returned to the patient for shipping
- The laboratory and Sonoma Valley Hospital assume no responsibility for the kit after it is returned to the patient.
- The lab will not fill out the paper work included in the kit
- The service is subject to an all inclusive Kit Draw fee
- Payment is due at time of service
- Minimum of 50% deposit is required; balance can be billed to the patient.
- SVH will not bill insurance or a 3rd party for the Kit Draw
- The Kit Draw fee is not subject to the cash discount
- If the Kit Draw is accompanied by other lab work; the Kit Draw fee will not be waived.
- The Kit Draw and the lab work must have separate registrations.

Reference:

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SUBJECT: Reflex Testing Policy	POLICY # 7500-58 PAGE 1 OF 3
DEPARTMENT: Laboratory	EFFECTIVE: 6/11
APPROVED BY: Director of Laboratory	REVIEW/REVISED: 9/13 7/15,10/15, 3/16

Purpose:
Reflex testing will be performed when an initial test result is outside the normal range and indicates a second related test is medically appropriate. The reflex test result will add useful diagnostic, prognostic and/or therapeutic information.

Policy:
The Laboratory Director selects tests that will be automatically reflexed to additional testing without intervention from the ordering physician.

Procedure:
REFLEX TESTING: The table below indicates testing that is reflexed in the specified area.

Blood Bank

Original Order	*Threshold for Reflex*	*Reflexes to:*	*Reflex test Billed?*
Antibody Screen	Antibody Identified	Antibody ID, Antigen Typing, Antibody titer for prenatal patients, Screening units for crossmatch patients. Sent to BCP	Yes
Rh Typing	D Negative	Du testing	Yes
Direct Coombs (DAT)	Positive	IgG, C3d	Yes
Immediate Spin (IS) Crossmatch	If positive antibody screen	Full crossmatch with 37° incubation AHG	Yes

Microbiology

Original Order	*Threshold for Reflex*	*Reflexes to:*	*Reflex test Billed?*
Rapid Strep A Antigen Screen	Negative Screen	Strep Culture	Yes
Wound Culture, Aerobic	Dependent on source of specimen	Anaerobic Culture	Yes
Culture	Variable, dependent on organism growth	Sensitivity and ID of organism	Yes

Chemistry

Original Order	*Threshold for Reflex*	*Reflexes to:*	*Reflex test Billed?*
Glucometer	Result > 400 mg/dl	Plasma/serum glucose	Yes
Glucometer	Result < 50 mg/dl	Plasma/serum glucose	Yes

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SUBJECT: Reflex Testing Policy	POLICY # 7500-58
	PAGE 2 OF 3
DEPARTMENT: Laboratory	EFFECTIVE: 6/11
APPROVED BY: Director of Laboratory	REVIEW/REVISED: 9/13 7/15,10/15, 3/16

Hematology

Original Order	*Threshold for Reflex*	*Reflexes to:*	*Reflex test Billed?*
CBC	WBC < 1,000 or > 30,000 HGB < 10.0 MCV < 70 or > 110 RDW > 18.5 Platelets < 50,000 or > 500,000 Lymphs > 65% Monos > 20% WBC flag (s) Platelet flag (s)	Slide scan review	Yes
CBC	Any abnormal WBC's (metas, myelos, pros, blasts and immature/atypical lymphs or monos	Manual Differential	No
CBC	> 10% Bands	No Manual Diff Needed. Add Comment (>10% band forms seen)	No
Manual Differential	Meets Peripheral Smear Review by Pathology: ➢ Presence of Blasts and immature cell with prominent nucleoli ➢ Presence of large, bizarre or unidentified WBC's ➢ WBC counts < 1,000 or >30,000 ➢ Lymphs adults > 65% or children > 75% ➢ Eosinophil > 20% ➢ Basophil > 4% ➢ MCV < 65 or > 110 FL ➢ Platelets < 30,000 or > 900,000 (1st episode only) ➢ Plasma Cells > 3% ➢ Fluid: Malignant or abnormal appearance of cells ➢ Malaria suspected	Pathologist slide review	Yes
CBCPLUS	➢ Hgb ≥13.0 g/dL	Pathologist slide review	Yes
	➢ Hgb <13.0 g/dL	Retic, TIBC, Ferritin, Creat, Folic Acid, Vit B_{12}, CRP (non-Cardio) Pathologist slide review	Yes Yes

