



SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, FEBRUARY 28, 2018
5:00 p.m. Regular Session
 (Closed Session will be held upon adjournment
 of the Regular Session)

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

AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a Quality Committee meeting, please contact the District Clerk, Stacey Finn, at sfynn@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	<i>Hirsch</i>	
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.	<i>Hirsch</i>	
3. CONSENT CALENDAR • Minutes 01.24.18	<i>Hirsch</i>	Action
4. POLICIES & PROCEDURES	<i>Jones</i>	Action
5. ANNUAL INFECTION CONTROL REPORT	<i>Mathews</i>	Inform
6. DISCUSSION REGARDING HQI QUALITY TRANSPARENCY DASHBOARD	<i>Hirsch</i>	Inform/Action
7. QUALITY REPORT	<i>Jones</i>	Inform/Action
8. UPON ADJOURNMENT OF REGULAR OPEN SESSION	<i>Hirsch</i>	
9. CLOSED SESSION: <u>Calif. Health & Safety Code § 32155</u> Medical Staff Credentialing & Peer Review Report	<i>Jones</i>	Action
10. REPORT OF CLOSED SESSION	<i>Hirsch</i>	Inform/Action
11. ADJOURN	<i>Hirsch</i>	

3.

CONSENT



**SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
January 24, 2018, 5:00 PM
MINUTES
Schantz Conference Room**

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch Peter Hohorst Carol Snyder Susan Idell Ingrid Sheets	Cathy Webber Michael Brown, MD	Kelsey Woodward Howard Eisenstark, MD Michael Mainardi, MD	Danielle Jones Mark Kobe Fe Sendaydiego

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	<i>Hirsch</i>	
	Meeting called to order at 5:01 pm	
2. PUBLIC COMMENT	<i>Hirsch</i>	
	None	
3. CONSENT CALENDAR	<i>Hirsch</i>	Action
<ul style="list-style-type: none"> QC Minutes, 12.20.17 		MOTION: by Idell to approve, 2 nd by Sheets. All in favor
4. POLICY & PROCEDURES	<i>Jones</i>	Action
	Ms. Jones went through each of the policies and also explained the new digital process. Brief summaries of changes are included for revised policies rather than entire multiple page documents. Some editorial changes were provided by Dr. Eisenstark via e-mail and given to Ms. Jones.	MOTION: by Idell to approve, 2 nd by Sheets. All in favor.
5. INFORMATION SYSTEMS ANNUAL DEPT. UPDATE	<i>Sendaydiego</i>	
	Information Systems is responsible for technology and telecommunications in the Hospital. Ms. Sendaydiego discussed department staffing and duties. Quality metrics that are being monitored include overall system availability with a goal of 99.9%. The 2017 annual average was 99.39%. The	

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	<p>other metric is help desk management with a goal to fix 40% of open tickets within 4 hours. (There does not seem to be an industry benchmark for this metric.) The 2017 annual average was 44%.</p> <p>She mentioned initiatives that were completed for quality improvement (such as outsourcing the information system and EHR to improve security against cyber-attacks and migrating to a secured email system). For 2018 the work plan includes the Outpatient Rehab EHR, improving the patient health portal, and incorporating evidence based medicine practices in physician order sets.</p>	
6. QUALITY COMMITTEE DRAFT 2018 WORK PLAN	<i>Jones</i>	Action
	<p>Ms. Jones reviewed the 2018 work plan. A change will be made with the Feb. Patient Care Services report moving to Apr., and the Infection Prevention Report moving to Feb.</p>	MOTION by Idell to approve with change, 2 nd by Sheets. All in favor.
7. QUALITY REPORT	<i>Jones</i>	Inform
	<p>Ms. Jones reviewed the quality report. She has been meeting with department leaders to review the difference between quality assurance and performance improvement. Another focus area is the patient care contract process. Skilled Nursing had three surveys between Nov. and Dec. from CDPH, Federal life safety, and CMS; Ms. Jones will be monitoring action items.</p> <p>Mr. Kobe briefly reviewed the patient care services dashboard. A suggestion was made previously to put the data on falls into rolling quarters, and this has been done. As of Jan. 1 SVH began monitoring outpatient experience.</p>	
8. UPON ADJOURNMENT OF REGULAR SESSION	<i>Hirsch</i>	
	Regular session adjourned at 6:19 p.m.	
9. CLOSED SESSION <ul style="list-style-type: none"> • <u>Calif. Health & Safety Code § 32155</u> Medical Staff Credentialing & Peer Review Report 	<i>Jones</i>	Action

AGENDA ITEM	DISCUSSION	ACTION
10. REPORT OF CLOSED SESSION	<i>Hirsch</i>	Inform/Action
		MOTION: by Idell to approve, 2 nd by Brown. All in favor.
11. ADJOURN	<i>Hirsch</i>	
	Meeting adjourned at 6:25 p.m.	

4.

POLICIES &
PROCEDURES



SUBJECT: 340B Drug Discount Purchasing Program

POLICY #MM8610-158

DEPARTMENT: Organizational

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EFFECTIVE: 7/2017

REVISED:

NEW POLICY

New policy that defines the processes that allow Sonoma Valley Hospital to purchase pharmaceuticals at discounted prices for its qualified outpatients that is consistent with the Human Resources Services Administration (HRSA) 340B Drug Discount Purchasing Program as defined by the enactment Section 340B of the Public Health Service Act.

AUTHOR JOB TITLES:

Chris Kutza, Director of Pharmacy
Michael Brown, M.D., Pharmacy & Therapeutics Chair

COMMITTEE APPROVALS:

Michael Brown, M.D., Pharmacy & Therapeutics Chair:
Policy & Procedure Team: 6/20/17
P&T Committee: 7/6/17
Medical Executive Committee: 7/20/17
Board Quality Committee:
Board of Directors:



SUBJECT: 340B Drug Discount Purchasing Program

POLICY #MM8610-158

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Purpose:

To define the processes that allow Sonoma Valley Hospital to purchase pharmaceuticals at discounted prices for its qualified outpatients that is consistent with the Human Resources Services Administration (HRSA) 340B Drug Discount Purchasing Program as defined by the enactment Section 340B of the Public Health Service Act.

Definitions:

- 340B Eligible “Covered Entity”: The statutory name for facilities and programs eligible to purchase discounted drugs through the Public Health Service's 340B Drug Pricing Program
- Covered Outpatient Drug: Sonoma Valley Hospital interprets Section 1927 (k) of the Social Security Act to include prescription drugs, over-the-counter (OTC) drugs that are written on a prescription, and biological products that can be dispensed by a prescription when used in the eligible outpatient areas.
 - Non-covered outpatient drugs include vaccines, hyaluronadase, saline flushes, IV hydration and piggybacks, parenteral nutrition, outsourced compounded drugs, radiopharmaceuticals, bundled medications (see policy section on “Billing/Utilization”, and any other medications that do not fall under the definition of Covered Outpatient Drug above.
- Disproportionate Share Hospital (DSH): A hospital with a disproportionately large share of low income patients. The Medicare and Medicaid programs augment payments to DSH hospitals to compensate for the added financial burden.
- Sole Community Hospital (SCH): A hospital as defined by section 1886(d)(5)(C)(iii) of the Social Security Act that may be eligible to access 340B discounted drugs.
- Critical Access Hospital (CAH): A specially designated, small rural hospital that qualifies for cost-based payments for Medicare services.
- Disproportionate Share Adjustment (DSA): The Medicare disproportionate share adjustment is an additional Medicare payment to hospitals which treat a high percentage of low-income patients. The factors used to calculate this adjustment are the sum of the ratios of Medicare Part A Supplemental Security Income (SSI) patient days to total Medicare patient days, and Medicaid patient days to total patient days in the hospital.
- Medicare Cost Report: Required by CMS, an annual financial report that details all fixed and variable costs expensed to the care of Medicare patients.
- Contracted Pharmacy: An arrangement through which a covered entity may contract with an outside pharmacy to provide comprehensive pharmacy services utilizing medications purchased under 340B.



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- HRSA: Health Resources and Services Administration of the Department of Health and Human Services.
- GPO Prohibition: Prohibits 340B participating Disproportionate Share Hospitals (DSH), Children’s Hospitals (PED), and Free Standing Cancer Hospitals (CAN) from obtaining covered outpatient drugs through group purchasing organizations.
- Wholesale Acquisition Cost (WAC): The price paid by a wholesaler (or direct purchasers) in the United States for drugs purchased from the drug’s manufacturer or supplier.
- Orphan Drugs: Drugs designated by the Food and Drug Administration (FDA) as “orphan drugs”, drugs used for rare diseases or conditions. The official Orphan Drug list is posted on the OPA website.
- Parent/Child Sites: The primary covered entity is often referred to as the “parent” site. All outpatient services of the covered entity that are not located within the four walls of the parent location (same physical address) must be registered on the HRSA/OPA database as a “child” of the covered entity (Parent).
- Medicaid Carve-out: 340B entities may elect to purchase drugs for Medicaid patients on a non-340B contract. This activity is termed a “Medicaid carve-out.” Entities may choose to do this in order to receive fair Medicaid reimbursement (many states reimburse entities that use 340B for Medicaid patients on a cost plus dispensing fee basis, as the dispensing fee is often not high enough to cover costs). Entities must inform OPA whether they are carving in or out.
- Inpatient status: The hospital determines that patients have an inpatient status according to Policy # UR8610-100 Patient Status Determinations
- Outpatient status: The hospital determines that patients have an outpatient status according to Policy # UR8610-100 Patient Status Determinations

OVERVIEW OF 340B DRUG DISCOUNT PURCHASING PROGRAM REQUIREMENTS

Covered Entity/Facility Eligibility

Facilities that receive discounted outpatient drug pricing under the 340B Drug Pricing Program include certain hospitals that are public or private non-profit hospitals serving higher percentages of Medicare, Medicaid or other indigent populations. To be eligible the hospital must meet three requirements:

- 1) The hospital must have a Medicare Disproportionate Share Adjustment Percentage based on their latest Medicare Cost Report as follows:



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- ♦ Disproportionate Share Hospitals (DSH) Adjustment Percentage greater than 11.75%
 - ♦ Sole Community Hospitals (SCH) require DSH Adjusted Percentage of 8%
 - ♦ Critical Access Hospitals (CAH) do not have a Disproportionate Share Adjustment Percentage requirement.
- 2) The hospital meets the following criteria:
- ♦ Be owned or operated by a unit of State or local government.
- 3) DSH hospitals, children's hospitals, and free-standing cancer hospitals that meet the first two criteria are eligible to participate in the 340B program if they sign a written certification stating that they will not obtain covered outpatient drugs through a group purchasing organization (GPO) or other group purchasing arrangement in compliance with the third criterion. Rural and Critical Access hospitals are not subject to this GPO prohibition.

Site of Care

Off-site outpatient facilities of the covered entity (hospital) may purchase and/or provide 340B drugs to its patients, only if the site of care is listed on the HRSA/OPA 340B database. Off-site facilities eligibility is verified by HRSA/OPA as listed as part of the covered entity's most recently filed Medicare Cost Report. The facility must be listed as an integral part of the hospital and included as reimbursable section of the Medicare Cost Report. An eligible clinic/office is considered a "child" of the covered entity ("parent") even if the location is within the same building of a "parent"; they must be registered separately. Outpatient services within the four continuous walls of the covered entity (hospital/parent) do not need to be registered as a child.

Patient Eligibility

A patient is considered a 340B eligible patient of the covered entity, only if the following conditions are met:

- The patient is an *outpatient* of the covered entity.
- The covered entity has established a relationship with the individual, which includes maintaining records of the individual's health care at the covered entity (parent) or a HRSA/OPA registered site of care (child).
- The individual receives health care services from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the individual's care remains with the covered entity.

Note: Employees of the hospital (covered entity) **are not** automatically 340B eligible patients solely by virtue of their employment status. A medical relationship must extend beyond the



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dispensing of medications for subsequent self-administration or administration in the home setting.

Prescriber Eligibility

Eligible prescribers of 340B drugs are employed by the hospital/covered entity or are under contractual or other arrangement with the hospital/covered entity. The hospital maintains a separate listing for each type of prescriber.

Duplicate Discount - Medicaid Carve-in Medicaid Carve-out

A covered entity may choose to carve-in 340B drugs for their Medicaid patients. On the HRSA/OPA database the covered entity would check 'yes' on the Medicaid tab and provide the Office of Pharmacy Affairs (OPA) with their Medicaid provider number, which is then placed in the HRSA Medicaid Exclusion file provided to the State agencies. This prevents the State from taking a duplicate discount with the manufacturer's rebates.

GPO Exclusion/Prohibition

Disproportionate Share Hospitals (DSH), Children's Hospitals, and Free Standing Cancer Hospitals (CAN) are prohibited from obtaining 340B covered outpatient drugs through Group Purchasing Organizations (GPO).

Orphan Drug Rule

Orphan Drugs as designated by the Food and Drug Administration (FDA) may **not** be purchased by Critical Access Hospitals (CAH), Sole Community Hospitals, Rural Referral Centers (RRC) or Free Standing Cancer Hospitals (CAN) under the 340B Program. Effective October 1, 2013, FDA designated Orphan Drugs may be purchased by these covered entities under the 340B Program for **non**-Orphan Drug status indications. Auditable records must be maintained to show the drug was dispensed for a **non**-Orphan Drug Status indication.

Policy:

- Sonoma Valley Hospital participates in the 340B Drug Pricing Program.
- It is the policy of Sonoma Valley Hospital to operate the 340B Drug Pricing Program in compliance with guidelines set forth by the Office of Pharmacy Affairs (OPA) of the Health Resources and Services Administration (HRSA); and any accompanying regulations or guidelines including the prohibition against duplicate discounts/rebates under Medicaid and the prohibition against transferring drugs purchased under 340B to anyone other than a patient.
- Sonoma Valley Hospital is listed correctly as an eligible covered entity with the Office of Pharmacy Affairs (OPA) on the website <http://www.hrsa.gov/opa/>



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- Sonoma Valley Hospital's eligible off-site outpatient facilities/clinics and outpatient services outside of the four walls of the hospital are listed correctly as eligible child sites of the covered entity with the Office of Pharmacy Affairs (OPA) on the website <http://www.hrsa.gov/opa/> as applicable. The cost of operating these sites appears on the reimbursable section of the Medicare Cost Report.
- If applicable, contract pharmacies of Sonoma Valley Hospital, as stipulated in the *Contract Pharmacy Services Agreement(s)* between the hospital and the contract pharmacy, are correctly registered with the Office of Pharmacy Affairs (OPA).
- 340B medications are purchased for 340B eligible outpatient use only (i.e. a patient is an outpatient at the time the medication is administered).
- The Prime Vendor Program (Apexus) is utilized to increase savings opportunities via the 340B program.
- The hospital maintains lists of eligible prescribers, eligible outpatient treatment areas and off-site clinics, and registered contract pharmacies.
- Sonoma Valley Hospital maintains auditable records demonstrating compliance with the 340B requirement.

Procedure:

Responsible Parties

Authorizing Official

- Attests to the compliance of the program during the OPA recertification process

Contact Official

- Designated as the hospital's primary contact as listed on the OPA website

Director of Pharmacy

- Acts as an agent of the authorizing official and is responsible for administering the 340B program to optimize appropriate savings and ensure policies and procedures are in place to maintain program compliance
- Maintains knowledge of policy changes impacting the 340B program including but not limited to, HRSA/OPA rules and Medicaid changes

340B Oversight Committee

- Sonoma Valley Hospital has established a 340B Oversight Committee that is responsible for the oversight of the 340B Program.



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- The 340B Oversight Committee:
 - ♦ Meets on at least a semi-annual basis
 - ♦ Reviews 340B rules/regulations/guidelines to ensure consistent policies/procedures/oversight throughout the entity.
 - ♦ Identifies activities necessary to conduct comprehensive reviews of 340B compliance.
 - i. Ensure that the organization meets compliance requirements of program eligibility, patient definition, 340B drug diversion, and duplicate discounts via ongoing multidisciplinary teamwork.
 - ii. Integrates departments such as information technology, pharmacy, and patient financial services to develop standard processes for contract/data review to ensure program compliance.
 - ♦ Oversees the review process of compliance activities, as well as taking corrective actions based on findings.
 - ♦ Reviews potential violations, performs materiality assessment, and determines if a material breach has occurred.
 - i. The committee identifies to whom to self-disclose the breach dependent on that materiality determination and the corrective action plan resolution (see section on Material Breach below).
 - ♦ Reviews and approves work group recommendations (process changes, self-monitoring outcomes and resolutions).
 - ♦ Reviews this policy annually.

The following Sonoma Valley Hospital staff are potential key players in the 340B Program, including governance and compliance, and should be standing members of the 340B Steering Committee. Sonoma Valley Hospital will identify who serves as the entity's authorizing official and primary contact for the 340B Program. These individuals should be the sponsors of the 340B Oversight Committee.

1. Chief Executive Officer (CEO)
 - Responsible as the authorizing official in charge for the compliance and administration of the program
 - Responsible for attesting to the compliance of the program through recertification
2. Chief Financial Officer (CFO)
 - Responsible as the authorizing official in charge for the compliance and administration of the program in many cases



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- Potentially responsible for attesting to the compliance of the program through recertification
 - Must account for savings and use of funds to provide care for the indigent under the indigent care agreement
3. Director of Pharmacy
- Accountable agent for 340B compliance
 - Agent of the CEO or CFO responsible to administer the 340B Program to fully implement and optimize appropriate savings and ensure that current policy statements and procedures are in place to maintain program compliance
 - Must maintain knowledge of the policy changes that affect the 340B Program, including, but not limited to, HRSA rules and Medicaid changes
 - Must coordinate constant knowledge of any change in clinic eligibility/information
 - Often responsible as the primary contact for the 340B Program
 - Responsible for documentation of policies and procedures
 - Oversees maintenance of system databases to reflect changes in the drug formulary or product specifications
 - Ensures appropriate safeguards and system integrity
 - Ensures there is an annual inventory
 - Ensures compliance with 340B Program requirements for qualified patients, drugs, providers, vendors, payers, and locations
4. Pharmacy Buyer
- Responsible for establishing three distribution accounts and maintaining those accounts: non-GPO account, 340B account, and GPO account
 - Responsible for establishing and maintaining direct accounts for GPO ("own use") class of trade, as well as direct 340B accounts
 - Responsible for overseeing the ordering all drugs from the specific accounts as specified by the process employed
 - Responsible for segregation, removal, and/or return of 340B drugs, including reverse distributor transactions
 - Responsible for reconciliation of lend and borrow transactions
 - Responsible for maintenance of tracking software
 - Manages purchasing, receiving, and inventory control processes
 - Continuously monitors product minimum/maximum levels to effectively balance product availability and cost-efficient inventory control
 - Reviews and refines 340B cost savings report, detailing purchasing, and replacement practices as well as dispensing patterns
 - Monitors ordering processes, integrating most current pricing from wholesaler, and analyzes invoices, shipping, and inventory processes



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5. Controller/Patient Accounting Reimbursement Specialist
 - Responsible for communication of all changes to the Medicare cost report regarding clinics or revenue centers
 - Responsible for communication of all changes to Medi-Cal reimbursement for pharmacy services/products that affect 340B status
 - Responsible for modeling all managed care contracts (with/without 340B)
 - Engages pharmacy in conversations that affect reimbursement
 - Responsible for annual physical inventory of pharmacy items
 - Responsible for establishment of “inventory average” process approved by the external audit firm (reference policy or type of process used, e.g., FIFO)
6. Chief Information Officer (CIO) or department designee
 - Responsible for the support of interface requirements for proper functioning of tracking software
 - Responsible for the support of charge master and billing system functions as they support the 340B program.

