SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE REGULAR MEETING
AGENDA
WEDNESDAY, August 26, 2015
5:00 p.m. Regular Session
(Closed Session will be held upon adjournment of the Regular Session)

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

AGENDA ITEM	RECOMMENDATION	
MISSION STATEMENT The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.		
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
2. PUBLIC COMMENT SECTION At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less, Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.	*Hirsch*	
3. CONSENT CALENDAR • QC Minutes, 7.22.15	*Hirsch*	Action
4. SURGICAL SERVICES TRANSFORMATION PROJECT	*Sendaydiego*	Inform/Action
5. POLICY, PROCEDURE & ORDER SET ▪ Medical Management MM8610-154 and 155 ▪ Critical Values and Critical Tests • Order Set Alcohol Withdrawal	*Lovejoy*	Action
6. QUALITY REPORT AUGUST 2015	*Lovejoy*	Inform/Action
7. CLOSING COMMENTS/ANNOUNCEMENTS	*Hirsch*	
8. ADJOURN	*Hirsch*	
9. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*	
10. CLOSED SESSION: Calif. Health & Safety Code § 32155 • Medical Staff Credentialing & Peer Review Report • Board Quality Dashboard	*Chamberlin*	Action
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
12. ADJOURN	*Hirsch*	

3.

CONSENT CALENDAR

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
Wednesday, July 22, 2015
Schantz Conference Room

Committee Members Present	Committee Members Present cont.	Committee Members Excused	Admin Staff /Other
Jane Hirsch Carol Snyder H. Eisenstark Susan Idell Joshua Rymer M. Mainardi	Keith Chamberlin, MD, MBA Kelsey Woodward Ingrid Sheets	Cathy Webber	Robert Cohen MD Leslie Lovejoy Mark Kobe Kathy Mathews Gigi Betta

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*		
	The meeting was called to order at 5:00pm		
2. PUBLIC COMMENT	*Hirsch*		
3. CONSENT CALENDAR	*Hirsch*	Action	
• QC Minutes, 6.24.15		**MOTION** by Eisenstark to approve and 2nd by Rymer. All in favor.	
4. POPULATION HEALTH STRATEGY PRESENTATION	*Mather*	Inform	
	Ms. Mather gave an overview of Population Health, a plan offering screenings, health education, counseling and targeted coaching. The population is segmented into three major groups: kids under 18, asymptomatic adults and symptomatic adults. This health improvement strategy is based on the "5 Keys to Wellness" and overall success of the plan is measured by the number of screenings, pre/post knowledge and/or return		

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
	demonstration after education, and whether or not coaching/counseling patients meet/make improvement toward their health goals.		
5. QUARTERLY PATIENT CARE SERVICES DASHBOARD	*Kobe*	Inform/Action	
	Mr. Kobe presented the newly revised and ***nursing specific*** patient care services dashboard for 2015.		
6. POLICY AND PROCEDURE	*Lovejoy*	Action	.
• Ebola Viral Disease Policy_IC8610-145 • NEW Dietician Nourishments Modification_8340-173 • Universal Protocol_PC8610-125 • Counts, Sponges, Sharps, Instruments_PC7420-119	There was one correction to the Universal Protocol Policy and then it was approved *as amended* with all in favor.	**MOTION** by Rymer to approve policies *as amended* and 2nd by Idell. All in favor.	
7. QUALITY REPORT JULY 2015	*Lovejoy*	Inform/Action	
	July 2015 priorities include CIHQ Mid-Cycle Survey and Quality E Measure. Ms. Lovejoy reminded the Committee about the upcoming Annual Performance Improvement Fair and asked for volunteer judges. Ms. Woodward and Ms. Sheets volunteered to be judges at the event. The Surgical Services Action plan will be covered at the next Quality Committee. The Risk Management Program develops implements, improves and maintains the processes for making decisions that minimize adverse effects of potential losses to the Hospital in three areas of risk: business, regulatory and clinical. The governing body delegates responsibility to the CEO, Senior Leadership and the Medical Executive Committee.	**MOTION** by Rymer to approve Quality Report and 2nd by Idell. All in favor.	
8. CLOSING COMMENTS	*Hirsch*		
			.
9. ADJOURN	*Hirsch*		
	Regular Session adjourned at 6:15 pm		

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
10. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*		
11. CLOSED SESSION	*Chamberlin*	Action	
Calif. Health & Safety Code § 32155 • Medical Staff Credentialing & Peer Review Report • Revised Medical Staff Bylaws Rules & Regulations	The Committee asked for two corrections to the credentialing report. Ms. Lovejoy will pass these changes to the Ms. Iredale, MSO Coordinator. The Credentialing Report was approved *as amended* and all were in favor.	**MOTION** by Hirsch to approve Credentialing *as amended* and 2nd by Sheets. All in favor. **MOTION** by Rymer to approve changes to Bylaw Rules and Regulations and 2nd by Sheets. All in favor.	
12. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action	
13. ADJOURN	*Hirsch* Closed Session adjourned at 6:25 pm		

4.

SURGICAL SERVICES TRANSFORMATION PROJECT UPDATE

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SURGICAL SERVICES TRANSFORMATION PROJECT

Project Update

New Page 7

PROJECT OUTLINE

- Purpose:

  1. To develop a model for defining the future of this department.

  2. To standardize, right size and streamline surgical department services.

- Goal: Reduce operational expenses from 7 million annually to at or below 5.5 million in FY 2015.

  Total Expenses for Perioperative Services roll-up is $5,383,433.00.

- Team: Surgeons, Anesthesiologists, Surgical Services Leadership and staff

PROJECT OUTLINE

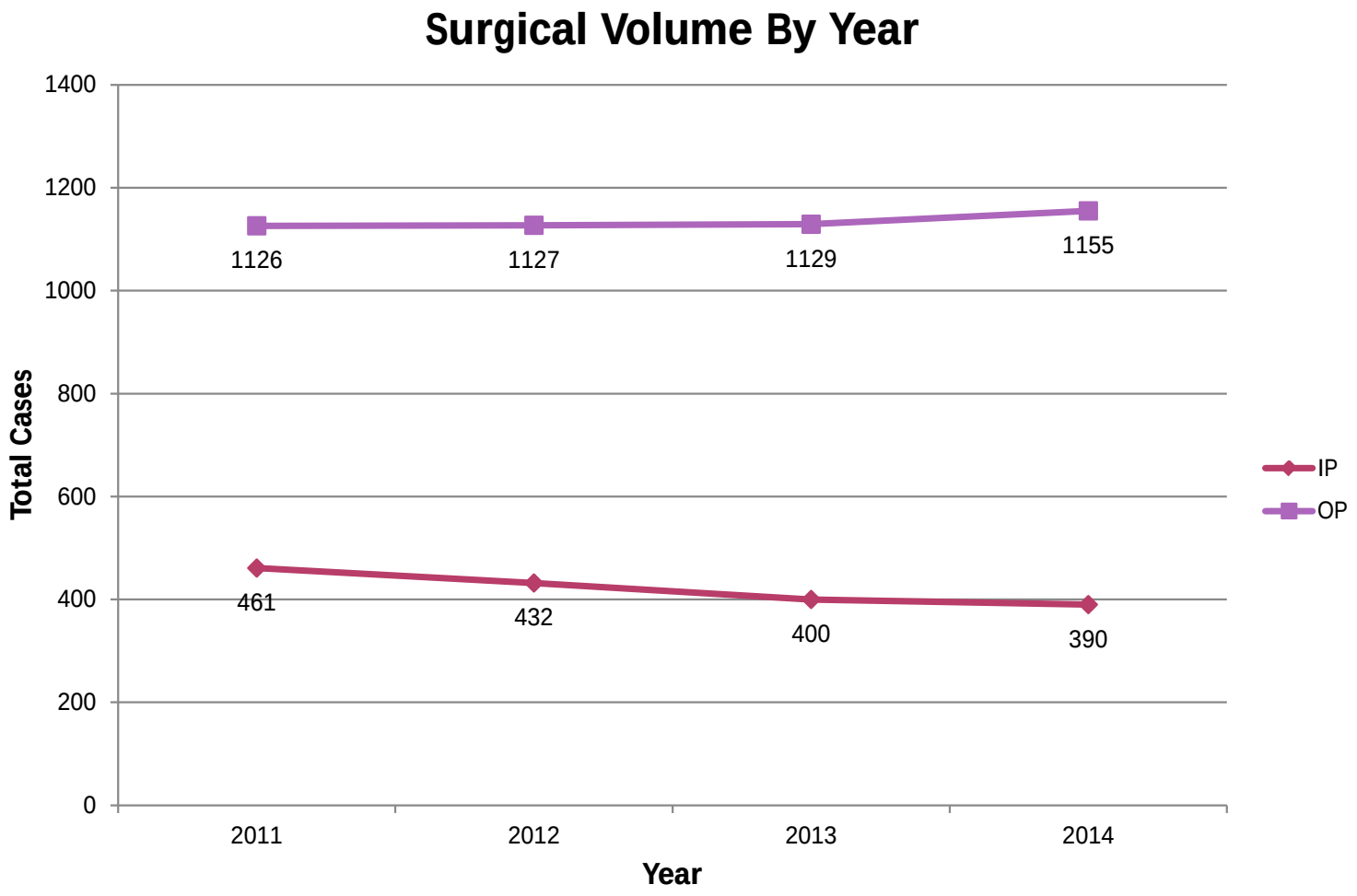
- Executive Champions: CMO & CNO/CQO
- Interventions will be based on:
  1. Kurt Salmon Consulting Recommendations
  2. Best Practices in the Literature
  3. Best Practice Hospital visits
  4. Cost Accounting Data and Historical Trends.
  5. Accreditation and Mid Cycle Surveys