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SUBJECT: Reflex Testing Policy	POLICY # 7500-58 PAGE 3 OF 3
DEPARTMENT: Laboratory	EFFECTIVE: 6/11
APPROVED BY: Director of Laboratory	REVIEW/REVISED: 9/13 7/15,10/15, 3/16

Urinalysis

Original Order	*Threshold for Reflex*	*Reflexes to:*	*Reflex test Billed?*
Urine Screen	Leukocyte esterase, Nitrites, Bacteria or RBC are positive	Urinalysis with microscopic	Yes
Urinalysis, culture if indicated	1, Leukocyte esterase is positive on the dipstick, or 2. Nitrites are positive on the dipstick, or 3. if >6 WBC's/hpf are seen in the microscopic, or 4. 2+ bacteria are seen in the microscopic if voided specimen, 1+ bacteria if catheterized	Culture & Sensitivity	Yes
Timed urines	Always	Volume measurement	Yes

Serology

Original Order	*Threshold for Reflex*	*Reflexes to:*	*Reflex test Billed?*
Rheumatoid Arthritis	Positive	RA Titer Sent to Reference Lab	Yes
RPR, Syphilis serology	Reactive or Weakly Reactive	Treponema pallidum Abs	Yes
ASO	Positive	ASO Titer Sent to Reference Lab	Yes
Rapid HIV Screen	Positive	Western Blot—sent to Reference Lab	Yes

Anticoagulant Testing Specifications

The table below lists Pathologist recommendations concerning which laboratory tests to use for monitoring heparin, low molecular weight heparin, low molecular weight heparin, direct thrombin inhibitors and/or oral anticoagulant therapy.

Anticoagulant Therapy	*Recommended Laboratory Test*
Oral Anticoagulant (Warfarin)	• PT/INR
Unfractionated Heparin	• APTT
Low Molecular Weight Heparin (Lovenox)	• Monitoring not necessary • Factor Xa Assay
Direct Thrombin Inhibitors	• APTT

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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 Policies May List 2016	
APPROVED BY:	DATE: **4-22-16**
Director's/Manager's Signature	Printed Name **Mark Kobe, RN MPA**

Douglas S Campbell, MD — Date: 6/3/16
Chair Medicine Committee

Michael Brown, MD — Date: 6/6/16
Chair Surgery Committee

Keith J. Chamberlin, MD MBA — Date: 6/2/16
President of Medical Staff

Kelly Mather — Date
Chief Executive Officer

Jane Hirsch — Date
Chair, Board of Directors

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Policy Submission Summary Sheet

Title of Document: **Organizational Policies**

New Document or Revision written by: **Multiple Policies**

Date of Document: **4-22-16**

Type:	**Regulatory:**
X Revision **X New Policy**	**X CIHQ** **X CDPH** **X CMS** ❑ **Other:**
Organizational: **X Clinical** **X Non-Clinical**	**X 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)

GL8610-140 Culture of Safety - Revised; took out references to the Joint commission, added CHPSO and fixed format. No other changes.

GL8610-148 Good Catch Program - Reviewed; no changes

PR8610-158 Patient Grievance and Complaint Policy - Revised; added Social Media section
Posts on social media websites like Facebook are not grievances as defined by CMS and are treated in the following manner.
• Public Relations will respond to complaints regarding patient care with contact information for our Risk Manager.
• Public Relations will respond to patient accounting and billing issues with contact information for our Director of Patient Financial Services.

QA8610-101 Patient Safety Evaluation System – New Policy

QS8610-105 Code Blue and Broselow Emergency Resuscitation Cart Maintenance - Revised; minor changes to reflect current practices

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	2/16/2016	Yes	
Surgery Committee	5/11/2016	Yes	Rescheduled from 5/04
Medicine Committee	5/12/2016	Yes	
P.I. or P. T. Committee	n/a		
Medical Executive Committee	5/19/2016	Yes	
Board Quality	6/22/2016		
Board of Directors	7/07/2016		

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SUBJECT: Patient Safety Evaluation System – New Policy	POLICY # QA8610-101
	PAGE 1 OF 3
DEPARTMENT: Organizational	EFFECTIVE: 4/16
APPROVED BY: Chief Quality Officer	REVIEW/REVISED:

PURPOSE:
The purpose of this policy is to describe and define the Sonoma Valley Hospital Patient Safety Evaluation System

POLICY:
The Sonoma Valley Hospital Patient Safety Evaluation System (PSES) shall serve as the interface for data collection and analysis between Sonoma Valley Hospital and its Patient Safety Organization, the California Hospital Patient Safety Organization (CHPSO).