340B Enrollment, Recertification and Change Requests

- The hospital's authorizing official annually recertifies information listed on the OPA website
- New service areas or clinics/facilities are evaluated to determine if the location is eligible for participation in the 340B Program. If deemed eligible the authorizing official completes the online registration process during the registration window and submits cost report information as required by OPA. New service areas are not eligible to purchase 340B drugs until they are listed on the OPA website.
- It is the ongoing responsibility of Sonoma Valley Hospital to inform OPA of any changes to its information or eligibility. An online change request is submitted as soon as the hospital is aware of the need to make a change to the database entry. If the hospital loses eligibility, it will notify OPA immediately and stop purchasing 340B discounted drugs.

340B Drug Utilization

Medications purchased under the 340B Drug Pricing Program are ONLY utilized for 340B eligible outpatients, as defined above, receiving medical care at:

- Sonoma Valley Hospital
- OPA registered child sites (clinics/offices) of Sonoma Valley Hospital
- OPA registered 340B Contract Pharmac(ies) of Sonoma Valley Hospital as stipulated in the *Contract Pharmacy Services Agreement(s)* between the hospital and the contract pharmacy.



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Purchasing

As a DSH, Children's or Free-Standing Cancer hospital, purchase of 340B eligible drugs for outpatient use through the group purchasing organization (GPO) or group purchasing arrangement is **prohibited**.

- As a hospital subject to the GPO prohibition, the hospital does **not** purchase covered outpatient drugs through a GPO for any of its clinics/departments within the four walls of the hospital (same physical address) or any of its registered child sites.
- Off-site outpatient clinics/facilities of the hospital **may** use a GPO account to purchase covered outpatient drugs if those off-site outpatient clinics/facilities meet all of the following criteria:
 1. Are located at a different physical address than the hospital;
 2. Are **not** registered on the OPA 340B database as participating in the 340B Program;
 3. Purchase drugs through a separate pharmacy wholesaler account other than the 340B account; and
 4. The hospital maintains records demonstrating that any covered outpatient drugs purchased through the GPO at these sites are not utilized or otherwise transferred to the parent hospital or any outpatient facilities registered on the OPA 340B database.

Drug Wholesaler Accounts

Separate accounts are maintained with the hospital's medication wholesaler. Purchase orders are entered in the wholesaler system under the appropriate account.

340B Account

The 340B account is used for purchasing:

- 340B medications for eligible outpatient use as defined in this policy.

Group Purchasing Organization (GPO) Account or Other Discount Purchasing Arrangements

The GPO account may be used for purchasing:

- Inpatient medications
- Outpatient medications used in off-site outpatient areas that are not registered as child sites as defined above.
- Drugs that are "bundled", i.e. drugs that are part of/incident to another service and payment is not made as direct reimbursement of the drugs, are not 340B eligible drugs and may be purchased on the GPO account. See section below on Billing/Utilization and Bundling.



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Wholesaler Acquisition Cost (WAC) Account

A WAC account is used by facilities that are subject to GPO exclusion/prohibition.

[Note: The Apexus Prime Vendor Program contracts may be used in place of the WAC acquisition, if applicable.] The account is used for:

- New drugs or NDC products that are purchased for the first time and will be used in a mixed inpatient outpatient setting.
- Drugs purchased to replace stock due to wastage, expiration, or lost charges and therefore have not accumulated equivalent usage under 340B or GPO accounts will be purchased using the WAC account and pricing.
- Drug utilization that cannot be attributed to either inpatient or outpatient use.
 - Outpatient drugs ordered for personal use by employees of Sonoma Valley Hospital will be ordered using the WAC account and pricing.
 - The hospital will be reimbursed by the employee for the cost of the drug(s) ordered for personal use.
 - This includes covered OTC medications and drugs ordered pursuant to a valid prescription.

Inventory Management

Virtual Inventory Separation

- Virtual inventory separation is generally used in mixed settings where some patients are inpatient and some patients are outpatient.
- Drug utilization in mixed settings is separated into different buckets based on 340B eligibility;
 - Wholesale Acquisition Cost (WAC), 340B or GPO
- Mixed setting 340B drug utilization is purchased retrospectively.

Automated Split-ordering/billing Virtual 340B Inventory Management Systems

Sonoma Valley Hospital utilizes Wellpartner's "340B Smart" software to manage the process of identifying eligible prescriptions/orders for inpatient GPO purchases and outpatient 340B purchases. The split-billing software determines the eligibility and patient's status; medication dispensed and maintains a virtual drug inventory for each of the purchasing accounts. The software is used to manage the drug inventory in 'mixed use' patient population where both outpatient and inpatient medications are used.

- Split-billing software separates or 'splits' the purchase order (PO) for each item based on eligibility determination of the patient's status, provider, treatment location and 11 digit NDC



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match. Based on the eligibility determination, the PO is “split” between WAC, 340B eligible drugs, and GPO eligible drugs.

- Split-billing software submits the order back to the wholesaler electronically in separate PO’s:
 - WAC Account
 - 340B Account (340B eligible drugs) and
 - GPO Account (GPO eligible drugs)
- The separate purchase orders are submitted to the wholesaler.

Changes to Wholesaler Drug Ordering Procedures

For the purpose of 340B compliance, changes in wholesaler drug ordering procedures are managed using the following guidelines:

Long Term Shortages

For situations in which there will be an extensive shortage of a medication (e.g., manufacturer backorder), the following steps occur:

- The first acquisition of a new NDC# is purchased on the WAC account.
- The pharmacy information system is updated with the new NDC number.
- It is assumed that drugs in stock in the pharmacy as of this date will be used on qualified outpatients for the next 30 days.
- The 340B database is updated 30 days later to allow existing inventory to be used.

GPO Contract Rolls

For GPO contract rolls, the following steps occur:

- Identify the start date of the new contract(s).
- The pharmacy information system is updated with the new NDC number.
- It is assumed that drugs in stock in the pharmacy as of this date will be used on qualified outpatients for the next 30 days.
- The 340B database is updated 30 days later to allow existing inventory to be used.
 - Database will be updated sooner than 30 days if stock is depleted

Package Size Changes

Changes in the manufacturer package sizes result in changes in the number of doses required for reorder. In these instances, a new CDM is assigned to the line item to maintain the integrity of the inventory database.



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Billing/Utilization

Bundling

Based on the current Ambulatory Payment Classification (APC) group payments for a particular service, appropriate billing practices for bundled drugs is determined. The application of bundling charges is consistent throughout the organization. Based on these practices, the hospital determines which drugs may be separately “billable” and therefore, “unbundled” in order to utilize 340B pricing.

- Drugs that are part of/incident to another service, and payment is not made as direct reimbursement of the drugs, are “bundled” drugs.
- Drugs that are “bundled” are not 340B eligible drugs and may be purchased on a GPO account.
 - Examples of bundled drugs include anesthesia gasses and some drugs used in diagnostic testing.
- Bundling charges is not used to avoid compliance with GPO prohibition.

Third Party Payers

Prescriptions for outpatient medications are priced according to specific price agreements with payers.

Medicaid

Prescriptions for Medi-Cal patients are priced in accordance with state requirements:

- CARVE IN: The hospital/covered entity uses 340B drugs for Medicaid patients.
 - Sonoma Valley Hospital has opted to carve-in Medicaid 340B utilization
 - The hospital confirms that all Medicaid billing numbers and NPIs used by the hospital to bill Medicaid for 340B drugs are listed in Medicaid’s Exclusion File Database.
 - Claims must be filled out correctly to prevent “duplicate discounts” which occur when the drug manufacturer gives the provider the discounted 340B price and pays a Medicaid rebate.
 - In order to prevent the “duplicate discount”, Sonoma Valley Hospital identifies drug claims in which 340B drugs were used with a “UD” modifier to inform DHCS that a 340B purchased drug was used for the claim.

Monitoring and Auditing

Material Breach:



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REVISED:

1. Sonoma Valley Hospital defines a material breach of compliance as a violation(s) that exceeds 5% of hospital drug purchases or impact to any one manufacturer and remain non-correctable within 30 days.
 - a. Sonoma Valley Hospital ensures that identification of any threshold variations occurs among all its 340B settings, including contract pharmacies (if applicable).
 - b. Violations identified through internal self-audits, independent external audits, or other methods that exceed this threshold and remain non-correctable within the entity-defined period timeframe of review, will be immediately reported to HRSA (at 340Bselfdisclosure@hrsa.gov) and applicable manufacturers using the following self-disclosure report template:
 - i. https://docs.340bpvp.com/documents/public/resourcecenter/ALL_Entities_Self_Reporting_340B_Non_Compliance.docx
2. Sonoma Valley Hospital maintains records of materiality assessments.
3. Sonoma Valley Hospital maintains records (including all internal or external correspondence and corrective action plans) of violations, materiality assessment, and resolution of manufacturer self-disclosure and/or formal self-disclosure to HRSA.
4. The Sonoma Valley Hospital 340B Committee oversees this process, reviews potential violations, performs materiality assessment, and determines if a material breach has occurred.
 - a. The committee identifies to whom to self-disclose the breach dependent on that materiality determination and the corrective action plan resolution.

The following guidelines are used for the purpose of monitoring 340B compliance:

Monthly:

Database Crosswalk

- Randomly select any drugs from the Pharmacy Information System.
- Record the NDC number assigned to each drug product.
- Determine if each NDC number matches the NDC number of the product on the shelf.
- Review accuracy of units of measure for each product.
- Validate that the product is currently mapped accurately in the database crosswalk.

Quarterly:

Validation of Eligibility

- Log onto the Office of Pharmacy Affairs web site to validate participation in the program. <http://www.hrsa.gov/opa/introduction.htm>.
- Review the hospital Medicare Cost Report to identify:



SUBJECT: 340B Drug Discount Purchasing Program

POLICY #MM8610-158

DEPARTMENT: Organizational

PAGE 15 OF 16

EFFECTIVE: 7/2017

REVISED:

- Changes in classifications of departments and outpatient treatment areas.
- The DSA% on the Medicare Cost Report remains at 11.75% or higher for DSH

Outpatient Treatment Areas (if applicable)

- Review the treatment area cost centers and center numbers. This list identifies treatment areas as 'Clean' (outpatients only treated), 'Mixed' (inpatient and outpatients treated) or 'Not Eligible' for 340B pricing.
- Re-classify clinics as necessary.
- Classify any new clinics and cost centers. Verify with Information Systems staff that the clinic cost centers are included in the Outpatient Charge Capture Report.

PO Generator Facilities

- Download a 340B purchase history report for a three month period for several drugs that are administered only in outpatient treatment areas. Compare the number of units purchased against the number of units justified by documented charges.
- Investigate discrepancies that are larger than can be explained by small shifts in on hand inventory.

Wholesaler Pricing

- The availability of the prices are verified by random checks of pricing in the wholesaler database.

Compliance Checklists

- Complete 340B Health's 340B Compliance Checklist. Any significant findings are addressed with a plan of correction and reported to the Sonoma Valley Hospital CEO.

Training

1. Sonoma Valley Hospital determines the knowledge and educational requirements for each 340B Program role
2. 340B key stakeholders complete initial basic training upon hire via the link below:
 - a. <https://www.brainshark.com/apexus/TopFive340BBasics> OR
 - b. Attend 340B University or view the 340B University OnDemand modules on the Apexus website
3. Sonoma Valley Hospital provides educational updates and training as needed (including but not limited to 340B policy changes, updates in HRSA guidance, etc.)



SUBJECT: 340B Drug Discount Purchasing Program

POLICY #MM8610-158

DEPARTMENT: Organizational

PAGE 16 OF 16

EFFECTIVE: 7/2017

REVISED:

Reference:

- Section 340B of the Public Health Service Act
- Office of Pharmacy Affairs 340B Drug Pricing Program website, <http://www.hrsa.gov/opa/> (accessed September 2013)
- 340B University Glossary of Terms <https://docs.340bpvp.com/documents/public/resourcecenter/glossary.pdf> (accessed September 2013)
- Policy # UR8610-100 Patient Status Determinations

DRAFT



SUBJECT: Access to Medication When the Pharmacy is Closed POLICY #MM8610-146
DEPARTMENT: Organizational PAGE 1 OF 1
REVISOR: 06/14, 7/17 EFFECTIVE: 08/2007

- Revised Reviewed/No Changes Retired

CHANGE SUMMARY:

Briefly state changes and include reasons for making change(s).

What:

Medications obtained when the pharmacy is closed are documented, tracked, and trended and the results analyzed to identify the need for access to additional emergency medications and the need for additional medication storage resources; as well as overall compliance and appropriateness of the hospital's after-hours medication practices. Updated units that are not on Pyxis Profile mode to reflect change in practice.

Why:

To establish a procedure for providing safe, quality care to meet a patient's urgent or emergent medication needs when the pharmacy is closed.

AUTHOR JOB TITLES:

Chris Kutza, Director of Pharmacy
Michael Brown, M.D., Pharmacy & Therapeutics Chair

COMMITTEE APPROVALS:

Michael Brown, M.D., Pharmacy & Therapeutics Chair:
Policy & Procedure Team: 6/20/17
P&T Committee: 7/6/17
Medical Executive Committee: 7/20/17
Board Quality Committee:
The Board of Directors:



SUBJECT: Diet Manual and Approval	POLICY # NU8340-151
DEPARTMENT: Nutritional Services	PAGE 1 OF 2
REVIEW/REVISED:	EFFECTIVE:

NEW POLICY

The new policy is eliminating a physical Diet Manual and using an online manual from the American Dietetic Association. Access will be given to all care givers through the ADA Website.

AUTHOR JOB TITLES:

Bob Harrison, Nutritional Manager
Michael Brown, M.D., Pharmacy & Therapeutics Chair

COMMITTEE APPROVALS:

Policy & Procedure Team: 6/20/17
Performance Improvement Committee: 10/26/17
Medical Executive Committee: 11/19/17
Board Quality Committee:
The Board of Directors:

DRAFT



SUBJECT: Diet Manual and Approval

POLICY # NU8340-151

DEPARTMENT: Nutritional Services

PAGE 2 OF 2

EFFECTIVE:

REVIEW/REVISED:

Policy:

To provide patients with daily meals which provide the Recommended Food and Nutrition Allowances. It is the policy of the hospital that the Clinical Dietitian provides up-to-date clinical information to patients instructed on modified diets. The Diet Manual outlines current guidelines for regular and modified diets which will meet the patient's nutrient needs. All diets that do not meet the RDA are identified in the diet manual.

Procedure:

The Diet Manual used at Sonoma Valley Hospital is the Clinical Diet Manual – A Handbook for Medical Nutrition Therapy 16th Edition, by Food and Nutrition Management Services Inc. It will serve as a clinical resource for patients on modified diets. Also available for reference is the Online Nutrition Care Manual of the Academy of Nutrition and Dietetics.

1. The Diet Manual used at Sonoma Valley Hospital is the Online Nutrition Care Manual of the Academy of Nutrition and Dietetics. This will serve as a clinical resource for patients staff, and physicians, on modified diets. Also available for reference is the
2. A link to the Manual will be available in all patient care areas.
3. When necessary, the Director of Food and Nutrition Services and the Clinical Dietitian will adapt the Diet Manual to hospital policies and procedures.
4. The physician is urged to order patient diets according to the hospital's Diet Manual. Arrangement for other modifications may be made by consulting with the dietitian.

Reference:

CIHQ Standard of Care NU-04

SUBJECT: Emergency Operations Plan 2018

POLICY # EM8610-100

DEPARTMENT: Organizational

EFFECTIVE: 09/07

REVIEW/REVISED: 05/12, 3/13, 1/14, 2/15, 12/17

Revised

Reviewed/No Changes

Retired

CHANGE SUMMARY:

The EOP plan has been revised to reflect current changes in Emergency Management Committee structure and associated FEMA educational requirements for team members. CMS has added 3 additional standards and requirements to Emergency Preparedness in 2017 and the policy reflects the new requirements. Phone lists for contact agencies listed in the Appendices were updated.

What: This policy is required to be updated annually and had not been updated since 2015. Changes to regulatory requirements have since been added. Structure of Emergency management committee

Why: Much of the policy and appendix information was out of date. The recent fire storm last October brought much of that to light.

OWNER:

Emergency Management Committee

AUTHORS/REVIEWERS:

Mark Kobe, Chief Nursing Officer

Dawn Kuwahara, Chief Ancillary Services Officer

Gregory Gatenian, Engineering Manager

Celia Kruse dela Rosa, Marketing & Public Relations Coordinator

APPROVALS:

Policy & Procedure Team: 2/20/2018

Board Quality Committee:

The Board of Directors:



SUBJECT: Handling of Medical Gas Cylinders in Patient Care Areas

POLICY #QS8610-131

PAGE1 OF3

DEPARTMENT: ORGANIZATIONAL

DATE:

REVISED:

NEW POLICY

Why: During recent CDPH survey the need for this policy was identified by the surveyor per NFPA 99 2012, 11.5.2.1.3.