WHO ARE WE?

- Develop a business model that includes the efficiencies that are present in an ambulatory surgery center

- Challenges: we can't be a free standing ambulatory surgery center as we provide services for emergent and elective inpatient surgical care. Our volumes indicate that we are more ambulatory than inpatient at this time and the trend will continue into the future.

HISTORICAL VOLUMES



STANDARDIZE, RIGHT SIZE AND STREAMLINE

Current State of Operations: what's working

- Smooth Transition to the new wing

  More efficient and promotes healing

- Integration of ACU & PACU

  Patient transition from pre-op, intra-op, and post-op phases of surgery is smoother and more conducive to better practice and best patient care.

- New Accountable Leadership

  Building a culture that promotes patient safety.

STRATEGIES

- Renegotiate total joint implant contracts with cost savings

  Attained Tier 2 Depuy pricing by exceeding implant usage of $400,000.00. This equates to 9% discount off list price. Tier 2 pricing has been extended for this fiscal year.

- Supply costs by procedure and surgeon data was shared with surgeons to increase awareness of their costs.

  Completed. Meetings with Chief Revenue Officer scheduled to understand margins.

STRATEGIES

- Surgery Department par levels and bar coded inventory structure developed and implemented.
- Put into place a process to manage expirables and rotate stock.

  Management of inventory par levels have been divided and delegated to the OR Staff. A case planning meeting is held on a weekly basis to ensure we have sufficient par levels for upcoming cases.

- Changes were made to ensure the charge master is managed accurately and efficiently.

  The Surgery Buyer and Director of Surgery are now responsible for finalizing charges and checking accurate clinical documentations for all prior day cases.

ACTIONS TAKEN

- A. Anesthesia, Surgeons & the Leadership Team developed a process to manage the surgery schedule to improve efficiencies that addressed:

  1. Efficient use of OR suites.
  2. Standardizing the decision making process regarding when to staff another OR.
  3. Developing a triage system that clearly defines parameters for after hour and add on cases & monitor.

ACTIONS TAKEN

B. Improved Productivity through efficient scheduling of cases.

Cases are Consolidated and Verticalized as much as possible. OR Staff are "flexed off" or sent home early when there are no cases. As a result, our Productivity Index for Perioperative Services are as follows: ACU = 116%; Anesthesia = 110%; Central Sterile = 116%; PACU = 122%; Endoscopy = 117%; Surgery = 102%. So our productivity index roll-up is 114% for FY2015.

C. Anesthesiology and Leadership Team standardized the recovery process for ambulatory surgeries.

ACTIONS TAKEN

D. Fully operate Monday through Thursday; emergent cases on Fridays only. Integrate current Friday blocks into rest of week.

Friday Surgeon block days have been consolidated to Mondays to Thursdays. Fridays are then used to accommodate add-on and urgent cases. OR staff are flexed off when there are no cases. Changed Anesthesia coverage from 2/3/3/3/2 to 2/3/3/3/1.

ACTIONS TAKEN

F. Develop and implement a more efficient ambulatory pre-admission process; streamline paperwork, testing and patient education.

Organized a team consisting of Scheduling Coordinator, Nurse Navigator, OR Clinical Coordinator, Pre-op Nurse, Admitting Insurance specialist, and Surgery director. The team Revised and standardize our outdated OR Scheduling Form, Patient Instructions, and questionnaires.

2. Reduce burden of paperwork and documentation for pre-op & SCU nurses.

Went to a paper ambulatory surgery record.

ACTION TAKEN

3. Consider clerical support for pre-op and reducing RN Navigator time to RN functions.

Moved pre-op nurses into case management & added clerical support.

ACTIONS TAKEN

G. Physicians will know their costs and margins and work with the Leadership Team to improve margins and implement changes as appropriate and based on best practices.

Every new implants/devices used in a surgical procedure has to go through an approval process. A quote is requested from the vendor then run through a reimbursement analysis – taking into account the patient's insurance reimbursement, implant cost, OR operating cost and other factors.

CONCLUSION

- Questions?

5.

POLICY & PROCEDURE

Note: signed signature pages will be distributed at the meeting

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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: Medical Management Policies MM8610-152, MM8610-154, MM8610-155	
APPROVED BY **Director of Pharmacy**	DATE: **7/08/15**
Director's/Manager's Signature	Printed Name: **Chris Kutza**

Leslie Lovejoy, RN, PhD
Chief Quality Officer, CQO
Date

Brian Sebastian, MD
Chair, P.I. & P.T. Committee
Date

Keith J. Chamberlin, MD
President of Medical Staff
Date

Kelly Mather
Chief Executive Officer
Date

Sharon Nevins
Chair, Board of Directors
Date

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Policy Submission Summary Sheet

Title of Document: **Organizational Policies-Medical Management**

New Document or Revision written by: **Chris Kutza, Director of Pharmacy**

Date of Document: **7-08-2015**

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

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

MM8610-151 Parenteral Nutrition Protocol—Reviewed & Updated order form and consolidated ordering protocol and monitoring guidelines into one policy

MM8610-152 DVT-PE Prophylaxis and Treatment Protocol—Reviewed & Updated; Changed platelet monitoring to day 2, 7, and weekly x2

MM8610-154 Patient Controlled Analgesia (PCA)—Reviewed & Updated; Removed Meperidine PCA from dosing chart

MM8610-155 Pharmaceutical Waste Management—NEW policy

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	n/a	—	
Surgery Committee	n/a	—	
Medicine Committee	n/a	—	
P.I. or P. T. Committee	**7/23/2015**	Yes	
Medical Executive Committee	**8/20/2015**		
Board Quality	**8/26/2015**		
Board of Directors	**9/03/2015**		

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SUBJECT: Pharmaceutical Waste Management	POLICY #MM8610-155
	PAGE 1 OF 6
DEPARTMENT: Organizational	EFFECTIVE: 7/15
APPROVED BY: Director of Pharmacy	REVIEW/REVISED:

Purpose:
To provide a systematic approach to identify, manage and properly dispose of all regulated hazardous and non-hazardous pharmaceutical waste.

Policy:
It is the policy of Sonoma Valley Hospital to manage its Resource Conservation and Recovery Act's (RCRA) regulated hazardous and non-hazardous pharmaceutical waste in accordance with local, state, and federal laws.