Information created, or analysis generated within this patient safety evaluation system is deemed protected patient safety work product as long as 1) Sonoma Valley Hospital intends to submit the information and/or analyses to its Patient Safety Organization or 2) Sonoma Valley Hospital authorizes its Patient Safety Organization to access such information to process and analyze similar information transmitted to its Patient Safety Organization by Sonoma Valley Hospital Information removed from the patient safety evaluation system is not considered protected under the applicable privileges.

This patient safety evaluation system shall be used to reduce mortality and morbidity and to improve patient care and patient safety by the identification, analysis and reduction of risks within a legally protected environment.

DEFINITIONS:
The following terms have the meanings assigned under the federal regulations promulgated to implement the Patient Safety and Quality Improvement Act of 2005.

Patient Safety Organization (PSO) means a private or public entity or component thereof that is listed as a PSO by the Secretary of the United States Department of Health and Human Services

Patient Safety Evaluation System (PSES) means the collection, management, or analysis of information for reporting to or by a PSO.

Patient Safety Work Product (PSWP) means any data, reports, records, memoranda, analyses, such as root cause analyses and care reviews documentation or written or oral statements, or copies of any of this material, which could improve patient safety, health care quality, or health care outcomes; and

1. Which are assembled or developed by any Sonoma Valley Hospital employee, medical staff member, agent, student or house staff for reporting to CHPSO, which includes information that is documented as within a patient safety evaluation system for reporting

to a PSO and has not yet been sent to the PSO, and such documentation includes the date the information entered the PSES; or
2. Which are developed by a PSO for the conduct of patient safety activities; or
3. Which identify or constitute the deliberations or analysis or, or identify the fact of reporting pursuant to, a patient safety evaluation system.

Patient Safety Activities mean the following activities carried out by or on behalf of the PSO or any Sonoma Valley Hospital employee, medical staff member, agent, student or house staff:
1. Efforts to improve patient safety and the quality of health care deliver;
2. The collection and analysis of PSWP;
3. The development and dissemination of information with respect to improving patient safety, such as recommendations, protocols, or information regarding best practices;
4. The utilization of PSWP for the purposes of encouraging a culture of safety and of providing feedback and assistance to minimize patient risk effectively;
5. The maintenance of procedures to preserve confidentiality with respect to PSWP;
6. The provision of appropriate security measures with respect to PSWP;
7. The utilization of qualified staff; and
8. Activities related to the operation of the PSES and to the provision of feedback to participants in the PSES.

Midas Datavision is the data collection program used for reporting, reviewing and commenting upon events and is the main process for transmitting information from the patient safety evaluation system to the California Hospital Patient Safety Organization.

PROCEDURE:

Patient Safety Evaluation System

The Quality and Resource Management Department is responsible for the oversight of Sonoma Valley Hospital's PSES.

The Sonoma Valley Hospital patient safety evaluation system consists of individual and committee activities, data collection processes, reports, databases, analyses, discussions, systemic reviews, and regular, ad hoc and specially called meetings, whether recorded in writing or otherwise that constitute patient safety work product, including but not limited to those listed below.

- Safety Committee
- Medical Executive Committee
- Medical Staff Performance Improvement Committee

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SUBJECT: Patient Safety Evaluation System – New Policy	POLICY # QA8610-101
	PAGE 3 OF 3
DEPARTMENT: Organizational	EFFECTIVE: 4/16
APPROVED BY: Chief Quality Officer	REVIEW/REVISED:

The Chief Quality Officer and Risk Manager shall be responsible for the day to day administration of the technical aspects of the PSO activities.