What:

To establish safe handling procedures for oxygen and other medical gases cylinders stored and used in patient care areas. Cylinders under pressure present potential danger of explosion, fire or become a projectile if not secured properly

OWNER:

Director of Facilities

AUTHORS/REVIEWERS:

Kimberly Drummond, Director of Facilities
Grigory Gatenian, Plant Operations Manager
Lynn McKissock, Director of Human Resources

APPROVALS:

Policy & Procedure Team: 2/20/2018
Board Quality Committee:
The Board of Directors:



SUBJECT: Handling of Medical Gas Cylinders in Patient Care Areas	POLICY #QS8610-131
DEPARTMENT: ORGANIZATIONAL	PAGE 2 OF 3
REVISED:	DATE:

PUPROSE:

To establish safe handling procedures for oxygen and other medical gases cylinders stored and used in patient care areas.

Cylinders under pressure present potential danger of explosion, fire or become a projectile if not secured properly.

POLICY:

Personnel involved in application, handling and maintaining medical gases and cylinders containing medical gases shall be trained on the risks associated with such duties.

All freestanding cylinders shall be stored in a rack, on a cart, in a portable cylinder holder or secured with a chain to protect them from falling over. Full cylinders shall be segregated from partially filled and empty cylinders. Signs shall be installed on racks to identify them as **full** and **empty**.

PROCEDURE:

All employees involved in direct patient care, as well as employees in Materials Management and Engineering, will be assigned the online training module in regards to the safe administration and handling of medical gas cylinders and gases upon hire.

All employees involved in the handling and use of medical gas cylinders and gases will be assigned continuing education for the safe administration and management of medical gas cylinders and gases on an annual basis.

Gas Cylinder Fill Status:

FULL means the cylinder has not been opened, the gauge arrow is in the “green.”
EMPTY means the cylinder has been used (regardless of remaining pressure)

Cylinders IN-USE vs. IN-STORAGE:

“IN-USE” - Cylinders properly secured to a gurney, wheel chair, crash cart, medical equipment, etc., are considered “IN-USE.” In addition, pursuant to CMS letter S&C-



SUBJECT: Handling of Medical Gas Cylinders in Patient Care Areas

POLICY #QS8610-131

PAGE3 OF3

DEPARTMENT: ORGANIZATIONAL

DATE:

REVISED:

07-10, an individual cylinder placed in a patient room for immediate use by a patient is also "IN-USE."

"IN-STORAGE" - All other cylinders placed in the appropriately labeled racks.

Inventory Control:

The end user department should establish PAR levels based on anticipated and historical use data. The Materials Management distribution tech will monitor and maintain that level.

The distribution tech along with the end user department shall ensure the 300 cubic feet (12 e-size cylinders) limit is not exceeded.

REFERENCE:

National Fire Protection Association, NFPA 99-2012 section 11.5.2.1.1; 11.5.2.1.2

DRAFT



SUBJECT: Handoff Communications with HealthCare Providers/SBAR	POLICY #PC8610134
DEPARTMENT: Organizational	PAGE1 OF1
REVIEW/REVISED: 12/08, 2/14	EFFECTIVE: 12/07

- Revised Reviewed/No Changes Retired

CHANGE SUMMARY:

Briefly state changes and include reasons for making change(s).

What:

Added: "Use Ticket to Ride SBAR form" under Transport of Patient to/from Diagnostic or Procedural Areas

Changed: reference "2009 Joint Commission Standards: NPSG" to "National Patient Safety Goals 2009, 02.02.01"

Why:

To provide accurate information about a patient's care, treatment, or services when responsibilities are "handed off" from one care provider to another.

New Cal OSHA requirement to include information on patients who are at risk for violence during patient handoffs. The question: "At risk for violence- yes or no" was added to the Ticket to Ride form used when patient is off the nursing unit for diagnostics or procedure. The Ticket to Ride form was added to the Handoff Communications with HealthCare Providers/SBAR policy.

AUTHORS:

Education Coordinator

APPROVALS:

Policy & Procedure Team: 12/19/17

Medicine Committee: 1/11/18

Medical Executive Committee: 1/18/18

Board Quality Committee:

The Board of Directors:



SUBJECT: Humidity and Temperature Monitoring in Surgery and Birthplace Surgical Suites

POLICY #OI8610-102

DEPARTMENT: Organizational

PAGE 1 OF 1

EFFECTIVE: 6/11

REVIEW/REVISED: 3/12, 2/16

Revised Reviewed/No Changes Retired

CHANGE SUMMARY:

Briefly state changes and include reasons for making change(s).

What: Removed the verbiage “include the comfort of the surgery team, excessive perspiration” and changed to “Recommended temperature range is 68-73°F but considerations for adjustments to temperature include clinical needs of the patient or the procedure” as this is not in alignment with ASHREA Standard 170.

Removed “The Surgery and Birthplace Department staff shall be responsible for monitoring temperature and relative humidity levels on a daily basis when the surgical suites are in use” and changed to “The Surgery and Birthplace Department staff shall be responsible for monitoring and documenting temperature and relative humidity levels during stable times (first thing in the morning, before surgical cases)”

Why:

The changes reflect the current recommendations by ASHREA Standard 170 for monitoring and documenting temperature in the operating rooms to ensure regulatory compliance and patient safety. Reading should be taken in stable environment, per regulations.

AUTHORS:

Janine Clark, Surgery Manager
Andrew Solomon, M.D., Medical Director of Surgical Services

APPROVALS:

Policy & Procedure Team: 11/21/17
Surgery Committee: 12/6/17
Medical Executive Committee: 12/21/17
Board Quality Committee:
The Board of Directors:



SUBJECT: Medical Imaging Operational Hours and Support Services

POLICY #PC7630-109

DEPARTMENT: Medical Imaging Department

PAGE 1 OF 2

EFFECTIVE: 02/93

REVISED: 01/05, 08/13, 01/15, 09/16, 08/17

Revised Reviewed/No Changes Retired

CHANGE SUMMARY:

This policy updates the previous policy to make it Title 22 compliant.

Sonoma Valley Hospital was cited for non-compliance with Title 22 for not providing 24 hours ultrasound coverage. Title 22 doesn't spell requirement for 24 hours coverage by ultrasound, but it does require that the Imaging Department supports Basic Emergency Medical Services. The minimum requirement is one x-ray room with Fluoro capability and personnel trained to operate that equipment. The Imaging Department is, in fact compliant with Title 22, but the previous policy made us vulnerable to interpretation, because it listed all different modalities and their operational hours. State requirements are not separate for different modalities and Title 22 is at best ambiguous. The only specific requirement is for x-ray, as mentioned above.

What:

The Imaging Department operational hours and support services hours are globalized without breaking the hours by department. This is necessary for compliance. See explanation below:

Why:

To establish the Imaging services scope and operational hours and provide support for the Hospital and Basic Emergency Medical services. The previous policy was based on the operational capabilities and detailed services that we provide without mention of compliance with Title 22. The revised policy is drafted to reflect the overall services Imaging Department provides to comply with Title 22 and is not open for interpretation by inspectors.

AUTHORS:

Sonya Todorova, Imaging Manager

APPROVALS:

Adam Nevitt, M.D., Medical Director of Imaging: 9/18/17

Policy & Procedure Team: 9/19/17

Surgery Committee: 12/6/17

Medical Executive Committee: 12/21/17

Board Quality Committee:

The Board of Directors:



SUBJECT: Medical Imaging Operational Hours
and Support Services

POLICY #PC7630-109

DEPARTMENT: Medical Imaging Department

PAGE 2 OF 2

EFFECTIVE: 02/93

REVISED: 01/05, 08/13, 01/15, 09/16, 08/17

DRAFT



Policy and Procedure – Summary of Minor Changes

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

REVIEWED / NO CHANGES

Disposal of Medical and Biohazardous Waste IC8610-120

MINOR CHANGES

Compounding Drug Products MM8610-137

added California requirement for “Compounded in Pharmacy” labeling requirement

Reporting Controlled Substance Theft or Loss MM8610-141

added detail for California requirements for number of days allowed before reporting is required

Unit Dose Packaging MM8610-143

updated California expiration dating requirements

UPDATED REFERENCES

Authorized Access to Medication Storage Areas MM8610-145

Compounding Drug Products MM8610-137

Fentanyl Patch MM8610-130

Herbal and Natural Product Use MM8610-136

High Alert Medications MM8610-131

Investigational Drug Use MM8610-135

Labeling of Medications MM8610-132

Licensed Pharmacy Employee Theft or Impairment MM8610-140

Medication Recalls MM8610-139

Medication Reconciliation MM8610-144

Medication Shortages MM8610-142

Nursing Screening for Nutritional Risk NU8610-102

Pyxis Medstation, Management and Use of MM8610-147

Standing Orders and Protocols MM8610-134

Unapproved Abbreviations MM8610-128



SUBJECT: MRI, Patient Preparation

POLICY #MM7630-102

DEPARTMENT: Medical Imaging Department

PAGE1 OF4

EFFECTIVE:

Reviewed/Revised:

NEW POLICY

Why:

To establish the oral sedation and safety procedures for all MRI exams.

AUTHOR JOB TITLES:

Sonya Todorova, Imaging Manager
Adam Nevitt, M.D., Medical Director of Imaging

APPROVALS:

Adam Nevitt, M.D., Medical Director of Imaging: 9/18/17
Policy & Procedure Committee: 9/19/17
Surgery Committee: 12/6/17
Medical Executive Committee: 12/21/17
Board Quality Committee:
Board of Directors:

DRAFT



SUBJECT: MRI, Patient Preparation	POLICY #MM7630-102
DEPARTMENT: Medical Imaging Department	PAGE2 OF4
Reviewed/Revised:	EFFECTIVE:

PURPOSE:

To establish the oral sedation and safety procedures for all MRI exams.

POLICY:

Two safety screening forms must be completed and signed by a qualified nurse or clinician. These forms are found on the SVH intranet. If a detailed full medical and surgical history cannot be completed due to patient condition, family members can assist with completing the safety forms.

All safety questions need to be answered as fully as possible. These forms must be signed and dated by floor personnel or clinician. MRI screening forms should be faxed to MRI at 935-5249 as soon as possible after completion.

This process satisfies the medical legal requirement involving MRI safety and must be completed in its entirety to move forward with the exam. MRI scans cannot be performed without completed Safety forms.

PROCEDURE:

Many patients experience situational anxiety when providers order MRI exams. These problems are usually remedied with oral sedation. Patient's ability to be still during their MRI test is very important for the quality of the exam and allows as to provide the best standard of care.

Sedation cannot be done at the MRI van for safety reasons and it has to be administered 30 minutes before the inpatient's MRI scheduled time. Due to scheduling limitations, if sedation fails, or the patient declines the MRI exam, they will be rescheduled for the next business day.

Scope/Responsible Persons:

- Manager of Medical Imaging
- Medical Director
- Nurse Supervisor
- Chief Nursing Officer
- Skilled Nursing Director



SUBJECT: MRI, Patient Preparation

POLICY #MM7630-102

DEPARTMENT: Medical Imaging Department

PAGE 3 OF 4

EFFECTIVE:

Reviewed/Revised:

DRAFT



SUBJECT: MRI, Patient Preparation

POLICY #MM7630-102

DEPARTMENT: Medical Imaging Department

PAGE4 OF4

EFFECTIVE:

Reviewed/Revised:

REFERENCE:

<http://www.IMRSER.org>; website for the Institute for Magnetic Resonance Safety, Education, and Research

Shellock FG, Spinazzi A. MRI Safety Update: 2008, Part 2, Screening patients for MRI. American Journal of Roentgenology. 2008;191:12-21.

Bangard C, et al. MR imaging of claustrophobic patients in an open 1.0T scanner: Motion artifacts and patient acceptability compared with closed bore magnets. Eur J Radiol 2007;64:152-7.

DRAFT



SUBJECT: Non-Obstetric Elective Surgery During Pregnancy

POLICY: PC8610-178

DEPARTMENT: Surgical Services

PAGE 1

EFFECTIVE:

REVISED:

New Policy

WHAT:

A policy with guidelines regarding elective surgery for pregnant patient at SVH

WHY:

Inherent risks to fetus from anesthetics as well as limited resources for provision of care to prematurely delivered neonate. We will use a team approach involving all caregivers to decide best scenario for mother/fetus using these guidelines and rules.

OWNER:

Mark Kobe, Chief Nursing Officer

AUTHORS/REVIEWERS:

Janine Clark, Surgery Manager

Andrew Solomon, M.D., Medical Director of Surgical Services

D. P. Amara, M.D., Medical Director of Obstetrics and Gynecology

APPROVALS:

Surgery Committee: 12/7/17

Policy & Procedure Team: 12/19/17

Medical Executive Committee: 12/21/17

Board Quality Committee:

The Board of Directors:



SUBJECT: Non-Obstetric Elective Surgery During Pregnancy

POLICY: PC8610-178

DEPARTMENT: Surgical Services

PAGE 1

EFFECTIVE:

REVISED:

PURPOSE:

To establish clear guidelines in determining safest options for pregnant patient who presents to SVH for surgical procedures with the existing services provided at SVH in consideration of both the pregnant patient as well as her unborn fetus.

POLICY:

Because of limited neonatal services at SVH, SVH will not perform elective and/or non-urgent surgeries on any pregnant patient with gestation of 22 to 36 weeks.

In cases or urgent or emergent surgeries, each case will be decided upon using a team approach and will include anesthesia, surgeon, nurses, and the obstetric and pediatric provider to determine optimal safety and outcome for the woman and fetus.

PROCEDURE:

Based on ACOG Committee Opinion, Number 696, April 2017:

- A pregnant woman should never be denied indicated surgery, regardless of trimester.
- Elective surgery should be postponed until after delivery. If possible, nonurgent surgery should be performed in the second trimester when preterm contractions and spontaneous abortions are least likely.
- If fetal monitoring is to be used, surgery should be done at an institution with neonatal and pediatric services and an obstetric care provider with cesarean delivery privileges should be readily available.
- When nonobstetric surgery is planned, the primary obstetric care provider should be notified. If that health care provider is not at the institution where surgery is to be performed, another obstetric care provider with privileges at that institution should be involved.
- Ultimately, each case warrants a team approach (anesthesia and obstetric care providers, surgeons, pediatricians, and nurses) for optimal safety of the woman and the fetus.

REFERENCE:

ACOG Committee Opinion, Number 696, April 2017
(Replaces Committee Opinion Number 474, February 2011)



SUBJECT: Pharmacist Review of Medication Orders	POLICY #MM8610-119
DEPARTMENT: Organizational	PAGE1 OF1
REVIEWED/REVISED: 2/16	EFFECTIVE: 2/14

Revised Reviewed/No Changes Retired

CHANGE SUMMARY:

Briefly state changes and include reasons for making change(s).

What: Added:

- When auto-processing of Computerized Physician Order Entry (CPOE) is used to bypass prospective pharmacist review using existing Electronic Medical Record (EMR) functionality
 - ✓ Auto-processing is only applied to designated medication order sets that originate in the Emergency Department (ED)
 - ✓ Order sets to be auto-processed will be approved by the medical staff via applicable committee review (refer to list of order sets approved for auto processing found on the SVH Intranet under Pharmacy)
 - ✓ The pharmacist will retrospectively review all medications that underwent auto-processing

Why: To improve turnaround time for medication orders in the ED.

OWNER:

Chris Kutza, Director of Pharmacy

AUTHORS/REVIEWERS:

Chris Kutza, Director of Pharmacy

APPROVALS:

Policy & Procedure Team: 12/19/17

P&T Committee: 1/25/18

Medical Executive Committee: 2/15/18

Board Quality Committee:

The Board of Directors:



SUBJECT: Pharmacy and Therapeutics Committee

POLICY #8610-129

DEPARTMENT: Organizational

PAGE 1 OF 2

EFFECTIVE: 03/2012

REVISED: 03/14, 7/17

Revised Reviewed/No Changes Retired

CHANGE SUMMARY:

Briefly state changes and include reasons for making change(s).

What:

Added section on conflict of interest

Conflict of Interest

To assure decisions made by the Pharmacy and Therapeutics Committee are of the highest ethical quality and not influenced by any associations with outside sources with respect to an alternate agenda the following is required:

- Pharmacy and Therapeutics Committee members in order to serve are required to complete and sign a Conflict of Interest Disclosure Statement. See **Appendix A: Conflict of Interest Disclosure Form** below.
- Anyone who provides information or recommendations to the committee related to medication use is required to sign a Conflict of Interest Disclosure Statement.
- Any practitioner submitting a request for formulary revision is required to provide a Conflict of Interest Disclosure Statement.
- Conflict of Interest Disclosure Statement forms are submitted to the Pharmacy and Therapeutics Committee Chairperson or the Director of Pharmacy and are reviewed by the committee. Any actual or potential conflicts identified will attempt to be resolved. Conflict of Interest Disclosure Statements are retained on file by the Director of Pharmacy Services.
- Any member of a hospital committee who perceives a conflict of interest for himself/herself is required to take the following actions:
 - Declare the conflict of interest prior to beginning discussions or debate.
 - Refrain from voting on an issue in which the conflict of interest exists.
 - Refrain from influencing other members' votes for an issue in which a conflict of interest exists.
- Any member that perceives or suspects another member of a potential conflict of interest is required to request tabling the discussion until the suspicions and conflicts are resolved.



SUBJECT: Pharmacy and Therapeutics Committee

POLICY #8610-129

DEPARTMENT: Organizational

PAGE 2 OF 2

EFFECTIVE: 03/2012

REVISED: 03/14, 7/17

Why:

To add current best practice of indicating conflict of interest for committee members or presenters. The Pharmacy and Therapeutics Committee must assure balance, independence, objectivity and credibility in all of its actions and resolutions. To do so the committee maintains and enforces a Conflict of Interest policy and procedure that requires disclosure of interests or relationships with drug manufacturer(s) or any pharmaceutical product(s)

AUTHOR JOB TITLES:

Chris Kutza, Director of Pharmacy
Michael Brown, M.D., Pharmacy & Therapeutics Chair

COMMITTEE APPROVALS:

Policy & Procedure Team: 6/20/17
P&T Committee: 7/6/17
Medical Executive Committee: 7/20/17
Board Quality Committee:
The Board of Directors:



SUBJECT: Rapid Response Team-Unexpected Clinical Deterioration

POLICY #QS8610-124

DEPARTMENT: Organizational

PAGE1 OF1

EFFECTIVE: 11/05

REVIEW/REVIEW: 2/08, 8/13, 6/16

Revised Reviewed/No Changes Retired

CHANGE SUMMARY:

Briefly state changes and include reasons for making change(s).