Definitions:
Pharmaceutical Waste: Prescription medications, chemotherapy agents, controlled substances, or over the counter items that are either expired, damaged, or otherwise not usable for their intended purpose. This includes medications taken to (or from) the patients' bedside and not fully consumed such as, pills that fall on the floor and are not administered, the removal of used medication patches and any other circumstance that causes a pharmaceutical to be unusable. Pharmaceutical waste sources include but are not limited to:

- Outdated or expired medications (that cannot be processed by a reverse distributor).
- Patients' personal medication supplies (prescription or over the counter).
- Containers used in IV preparation and/or administration (i.e., syringes, IV bags, IV tubing, vials, ampules).
- Spilled or broken products no longer useable for intended purpose.
- Any item used in cleaning up a spill is treated as a waste pharmaceutical, either hazardous or non-hazardous.

Non-Hazardous Waste: All pharmaceutical waste that is not hazardous.

Hazardous Waste: A product is categorized as hazardous waste if it is listed as hazardous waste in the Code of Federal Regulations 40 CFR Part 261. http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=/ecfrbrowse/Title40/40cfr261_main_02.tpl

Listed Pharmaceutical Hazardous Waste:
There are three types of listed pharmaceutical hazardous wastes.

- *P-Listed Pharmaceutical Waste* – These wastes are known as acutely toxic. A primary criterion for including a drug on the P-List is an oral lethal dose of 50mg/kg or less.
    - Note: The EPA has excluded epinephrine salts and weak medicinal nitroglycerin.

- *U-Listed Pharmaceutical Waste* – These wastes are known as toxic. These include chemotherapy agents, such as chlorambucil, cyclophosphamide, daunomycin, diethylstilbestrol, melphalan, mitomycin C, phenol, streptozocin and uracil mustard.
- *D-Listed Characteristic Hazardous Waste* – This solid waste exhibits any of the properties included in the definitions below.
  - *Ignitable* – Ignitable waste are easily combustible or flammable, if they have a flash point of 140 °F or less, or an alcohol content of 24% or more they are hazardous waste.
  - *Corrosivity* – Corrosive wastes corrode metals or other materials or burn the skin. These liquids have a pH of 2 or lower or 12.5 or higher
  - *Reactive* – Reactive wastes are unstable and may explode or react rapidly or violently with water of other materials
  - *Toxic* – Wastes are toxic if they contain toxic organic chemicals or certain heavy metals, such as chromium, lead, mercury, or cadmium.

Trace Hazardous Waste: Trace hazardous waste includes containers and other preparation and administration devices that are empty (i.e., empty vials, empty syringes, drained tubing, and empty IV bags etc).

- Per *federal* rules, a container is considered RCRA empty (i.e. non-hazardous pharmaceutical waste) when no more than 3% by weight of the total capacity of the container remains in the container.
- ***In California RCRA empty vials and containers are treated as hazardous waste unless the meet the following standards:***
  - **Containers That Held Pourable Materials:** For containers that held a material that can be readily poured, all material must be removed by any practicable means (including draining, pouring, pumping or aspirating) before the container can be considered empty. In regards to draining, a container is empty when there is no longer a continuous stream of material coming from the opening when the container is held in any orientation (see the first question in the list of commonly asked questions at the end of this document).
  - **Containers Holding Non-Pourable Materials:** For containers that previously held materials that are non-pourable, no hazardous material shall remain in the container that can feasibly be removed by physical methods, including scraping and chipping, but not rinsing. This standard applies to materials that pour slowly or don't pour at all from the container, including, but not limited to, viscous materials, solids which have "caked up" inside the container, and non-pourable sludges.
  - **Containers Holding Acute or Extremely Hazardous Waste:** Containers which previously held acute or extremely hazardous waste are considered empty only if the container has been triple-rinsed using a solvent capable of removing the material, or

cleaning by another method which is proven to achieve equivalent removal to triple-rinsing. These activities may require formal authorization (permitting) by DTSC or the CUPA. This standard is similar to the federal standard.

Dual Waste: This is the combination waste that is both infectious Regulated Medical Waste (RMW) and hazardous waste. Hazardous waste pharmaceuticals mixed with blood or bodily fluids.

Procedure:

Pharmaceutical Waste Management

- Sonoma Valley Hospital maintains a Pharmaceutical Waste Management Plan to include:
  - A reverse distributor that is contracted to manage the disposal of outdated/unusable pharmaceuticals.
  - Partially used pharmaceuticals discarded by the facility are evaluated for hazardous waste status.
  - Hazardous waste disposal is contracted to a hazardous waste disposal transporter permitted and insured to transport and manage hazardous waste.
  - Hazardous waste is not discarded to a drain that is connected to a publicly owned water treatment facility without written permission.
  - Hazardous waste is not mixed with biomedical waste disposal.
  - Hazardous waste is not combined with non-hazardous waste.
  - The pharmacy will identify drugs and communicate to appropriate staff proper disposal. Examples include labeling and clinical alerts in the automated dispensing units.
- Expired medications will be sent out through the designated reverse distributor as returnable medication.
- Sonoma Valley Hospital will manage pharmaceutical waste and hazardous waste by disposing waste in designated color coded containers.

Wasting Pharmaceuticals in the Patient Care Areas (Non–Hazardous Waste)

- Expired or otherwise unusable intact medications found within the facility are returned to pharmacy for disposition.
- Non-hazardous pharmaceuticals that are no longer contained in the original container, are partially used, dropped, or contaminated, refused by the patient etc. will be wasted as close to the point of origin as possible.

- Wasting will render the product unusable and irretrievable.
- When applicable, waste must be documented as per hospital policy.

Non-Hazardous Pharmaceutical Waste

- These items should be segregated and incinerated at either a regulated medical waste (RMW) incinerator or a municipal incinerator permitted to accept non-hazardous pharmaceutical waste.

Hazardous Pharmaceutical Waste

- When a drug waste contains P-listed or U-listed ingredients it must be managed as hazardous waste if the following two conditions are satisfied:
  - The discarded drug waste contains a sole active ingredient that appears on the P or U List **AND**
  - It has not been used for its intended purpose, i.e., it has not been given to the patient or a portion of the drug is left and needs to be discarded.
- P- Listed and U-Listed drugs and drug containers are managed as RCRA regulated hazardous waste regardless of whether or not all the contents have been removed.
- D Listed chemicals and containers are handled the same as U -Listed waste.

Dual Waste or Mixed Waste

When a P- or U- listed waste is remaining in bloody tubing, syringes, or needles, this is considered "mixed waste" as it contains both bio-hazardous (infectious) medical waste and RCRA hazardous waste.

- If the sharps can be safely removed from the tubing or syringes they can be placed in the sharps container.
  - The remaining non-sharps can then be disposed of as hazardous waste.
- If the bag, tubing, syringes, and needles containing medical waste (blood, etc.) cannot be safely separated then they must be disposed of as hazardous waste.

Trace Hazardous Waste

- RCRA does not differentiate between trace waste for P and U-listed waste.
- At Sonoma Valley Hospital paraphernalia (empty vials, empty syringes, drained tubing, and empty IV bags) used in the preparation or administration of drugs considered as hazardous waste should be managed as hazardous waste unless it meets the California standards listed under "definitions" above.

- Gloves, gowns, wipes and other paraphernalia associated with routine handling, preparation, and administering of medications considered hazardous waste may be disposed of as non-hazardous waste (i.e. garbage).

Bulk Chemotherapy Waste
Bulk chemotherapy waste is managed as RCRA regulated hazardous waste.

Waste Stream Color Coded Containers:

- Appendix A lists the waste containers carried at Sonoma Valley Hospital and what items are to be disposed of in each one.
- RCRA Hazardous waste of all categories will be disposed of in the **BLACK** waste containers.
- Non-hazardous pharmaceutical waste will be disposed of in the **PURPLE-TOP** waste containers.