- Confirming the information submitted to the PSES and providing quality oversight to the process for collecting, managing, analyzing, and submitting information to CHPSO;
- Communicating the intent and purpose of the PSES with Sonoma Valley Hospital employees, medical staff members, agents, students, and house staff;
- Providing guidance on the removal of material from the PSES;
- Receiving materials created by CHPSO and distributing as appropriate within the PSES;
- Using CHPSO as a resource and maintaining communication with CHPSO;
- Coordinating related training upon implementation of the PSO and on an ongoing basis; and
- Notifying CHPSO if any Sonoma Valley Hospital contact changes.

Removal of Patient Safety Work Product
Patient Safety Work Product may be removed from the PSES by The Chief Quality Officer or Risk Manager and no longer considered Patient Safety Work Product if:

1. The information has not yet been reported to CHPSO; and
2. The Chief Quality Officer or Risk Manager documents the act and date of removal of such information from CHPSO.

Disclosure of Patient Safety Work Product
Patient Safety Work Product is privileged and confidential and shall not be disclosed except as provided by the Patient Safety Act.

REFERENCE:
Patient Safety and Quality Improvement Act 2005

7.

QUALITY REPORT JUNE 2016

To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 06/22/16
Subject: Quality and Resource Management Report

June Priorities:

1. Plan of correction for the CDPH survey
2. PRIME Grant
3. Attendance at CIHQ Annual Regulatory and Accreditation Conference

1. *Plan of Correction for the CDPH survey*

The following table consists of the Plans of Correction for the cited deficiencies from our CDPH Licensing Survey in April. The plans were accepted by CDPH.

Deficiency	Action Plan	Monitoring	Responsible Leader
Lack of protective shielding when using mini-C Arm	1. Memo regarding immediate use of protective shielding with attestation by nursing and medical staff	1. Monitoring of 100% of procedures requiring the use of the mini C-Arm, for 2 weeks for compliance with protective shielding. 2. If above is 100%, then radon audits of 50% of all procedures For compliance. If 100% then retire	A. Sendaydiego
Use of the Scope Buddy did not follow Manufacturer's recommendations for storage between uses.	1. Revised policy to include manufacturer's recommendation for storage between uses. 2. Copy of the policy was provided to staff and re-education was completed with a signed attestation to the change in practice.	1. Direct observation audits to ensure compliance with storage procedure weekly for one month to ensure 100% compliance. 2. Random inspections to maintain 100% compliance monthly for three months. If 100% retire.	A. Sendaydiego

	3. Manufacturer rep will provide additional in-service at the June staff meeting to reinforce.		
Improper discarding of medication into sharps container rather than pharmaceutical waste.	1. Staff were provided with Pharmaceutical waste policy with re-education and a signed attestation was obtained. 2. Leaders of all nursing units will address the deficiency in their staff meeting and reinforce the proper procedure for the disposal of pharmaceutical waste.	1. Nursing leaders will conduct 30 direct observations of medication administration including the disposal of medications in the proper manner. The threshold is set for 95% over a period of three months. 2. Once compliance has been met, the nursing leaders will conduct 15 direct observations over 90 additional days to ensure compliance is at or above 95%. Then retire.	M. Kobe
Improper storage of IV fluid in warmer	1. Memo sent to staff to remind them that IV fluids in the warmer must retain their overwrap. 2. Re-education through review of policy with attestation to be followed by reinforcement at June staff meeting. 3. Post laminated reminder tool on all warmers in the OR and SCU.	1. Daily inspection by staff to ensure that overwrap remains intact while IV fluids are stored in the warmers. Audits will be completed weekly for one month until 100% compliance is reached. Random audits will be conducted for three month to insure compliance is hardwired.	A. Sendaydiego
Lack of appropriate labeling of expiration or end of use date on an IV compounded of Potassium Phosphate	1. Re-education of pharmacy staff as to proper method of labeling via memo with attestation of understanding.	1. Review of 100% of potassium phosphate compounded IVs to ensure that there is an expiration and end of use date on the label until 10 observations indicate 100% compliance.	C. Kutza
Found a Cervidil dose to be expired upon inspection.	1.Removed Cervidil from storage area. 2. Re-education of pharmacy staff as to	1. Weekly audits of storage to ensure that no expired product is present. Monitoring will be considered complete once 100% compliance is observed for 4	C. Kutza