What: The construct of the team is being changed. Primary responding RN will no longer be the ICU RN. Changing to primary responding RN is ED RN

Why: ICU staffing per CDPH title 22 is mandated 2 RNs. When an RRT is called the ICU RN must be replaced by a M/S RN to maintain title 22 standards. This can slow response time. ED has more staffing and therefore more flexibility to send an RN to an RRT. Additionally, ED RNs PALS certified.

OWNER:

Chief Nursing Officer

AUTHORS/REVIEWERS:

Mark Kobe, Chief Nursing Officer

COMMITTEE APPROVALS:

Policy & Procedure Team: 1/16/18

Medicine Committee: 2/8/18

Medical Executive Committee: 2/15/18

Board Quality Committee:

The Board of Directors:



SUBJECT: Warfarin Dosing Protocol

POLICY #MM8610-103

DEPARTMENT: Organizational

PAGE 1 OF 1

EFFECTIVE: 7/26/99

REVIEWED/REVISED: 8/04, 12/05, 11/07, 11/12, 7/17

Revised Reviewed/No Changes Retired

CHANGE SUMMARY:

Briefly state changes and include reasons for making change(s).

What:

Removal of monitoring UA, updating to reflect use of CPOE for process, reducing the number of in range INRs to allow expanding the days between lab draws, defined nursing eMAR task for “No Dose Due”.

Why:

To outline the pharmacist’s responsibilities when an order is written for pharmacy to dose warfarin (Coumadin) per protocol. To match current practice and reduce the number of lab draws.

AUTHOR JOB TITLES:

Chris Kutza, Director of Pharmacy
Michael Brown, M.D., Pharmacy & Therapeutics Chair

COMMITTEE APPROVALS:

Policy & Procedure Team: 6/20/17
P&T Committee: 7/6/17
Medical Executive Committee: 7/20/17
Board Quality Committee:
The Board of Directors:



SUBJECT: Workplace Violence Prevention Program

POLICY #HR8610-371

DEPARTMENT: Organizational

PAGE 1 OF 7

EFFECTIVE: 4/18

REVIEW/REVISED:

NEW

This policy replaces "Prevention of Workplace Violence HR8610-354" which will be concurrently retired.

Why: California's division of Occupational Safety and Health (Cal/OSHA) has implemented new regulatory requirements specifically aimed at protecting health care workers against workplace violence. A written Workplace Violence Prevention Plan meeting specific requirements is part of this new regulation, with an effective date of April 1, 2018.

OWNER:

Safety Committee

AUTHORS/REVIEWERS:

Lynn McKissock, Director of Human Resources
Danielle Jones, Director of Quality and Risk Management
Kimberly Drummond, Director of Facilities
Grigory Gatenian, Plant Operations Manager/Safety Officer
Mark Kobe, Chief Nursing Officer
Bonnie Bernhardt, Education Coordinator
Dawn Kuwahara, Chief Ancillary Officer
Lisa Duarte, Admitting Manager

APPROVALS:

Safety Committee: 2/14/18
Policy & Procedure Team: 2/20/2018
Board Quality Committee:
The Board of Directors: /



SUBJECT: Workplace Violence Prevention Program

POLICY #HR8610-371

DEPARTMENT: Organizational

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EFFECTIVE: 4/18

REVIEW/REVISED:

PURPOSE:

Sonoma Valley Hospital (SVH) is committed to preventing workplace violence and to maintaining a safe work environment. SVH has adopted the following guidelines to deal with intimidation, harassment or other threats of or actual violence that may occur during work-related activities.

POLICY:

SVH refuses to tolerate any form of violence in the workplace and will make every effort to prevent violent incidents from occurring by implementing a Workplace Violence Prevention (WVP) Program. We will provide adequate authority and budgetary resources to responsible parties so that our goals and responsibilities can be met, to every extent possible.

All staff are responsible for actively supporting and adhering to our WVP Program and we encourage employee participation in designing, implementing and updating our program. We require prompt and accurate reporting of all violent incidents whether or not physical injury has occurred. SVH shall take appropriate action to correct any violation of this policy, after an investigation into the facts and circumstances of each reported incident.

SVH prohibits retaliation against an individual who has alleged that a workplace violence incident has occurred, who has participated in an investigation of a workplace violence incident or who has reported an incident of workplace violence to law enforcement. Additionally, we will not discriminate against victims of workplace violence.

A copy of this policy statement and WVP Program is readily available to all employees, and the WVP Program Policy will be reviewed and updated annually.

PROCEDURE:

Workplace Violence pertains to any situation involving use of physical force against an employee by a patient or a person accompanying a patient that results in, or has the high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury AND regardless of the offender's intentions. Additionally, any use of a firearm or other dangerous weapon, regardless of whether the employee sustains an injury.

Incident Response

If an urgent or emergent threat is present or if the incident involves a firearm or other dangerous weapon, call 911 or use your panic button, if your unit is equipped with one. Call 5555 to initiate Code Grey, if applicable. Administer first aid and other care as appropriate to injured parties.

SUBJECT: Workplace Violence Prevention Program

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Any phone call received that is of a threatening manner should be documented – write down what the caller says and any details of the voice such as deep voice, calm or panicky, slurred speech, etc. If you have a display phone, write down the caller's number. Report the incident to your department leader or Nursing Supervisor and the Sonoma Police dispatch office, if appropriate.

Post-Incident Response/Investigation

Nursing Supervisor on duty will be notified by staff as well as department leader, if not already present. If the department leader is off duty, they may be called in, depending on the type of incident.

Types of Incidents and Response Steps

Type 1 (24-hour reporting requirement)

- Involves the use of a firearm or other dangerous weapon.
 - Results in injury that requires inpatient hospitalization in excess of 24 hours, other than medical observation.
 - Presents an urgent or emergent threat (hospital personnel are exposed to a realistic possibility of death or serious physical harm.
- 1) Admin Team member and department leader immediately present on-site (if not already present).
 - 2) Ensure appropriate care (physical and psychological) is provided to staff present. (See Support for Victims of Violence below.)
 - 3) Investigation Report completed (Parts 1 and 2) – SVH Intranet: Emergency/Infection/Safety, WVP Investigation Form (Excel spreadsheet with two sheet tabs). Must be completed electronically, printed, and signed.
 - 4) Online report submitted to Cal/OSHA by Admin Team member within 24 hours of the incident.
 - 5) All completed documentation turned over to Safety Officer for retention and Incident Log.

Type 2 (72-hour reporting requirement)

- Involves use of physical force against an employee that results in, or has the high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury.
- 1) Department leader presents on-site as soon as possible, no later than next day.
 - 2) Ensure appropriate care (physical and psychological) is provided to staff present. (See Support for Victims of Violence below.)



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- 3) Investigation Report completed (Parts 1 and 2) – SVH Intranet: Emergency/Infection/Safety, WVP Investigation Form (Excel spreadsheet with two sheet tabs). Must be completed electronically, printed and signed.
- 4) Completed Investigation Report submitted to Safety Officer for Online Report to Cal/OSHA, retention, and Incident Log.

Support for Victims of Violence

Victims of incidents under this policy may have to contend with a variety of medical, psychological, and legal consequences. SVH shall assist victims by:

- Referring victims to appropriate medical care
- Referring victims to appropriate community resources.
- Providing flexible work hours or short-term or extended leave as appropriate.
- Cooperating with law enforcement personnel in the investigation of any crime.

RESPONSIBILITIES AND ACCOUNTABILITY:

The SVH Safety Officer is the WVP Program Administrator and has the authority and responsibility for implementing the provisions of this program for SVH. All managers, supervisors and employees are responsible for implementing and maintaining the WVP Program in their work areas and for answering employee questions about the program. A WVP Program taskforce has been established to assess the vulnerability to workplace violence at our establishment and reach agreement on preventive actions to be taken. This group will be responsible for developing the WVP Program and determining appropriate employee training programs according to specific employee positions/roles. The WVP Program taskforce will also be responsible for regular audits/reviews our overall WVP Program and will convene on an ad hoc basis.

The WVP Program taskforce consists of:

Safety Officer
Director of Facilities
Director of Quality & Risk Management
Chief Nursing Officer
Chief Ancillary Officer
Director of Human Resources
Director of Healing at Home
Education Coordinator

Identifying Environmental Risk Factors

Regular, periodic workplace safety inspections of all departments are conducted. Regular inspections will be supplemented with additional inspections whenever new substances,



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processes, procedures, or equipment introduced into the workplace represent a new safety hazard, or whenever leaders are made aware of a new or previously unrecognized hazard.

Leaders are responsible for identification and correction of hazards that their staff face and should ensure that work areas they exercise control over are inspected at least annually. Leaders shall check for safe work practices with each visit to the workplace and provide immediate verbal feedback where hazards are observed. (Refer to Safety Rounds Policy, # CE8610-174)

Identifying & Communicating Patient-Specific Risk Factors

As trained, staff will identify and evaluate specific risk factors which may increase the likelihood that a patient or visitor may become violent, such as history of violent behavior, use of drugs or alcohol and psychiatric or other diagnosis associated with disorientation or confusion. This information will be documented in the electronic medical record (EMR).

If a patient displays signs of threatening or violent behavior, RNs will document the event in the EMR and mark the "At Risk for Violence" checkbox located under the Psych Tab in Clinical Care Station. This checkbox will create a Patient Alert to notify future RNs of this event. This information will also be communicated to staff during patient hand-off.

In departments with patient door placards, a gray strip will be inserted to notify all staff of the potential for violent behavior, prior to entering the room, allowing staff to take appropriate precautions. If the person at risk for violent behavior is a visitor, a gray strip with a "V" will be inserted (See Color Coded Wrist Bands and Door Placards policy, # PC8610-126).

All patients and visitors located in the Emergency Department will be considered to have potential for violent behavior and staff providing care will take precautions.

When a patient has been determined to be at risk for violent behavior and is being transported for diagnostics or a procedure, RNs will use the Ticket to Ride form and mark the checkbox "At Risk for Violence" to allow staff to take precautions. (See Handoff Communications with HealthCare Providers/SBAR policy, # PC8610-134)

Coordination with other Employers

Employers who have contracted with SVH to send regular workers (i.e., Registry, Travelers) will be contacted and notified of the SVH WVP Program. Such workers will receive WVP orientation and education prior to and on arrival to SVH.

Coordination with Local Law Enforcement

Local law enforcement response is established via 'panic buttons' placed in the emergency department and selected patient care areas. The WVP Program taskforce may seek assistance and/or input from sources to include; local law enforcement, employee assistance program



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counselors, Sonoma Valley Hospital liability insurance carrier, and/or a security/safety specialist.

Communication Plan

Leaders are responsible for communicating with all staff about safety and workplace violence issues in a way that is readily understandable by all. All department personnel are encouraged to communicate safety concerns to their department leader without fear of reprisal. The Safety Committee is another resource for communication regarding safety issues for department employees.

Training

All employees shall receive training upon hire and annually thereafter. Certain employees may receive additional specific training depending upon their particular job and/or work location. When there is a change to equipment, work practices or the work environment due to hazard correction, affected employees shall be trained accordingly.

Employee WVP training is provided at no cost to the employee and is conducted during the employee's working hours, when possible. WVP training may be presented by a knowledgeable supervisor, other department personnel, or by representatives from other relevant departments, agencies, and/or electronic methods. All training will be documented.

Who Must Be Trained	Training Requirement
All employees	One-time initial training on the employer's workplace violence prevention plan and other topics
All employees	Additional training when new equipment or work practices are introduced or when a new or previously unrecognized workplace violence hazard has been identified
Employees who perform patient contact activities	Annual refresher training on the topics included in the initial training and the results of review of the employer's workplace violence prevention plan
Employees who respond to alarms or other notifications of violent incidents whose assignments involve confronting or controlling persons exhibiting aggressive or violent behavior	Initial and annual training specific to the safe handling of violent incidents



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All personnel will be trained on the structure of the WVP Program and location of the written policy upon program implementation and upon hire thereafter. Training will also be provided on how to report unsafe conditions and/or incidents of violence.

Regular refresher training will be provided to all employees on an annual basis.

Compliance

It is the responsibility of all staff to comply with all applicable workplace violence prevention and safety regulations, SVH policies, and established work practices. This includes, but is not limited to:

- Observing workplace violence and safety-related signs, posters, warning signals and directions.
- Reviewing the SVH WVP Program and emergency plan.
- Learning about the warning signs and risk factors associated with potential violence.
- Taking part in appropriate safety and workplace violence prevention training.
- Following all safe operating procedures and precautions.
- Reporting incidents of workplace violence immediately to a Nursing Supervisor and/or department leader.
- Participating in environmental workplace safety inspections and surveys.

Standard progressive disciplinary measures in accordance with the applicable personnel policy will result when employees fail to comply with applicable regulations, policy, and/or departmental workplace violence prevention procedures. Staff members will be disciplined for unsafe practices. Repeated failure to comply or willful and intentional noncompliance may result in disciplinary measures up to and including termination.

REFERENCES:

Workplace Violence Prevention in Health Care Regulation (Title 8, CCR, Section 3342)

5.

ANNUAL INFECTION
CONTROL REPORT



THE INFECTION PREVENTION PROGRAM-

WHERE WE'VE BEEN AND WHERE WE'RE GOING

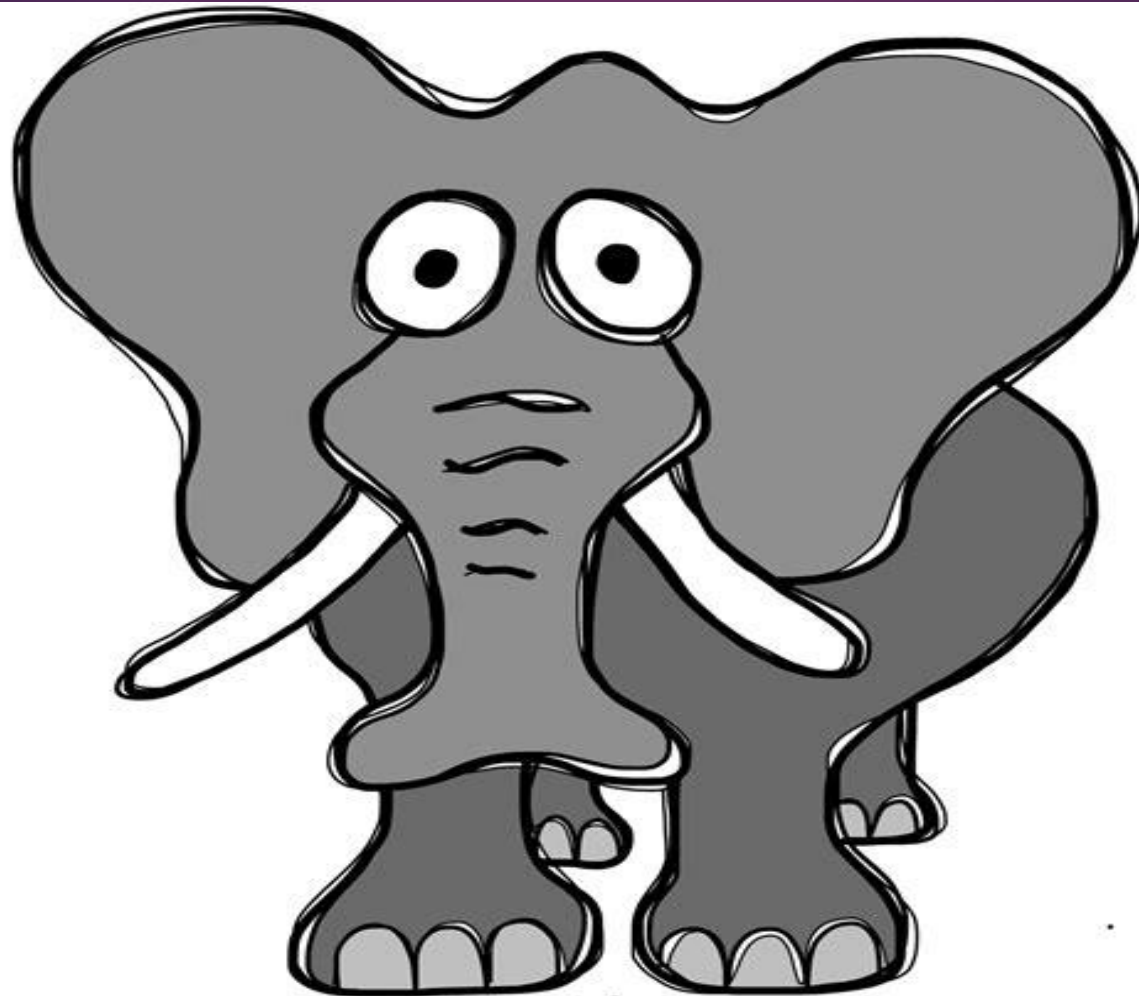
SONOMA VALLEY HOSPITAL

BOARD QUALITY COMMITTEE

FEBRUARY 28, 2018

KATHY MATHEWS

SCOPE: BIG AND WIDE



SCOPE

- Infection Prevention (IP) is an organization-wide program that complies with standards established by CMS, CDPH, CDC, AORN, CIHQ, and other regulatory bodies e.g., OSHA
- IP standards apply to all services e.g., lab, PT, imaging
- All settings including ED, inpatient, Birthplace, outpatient, SNF, Healing at Home
- All healthcare providers, including physicians, licensed independent practitioners, staff, students, trainees, volunteers, and as appropriate, visitors, and patients.

IT'S A JOURNEY



WHERE WERE WE HEADED IN 2017?