Reference:

- U.S. Environmental Protection Agency (EPA) http://www.epa.gov/ Accessed May 2013
- RCRA On-line, http://www.epa.gov/epawaste/inforesources/online/index.htm Accessed May 2013
- RCRA Orientation Manual 2011 http://www.epa.gov/epawaste/inforesources/pubs/orientat/index.htm Accessed May 2013
- ASHP *Managing Pharmaceutical Waste: A Discussion Guide for Health-System Pharmacists* http://www.ashpadvantage.com/docs/PharmaWaste-Discussion-Guide.pdf Accessed May 2013
- HERC Pollution Prevention and Compliance Assistance Information for the Healthcare Industry http://www.hercenter.org/hazmat/hazdeterm.cfm Accessed May 2013
- Managing Pharmaceutical Waste: A 10-Step Blueprint for Health Care Facilities In the United States, http://www.premierinc.com/quality-safety/tools-services/safety/topics/pharma-waste/downloads/h2e-pharma-blueprint-04-15-06.pdf
- NIOSH List of Antineoplastics and Other Hazardous Drugs in Healthcare Settings 2012 http://www.cdc.gov/niosh/docs/2012-150/pdfs/2012-150.pdf Accessed May 2013
- State of California Department of Toxic Substances Control http://ehs.ucr.edu/waste/DTSC_Empty%20Containers%20Fact%20Sheet.pdf Accessed June 2015

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SUBJECT: Pharmaceutical Waste Management	POLICY #MM8610-155
	PAGE 6 OF 6
DEPARTMENT: Organizational	EFFECTIVE: 7/15
APPROVED BY: Director of Pharmacy	REVIEW/REVISED:

Appendix:

Appendix A: SVH Medication Waste Disposal Guide

SVH MEDICATION WASTE DISPOSAL

Requirements	RCRA Waste * 	RCRA Waste 	Pharmaceutical Waste 	Needles/Sharps 	Regular Garbage 
Color/ Container Description	**Black Container (Black Dot Medications)**	**Black Container (continued)**	**Blue & White Container**	**White Container**	**White Garbage Container**
What can go in the container?	**RCRA Waste** • Hazardous RCRA waste of a sufficient quantity that can be poured or will flow out of the container • Hazardous RCRA waste generated by cleaning up a spill • Hazardous RCRA waste contained as partial or full vial, ampule or syringe • **RCRA List** • Albuterol MDI- Any MDI or Spray with a Propellant • Alcohol (Isopropyl or Ethyl) liquid only • Ammonia inhalants • Anastrozole (Arimidex) • Barium Sulfate • Benzocaine spray (Hurricaine/Dermoplast) - Any Spray with a Propellant • Bicalutamide (Casodex) • Estrogen (Premarin/Estrace) • Formalin solution • Hydroxyurea (Hydrea) • Iodine-Potassium Iodide (Lugol's Solution) • Insulin (all kinds)	**RCRA List Continued** • medroxyPROGESTERone (Provera/Depo-Provera) • Megestrol (Megace) • Methotrexate • Mitomycin (Mitosol) • Nicotine (Gum/Patch)-Both medication and packaging • Nitroglycerin (Patch, Tablets, Ointment) • Selenium Sulfide (Selsun) • Silver Nitrate Applicators • Silver Sulfadiazine (Silvadene) • Sodium Hypochlorite (Dakin's Solution) • Tamoxifen (Novaldex) • Tincture of Benzoin Compound • Warfarin (Coumadin)-Both medication and packaging (Open liquid or leaking containers should be bagged)	**Non-RCRA Meds** • All used or partially used medications • Vials and ampules-empty and those with residual medication • Needless syringes and oral syringes with residual medication • IV bags and tubing that contains residual medication • No Needles! Use Sharps Container (Open liquid or leaking containers should be bagged)	**Needles/Sharps** • Needles • Needles with blood • Empty syringes • Lancets • Disposable blades and scalpels • Pipettes • Broken glass • Razors • Staples • Pins	**Regular Trash** • Only IV bags with Nacl, dextrose, vitamins, and electrolytes can be poured down the drain and empty bag can be disposed of in the regular garbage. No Exceptions • Non-RCRA pharmaceutical packaging and empty dosing cups (Open liquid or leaking containers should be bagged)

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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: Critical Values & Critical Tests (No #)	
APPROVED BY:	DATE: **6/17/15**
Director's/Manager's Signature	Printed Name **Leslie Lovejoy, RN PhD**

Douglas S Campbell, MD
Chair Medicine Committee
Date

Michael Brown, MD
Chair Surgery Committee
Date

D. Paul Amara, MD
President of Medical Staff
Date

Kelly Mather
Chief Executive Officer
Date

Sharon Nevins
Chair, Board of Directors
Date

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Policy Submission Summary Sheet

Title of Document: **Critical Values & Critical Tests Chart**

New Document or Revision written by: **Dr Kretzschmar**

Date of Document: **6-17-15**

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

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

Critical Values & Critical Tests Chart-Laboratory critical test and values chart updated; Dr Kretzschmar to present to committees

Reviewed by:	Date	Approved (Y/N)	Comment
Dr Kretzschmar	6/08/2015 ✓	Yes	
Surgery Committee	7/01/2015	No	
Medicine Committee	7/09/2015	Yes	
P.I. or P.T. Committee	n/a		
Surgery Committee	8/05/2015 ✓	YES	
Medical Executive Committee	8/20/2015		
Board Quality	8/26/2015		
Board of Directors	9/03/2015		

SONOMA VALLEY HOSPITAL
CRITICAL LABORATORY VALUES

Test	Critical value		Units	Special Instructions
HEMATOLOGY				
WBC	<2,000	>30,000	x 10^3/µL	**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/µL	**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	
TROPONIN		>0.035	ng/dL	
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		>10	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**

Previous copy before 2014; values in RED are updated on revision copy

SONOMA VALLEY HOSPITAL LABORATORY

Sonoma Valley Health Care District

Critical Values & Critical Tests Requiring Physician Notification

CRITICAL VALUES:

CHEMISTRY

• Sodium	≤120 meq/lL (pre-op 124)	≥155 meq/L
• Potassium	<3.0 meq/lL (pre-op 3.2)	>5.5 meq/L
• Glucose	<50 mg/dL	>500 mg/dL
• Calcium		>12.0 mg/dL
• Creatinine		>4.9 mg/Dl
• Bilirubin, Serum (Pediatric patients)		>16.0 mg/dL
• Troponin		>0.40 ng/mL
• CK-MB		>7.0 ng/mL and >5.5%
• Digoxin		>2.5 ng/mL
• Dilantin		>20 ug/mL
• Phenobarbital		>40 ug/mL

ANTIBIOTIC LEVELS CALLED TO PHARMACIST (REPORTED BY PHARMACY)

• Vancomycin Peak	>40 ug/mL
• Vancomycin Trough	>10 ug/mL
• Gentamicin Peak	>10 ug/mL
• Gentamicin Trough	>2ug/mL

BLOOD GAS (REPORTED BY CARDIOPULMONARY)

• PCO2	<20 mm/Hg	>80 mm/Hg
• PH	<7.20	>7.60
• PO2	<50 mm/Hg	

HEMATOLOGY

• WBC	<2,000 x 10^9/L	>20,000 x 10^9/L
• Hemoglobin	<8.0 g/dL	
• Hematocrit	<24%	
• Eosinophils		>20%
• Platelets	<50,000 x 10^9/L	

COAGULATION

• Prothrombin Time	non-anticoagulated patient	>38.7 sec
	INR	>4.0
• PTT	non-anticoagulated patient	>68 sec
	therapeutic	>101 sec
• Anti-Xa	Heparin therapy	>1.00 IU/ML

ANTI-Xa CALLED TO A PHARMACIST (REPORTED BY PHARMACY)

MICROBIOLOGY

- Positive joint fluid cultures
- Positive blood cultures
- Positive CSF gram stains and cultures
- Group B Strep on Labor & Delivery patients
- Significant or unusual organisms (*Salmonella, Shigella*, MRSA, VRE)

BLOOD BANK

- Atypical antibodies
- Transfusion reaction results

ANY SIGNIFICANT ABNORMAL PRE-0P RESULTS WILL BE CALLED TO THE SURGEON

CRITICAL TESTS:

Requiring Immediate Response & Physician Notification

Critical tests are defined as tests which are **always** the first priority in lab testing. Reporting to the physician or nursing unit will follow the Critical Value Reporting policy. Blood Gas results will be given to Cardiopulmonary to communicate to the nursing unit or physician.