	compliance with the statute via memo with attestation of understanding.	consecutive weeks.	
Found delinquent malpractice certificate of insurance during medical staff document review	1. Immediate request for malpractice certificate, obtained and filed. 2. Medical Staff Coordinator will run reports every three weeks to identify upcoming expirations and to obtain and file updates in a timely manner.	1. Every three week audits of all expirations dates for malpractice insurance will be completed. 100% of all certificates that are to expire will be obtained prior to the expiration date on the current certificate.	L. Lovejoy
Lack of compliance with 1. Handwashing post surgical glove removal 2. Disposal of surgical masks	1. Staff education was conducted by the Infection Control Practitioner on proper handwashing after proper removal of gloves in the May staff meeting. 2. Updated the current policy to include that surgical masks are changed after each surgery and that they are discarded after leaving the OR or the SCU. 3. Staff will be provided a copy of the revised policy and compliance documented through attestation. 4. All of the above will be reinforced at the June staff meeting.	1. Direct observation and audits using a question and answer format to test knowledge and learning will be conducted weekly for one month to ensure 100% compliance with policies and procedures regarding proper handwashing and disposal of gloves. Once 100% compliance has been reached, random audits will be conducted for another month to maintain improvement.	A. Sendaydiego
Lack of awareness of staff regarding the dwell and contact times of disinfectants used to kill bacteria and viruses.	1. Provided staff with a spreadsheet tool that addresses dwell/contact time for all disinfectants used in the OR. Reviewed in staff meeting.	1. Direct observation and audits using a question and answer format to test knowledge and learning will be conducted weekly for one month to ensure 100% compliance with policies and procedures regarding contact	A. Sendaydiego

		times for disinfectants. Once 100% compliance has been reached, random audits will be conducted for another month to maintain improvement.	
Motion activated paper towel dispensers were allowing paper towels to drape on counter or on sink.	1. Engineering adjusted the motion activated dispensers to prevent contact with surfaces.	1. Monitored by the regularly scheduled Safety Rounds in each unti for a period of one year to ensure that the setting has not been changed.	K. Drummond
Lack of CDPH notification of pre-planning phase of construction in lobby.	1. All plans at the time of of OSHPD permitting and completion of the ICRA will be communicated to CDPH prior to the start of any construction. The policy and procedure has been updated to reflect the early notification of CDPH. 2. The Facilities Director and the Chief Quality Officer will communicate monthly regarding anticipated projects, their status and a letter will be sent to CDPH notifying them of the project.	1. 100% audits of all construction projects to include notification of CDPH.	K. Drummond/L. Lovejoy
Failure to include a multidisciplinary approach for review of all medication errors: Pharmacy, Nursing Medical Staff and Quality.	1. Updated the Midas medication error system to require the incorporation of a documented analysis of all medication errors by a pharmacist, nurse, administrator, and physician before completion of the report.	1. Medication error reports will be monitored on a weekly basis until analysis by the four disciplines achieves 100% for 12 consecutive weeks.	C. Kutza

2. *Prime Grant Completion and Final Decision*

The State Department of Health Services reviewed and approved our PRIME grant that will focus on a five year project to improve care transitions from the acute setting to the community and

from the ED visit into the community. I have attached a power point that outlines the project goals and the metrics required to ensure success.

3. *CIHQ Annual Regulatory and Accreditation Conference*

I attended this annual conference the first full week in June. It was very comprehensive. Topics for further exploration and improvement as we move to our triennial survey the first half of 2017 include: compounding of medications in pharmacy; changes to alcohol gel dispenser sizes due to new ADA guidelines; new life safety regulations; the addition of prevalence audits; and changes in the radiology department and nuclear medicine standards.

Topic for discussion this meeting:

- Hospitalist Services Presentation: Drs Cohen & Verducci
- Patient Care Services Report: Mark Kobe
- Prime Grant

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PRIME GRANT: IMPROVING CARE TRANSITIONS

HISTORICAL CONTEXT

- Prior to Affordable Care Act; hospitals were not accountable for the health and well-being of patients upon discharge from the Acute side or the Emergency side of patient care.

- With the ACA came the idea that hospital quality includes post discharge outcomes and the first measure of quality was the number of patients that came back and were readmitted within 30 days.