- ▶ Make hand hygiene the 2017 performance improvement project. Audits reveal >95% compliance New hand hygiene products!
- ▶ Prevent or reduce the risk of exposure to and development of hospital-associated infections e.g., influenza, HA pneumonia
- ▶ Minimize the risk of transmitting infections via medical equipment and medical devices e.g., central lines, ventilators, foleys
- ▶ Maintain a sanitary environment to reduce the risk of fomite-associated infections and communicable diseases



2017 GOALS CONTINUED

Identify, investigate, report and control infections:

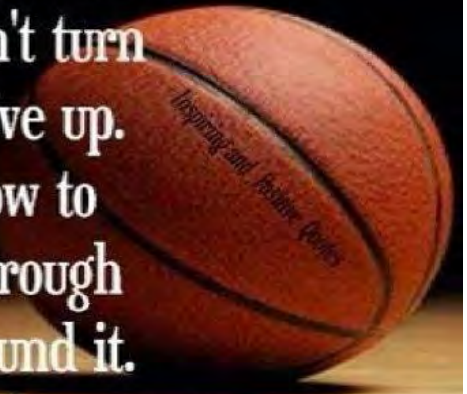
- ▶ Central Line-Associated Bloodstream Infection (CLABSI),
- ▶ Multi-drug Resistant Organisms e.g., MRSA, VRE
- ▶ Surgical Site Infections
- ▶ Ventilator-Associated Events (VAE),
- ▶ Hospital-Acquired Pneumonia (non-ventilator)
- ▶ Catheter-Associated Urinary Tract Infection (CAUTI),



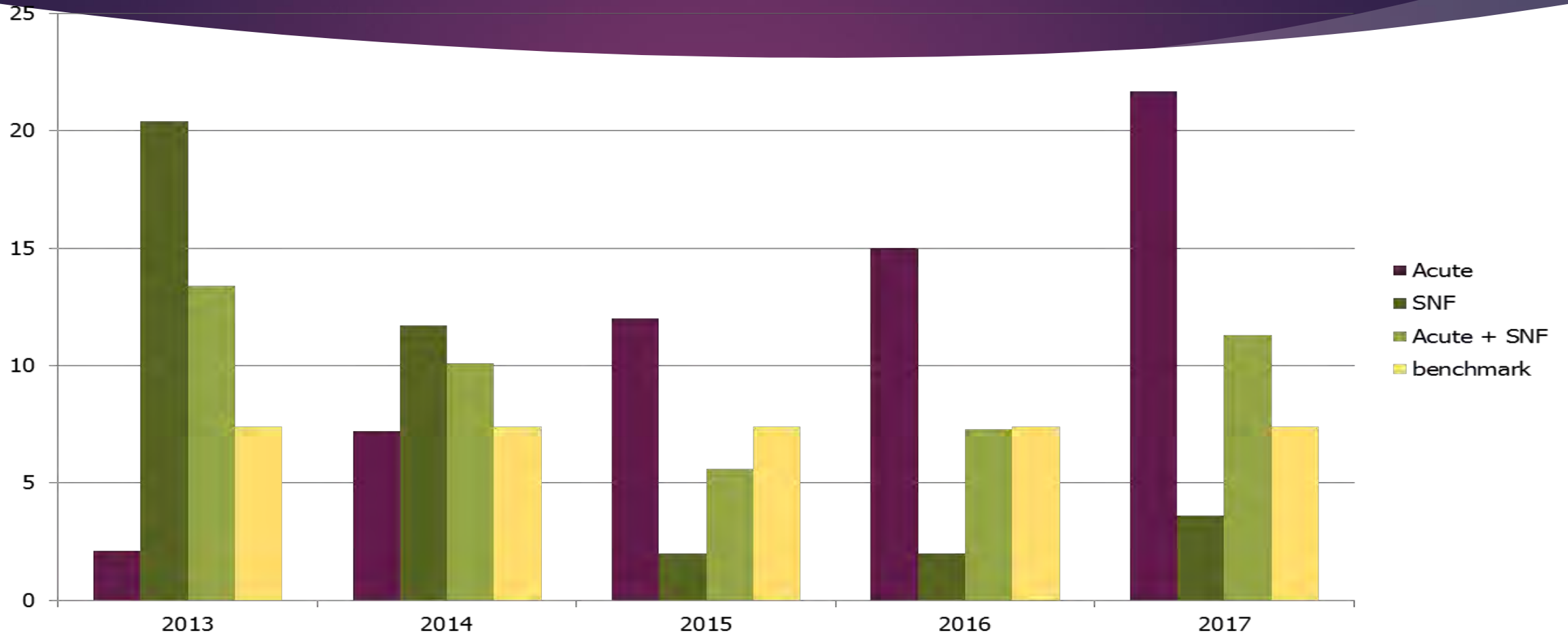
OBSTACLES



Obstacles don't have
to stop you. If you run
into a wall, don't turn
around and give up.
Figure out how to
climb it, go through
it, or work around it.
— Michael Jordan



C. Difficile Infections per 10,000 Pt. Days



CDI INTERVENTIONS

- ▶ Education: Nursing, Physicians, Environmental Services, Pharmacy, Nutrition and patients
- ▶ New hand hygiene products
- ▶ De-escalate PPIs. Revise CPOE order sets
- ▶ Live culture yogurt/Probiotics while on antibiotics
- ▶ Bleach and UV disinfection with robot
- ▶ New environmental disinfection detection tool (2018)
- ▶ New nurse driven testing protocol (2018)

2017 GOALS CONTINUED

- ▶ Ensure that the hospital-wide quality, performance improvement and training programs address problems identified by Infection Prevention, and that subsequent corrective action plans are successfully implemented

Annual Skills Fair

- ▶ Over 200 staff attended
- ▶ Venue: Simulated haunted house
- ▶ Topic: What's Scariest than a Haunted House
 1. CAUTI
 2. HA PNEUMONIA
 3. STOP SEPSIS



STOP SEPSIS

- ▶ 250,000 Americans die from sepsis each year
- ▶ Recognize the symptoms:
 - ▶ Confusion or disorientation
 - ▶ Shortness of breath
 - ▶ High heart rate
 - ▶ Fever, shivering or feeling very cold
 - ▶ Extreme pain or discomfort
 - ▶ Clammy or sweaty skin



2018 The HAPPI Project

- ▶ Pneumonia is the second most common nosocomial infection in the United States
- ▶ 19% mortality, 4-9 extra days, >50% develop sepsis, 34% to SNF
- ▶ \$40,000 per occurrence
- ▶ In 2017, 7 patients developed healthcare-associated pneumonia (not ventilator related).
- ▶ Goals: decrease aspiration risks,
- ▶ prevent cross-contamination or colonization via hands of personnel,
- ▶ appropriate disinfection or sterilization of respiratory-therapy devices,
- ▶ Use vaccines to protect against preventable infections, and
- ▶ ORAL CARE!!! New products, more education, EMR alerts for nursing

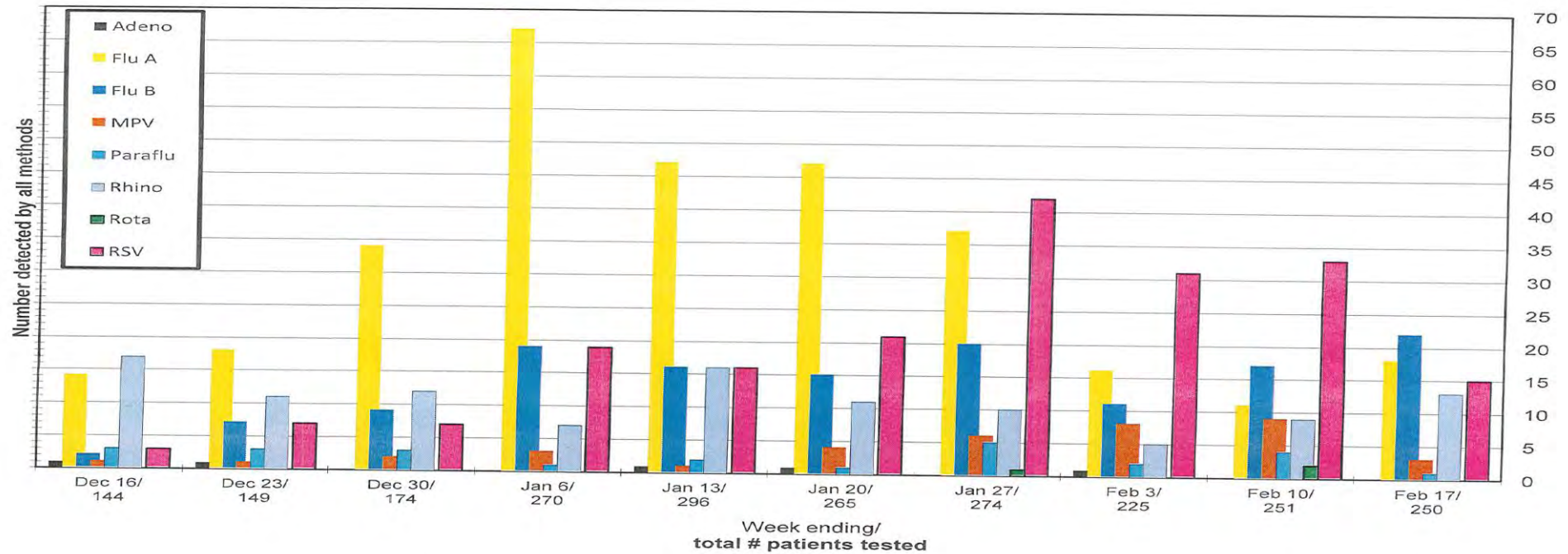
Influenza



BAY AREA FLU STATS

graph

VIRAL IDENTIFICATIONS AT UCSF CLINICAL VIROLOGY LABORATORY
ADULT/PEDIATRIC AND INPATIENT/OUTPATIENT
(updated 02/17/18)



SVH Influenza Stats

- ▶ 128 laboratory confirmed cases 10/27/17-2/21/18
- ▶ New cough etiquette stations and signage posted
- ▶ 2 physician exposures ED during intubation. 1 Received Tamiflu. PAPR education for other. No reported secondary illness.
- ▶ Consistent isolation of inpatients with influenza. Reinforced in ED
- ▶ 0 patients developed healthcare-associated influenza
- ▶ 83 patients were given influenza immunization
- ▶ HCW Influenza immunization compliance:
 - ▶ Physicians 88%
 - ▶ Staff 81%

WHERE ARE WE GOING IN 2018?

- ▶ As part of its commitment to quality care and service, Sonoma Valley Hospital IP, conducts a risk assessment for transmission and acquisition of infectious agents.
- ▶ Analysis of surveillance data are central to the annual risk assessment
- ▶ The 2018 Risk Assessment and Goals are available in your packet

2018 Water Management Program

- ▶ Legionella in US 2000-2014: 19% associated with LTC, 15% with hospitals
- ▶ 9% mortality
- ▶ 5000 cases reported in 2014 (286% increase 2000-2014)
- ▶ 2002-2017: 1 community-acquired case at SVH (4 tested)
- ▶ CMS mandate June 2, 2017
- ▶ SVH Policy: Implement a program compliant with ASHRAE industry standards and CDC guidelines to prevent Legionellosis
- ▶ Currently assessing any improvement opportunities e.g., baseline testing for Legionella, expert guidance if recovered from SVH water

“Going so soon? I wouldn't hear of it. Why my little party's just beginning.
~ Wicked Witch of the West Wizard of Oz”



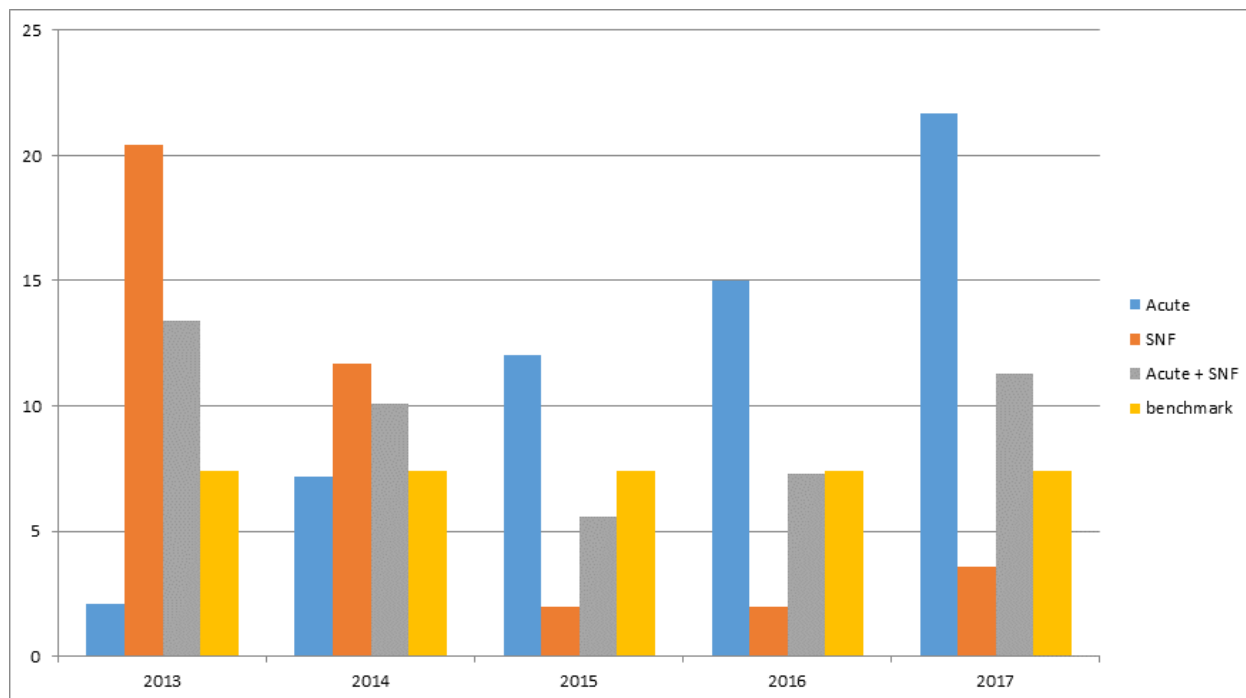
Infection Prevention HAI Report for 4th Quarter 2017

Indicator	Comparison Rates: 2013 /2014/2015/2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Benchmarks/Actions/Comments
Quarterly reporting of National Healthcare Safety Network (NHSN) indicator data is required by CDPH. NHSN provides the predicated number of HAIs based on standardized infection ratios (SIRS). ** Indicates public reporting on CDPH website. Green indicates no action indicated, yellow indicates above the predicted number of infections, red indicates twice the predicted number of HAIs. Action is recommended for "red" values.						
**CLABSI (NHSN) (CMS Never Event) # Central Line Associated Bloodstream Infections (CLABSI)/1000 central line days	0 since 2011	0 0/219	0 0/171	0 0/163	0 0/72	NHSN predicts 0.51 CLABSIs per year. Zero CLABSIs in the acute units since 2011! Practitioner CLIP practices remain excellent and are also reported to NHSN. Pt with bacteremia not CLABSI day 14. Had leaking IV that was later pulled out by pt vs. occult colon ca vs. recurrence of previous UTI vs left kidney stone.
**CDI (NHSN) #Inpatient Hospital Acquired infections due to C. difficile per 10,000 patient days	2.1 /7.2 /12 15	25.5 3/1222	0 0/1032	34.8 3/860	29.3 3/1022	NHSN predicts 3.51 cases per year (4). Benchmark (MMWR) is 7.4/10,000 patient days. 2017 21.7 CDI per 10,000 pt days. 4th qtr, 2 SDC pts. Both admitted on antibiotic. One on PPIs. Pt. #3 had history of diarrhea for "last month" but testing not done until day 4. Environmental disinfection with bleach, protocol change: test asap with diarrhea, new hand hygiene products were installed to promote optimal handwashing.
**MRSA Bloodstream Infections (NHSN) #bloodstream infections due to MRSA per 1000 pt. days	1.3 /0 /0 0	0 0/1295	0 0/1102	0 0/860	0 0/1091	NHSN predicts 0.13 infections per year. Zero in 2017. All ED and acute care unit infections are reported to NHSN.
**VRE Bloodstream Infections (NHSN) #Hospital Acquired bloodstream infections due to VRE per 1000 pt. days	0 x 4 yrs	0 0/1295	0 0/1102	0 00/860	0 0/1091	SVH Benchmark: 1 per 1,000 patient days. Zero in 2017. All ED and acute care unit infections are reported to NHSN. (Note: Only 3.5% of all SVH Enterococcus isolates are VRE).
**Hip: Deep or Organ Space Surgical Site Infections (NHSN) # infections/ # Total Hip Cases x 100	0 / 1.8% / 0 1.6	0 0/8	0 0/14	0 0/13	0 0/19	NHSN predicts 0.26 SSIs per year. IHI benchmark SSI rate: 0.67%-2.4%. SVH hip SSI rate 0 (54 cases) in 2017.
**Knee: Deep or Organ/Space Surgical Site Infections (NHSN) # infections/ # Total Knee Cases x 100	0 / 1.7% / 2 1.4	0 0/23	0 0/22	0 1/10	0 0/24	NHSN predicts 0.28 SSIs per year. IHI benchmark range for total knee SSI rates: 0.68%-1.6%. SVH SSI rate 1.2% (1 knee SSI/ 79cases) in 2017.
**Overall Surgical Site Infections (SSI) Total # SSI/Total # surgeries x 100	0.2%/0.7% (12)/ 0.4% (6)/ 0.5 (8)	0.43% 2/464	0.18% 1/541	0.97% 4/513	0.2% 1/435	NHSN predicts 1.6 SSIs per year however, CMS assesses SSIs for colon and hysterectomy surgery only, deep or organ space infections, within 30 days. Overall SSI rate 2017: 0.4% (8 SSIs)
Class I SSI rate	<1% x 4 yrs	0 0/330	0.2% 1/441	1.0% 2/378	0 0/357	Class I (Clean Wound) rate: 0.2% (3 SSI/1506 cases) in 2017
Class II SSI rate	< 1.3% x 4 yrs	0 0/109	0 0/77	1.76% 2/113	1.4% 1/68	Class II (Clean Contaminated) rate: 0.8% (3 SSIs/367 cases) in 2017
Total Joint SSI rate	0 / 0.8% / 1.9%/1.4%	0 0/33	0 0/43	7.69% 2/26	0 0/43	Total Joint SSI rate: 1.4% (2 SSIs - elbow (superficial), knee/ 145 cases).
Post discharge surveillance surgeon compliance	57% 2014, 64% 2015, 84% 2016	93%	96% (Apr)	98% July/ Aug	99% Oct/ Nov	2014 Surgery Committee approved SSI reporting by surgeons monthly, to promote accurate SSI rates. Excellent participation by SVH surgeons.