- Frozen Sections
- Transfusion Reaction
- CSF—Chemistry, Count and Gram Stain
- Blood Gas
- First STAT Troponin ordered from ER

modifies policy of 02/02
modifies policy of 07/03
MODIFIES POLICY OF 2005
Modifies policy of 4/07
Modifies policy of 11/2007
Modifies policy of 12/2007
Modifies policy of 2/2008
Modifies policy of 03/2009, 04/2008
Modifies policy of 5/2009
Modifies policy of 12/2009

Lois Valenzuela, CLS, Laboratory Manager

Paul Wasserstein, MD, Laboratory Director

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

ORDER SET Summary Sheet

Title of Document: **Alcohol Withdrawal**

New Document or Revision written by: **Mark Kobe , CNO**

Date of Document: **July 23, 2015**

Type:	**Regulatory:**
X Revision **❑ New Policy**	**X CIHQ** **x CDPH** **x CMS**
X Organizational: ICU/Med Surg **❑ Clinical** **❑ Non-Clinical**	**❑ Departmental** **❑ Interdepartmental** (list departments effected)

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

The following Organizational Order Set has been revised:

ALCOHOL WITHDRAWAL ORDER SET:

1. Addition of optional order to service 4-8 ounces wine or beer with lunch and dinner
2. Lowered threshold on Severity Assessment Score to admit patient to ICU from Med/Surg
3. Lowered threshold on Severity Assessment Score to administer PO Benzodiazepines in Med/Surg
4. Lowered threshold on Severity Assessment Score to administer IV Benzodiazepines in ICU
5. Increased reassessment times to assure safe monitoring with lower Severity Assessment thresholds

The revision reflects a philosophical shift to addressing the withdrawal patients need for intervention early on in the plan of care. Allowing beer and wine with meals is common practice in the region and may help ward off early DTs especially in the elderly. Allowing earlier intervention with IV Benzodiazepines in the ICU may help control the patient sooner and avoid over sedation and potential intubation.

Reviewed by:	Date	Approved (Y/N)	Comment
P.I. or P. T. Committee	7/23/15	y	
Surgery Committee	8/5		
Medicine Committee	8/13		
Medical Executive Committee	8/20		
Board Quality	8/26		
Board of Directors	9/3		

Alcohol Withdrawal Order Set

Allergies_____

1. **Discontinue any other sedatives/hypnotics, CNS depressants, and narcotics upon initiation of this order set unless rewritten on this form.**
2. **Admit to:** ☐ Med/Surg ☐ Telemetry ☐ ICU
3. **Initial laboratory tests (if not previously ordered):**
   - ☐ Serum alcohol ☐ Phosphorus
   - ☐ CBC ☐ Magnesium
   - ☐ PT/INR ☐ GGT
   - ☐ AST ☐ CMP
   - ☐ ABG (for patient with history of obstructive airway disease
   - ☐ _____
4. **Diet:** ☐ NPO; ☐ Clear Liquids; ☐ Full Liquid; ☐ Regular, no caffeine
   - ☐ Wine or beer with lunch and dinner, 1-2 servings (4-8 ounces) if no medical contraindication (alcoholic hepatitis)
5. **Monitoring parameters:**
   - Score patient using Severity Assessment Score Q4hrs if the score is ≤5
   - Obtain vital signs and oximetry Q4hrs if Severity Assessment Score is ≤5
   - If the Severity Assessment Score is 6-7, repeat scoring in 2 hours
6. **Initiate fall protocol**
7. **Medications:**
   - ☐ PO Benzodiazepines:
     - ☐ Chlordiazepoxide (Librium) 50mg PO Q6hr x 4 doses, then 25mg PO Q6hr x8 doses, then 25mg PO daily (hold for excessive sedation) PLUS Chlordiazepoxide (Librium) 50mg PO Q1hr PRN Severity Assessment Score ≥~~8~~ 7
     - ☐ Diazepam 10mg PO Q6hr x4 doses, then 5mg PO Q6hr x8 doses, then 5mg PO BID (hold for excessive sedation) PLUS Diazepam 10mg PO Q1hr PRN Severity Assessment Score ≥ ~~8~~ 7
   - ☐ IV Benzodiazepines:
     - ☐ Lorazepam 2mg IV Q6hr x4 doses, then 1mg IV Q6hr PLUS Lorazepam 2mg IV Q1hr PRN Severity Assessment Score ≥ ~~8~~ 7
   - ☐ IV Fluids
     - ☐ Saline lock every shift and PRN
     - ☐ IV _____ at _____ml/hr
   - ☐ Vitamins
     - ☐ Thiamine 100mg PO Daily + Multivitamin 1 tab PO Daily + Folic acid 1mg PO Daily + Magnesium SO_4 1gm IVPB Daily
     - ☐ Add multivitamin 10ml, thiamine 100mg, folic acid 1mg, magnesium SO_4 1gm to first liter of IV fluid Daily
   - ☐ Metoprolol tartrate (hold for SBP ≤90, HR ≤60)
     - ☐ 12.5mg PO BID
     - ☐ 25mg PO BID
     - ☐ 50mg PO BID
     - ☐ 5mg IV q6hr PRN SBP ≥180; HR≥120
   - ☐ Clonidine (hold for SBP ≤90)
     - ☐ 0.1mg PO Q8hr
     - ☐ 0.2mg PO Q8hr

_____ _____ _____

Attending Physician Signature **Date** **Time**

- ☐ Promethazine
  - ☐ 25mg PO Q4hr PRN nausea/vomiting
  - ☐ 25mg IM Q4hr PRN nausea/vomiting
  - ☐ 25mg IV Q4hr PRN nausea/vomiting
- ☐ Ondansetron 4mg IV Q6hr PRN nausea/vomiting

8. **Notify physician:**
   - SBP >180mmHg, <90mmHg, DBP >110mmHg, HR >120, HR <60, Temp >102.1, RR <8, Oxygen saturation <90%
   - Severe agitation not relieved after 3 doses of benzodiazepine
   - Patient unresponsive or significant change in mental status
   - Seizures
9. **Transfer to ICU if Severity Assessment Score is >~~8~~ 7 x 2 assessments 4 hours apart**
   - ☐ Initiate ICU Alcohol Withdrawal Benzodiazepine Algorithm (follow algorithm on next page)
10. **Other orders:**
    - ☐ _____
    - ☐ _____

ICU Alcohol Withdrawal Benzodiazepine Algorithm

Step 1

- No benzodiazepine needed for Severity Assessment Score of ≤5; reassess in ~~60~~ (30) minutes
- If Severity Assessment Score remains ≤5 x3 consecutive assessments, continue assessments ~~Q4hr~~ (Q2hr)
- Lorazepam 2mg IV for Severity Assessment Score of ~~6-8~~ (5-7); reassess in ~~30~~ (15) minutes
- Lorazepam 4mg IV for Severity Assessment Score of ~~9-11~~ (8-10); reassess in ~~30~~ (15) minutes
- Midazolam 10mg IV for Severity Assessment Score of ≥ ~~12~~ (10); reassess in 15 minutes
- If Severity Assessment Score remains ≥ ~~12~~ (10) for 3 consecutive assessments, proceed to step 2

Step 2:

Give lorazepam 4mg IV AND initiate lorazepam infusion at 4mg/hr; reassess in 30 minutes

- Severity Assessment Score of ~~≤8~~ (≤6); decrease rate by 2mg/hr and reassess in ~~2 hrs~~ (1 hr)
- After reassessment may titrate in 2mg/hr increments to off if score remains ~~≤8~~ (≤6)
- Resume treatment at step 1 once infusion is stopped
- Severity Assessment Score of ~~9-11~~(7-9); no change in infusion rate and reassess in ~~60~~ (30) minutes
- Severity Assessment Score of ≥ ~~12~~ (10); give lorazepam 4mg IV AND increase lorazepam rate by 4 (2) mg/hr; reassess in 30 minutes
- If rate exceeds 20mg/hr, call physician to reassess

_____ _____ _____

Attending Physician Signature **Date** **Time**

6.