HISTORICAL CONTEXT

- With the emergence of the population health movement and the push to reduce hospital stays and utilization in general, hospitals can not longer afford to take the short view of patient care.

- The future of healthcare involves both the provision of care in the hospital but also the coordination of care once the patient leaves our setting.

HISTORICAL CONTEXT

- Hospitals become stewards of the life long journey of health and well-being for their community members and through innovation and collaboration, become partially responsible for the health of the community they serve.
- Since this is a new concept hospitals are receiving funding, through grants for innovative ways to make the transition to population health as a strategic goal.

WHAT IS THE PRIME GRANT?

- Funded by CMS and administered by CDPH; grants to tertiary care, county and district hospitals to fund innovation and evidence based strategies for healthcare delivery.
- Funded over 5 years to transform an aspect of care delivery.
- Focus of SVH grant: Improving Care Transitions
- Expectation: transform healthcare through innovation, must be stretch

DUAL FOCUS

- Inpatient to next provider: managing patients for at least 30 days to reduce the likelihood of readmissions
- ED patient to next provider: manage at risk patients with the primary care provider to reduce ED utilization

WHY CARE TRANSITIONS?

- Opportunity to improve:

1. Handoffs between providers;

2. Manage transition over a 45 day period post hospitalization;

3. Improve medication reconciliation on admission, at discharge and within 30 days post discharge;

WHY CARE TRANSITIONS?

- Opportunity to:

4. Develop a community health coaching role;

5. Improve the patient experience during transitions of care; and

6. Build network of community support agencies.

GRANT POPULATION?

- Medi-Cal patients are primary, ages 18-65+
- Will also include Medicare patients as our census is low and it makes sense
- Departments: IP, ED, Skilled Nursing and Healing at Home

HOW?

- Multidisciplinary Steering Committee for oversight

Current Members: Drs Robert Cohen & Ellen Barnett, Chris Kutza, Steven Lewis, Allison Evanson, Peggy Zuniga, Barbara Lee, Alison Kelly (Community Health Coach); Kathryn Crouch ad hoc (Ceres Project)

Needed: SVH Community Case Manager, community member, SCCHC rep, La Luz rep and sub committee project participants. Meritage ad hoc?.

WHAT ARE WE GOING TO DO?

- Revise and improve the discharge process:

1. Improve med rec and discharge instructions

2. Provide a transfer record to patient and next provider at time of discharge

3. Follow up phone calls within 48 hours of discharge to review discharge instructions, confirm med pick up and prepare for follow up appointment with PCP.

WHAT ARE WE GOING TO DO?

- 4. Follow up phone calls and/or home visit by Community Health Coach and/or CM/Social Worker every 7 days through 45 days post discharge with interface to PCP as needed.

- 5. Build a cadre of volunteer Community Health Coaches. Collaborate with colleges, schools and community organizations to develop roles, map workflows, develop core competencies and training.

HOW DO WE MEASURE SUCCESS?

- Initially by achieving infrastructure goals that are due to be completed and implemented by June 30, 2017

Infrastructure goals:

Expand Case Management Into ED/Community

Build Midas Community Case Management module for tracking and data management

Build ability to track and document medication reconciliation within 30 days of discharge

Build transitional record with all elements

Integration of Community Health Coaches into program

HOW DO WE MEASURE SUCCESS?

- Pay For Performance begins last half of 2017

Metrics:

Medication Reconciliation and completed discharge instructions at time of discharge;

Medication reconciliation within 30 days of discharge;

Patient leaves with a transition record and the transition record is provided to the PCP;

HOW DO WE MEASURE SUCCESS?

Performance on the three Care Transitions questions from HCAHPS;

30 day all cause readmission rate; and

ED Utilization Rate.

The metrics above are all defined by the grant. We may want to add some metrics for our own program performance improvement as continuous improvement is a big piece of this project.

FUNDING

- Grant money is allocated in the following manner and is dependent on completion of project reports for the first year and a half and then on pay for performance metric reporting.
  - Year 1: 1,500,000.00
  - Year 2: 1,500,000.00
  - Year 3: 1,500,000.00
  - Year 4: 1,350,000.00
  - Year 5: 1,147,500.00
    - *Total: 6,997, 500.00*