Infection Prevention HAI Report for 4th Quarter 2017

Indicator	Comparison Rates: 2013 /2014/2015/2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Benchmarks/Actions/Comments
Quarterly reporting of National Healthcare Safety Network (NHSN) indicator data is required by CDPH. NHSN provides the predicated number of HAIs based on standardized infection ratios (SIRS). ** Indicates public reporting on CDPH website. Green indicates no action indicated, yellow indicates above the predicted number of infections, red indicates twice the predicted number of HAIs. Action is recommended for "red" values.						
Hand Hygiene Compliance		100%	100%	95%	100%	
**Ventilator Associated Event (VAE): Pneumonia # Ventilator Associated Pneumonias or events/ # vent days x 1000	0 x 4 yrs.	0	0	0	0	NHSN Benchmark: 1.1 per 1,000 ventilator days.
		0/75	0/44	0/44	0/7	
**Hospital Acquired Pneumonia (HAP) # hospital acquired pneumonia/# pt days x 1000	0.2 /0.5 / 0.9 per 1000 pt days	1.5 /2/1295	1.8 /2/1102	1.1 /1/890	1.8 /2/1091	Benchmark 1.2 per 1,000 pt days. Skills Fair presentations to Nursing leaders and clinical staff to include comprehensive oral care, reducing aspiration risks, increasing host resistance. Oral care identified as risk factor during EMR audit of pneumonia patients from 2016. EMR updates and PI project are underway. SVH 1.6 / 1000 pt days in 2017.
**Inpatient Hospital Acquired Catheter Associated Urinary Tract Infections (CA-UTI) (CMS Never Event) # inpatient CAUTI/# catheter days x 1000	0.7 /0 / 1.7 /1.4	0 /0/392	0 /0/343	7.1 /2/278	0 /0/131	NHSN predicts 1.04 CAUTIs per year. CAUTI prevention presentation mandatory for SNF staff attending attending Skills Fair.
SNF Hospital Acquired Catheter Associated Urinary Tract Infections (CA-UTI) # SNF CAUTI/# catheter days x 1000	2.6 / 3.3/ 5.7/ 7.6	0 /0/87	0 /0/187	11.9 /1/84	0 /0/109	NHSN provides no SIR for SNF. No mandatory reporting required. Previous NHSN SNF benchmark was 1.5 per 1,000 catheter days. CAUTI prevention presentation mandatory for acute staff during Skills Fair. 2.6 /1000 catheter days in 2017. Improvement from 2016,
SNF Hospital Acquired C. Difficile Infections (CDI) # SNF CDI/# patient days x 10,000	20 /11.7 /2/2	5.6 /1/1771	6.5 /1/1529	0 /0/1507	6.0 /1/1655	Benchmark (No SIR is available, data not reported to NHSN): 7.4 per 10,000 patient days. SNF CDI 3.6 in 2017. Below benchmark x 3 years.
SNF Central line associated bloodstream infections (CLABSI) # Central Line Associated Bloodstream Infections (CLABSI)/central line days x 1000	1 / 0/ 0 /0	0 /0/127	0 /0/85	13.8 /1/72	0 /0/81	No NHSN SIR available, data not reported to NHSN. Previous NHSN benchmark: 0.8 per 1,000 central line days. 1 CLABSI in 2017. 2017 SNF rate 2.7 per 1000 CL days. Pt. had severe psoriasis. CLABSI prevention education session provided to SNF staff.
Healing at Home Associated Infections # of infections/Total visits x 1000	0.3 / 0.6 / 0/0	0 /0/2705	0.4 /1/2775	0 /0/2372	0 /0/2229	SVH Benchmark: 1.5 per 1,000 home care visits
MRSA Active Surveillance Cultures (nares cultures only) # positives/total screened x 100	14% /20%/26%	9.2% /12/130	9.4% /9/96	11.1% /12/108	7.3% /8/110	SVH 3/96 = 3.1% vs SDC 5/14 = 35.7%. Patients have a nasal screen for MRSA in accordance with California law. Patients are notified and provided with patient education. (Note: 41.1% of all SVH S. aureus isolates are MRSA.)
% ESBL(E. coli;K. pneumoniae, K. oxytoca, # CRE	2% /3%	4%	5.10%	3.0%	4.7%	ASP monitors antibiogram and updates annually.
	0 / 0	0	0	1	0	Track and trend
References: 1.) NHSN SIR data per website 2.) MMWR, Vital Signs: Preventing Clostridium difficile Infections, March 9, 2012/61 (09); 157-162 3.) The Hidden Epidemic of Nonventilator Hospital-Acquired Pneumonia: A Serious and Costly Issue, APIC 2017, 4. HSAG, HAIN HAI Report August 2017 , 5.) How-to Guide: Prevent Surgical Site Infection for Hip and Knee Arthroplasty. Cambridge, MA: Institute for Healthcare Improvement; 2012. (Available at www.ihi.org)						

Healthcare-Associated C. difficile Infections per 10,000 Patient Days 2013-2017



Sonoma Valley Hospital

ANNUAL EVALUATION OF THE 2017 INFECTION PREVENTION PROGRAM

PURPOSE

To evaluate the effectiveness of the infection prevention program and to identify those activities that are effective, as well as those activities which require modification so as to improve care and services in 2017.

PROGRAM GOALS

The goals of the 2017 infection prevention program were:

- Reinforcing appropriate hand hygiene practices by staff, patients and visitors to achieve or surpass a 90% compliance rate.
- Prevention of all healthcare associated influenza among inpatients.
- Annual influenza immunization campaign results in improved immunization compliance e.g., reach 90% among staff, students, volunteers and clinicians by 2020.
- Comply with CDPH requirement to report influenza immunization compliance rates in healthcare workers.
- 100% of communicable disease exposures e.g., Tuberculosis, are investigated and appropriate follow up is performed.
- Continue implementation of surgeon reporting of post discharge surgical site infections.
- Appropriate cleaning, disinfection, sterilization, reuse, and/or disposal of supplies and equipment.
- Appropriate disposal of waste
- Maintaining a sanitary environment to reduce the risk of fomite-associated infections and communicable diseases
- 100% of waiting areas in the Lobby, North entrance, Emergency Department and Surgical Waiting have cough etiquette signage and supplies e.g., alcohol sanitizer, tissues, masks.
- Implement a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel including Central Line Associated Bloodstream Infection (CLABSI), CLIP monitoring, Ventilator Associated Events(VAE), Catheter Associated Urinary Tract Infection (CAUTI), Multi-drug Resistant Organism (MDRO), C. difficile infections, surgical site infections (SSI) and hospital-acquired pneumonia in accordance with California Department of Public Health (CDPH), National Health and Safety Network (NHSN), and CIHQ requirements
- Maintain the overall SSI rate at or below 1%.
- Ensuring that the hospital-wide quality, performance improvement and training programs address problems identified by infection prevention personnel, and that subsequent corrective action plans are successfully implemented
- Attend APIC National Conference
- Comply with Cal/OSHA regulations including Bloodborne Pathogen and Aerosol Transmissible Disease Standards
- Participate in the Antimicrobial Stewardship Program and attend 90% of weekly rounds.
- Perform an ICRA 100% of the time prior to the initiation of construction in the hospital.

PROGRAM SCOPE

The scope of the infection prevention program addresses all pertinent services and sites of care in the organization.

INFECTION CONTROL RISK ASSESSMENT

The organization conducts a periodic assessment of the risk(s) for transmission and acquisition of infectious agents. This risk assessment incorporates an analysis of the following:

1. The geographic location and community environment of the organization, the programs and services provided, and the characteristics of the population served.
2. The results of the organization's infection prevention and control data.
3. The care, treatment, and services provided.

The risk analysis is conducted / reviewed at least annually and whenever there is a significant change in any of the above factors. The most recent risk assessment required the following changes in the infection control program:

Assessed Risk	Changes to Program Activities
Hospital onset CDIs are above benchmark in acute hospital. Despite multiple interventions over the last 3 years, CDI rates continue to rise in the acute care setting.	Education, early implementation of contact/enteric isolation, routine disinfection using bleach (ICU/SNF), Xenon robot disinfection for all discharges. Continued vigilance and communication about appropriate antibiotic, PPI and probiotic use through the Antimicrobial Stewardship Program and alerts in the EMR. Promote ingestion of live culture yogurt or probiotics for patients receiving antimicrobials. Inform physicians about risk of PPI drugs taken with antimicrobials.
Hospital-acquired pneumonia (not VAE) rates are slightly above benchmark. A comprehensive Pneumonia Prevention P&P is needed.	Annual Skills Fair presentation addressing best practices to reduce pneumonia. Begin the HAPPI project (hospital-acquired pneumonia prevention initiative).
Hand hygiene compliance requires adequate auditing and feedback to maintain high compliance	Continue tracking and trending hand hygiene compliance and report back to all stakeholders and pertinent committees.
Environmental cleanliness monitoring system was not implemented in 2017.	Kimberly Drummond will initiate a fluorescent environmental monitoring system and report findings to Infection Prevention.

EMERGING / REEMERGING PROBLEMS IN THE HEALTHCARE COMMUNITY

The organization keeps abreast of infection control related issues occurring in the healthcare community. This is accomplished by reviewing the following:

1. Notices from the public health department
2. Notices and recommendations from the Center for Disease Control
3. Recommendations from CMS
4. Current literature and recommendations from professional organization's as well as accrediting and regulatory agencies.

Based on this review, the following infection control issues were identified in the healthcare community. The organization's response to these issues is also noted below.

Issue Identified	Organization Response
Wildfires in Sonoma Co put stress on the DPH and other hospitals were forced to close temporarily..	SVH remained open and cared for pts during the wildfires. HAI rates higher in 3 rd quarter.
Influenza circulating as of October 2017 with increased burden on the ED and acute units..	Provide immunizations for staff. Staff compliance decreased in 2017. Staff feel vaccine not useful or makes them sick. Implement Droplet Precautions for all patients with suspected or confirmed influenza. Perform influenza PCR testing to confirm the diagnosis. Inform staff of exposures.
June 2, 2017 CMS mandates a water management program	Establish team i.e., Safety Committee. Perform risk assessment. Create a water system diagram. Develop a water management P&P.

SUCCESS OF INFECTION CONTROL INTERVENTIONS

The organization undertook several initiatives to prevent and control infection during the evaluation period. A summary of the effectiveness of significant interventions is noted below.

Initiative / Intervention	Determination of Effectiveness
Hand Hygiene CAUTI prevention	Revised P&P, education of staff, improved EMR for foley necessity check. CAUTI rate above benchmark. Retain as an initiative in 2017.
Continued central line infection prevention procedures and monitored CLIP forms for consistent practice	Zero CLABSI in acute and one in SNF. Education provided to SNF staff.
Reduce the risk of HA CDI and MDROs e.g., MRSA and VRE BSI. Maintain an active Antimicrobial Stewardship Program.	Zero HA MRSA or VRE BSI in 2017. Antibiogram revealed some increases and decreases in resistance patterns.
Investigation of cluster of SSIs in 3 rd quarter Re-educated staff on pt skin prep, improved use of Xenex robot and terminal cleaning, CPOE needed for input of total joint nasal/skin decolonization procedure, install equipment to stabilize OR temperature Surgeon post discharge reporting of SSIs remains very good.	Overall SSI rate < 1%. The elevation in 3 rd quarter was contained. CPOE updates not completed in 2017 Temp stabilization equipment not installed in 2017
Address hospital acquired pneumonia by providing education at Skills Fair	Improvement still needed. PI project in 2018 to produce and train staff on risk reduction strategies.
HA influenza prevention	No cases of HA influenza in 2017

INFECTION PREVENTION AND CONTROL GUIDELINES

The organization evaluates relevant infection prevention and control guidelines that are based on evidence or, in the absence of evidence, expert consensus. This is accomplished by reviewing:

1. Notices from the public health department
2. Notices and recommendations from the Center for Disease Control
3. Current literature and recommendations from professional organization's as well as accrediting and regulatory agencies.

Based on this review, the following relevant guidelines were reviewed. The organization's response is also noted below.

Guideline Evaluated	Actions Taken
CMS water management (6/2/2017)	P&P approved

DETERMINATION OF EFFECTIVENESS

Based on the information noted above, the infection prevention program was determined to be effective in implementing its activities during the evaluation period. Activities which require improvement will be addressed by the program during the upcoming evaluation period.

WHERE THIS REPORT WILL GO

This report will be submitted to the Performance Improvement Committee. This committee is charged with overseeing the infection control program as well as the patient safety program. An annual report is also presented to the Board.

REFERENCES

CIHQ Standards, CDC guidelines

Sonoma Valley Hospital

Infection Prevention Risk Assessment and 2018 Goals

BACKGROUND

As part of its commitment to quality care and service, Sonoma Valley Hospital, conducts a risk assessment for transmission and acquisition of infectious agents. This risk assessment incorporates an analysis of the following:

1. The geographic location and community environment of the organization, the programs and services provided, and the characteristics of the population served.
2. Analysis of surveillance activities and **the results of the organization's infection prevention and control data.**
3. Infection prevention standards recommended by Center for Improvement in Healthcare Quality (CIHQ), CDPH, Cal/OSHA, CDC, AORN and other regulatory bodies.
4. The patient care, treatment, and other services provided by SVH and the inherent risk therein.

SCOPE OF ASSESSMENT

This risk assessment is organization-wide in scope. It covers inpatient acute medical/surgical, emergency, intensive care, maternal/newborn and skilled nursing units, ancillary services, as well as ambulatory care settings, outpatient care settings and Healing at Home.

PROCESS

The risk analysis is conducted at least annually and whenever there is a significant change in the scope or services. The assessment is facilitated by the Infection Preventionist and presented to the Performance Improvement Committee for review and approval.

Once risks are identified, the organization prioritizes those risks that are of epidemiological significance. Certain risks are automatically prioritized based on their nature, scope, and impact on the care, treatment, and services provided. These risks are outlined in this document as well.

Specific strategies are developed and implemented to address the prioritized risks. These strategies may take the form of policy and procedure establishment, surveillance and monitoring activities, education and training programs, environmental and engineering controls, or combinations thereof. Strategies may differ in approach, form, scope, application, and/or duration depending on the specific risk issue, the care setting(s), and environment involved,

ASSESSMENT FINDINGS / MITIGATION STRATEGIES

The table below outlines the prioritized risks identified as the result of the assessment; provides a brief description of those risks, assigns a risk level (L=low, 1point., M=medium, 5 points., or H=high, 10 points) based on the care setting*, summarizes actions that have been or will be taken by the organization to address the risks, and how the organization will evaluate the effectiveness of actions taken:

Prioritized Risk Description	Care Setting Risk Designation (See legend*)					Summary of Risk Mitigation Strategies	Goals/How the Effectiveness of the Strategies is Evaluated
	I	A	O	H	S		
Transmission of infection associated with non-compliance with CDC guidelines and CIHQ recommendations for hand hygiene (HH).	H	H	H	H	H	Information given to patients on admission on the importance of HH. HH education included	Goal is >90% compliance Assess compliance through audits, report compliance rates to PI

Prioritized Risk Description	Care Setting Risk Designation (See legend*)					Summary of Risk Mitigation Strategies	Goals/How the Effectiveness of the Strategies is Evaluated
	I	A	O	H	S		
50 points						<p>in hospital and nursing orientation and annual Healthstream education and/or Skills Fair.</p> <p>HH compliance rounds conducted by the Infection Preventionist plus "stealth audits" to obtain hospital-wide compliance data.</p> <p>Provide High Five awards to staff exhibiting hand hygiene compliance.</p>	Committee, Director of Quality, department managers and staff, Quality Board.
<p>Unprotected exposure to pathogens throughout the organization through potential non-compliance with standard precautions, empiric precautions, transmission-based precautions or other infection prevention measures.</p> <p>35 points</p>	H	M	M	M	H	<p>HR confirms immunity status at time of hire (MMR, varicella, pertussis, hepatitis B). TB testing upon hire and annually.</p> <p>Infection Prevention training provided during orientation and annually through Healthstream. Inservice education to physician and nursing staff prior to influenza season to prevent exposures. Post appropriate visitor posters during influenza season.</p> <p>Promote respiratory hygiene and cough etiquette in waiting areas and lobby. Patient education given on admission on 'covering your cough'.</p> <p>Monitor isolation practices for appropriate placement, precautions and adherence to policies.</p>	<p>Goal: 90% Influenza immunization compliance by staff and physicians.</p> <p>Zero cases of HAI influenza.</p> <p>Influenza immunization compliance is reported to CDPH and the aforementioned committees. Hospital-acquired infections are reported to Medicine, Surgery, Quality Board, and PI Committees.</p> <p>Communicable disease exposures and clusters of infection are investigated, tracked and actions are reported to PI Committee and other committees as appropriate.</p>

Prioritized Risk Description	Care Setting Risk Designation (See legend*)					Summary of Risk Mitigation Strategies	Goals/How the Effectiveness of the Strategies is Evaluated
	I	A	O	H	S		
						<p>Masks are worn by Anesthesia when performing epidurals.</p> <p>Investigate exposures and/or clusters of infections.</p>	
<p>Potential for transmission of infection related to procedures, medical equipment, and medical devices related to appropriate storage, cleaning, disinfection, sterilization, reuse and/or disposal of supplies and equipment, as well as use of personal protective equipment.</p> <p>40 points</p>	H	H	M	M	H	<p>Central Sterile Processing monitors QA logs on sterilizers, immediate use sterilization, temperature logs, and endoscope processing equipment on a daily basis.</p> <p>Medical Imaging utilizes the Trophon disinfection system.</p> <p>Endoscopy equipment is reprocessed in accordance with manufacturer's recommendation</p> <p>EVS receives training on IC for proper daily, OR, isolation and terminal room cleaning.</p>	<p>Goal: Monitor compliance with Endoscope reprocessing.</p> <p>Quarterly Immediate Use Sterilization report submitted to PI committee and Surgery Committee.</p> <p>Check for ongoing compliance with maintaining QA logs, appropriate cleaning, storage, disinfection, sterilization, reuse, and/or disposal of waste, supplies and equipment during Infection Prevention rounds.</p>
<p>Multi use vials (MUV) have the potential risk of contamination without proper handling</p> <p>25 points</p>	M	M	M	M	M	<p>MUVs must be kept in the medication prep area rather than the pts room.</p> <p>MUVs are dated when opened and discarded by day 28.</p>	<p>Infection Prevention rounds to confirm that there is compliance with strategies by Nursing, Anesthesia, OR. Report to PI Committee.</p>
<p>Potential for infection in ambulatory care and outpatient settings due to potential prolonged wait times in common areas and potential exposure to infectious individuals.</p> <p>20 points</p>	N A	H	H	N A	N A	<p>Respiratory hygiene and cough etiquette signage posted in all inpatient, ambulatory care and outpatient waiting areas (including offsite radiology and outpatient rehab services).</p> <p>Alcohol gel, face masks, and facial tissues</p>	<p>Goal: 100% of patient waiting areas have signage and supplies to promote cough etiquette.</p> <p>Monitor for evidence of exposures to infectious individuals and follow up as appropriate.</p> <p>Outpatient departments</p>