QUALITY REPORT AUGUST 2015

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

To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 08/26/2015
Subject: Quality and Resource Management Report

August Priorities:

1. CIHQ Mid Cycle Action Plan
2. Surgical Services Action Plan
3. National Quality Data Update

1. CIHQ Mid Cycle Survey Action Plan

The survey identified 9 standard Level deficiencies requiring action plans. Our Action Plans were accepted by CIHQ and are in the process of full implementation. The deficiencies and action plans are as follows.

Deficiency	***Action Plan/ Monitoring***	***Responsible Person(s)***
The copy of the medical staff by-laws provided did not have the required H&P language change from the 2014 survey and it was not nor did have approval by the governing body.	A revised version of the by-laws was identified with the correct verbiage and was sent to the governing body for approval on August 6, 2015. Monitoring: every time a change is made, the entire document with the change must be sent through MEC and the governing body. All previous versions will be archived.	Dr. Cohen Nancy Iredale
Equipment and storage carts were found in front of electrical panels in the Surgical Services Department.	Surgical Services team members were re-educated. Monitoring: compliance with the 3 foot clearance around electrical panels will be monitored monthly for 12 months.	Allan Sendaydiego Kimberly Drummond
Service provider name and dates where not entered into database when new medical equipment were accepted into service.	Added these data elements to the database. Monitoring: monthly for all new medical equipment for 6 months.	Kimberly Drummond
Service provider name and dates where not entered into database when new utility equipment were accepted into service.	Added these data elements to the database. Monitoring: monthly for all new utility equipment for 6 months.	Kimberly Drummond

When humidity levels fail to meet required parameters in Surgery & OB, there was no documentation in the log of actions taken.	OB and Surgical Services team members were re-educated. Monitoring: documentation of actions taken is included in the log and in the work order actions log. Will be monitored monthly for 6 months.	Cynthia McAleer Allan Sendaydiego Kimberly Drummond
1. Instrument tips were not separated during sterilization process. 2. Staff are not able to access manufacturer's instructions for sterilization of all instrumentation used in surgery. 3. Noncompliance in documentation of test strips, expiration dates for solutions of Rapicide for high level sterilization. 4. Overuse of flash sterilization for eye cases does not meet standard of care.	1. Invested in rubber tip protectors to ensure tips are separated with no risk of locking in the closed position during handling and processing. 2. Obtained manufacturer's information for most used instruments. Considering subscription to a company who has an extensive database to cover all instrumentation. 3. Surgical Services team members were re-educated. A new spreadsheet for documentation of required elements was developed. 4. Developed plan to either purchase additional eye trays or move to a special tray process that allows for more rapid turnaround of instruments. Present to Senior team for approval. Monitoring: monthly for compliance for 12 months.	Allan Sendaydiego
Gross decontamination of GI equipment was occurring in a negative pressure environment contiguous to a clean area. It requires positive pressure and should be done in a decontamination room. Also errors were found in the storage and processing of endoscopes.	Relocation of gross contamination to decontamination room.	Allan Sendaydiego Kimberly Drummond
Patient information was found on the counter in SCU where families could have access.	SCU team members were re-educated on the need to keep patient information secure at all times. Monitoring: walking rounds daily to ensure security of PHI and reported monthly for 6 months.	Allan Sendaydiego
IV fluids found in warmer were not labeled with expiration date not to exceed 14 days from placement in warmer.	Surgical Services team members were re-educated. Monitoring: all IV fluids in warmer will have a label with the expiration date not to exceed 14 days. Monitored monthly for 6 months.	Allan Sendaydiego

2. Surgical Services Action Plan for Adverse Event

The Surgical Services Team has been working on implementing their action plan to address the retained foreign body incident. The Action Plan, see attached, once completed will become part of the Surgery Director's quality monitoring and be reported up to the Surgery Committee monthly.

3. *National Quality Data Update*

The Centers for Medicare and Medicaid Services has published updates for a number of programs in the past few weeks. First, we received the Value Based Purchasing Payment Summary report that impacts fiscal year 2016 and is based on 2014 data (see attached). Then Marketing found this report on the Hospital Readmission Reduction Program penalties summary report for fiscal year 2016 (see attached article and data sheet). Both reports share very good news about the quality of the care provided at Sonoma Valley Hospital.

Topics for discussion: Surgical Services Transformation Project (Sendaydiego)

Surgical Services Corrective Action Plan

Identified Issue	***Action Steps***	***Date of Completion***	***Measures of Success***
1. Use of Universal Protocol is too passive	• Adopt WHO Checklist which requires verbal interchange and check off for each step • Place posters in each OR suite (7/16/15) • Create a check sheet that circulator will use which will include time and line item signature. • Educate OR team to new process.	6/30/15 7/16/15 6/30/15 7/15/15	1. Documentation of training of team members. 2. Real time observation audits to monitor compliance with new process. Immediate re-education for non-compliance. 3. Monthly reports of compliance and actions taken for non-compliance are reviewed in Surgery Committee.
	• Enforce verbal interchange and use of checklist. • Enforce debrief during closing.	7/27/15 7/27/15	
2. Lack of communication from OR Suite to liaison for equipment and other patient care needs	• Enable phone/speaker system to improve communication and reduce the need for the circulator to leave the suite. • Educate OR team on use of this system.	07/08/15 7/14/15	1. Documentation of training of team members. 2. Morning discussion in huddle of effectiveness of new process and identification of any process barriers. 3. Monthly reports of compliance and actions taken for non-compliance are reviewed in Surgery Committee.

3. Inadequate sponge count documentation and a lack of understanding of documentation requirements	• Memo with attestation to OR team addressing the immediate cessation of any pre-charting of sponge, needle and equipment counts. • Perioperative Risk Assessment scheduled Beta Healthcare Group consultant • Mandatory Nursing documentation Inservice for all Surgical Services Staff.	06/22/2015 6/24/15, 6/25/15 6/26/15	1. 100% of OR staff sign attestation. Completion of both a real time observation audit and retrospective audits on documentation of sponge, needle and equipment counts. 2. Assessment completed. Recommendations result in actionable items and a QAPI plan is developed and implemented with required tracking. 3. 100% of Nursing staff who document in the record have received mandatory training. 4. Monthly reports of action plan compliance are reviewed in Surgery committee.
4. RN Circulator leaving room to collect equipment during a case	• Increase staffing level and/or define role of liaison if additional equipment is needed during a case. Consider role of Coordinator as lead and liaison.	Pending	1. Posted position is filled. 2. Role of liaison is developed and implemented

Report Run Date: 08/04/2015

Hospital Value-Based Purchasing -- Value-Based Percentage Payment Summary Report
Percentage Summary Report
Provider: 050090
Reporting Period: Fiscal Year 2016

Data As Of: 07/28/2015

	Facility	State	National
Total Performance Score	44.107142857143	39.660549540329	40.471936058418
	Unweighted Domain Score	**Weighting**	**Weighted Domain Score**
Clinical Process of Care Domain	58.571428571429	10%	5.857142857143
Patient Experience of Care Domain	29.000000000000	25%	7.250000000000
Outcome Domain	40.000000000000	40%	16.000000000000
Efficiency Domain	60.000000000000	25%	15.000000000000

Value-Based Percentage Payment Summary - Fiscal Year 2016

Base Operating DRG Payment Amount Reduction	Value-Based Incentive Payment Percentages	Net change in Base Operating DRG Payment Amount	Value-Based Incentive Payment Adjustment Factor	Exchange Function Slope
1.7500000000%	2.1405075186%	+0.3905075186%	1.0039050752	2.7731271496

Calculated values were subject to rounding.
Reference the Hospital Value-Based Purchasing page on QualityNet for report information, calculations, and Hospital VBP resources.