Prioritized Risk Description	Care Setting Risk Designation (See legend*)					Summary of Risk Mitigation Strategies	Goals/How the Effectiveness of the Strategies is Evaluated
	I	A	O	H	S		
						<p>available to patients in waiting areas and lobby.</p> <p>ED patients and screened for obvious signs of contagious disease. Appropriate control measures are taken for those who may present a risk of transmission of infectious agents.</p>	<p>are responsible for reporting any noncompliance issues to Infection Preventionist for follow up as appropriate. Issues may be identified during Infection Prevention rounds as well.</p>
<p>Community-wide outbreaks of communicable diseases e.g., pandemic influenza, pertussis, that carry the potential of adversely impacting operations and service capabilities</p> <p>50 points</p>	H	H	H	H	H	<p>The Infection Preventionist is an active member of the Infectious Disease Task Force facilitated by the Deputy Health Officer of Sonoma County on a bi-monthly basis.</p> <p>Health alerts are received from the Public Health Department.</p> <p>IP is on email lists and CAHAN for notification of any potential emergencies.</p> <p>Remain in close communication with the communicable disease control nurses at the Sonoma County Public Health Department.</p> <p>Policies/Guidelines in place for outbreak management. Recommendations and guidelines set forth by the DPH for various diseases (e.g. Norovirus, Influenza, Pertussis, possible EVD) are available and followed during an outbreak.</p>	<p>Goal: Infection Preventionist attends 90% of ID Task Force meetings and shares health alerts and other pertinent information with appropriate staff.</p> <p>Evaluate all infectious clusters or outbreaks in a timely manner. Assess compliance with public health guidelines and recommendations. Prepare an action plan to interrupt the cluster/outbreak.</p> <p>Tdap, Hepatitis B, Influenza, MMR, and Varicella vaccination required for employees in accordance with Cal/OSHA regulations and CDC recommendations. Staff Influenza vaccination rates monitored and reported to NHSN as required by Ca law. TB testing performed annually and as needed post exposure.</p>

Prioritized Risk Description	Care Setting Risk Designation (See legend*)					Summary of Risk Mitigation Strategies	Goals/How the Effectiveness of the Strategies is Evaluated
	I	A	O	H	S		
<p>Potential for a bioterrorism (BT) event that would require specific responses from the organization to successfully meet the threat.</p> <p>25 points</p>	M	M	M	M	M	<p>BT response plan and the plan to manage an influx of infectious patients are included in the Emergency Operations Plan for SVH.</p> <p>Maintain communication with CDPH for updates and alerts.</p>	<p>Goal: IP attends 90% of Emergency Management Committee meetings and actively participates in emergency preparedness</p> <p>Evaluate and update plans as necessary.</p>
<p>Acquisition and transmission of multi-drug resistant bacteria that carry the potential for healthcare associated MDRO infections among patients and staff.</p> <ul style="list-style-type: none"> • MRSA <p>25 points</p>	M	M	M	M	M	<p>Contact precautions initiated for all patients currently infected or with a history of MRSA (not required for nares colonization).</p> <p>Patients are flagged in the system for identification and isolation on subsequent admissions.</p> <p>Develop a policy, consistent with CDC MDRO recommendations to discontinue isolation following appropriate testing.</p> <p>Hospital Acquired MRSA cases are tracked and reported.</p> <p>Active surveillance cultures for MRSA obtained on designated “high risk” patients as required by SB 1058.</p>	<p>Goal: Hospital Acquired MDRO cases are identified and reported quarterly to PI and appropriate medical staff committees.</p> <p>100% of HAI MRSA bacteremia cases are reported to CDPH including all cases identified in the ED.</p> <p>Pts colonized with MRSA (nares) are screened and informed in accordance with SB 1058.</p>
<ul style="list-style-type: none"> • VRE <p>25 points</p>	M	M	M	M	M	<p>Contact precautions initiated for all patient infected or colonized with VRE.</p> <p>Patients are flagged in the system for identification and</p>	<p>Goal: 100% of HAI VRE bacteremia cases are reported to CDPH including all cases identified in the ED.</p> <p>Hospital Acquired MDRO cases are</p>

Prioritized Risk Description	Care Setting Risk Designation (See legend*)					Summary of Risk Mitigation Strategies	Goals/How the Effectiveness of the Strategies is Evaluated
	I	A	O	H	S		
						<p>isolation on subsequent admissions.</p> <p>Develop a policy, consistent with CDC MDRO recommendations to discontinue isolation following appropriate testing. This will need review and approval by PI Committee and other committees as appropriate.</p> <p>Hospital Acquired VRE cases are tracked and reported.</p> <p>VRE bacteremia that is detected in the ED as well as after admission is required reporting to NHSN in 2015.</p>	<p>identified and reported quarterly to PI and appropriate medical staff committees.</p>
<ul style="list-style-type: none"> ESBL <p>25 points</p>	M	M	M	M	M	<p>Contact precautions initiated for all patients infected or colonized with ESBL.</p> <p>Patients are flagged in the system for identification and isolation on subsequent admissions.</p> <p>Develop a policy, consistent with CDC MDRO recommendations to discontinue isolation following appropriate testing. ESBL cases are tracked and reported.</p>	<p>Goal: ESBL rates are reported quarterly to PI and appropriate medical staff committees. ASP reviews antibiogram annually and assesses antibiotic use in accordance with ASP guidelines. Antibiotic prescribing guidelines are posted on the intranet and reviewed/revised annually.</p>
<ul style="list-style-type: none"> CDI 	H	M	M	M	L	<p>Contact/Enteric precautions initiated for all patient with diarrhea</p>	<p>Goal: 7.4 CDI per 10,000 patient days.</p>

Prioritized Risk Description	Care Setting Risk Designation (See legend*)					Summary of Risk Mitigation Strategies	Goals/How the Effectiveness of the Strategies is Evaluated
	I	A	O	H	S		
26 points						<p>until cause is determined to be noninfectious, or pt. completes treatment for CDI and symptoms subside.</p> <p>Environmental disinfection of the isolation room utilizing bleach. Xenex robot UV disinfection is employed with terminal cleaning.</p> <p>Use of handwashing rather than alcohol-based hand sanitizer.</p> <p>Daily antibiotic rounds by Dietary, live culture yogurt/probiotics administered until 48 hours after antibiotics are discontinued and recommend DC PPI for patients on antibiotics. Encourage patient education for patients prescribed antibiotics in the Emergency Department.</p> <p>Review of cases of concern in ASP weekly with MDs.</p> <p>Hospital Acquired CDI cases are tracked, trended, and reported.</p>	<p>The ASP program includes weekly review of pts on antibiotics, annual antibiogram and preoperative antibiotic recommendations to promote antimicrobial stewardship and CDI prevention. Hospital Acquired CDI cases are identified and reported quarterly to PI and appropriate medical staff committees.</p> <p>CDI cases are reported to CDPH including cases identified in ED.</p>
<ul style="list-style-type: none"> Infection Prevention policies and procedures reflect current CIHQ standards. <p>5 points</p>	L	L	L	L	L	IP policies and procedures were revised by March 31, 2017 prior to CIHQ survey.	Goal: Review and revise IP policies and procedures as required. Introduce new policies and procedures as indicated by IP literature, changes in the law or community standard.

Prioritized Risk Description	Care Setting Risk Designation (See legend*)					Summary of Risk Mitigation Strategies	Goals/How the Effectiveness of the Strategies is Evaluated
	I	A	O	H	S		
Potential for the following based on the results of surveillance and other data, review of the literature, patient population, and scope of services provided.							
<ul style="list-style-type: none"> Central line associated bloodstream infections (CLABSI) <p>21 points</p>	M	M	L	L	M	<p>Central line bundle in place, including Biopatch.</p> <p>CLIP monitoring for ICU central line insertions and reported to NHSN.</p> <p>Daily review of line necessity and line removal asap.</p>	<p>Goal: Review 100% of CLIP forms and follow with clinician whenever CLIP is not performed correctly.</p> <p>Goal: CLABSI rates at or below NHSN benchmarks. CLABSI rates are reported quarterly to PI committee and appropriate medical staff committees.</p>
<ul style="list-style-type: none"> Ventilator Associated Event (VAE) and Hospital-Associated Pneumonia <p>14 points</p>	H	L	L	L	L	<p>VAP and HAP prevention project underway in 2018.</p>	<p>Goal: Prepare a P&P for VAE and HAP prevention. Improve oral care. Update EMR re aspiration risk measures and documentation.</p>
<ul style="list-style-type: none"> Catheter associated UTI (CAUTI) <p>21 points</p>	M	M	L	M	M	<p>Daily review of catheter necessity to remove asap based on criteria.</p> <p>Include criteria in EMR.</p> <p>Promote the use of Vitamin C as appropriate to reduce risk of UTI.</p>	<p>Goal: Reduce CAUTI rates to NHSN benchmarks.</p> <p>Reported quarterly to PI committee and appropriate medical staff committees.</p>
<ul style="list-style-type: none"> Surgical Site Infections (SSI) <p>13 points</p>	M	M	L	L	L	<p>Elevated SSI rates (by procedure group) are investigated and action plans developed to reduce rates to baseline. CHG protocol in place for elective total joint patients. Consider change to CHG wipes. SSI outcomes (HAI report) are shared with OR staff.</p>	<p>Goal: Overall SSI rate <1%. < 2 colon or hysterectomy SSIs/ yr. 80% SSI post discharge reporting compliance by surgeons. SSI rates by procedure do not exceed benchmarks.</p> <p>Report SSI rates quarterly to Surgery Committee and PI Committee.</p>
<p>Potential for transmission of infection related to noncompliance with hospital sanitation measures.</p> <p>25 points</p>	M	M	M	M	M	<p>Quarterly meetings conducted with the EVS manager, the Nutritional services manager, and the Chief engineer and</p>	<p>Track patient satisfaction survey feedback on cleanliness of the hospital.</p>

Prioritized Risk Description	Care Setting Risk Designation (See legend*)					Summary of Risk Mitigation Strategies	Goals/How the Effectiveness of the Strategies is Evaluated
	I	A	O	H	S		
						<p>inservices provided on a prn basis to ensure maintenance of a sanitary environment.</p> <p>Infection control training of EVS staff on hire and annually thereafter to educate on maintenance of a sanitary environment.</p> <p>Policy on Cleaning of patient care equipment in place for a clear delineation of responsibility for cleaning specific areas of the hospital and equipment.</p>	<p>EVS provides cleanliness data to IP on a quarterly basis (TBD).</p> <p>Medication preparation is performed >3 feet from a sink or a splash guard is installed. (CIHQ)</p>
<p>Infection Prevention and Control involvement in construction activities</p> <p>15 points</p>	M	M	N A	N A	M	<p>Infection Control Risk Assessment completed for all construction activities.</p> <p>Construction workers educated on IC practices via an APIC video during safety orientation.</p>	<p>Goal: 100% compliance with Infection Control Risk Assessment (ICRA) and compliance checklist completed before initiating any construction projects. Documentation kept in Engineering.</p>
<p>A water management program that reduces the risk of microbial growth in building water systems and the accompanying risk of legionellosis and other waterborne infections</p> <p>35 points</p>	H	H	M	N A	H	<p>Complete a risk analysis and implement a water management program</p>	<p>Goal: zero healthcare associated legionellosis and compliance with the water management program policies and procedures</p>

*Legend for Care Settings Risk Designation

I = Inpatient services including medical surgical, critical care, maternal / child, and surgery

A = Ambulatory care services such as outpatient surgery, procedural and diagnostic services, and the Emergency Department

O = Outpatient services such as primary and specialty care clinics, wellness centers, infusion centers, rehabilitation clinics, and other services

H = Healing at Home

S = Skilled Nursing Facility

* For each setting, the risk assessment also takes into account - as applicable - support services such as facilities, environmental services, materials management, sterile supply and processing, dietary, clinical laboratory, and all other departments and services of the organization.

Risk Designation – Enter the Level of Assessed Risk for Each Care Setting:

L = Low risk (1 point)

M = Medium Risk (5 points)

H = High Risk (10 points)

REFERENCES: CIHQ Standards, CDC guidelines, AORN.



SUBJECT: Infection Prevention Program	POLICY # IC8610-140
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DEPARTMENT: Organizational	EFFECTIVE: 3/87
APPROVED BY: CQO/ Performance Improvement Committee	REVIEW/REVISED: 8/92 3/94 7/98 10/01 9/04 9/07 12/07 5/10 2/11 3/12 2/13 2/14 5/15, 2/16, 1/17, 1/18

Purpose

To codify the components of Sonoma Valley Hospital's Infection Prevention program and the mission to identify, prevent and control the spread of infections in accordance with all applicable regulatory standards and requirements.

Scope & Applicability

This is an organization-wide program. As such, it applies to all services and settings including inpatient, outpatient, Healing at Home, SNF and all healthcare providers, including physicians, licensed independent practitioners (LIP), staff, students, trainees, volunteers, and as appropriate, visitors, and patients.

Secondary Policy & Procedure

Unless otherwise noted herein, additional policies and procedures may be developed to address specific infection control and prevention issues on an organization-wide and/or department specific basis. In these instances, such policies and procedures must be consistent with the policy statements established in this document. These policies and procedures are – by this reference – incorporated into the scope of the Infection Prevention Program.

Goals

The 2018 goals of the infection prevention program include, but are not necessarily limited to:

- Hand hygiene performed in accordance with hospital policy
- Preventing or reducing the risk of unprotected exposure to pathogens throughout the organization.
- Minimizing the risk of transmitting infections via medical equipment, medical devices, hospital environment and multi-use vials.
- Reduce the risk of infection due to prolonged wait times in outpatient areas.
- Maintaining a sanitary environment to reduce the risk of fomite-associated infections and communicable diseases
- Reduce the risk of hospital outbreaks of community acquired infections e.g., influenza
- Ongoing implementation of a system for identifying, reporting, investigating, and controlling infections and communicable diseases in patients and personnel including: Central Line Associated Bloodstream Infection (CLABSI), Ventilator Associated Events (VAE), Catheter Associated Urinary Tract Infection (CAUTI), Multi-drug Resistant Organism (MDRO), C. difficile infections, surgical site infections (SSI) and hospital-acquired pneumonia in accordance with California Department of Public Health (CDPH), National Health and Safety Network (NHSN), and the Center for Improvement in Healthcare Quality (CIHQ).



SUBJECT: Infection Prevention Program	POLICY # IC8610-140
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- Ensuring that the hospital-wide quality, performance improvement and training programs address problems identified by the Infection Control Officer i.e., Infection Preventionist, and that subsequent corrective action plans are successfully implemented
- Complying with the MRSA active surveillance requirements of SB 158.
- Complying with Cal/OSHA regulations including Bloodborne Pathogen Exposure and Aerosol Transmissible Disease Standards.
- Reduce the risk of infections associated with construction.
- Establish a water management program to reduce the risk of microbial growth in building water systems and the risk of legionellosis or other waterborne infections.

The 2018 goals of the Healing at Home infection prevention program include, but are not necessarily limited to:

- To maintain low infection rates through a surveillance plan that includes monitoring and reporting surgical site infections (SSI) and home health associated infections including Central line associated bloodstream infections (CLABSI), Catheter associated urinary tract infections (CAUTI), Multi-drug resistant organisms (MDRO), and pneumonia as well as outbreak investigation and communicable disease exposures.
- Enhancing hand hygiene in the home setting.

Structure of the Infection Control Program

INFECTION CONTROL OFFICER

Sonoma Valley Hospital has an Infection Control Officer i.e., Infection Preventionist (IP) to oversee the development and day-to-day implementation of the infection prevention plan. This individual is qualified by virtue of her training, education, and experience to perform this function. The IP is expected to maintain her qualifications through ongoing education and training, which can be demonstrated by participation in infection prevention courses, or in local and national meetings organized by recognized professional societies (e.g. APIC) or certification.

In determining the number of infection prevention personnel and support staff, the organization considers patient census, characteristics of the patient population, and complexity of the healthcare services to assure that resources are adequate to accomplish the tasks required for the implementation of the goals of the infection prevention program.

Responsibilities of the infection preventionist include, but are not necessarily limited to:

- Develop and implement policies and procedures governing the prevention and control of infections and communicable diseases.



SUBJECT: Infection Prevention Program

POLICY # IC8610-140

DEPARTMENT: Organizational

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EFFECTIVE: 3/87

APPROVED BY: CQO/ Performance Improvement
Committee

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- Develop, implement and evaluate systems and measures governing the identification, investigation, reporting, prevention and control of infections and communicable diseases within the hospital, including both healthcare-associated infections and community-acquired infections.
- Take necessary steps to prevent or control the acquisition and transmission of infectious agents.
- Coordinate all infection prevention and control activities within the hospital.
- Facilitate ongoing monitoring of the effectiveness of prevention and/or control activities.
- Perform all the required reporting to NHSN, CDPH, Sonoma County DPH, CIHQ and other regulatory bodies as required.

PERFORMANCE IMPROVEMENT COMMITTEE

The Performance Improvement Committee is a multi-disciplinary body composed of representatives from Infection Prevention, medical staff, nursing, and other direct and indirect care staff and oversees the Infection Control Program. For the purposes of this document, the term “committee” may mean a distinct and stand-alone entity, or a function of an entity.

Composition of the committee ensures, through either membership or invitee, that administration, building maintenance/engineering, emergency, food service, Healing at Home, housekeeping, laboratory, pharmacy, SNF, sterilization services, and surgery are represented as applicable and necessary.

The functions of the Performance Improvement (PI) Committee include, but are not necessarily limited to:

- Provide a forum for departments and services to effectively collaborate in developing, implementing, and evaluating the infection prevention program plan.
- Develop strategies for each component/function in the program
- Assess the adequacy of the human, information, physical, and financial resources allocated to support infection prevention and control activities
- Review and revise the program as warranted to improve outcomes
- Monitor compliance with all policies, procedures, protocols and other infection control program requirements
- Provide mechanisms for integration of the infection prevention program into the organization’s quality assurance and improvement, environment of care, and safety programs.
- The committee maintains a record of, and reports a summary of its activities to the Medical Executive Committee.