Half Of Nation's Hospitals Fail Again To Escape Medicare's Readmission Penalties

By **Jordan Rau** August 3, 2015

Once again, the majority of the nation's hospitals are being penalized by Medicare for having patients frequently return within a month of discharge — this time losing a combined $420 million, government records show.

In the fourth year of federal readmission penalties, 2,592 hospitals will receive lower payments for every Medicare patient that stays in the hospital — readmitted or not — starting in October. The Hospital Readmissions Reduction Program, created by the Affordable Care Act, was designed to make hospitals pay closer attention to what happens to their patients after they get discharged.

Since the fines began, national readmission rates have dropped, but roughly one of every five Medicare patients sent to the hospital ends up returning within a month.

Some hospitals view the punishments as unfair because they can lose money even if they had fewer readmissions than they did in previous years. All but 209 of the hospitals penalized in this round were also punished last year, a Kaiser Health News analysis of the records found.

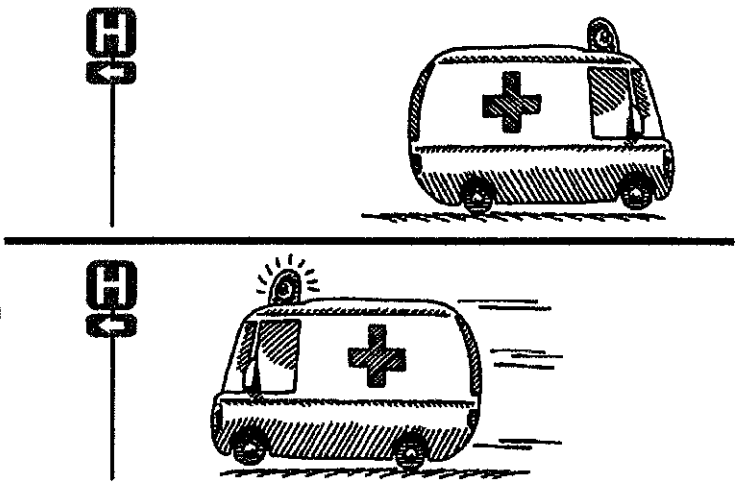

Illustration by Andrew Villegas/istockphoto

The fines are based on readmissions between July 2011 and June 2014 and include Medicare patients who were originally hospitalized for one of five conditions: heart attack, heart failure, pneumonia, chronic lung problems or elective hip or knee replacements. For each hospital, Medicare determined what it thought the appropriate number of readmissions should be based on the mix of patients and how the hospital industry performed overall. If the number of readmissions was above that projection, Medicare fined the hospital.

Get The Data

MEDICARE HOSPITAL READMISSION PENALTIES, YEAR 4

Medicare is penalizing hospitals that see patients return to the hospital too soon after being discharged. Medicare reduces what it pays each hospital per patient, per stay.

Medicare Readmission Penalties By Hospital (.csv)

Medicare Readmission Penalties By Hospital (.pdf)

Medicare Readmission Penalties By State (.csv)
Medicare Readmission Penalties By State (.pdf)

The fines will be applied to Medicare payments when the federal fiscal year begins in October. In this round, the average Medicare payment reduction is 0.61 percent per patient stay, but 38 hospitals will receive the maximum cut of 3 percent, the KHN analysis shows. A total of 506 hospitals, including those facing the maximum penalty, will lose 1 percent of their Medicare payments or more.

Overall, Medicare's punishments are slightly less severe than they were last year, both in the amount of the average fine and the number of hospitals penalized. Still, they will be assessed on hospitals in every state except Maryland, which is exempt from these penalties because it has a special payment arrangement with Medicare.

These lower payments will affect three-quarters of hospitals or more in Alabama, Connecticut, Florida, Massachusetts, New Jersey, New York, Rhode Island, South Carolina, Virginia and the District of Columbia. KHN found that fewer than a quarter of hospitals face punishments in Idaho, Iowa, Kansas, Montana, Nebraska, North Dakota and South Dakota.

Most of the 2,232 hospitals spared penalties this year were excused not because Medicare found readmissions to be sufficiently infrequent, but because they were automatically exempted from being evaluated — either because they specialized in certain types of patients, such as veterans or children, because they were specially designated "critical access" hospitals, or because they had too few cases for Medicare to accurately assess.

The readmission penalties are not the only fines hospitals face this year. As it did last year, Medicare is also giving out bonuses and penalties based on a variety of quality measures. The government has not yet announced those, but they also begin in October. Those financial incentives will total about $1.5 billon. Medicare will also punish hospitals with high rates of infections and other avoidable occurrences of patient harm.

The KHN analysis found that four hospitals have received the maximum readmission penalty every year. Two are in Kentucky: Harlan ARH Hospital, which is in the heart of the Appalachian coalfields, and Monroe County Medical Center in Tompkinsville. The other hospitals are the Livingston, Tenn., Regional Hospital — also in Appalachia — and Franklin Medical Center in Winnsboro, La. None of the hospitals immediately returned phone calls Monday.

Hospitals have been lobbying both Medicare and Congress to take into account the socio-economic background of patients when assessing readmission penalties. They argue that some factors for readmissions — such as whether patients can afford medications or healthy food — are beyond their control.

The Medicare Payment Advisory Commission, which advises Congress, has recommended altering the readmission penalties. The National Quality Forum, a nonprofit that Medicare looks to when creating quality metrics, is examining whether socio-economic factors should be included when calculating readmission measurements as well as other barometers of hospital quality. But that experiment will take two years to complete.

"Hospitals should not be penalized simply because of the demographic characteristics of their patients," Sens. Joseph Manchin III (D-W.Va.) and Roger Wicker (R-Miss.) wrote last week in the Journal of the American Medical Association. The senators have introduced a bill to consider socio-economic factors when calculating the penalties.

Their essay, co-written by Dr. Andrew Boozary, a health policy analyst, pointed to a study that found safety-net hospitals were nearly 60 percent more likely than other hospitals to have been penalized in all of the first three years of the penalties. Hospitals with the lowest profit margins were 36 percent more likely to be penalized than those in better financial shape, the essay said.

In regulations released Friday, the Centers for Medicare & Medicaid Services reiterated that it would not unilaterally make such changes in the program, noting that some safety-net hospitals have been able to keep their readmission rates low.

"While we appreciate these comments and the importance of the role that sociodemographic status plays in the care of patients," the agency wrote in the rule, "we continue to have concerns about holding hospitals to different standards for the outcomes of their patients of low sociodemographic status because we do not want to mask potential disparities or minimize incentives to improve the outcomes of disadvantaged populations."

KHN's coverage of aging and long term care issues is supported in part by a grant from The SCAN Foundation.

Medicare Readmission Penalties By State, Year 4

Medicare evaluated the readmission rates of the nation's hospitals in determining the fourth year of penalties in the Hospital Readmissions Reduction Program. Medicare will apply the penalties to all its payments for patient stays between Oct. 1, 2015, and Sept. 30, 2016. In this chart, the first column after the state name shows the total number of hospitals penalized in each state. That is followed by the percent of each state's hospitals that were penalized. That calculation includes hospitals exempted from the fines, such as those serving veterans and children. The final column shows the average penalty for penalized hospitals. *The penalties do not apply to Maryland hospitals, as that state has a unique reimbursement arrangement with Medicare, and thus Maryland is not included in this table.

State Name ▼	Number of Penalized Hospitals	Percent of All Hospitals Penalized	Average Hospital Penalty (Percent)
Alabama	72	79	0.61
Alaska	7	33	0.44
Arizona	49	62	0.48
Arkansas	41	53	0.83
California	224	65	0.4
Colorado	25	32	0.29
Connecticut	28	90	0.66
Delaware	5	71	0.35
District of Columbia	7	78	0.77
Florida	154	81	0.67
Georgia	89	67	0.47
Hawaii	10	56	0.33
Idaho	4	10	0.58
Illinois	113	62	0.72
Indiana	64	51	0.59
Iowa	25	21	0.62
Kansas	32	24	0.44
Kentucky	62	65	1.19
Louisiana	66	55	0.68
Maine	11	31	0.4
Massachusetts	51	78	0.70
Michigan	69	50	0.64
Minnesota	39	30	0.37
Mississippi	54	55	0.61
Missouri	67	61	0.71
Montana	5	9	0.70
NATIONAL	2,592	54	0.61
Nebraska	14	15	0.39

Hospital	Address	City	State	ZIP Code	FY2013 Readmission Penalty	FY2014 Readmission Penalty	FY2015 Readmission Penalty	FY2016 Readmission Penalty
SHARP MEMORIAL HOSPITAL	7901 FROST ST	SAN DIEGO	CA	92123	0.42%	0.08%	0.03%	0.02%
SHASTA REGIONAL MEDICAL CENTER	1100 BUTTE ST	REDDING	CA	96001	0.00%	0.04%	0.65%	1.49%
SHERMAN OAKS HOSPITAL	4929 VAN NUYS BLVD	SHERMAN OAKS	CA	91403	0.98%	0.65%	0.49%	0.48%
SIERRA NEVADA MEMORIAL HOSPITAL	155 GLASSON WAY	GRASS VALLEY	CA	95945	0.57%	0.75%	0.50%	0.23%
SIERRA VIEW MEDICAL CENTER	465 W PUTNAM AVE	PORTERVILLE	CA	93257	0.14%	0.02%	0.75%	0.68%
SIERRA VISTA REGIONAL MEDICAL CENTER	1010 MURRAY ST	SAN LUIS OBISPO	CA	93405	0.20%	0.07%	0.02%	0.02%
SILVER LAKE MEDICAL CENTER	1711 WEST TEMPLE STREET	LOS ANGELES	CA	90026	0.05%	0.14%	0.04%	0.02%
SIMI VALLEY HOSPITAL & HEALTH CARE SERV	2975 N SYCAMORE DR	SIMI VALLEY	CA	93065	0.36%	0.54%	0.75%	0.40%
SONOMA DEVELOPMENTAL CENTER	P O BOX 1493	ELDRIDGE	CA	95431	0.00%	0.00%	0.00%	0.00%
SONOMA VALLEY HOSPITAL	347 ANDRIEUX ST	SONOMA	CA	95476	0.02%	0.00%	0.00%	0.00%
SONORA REGIONAL MEDICAL CENTER	1000 GREENLEY ROAD	SONORA	CA	95370	0.00%	0.00%	0.00%	0.00%
SOUTHERN CALIFORNIA HOSPITAL AT HOLLY	6245 DE LONGPRE AVE	HOLLYWOOD	CA	90028	0.03%	0.01%	0.03%	0.14%
SOUTHERN INYO HOSPITAL	501 EAST LOCUST STREET	LONE PINE	CA	93545	Not Assessed	Not Assessed	Not Assessed	Not Assessed
SOUTHWEST HEALTHCARE SYSTEM	25500 MEDICAL CENTER DRIVE	MURRIETA	CA	92562	0.34%	0.30%	0.21%	0.22%
ST BERNARDINE MEDICAL CENTER	2101 N WATERMAN AVE	SAN BERNARDINO	CA	92404	0.39%	0.20%	0.20%	0.32%
ST ELIZABETH COMMUNITY HOSPITAL	2550 SISTER MARY COLUMBA DRIVE	RED BLUFF	CA	96080	0.04%	0.00%	0.00%	0.00%
ST HELENA HOSPITAL	10 WOODLAND ROAD	SAINT HELENA	CA	94574	0.03%	0.01%	0.00%	0.00%
ST HELENA HOSPITAL-CLEARLAKE	15630 18TH AVE - HWY 53	CLEARLAKE	CA	95422	Not Assessed	Not Assessed	Not Assessed	Not Assessed
ST JOHNS PLEASANT VALLEY HOSPITAL	2309 ANTONIO AVE	CAMARILLO	CA	93010	0.15%	0.11%	0.25%	0.07%
ST JOHNS REGIONAL MEDICAL CENTER	1600 N ROSE AVE	OXNARD	CA	93030	0.19%	0.01%	0.72%	0.54%
ST JOSEPH HOSPITAL	2700 DOLBEER ST	EUREKA	CA	95501	0.00%	0.00%	0.00%	0.00%
ST JOSEPH HOSPITAL	1100 WEST STEWART DR	ORANGE	CA	92868	0.00%	0.00%	0.06%	0.04%
ST JOSEPHS MEDICAL CENTER OF STOCKTON	1800 N CALIFORNIA ST	STOCKTON	CA	95204	0.35%	0.17%	0.02%	0.21%
ST JUDE MEDICAL CENTER	101 E VALENCIA MESA DRIVE	FULLERTON	CA	92835	0.00%	0.00%	0.07%	0.10%
ST MARY MEDICAL CENTER	18300 HIGHWAY 18	APPLE VALLEY	CA	92307	0.61%	0.61%	0.56%	0.80%
ST MARY MEDICAL CENTER	1050 LINDEN AVE	LONG BEACH	CA	90813	0.04%	0.12%	0.21%	0.13%
ST MARY'S MEDICAL CENTER	450 STANYAN ST	SAN FRANCISCO	CA	94117	0.15%	0.03%	0.16%	0.25%
ST ROSE HOSPITAL	27200 CALAROGA AVE	HAYWARD	CA	94545	0.55%	0.58%	1.06%	1.23%
STANFORD HOSPITAL	300 PASTEUR DRIVE	STANFORD	CA	94305	0.00%	0.18%	0.15%	0.06%
STANISLAUS SURGICAL HOSPITAL	1421 OAKDALE ROAD	MODESTO	CA	95355	0.00%	0.00%	0.68%	0.00%
SURPRISE VALLEY COMMUNITY HOSPITAL	741 NORTH MAIN STREET	CEDARVILLE	CA	96104	Not Assessed	Not Assessed	Not Assessed	Not Assessed
SUTTER AMADOR HOSPITAL	200 MISSION BLVD	JACKSON	CA	95642	0.00%	0.00%	0.22%	0.01%
SUTTER AUBURN FAITH HOSPITAL	11815 EDUCATION STREET	AUBURN	CA	95603	0.06%	0.00%	0.01%	0.00%
SUTTER COAST HOSPITAL	800 E WASHINGTON BLVD	CRESCENT CITY	CA	95531	0.00%	0.00%	0.05%	0.24%
SUTTER DAVIS HOSPITAL	2000 SUTTER PLACE	DAVIS	CA	95616	0.00%	0.00%	0.27%	1.15%
SUTTER DELTA MEDICAL CENTER	3901 LONE TREE WAY	ANTIOCH	CA	94509	0.44%	0.47%	0.50%	0.64%
SUTTER GENERAL HOSPITAL	2801 L STREET	SACRAMENTO	CA	95816	0.00%	0.00%	0.05%	0.08%
SUTTER LAKESIDE HOSPITAL	5176 HILL ROAD EAST	LAKEPORT	CA	95453	Not Assessed	Not Assessed	Not Assessed	Not Assessed
SUTTER MATERNITY & SURGERY CENTER OF	2900 CHANTICLEER AVENUE	SANTA CRUZ	CA	95065	0.00%	0.00%	0.00%	0.00%
SUTTER ROSEVILLE MEDICAL CENTER	ONE MEDICAL PLAZA	ROSEVILLE	CA	95661	0.00%	0.00%	0.46%	0.00%
SUTTER SANTA ROSA REGIONAL HOSPITAL	30 MARK WEST SPRINGS ROAD	SANTA ROSA	CA	95403	0.00%	0.00%	0.01%	0.02%
SUTTER SOLANO MEDICAL CENTER	300 HOSPITAL DR	VALLEJO	CA	94589	0.00%	0.00%	0.13%	1.45%