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Management of Infectious Risk

IDENTIFICATION OF RISK

The organization identifies risks for transmission and acquisition of infectious agents throughout the hospital based on the following factors:

- The geographic location and community environment of the hospital, program/services provided, and the characteristics of the population served, including Sonoma Developmental Center and Napa State Hospital patients
- The results of the analysis of the hospital’s infection prevention and control data
- The care, treatment, and services provided

This risk analysis is formally reviewed at least annually and whenever significant changes occur in any of the above factors. The infection preventionist performs the risk assessment and presents the results to the PI Committee.

Review of the risk assessment including significant changes that may occur from one formal review period to the next, may be codified in reports to the PI Committee or in other documents that provide evidence the risk was identified and addressed.

PRIORITIZATION OF RISK

Once risks are identified, the organization prioritizes those risks that are of epidemiological significance. Certain risks are automatically prioritized based on their nature, scope, and impact on the care, treatment, and services provided. These risks include, but are not necessarily limited to:

- Transmission of infection through potential non-compliance to CDC guidelines and recommendations for hand hygiene
- Unprotected exposure to pathogens throughout the organization due to non-compliance with policies addressing universal precautions, transmission-based precautions and other infection prevention measures
- Potential for transmission of infection related to procedures, medical equipment, and medical devices related to appropriate storage, cleaning, disinfection, sterilization, reuse and/or disposal of supplies and equipment, as well as use of personal protective equipment

STRATEGIES TO ADDRESS THE PRIORITIZED RISKS

Specific strategies are developed and implemented to address the prioritized risks. These strategies may take the form of policy and procedure establishment, surveillance and monitoring activities, education and training programs, environmental and engineering controls, or combinations thereof.



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Strategies may differ in approach, form, scope, application, and/or duration depending on the specific risk issue, the care setting(s), and environment involved.

A complete description of prioritized risks and subsequent mitigation strategies from the most recent formal risk assessment is by reference incorporated herein.

General Scope and Activities of the Infection Control Program

MAINTENANCE OF A SANITARY PHYSICAL ENVIRONMENT

The organization has developed specific policies, procedures, or other codified work processes that address the following:

- Ventilation, temperature, humidification and water quality control issues, including measures taken to maintain a safe environment during internal or external construction / renovation.
- Maintaining safe air handling systems in areas of special ventilation, such as operating rooms, intensive care units, and airborne isolation rooms
- Safe food storage, preparation, and handling
- Appropriate cleaning and disinfecting of environmental surfaces, carpeting, furniture, common areas, and medical equipment including a clear description of responsibility for cleaning the specific areas.
- Sanitary textile reprocessing, storage, and distribution
- Safe storage and disposal of regulated and non-regulated waste
- Adequate pest or vector control
- Procedures for animal visitation

MANAGEMENT OF STAFF, PHYSICIANS, AND OTHER PERSONNEL

The organization has developed specific policies, procedures, or other codified work processes that address the following:

- Communication with licensed independent practitioners (LIP), staff, students, trainees, volunteers, and as appropriate, visitors, patients, and families about infection control issues, including their responsibilities in preventing the spread of infection.
- New employee and annual training in preventing and controlling healthcare associated infections and methods to prevent exposure to and transmission of infections and communicable diseases;
- Screening for exposure and/or immunity to infectious diseases that LIP, staff, students, trainees, and volunteers may come in contact in their work including:
 - Policies articulating the authority and circumstances under which the hospital screens hospital staff for infections likely to cause significant infectious disease or other risk to



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the exposed individual, and for reportable diseases, as required under local, state, or federal public health authority

- Measures and authority for ensuring that hospital staff have documented immunity to designated infectious diseases, as recommended by the CDC and its Advisory Committee on Immunization Practices (ACIP)
- Referral for assessment, potential testing, immunization, and/or prophylaxis/treatment and counseling, as appropriate, of LIP, staff, students, trainees, and volunteers who are identified as potentially having an infectious disease or risk of infectious disease that may put the population they serve at risk including policies articulating when infected hospital staff are restricted from providing direct patient care and/or are required to remain away from the healthcare facility entirely;
- Referral for assessment, potential testing, immunization, and/or prophylaxis/treatment, and counseling, as appropriate of patients, students, trainees, and volunteers who have been exposed to infectious diseases in the organization, and LIP or staff who are occupationally exposed.

MITIGATION OF RISK ASSOCIATED WITH PATIENT INFECTIONS PRESENT ON ADMISSION

The organization has developed specific policies, procedures, or other codified work processes that address the following:

- Measures for the early identification of patients who require isolation in accordance with CDC guidelines;
- Appropriate use of standard precautions with all patients including personal protective equipment i.e., gowns, gloves, masks and eye protection devices;
- Transmission –based “isolation” precautions as recommended by the CDC for patients with suspected or confirmed communicable diseases.

MITIGATION OF RISKS CONTRIBUTING TO HEALTHCARE ASSOCIATED INFECTIONS

The organization has developed specific policies, procedures, or other codified work processes in accordance with CDC and AORN guidelines, that address the following:

Surgery-related infection risk mitigation measures:

- Implementing appropriate prophylaxis to prevent surgical site infection (SSI). Staff adhere to a protocol to assure that antibiotic prophylaxis to prevent surgical site infection for appropriate procedures is administered at the appropriate time, done with an appropriate antibiotic, and discontinued appropriately after surgery;
- Aseptic technique is used in all surgical and invasive procedures performed in Surgery and outside the operating room e.g., Interventional Radiology;



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- Instruments, equipment and the environment are disinfected or sterilized in accordance with Centers for Disease Control and AORN guidelines

Other hospital healthcare-associated infection risk mitigation measures:

- Promotion of hand washing/ hand hygiene among staff and employees, including utilization of alcohol-based hand sanitizers;
- Measures specific to prevention of infections caused by organisms that are antibiotic-resistant i.e., the Antimicrobial Stewardship Program and Contact Isolation.
- Measures specific to prevention of device-associated bloodstream infection (CLABSI),
- Measures specific to prevention of other device-associated infections, e.g., those associated with ventilators, tube feeding, indwelling urinary catheters, etc.;
- Isolation procedures and requirements for highly immuno-suppressed patients who require a protective environment.
- Care techniques for tracheostomy care, respiratory therapy, burns and other situations that reduce a patient's resistance to infection;
- Requiring disinfectants, antiseptics, and germicides to be used in accordance with the manufacturers' instructions;
- Appropriate use of facility and medical equipment, including negative and positive pressure air flow room systems, portable air filtration equipment, treatment booths and enclosed beds, UV lights, and other equipment used to control the spread of infectious agents;
- Adherence to nationally recognized infection prevention and control precautions, such as current CDC guidelines and recommendations, for infections/communicable diseases identified as present in the organization based on the following:
 - The potential for transmission
 - The mechanism of transmission
 - The care, treatment, and service setting
 - The emergence or reemergence of pathogens in the community that could affect the organization.
- Educating patients, visitors, caregivers, and staff, as appropriate, about infections and communicable diseases and methods to reduce transmission in the hospital and in the community;
- Adherence to a water management program to reduce the risk of waterborne infections e.g., legionellosis

ACTIVE SURVEILLANCE

The organization has developed specific policies, procedures, or other codified work processes that address the following:



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- Methods for obtaining and reviewing data on infections/communicable diseases selected for monitoring;
- Methods for monitoring and evaluating practices of asepsis;
- Authority and indications for obtaining microbiological cultures from patients and the environment as indicated.

Active surveillance consists of both targeted surveillance of selected patient populations or procedures, as well as organization-wide surveillance designed to identify infectious risks or communicable disease issues in any department or care setting.

The selection of patient populations and/or procedures for targeted surveillance is based on the following criteria:

- There is internal or external data and evidence that designates the patient population / procedure at a high risk of infection.
- The patient population / procedure ties directly to an issue or need identified in the organization
- There is internal data and evidence demonstrating a historical benchmark rate of infection tied to a patient population / procedure.

When targeted surveillance is utilized, appropriate data definitions, surveillance methodologies, internal or external benchmarks, monitoring frequencies, and display tools are developed.

Organization-wide surveillance does not imply or require total surveillance of all patients, and care settings. Instead the organization has developed the following mechanisms:

- Positive cultures on patients from any location in the organization are reviewed by either the infection preventionist or appropriate LIP.
- Adherence to infection prevention related quality control / assurance processes are monitored by management personnel in all applicable locations.
- Facilities personnel monitor environmental infection control processes related to air exchanges, temperature, humidity, and isolation rooms throughout the organization
- Infection preventionist or designee(s) conducts rounds throughout the organization to identify and correct practice or environmental issues.

COMMUNICATION / COORDINATION WITH OUTSIDE AGENCIES

The organization has developed specific policies, procedures, or other codified work processes that address the following:



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- Coordination with federal, state, and local emergency preparedness and health authorities to address communicable disease threats, bioterrorism, and outbreaks, including a plan to manage an influx of potentially infectious patients.
- Systems for reporting infection surveillance, prevention, and control information to the following:
 - The appropriate staff within the organization
 - Federal, state, and local public health authorities in accordance with law and regulation
 - Accrediting bodies
 - The referring or receiving organization, when a patient was transferred or referred and the presence of a healthcare acquired infection was not known at the time of transfer or referral

Integration of the Infection Prevention Program Within the Performance Improvement Program

The activities of the Infection Prevention Program fall under the umbrella and auspices of the organization’s Performance Improvement Program. Issues or problems noted are to be addressed through corrective action plans. These action plans are to include, when appropriate, education and training of staff.

Adherence to corrective action plans will be monitored, to assess the effectiveness of actions taken, with implementation of revised corrective actions as needed.

Evaluation of the Infection Prevention Program

The organization formally evaluates and revises the goals and program (or portions of the program) at least annually and whenever risks significantly change

- The evaluation addresses changes in the scope of the program
- The evaluation addresses changes in the results of the program risk analysis
- The evaluation addresses emerging and re-emerging problems in the health care community that potentially affect the hospital
- The evaluation addresses the assessment of the success or failure of interventions for preventing and controlling infection
- The evaluation addresses responses to concerns raised by leadership and others within the organization
- The evaluation addresses the evolution of relevant infection prevention and control guidelines that are based on evidence or, in the absence of evidence, expert consensus

The infection preventionist facilitates the program evaluation and submits the evaluation to the Performance Improvement Committee for review and approval.



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Reference:

1. The Center for Improvement in Healthcare Quality
2. CMS Conditions of Participation for Acute Care Hospitals, §482.42
3. CDC Guidelines

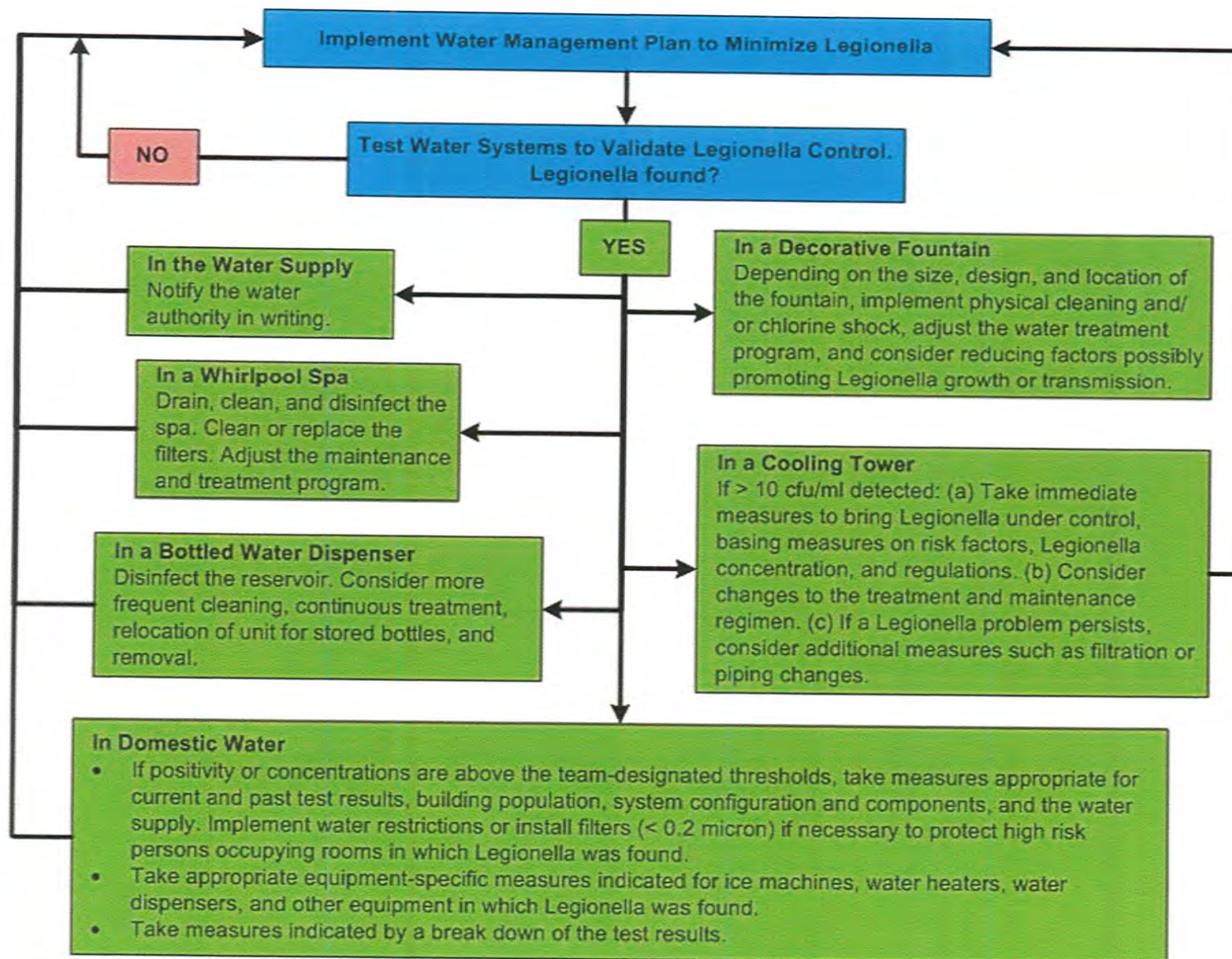


Figure Conf-1: Responding to Legionella Test Results in the Absence of Disease

Excerpted and adapted from the online training course *Interpreting Legionella Water Test Results and Responding Appropriately* (available at hcinfo.com).

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6.

HQI QUALITY
TRANSPARENCY
DASHBOARD



Hospital Quality Institute

Leadership in quality and patient safety

Q&A and Future Steps for the Quality Transparency Dashboard

21 February 2018

Housekeeping Items

- **All lines will be muted. Please use the chat or Q+A boxes on the right panel of the screen.**
- **Raise your hand to unmute your line.**
- **This call may be recorded.**
- **Slides released this week.**

Today's Speakers and Subject Matter Experts



Scott Masten, PhD
*Director, Performance
Analytics*



Steve Pon, MBA
Project Manager



**Kim Werkmeister, RN,
BA, CPHQ, CPPS**
Clinical Improvement
Educator



**Lyn Forsey, PhD, RN,
CPHQ, CPPS**
Director, Technical
Assistance and Support

Brief Recap of 2/14: HQI Webinar

The What, Why, When, and How of the Quality Transparency Dashboard

Link to replay:

<http://www.hqinstitute.org/event/hqi-webinar-what-why-when-and-how-quality-transparency-dashboard>

Recap of What & Why: Increased Quality Transparency

What:

- Advance transparency in quality data between hospitals and the public (5th level of healthcare transparency)
- Provide easily accessible, meaningful, shareable information about hospital quality

Why:

- Help California hospitals to lead the movement towards increased healthcare quality transparency
- Preempt legislative activity and avert additional compliance burden

Recap of How: Quality Transparency Dashboard

HQI will create dashboards of publicly-available quality data for each acute care CHA-member hospital:

- 5 outcome measures
- 3 program status measures
- No judgment, no stars, no rankings, no grades – HQI was founded by hospitals for hospitals

Quarterly email Excel file with 3 sheets to each hospital:

- Model Dashboard tab
- Raw data tab
- Explanations/notes tab

Model Quality Transparency Dashboard

Quality Transparency Dashboard										
Outcome Measures:	CLABSI	Lower is Better	Colon SSI	Lower is Better	NTSV	Lower is Better	Sepsis Mortality	Lower is Better	VTE	Lower is Better
ABC Hospital	0.89		0.93		24.0%		19.9%		2.0%	
California Level	0.89		0.92		25.0%		18.3%		2.0%	
National Level	1.00		1.00		25.7%		25.0%		2.0%	
Measure Period	04/01/2016-03/31/2017		04/01/2016-03/31/2017		01/01/2016-12/31/2016		01/01/2014-12/31/2014		04/01/2016-03/31/2017	
Program Status:										
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		This hospital has a Maternity Safety Program in place. A maternity safety program provides a coordinated approach and emergency response to risks associated with pregnancy and childbirth.								
<input type="checkbox"/> Yes <input type="checkbox"/> No		This hospital has a Sepsis Protocol in place. A sepsis protocol provides guidance for a coordinated approach to identification and treatment of an infection and inflammatory response which is present throughout the body.								
<input type="checkbox"/> Yes <input type="checkbox"/> No		This hospital has a Respiratory Monitoring program in place. Respiratory monitoring provides guidance for assessment of risk of respiratory depression, and includes continuous monitoring of breathing and functioning of the lungs and circulatory system when indicated.								
Measure Definitions:										
<p>CLABSI - Central line-Associated Blood Stream Infection: A serious infection that occurs when germs enter the bloodstream through a central line. A central line is a special intravenous catheter (IV) that allows access to a major vein close to the heart and can stay in place for weeks or months. The value shown above is a Standardized Infection Ratio (SIR), which is the ratio of observed-to-expected infections during the measure period. SIRs below 1.00 indicate that the observed number of infections during the measure period was lower than would be expected under normal conditions, whereas values above 1.00 indicate that the observed number of infections was higher than expected. Limitation: In the calculation of the Standardized Infection Ratio (SIR), the CDC adjusts for differences between hospitals. However, patient risk factors are not taken into account. These patient-specific variables (e.g., poor skin integrity, immunosuppression) can increase the risk of developing a central line infection. Hence, the SIR for hospitals that care for more medically complex or immunosuppressed patients may not be adequately adjusted to account for those patient-specific risk factors.</p> <p>Colon SSI - Colon Surgical Site Infection: An infection (usually bacteria) that occurs after a person has colorectal surgery that occurs at the body site where the surgery took place. While some involve only the skin, others are more serious and can involve tissues under the skin, organs, or implanted material. The value shown above is a Standardized Infection Ratio (SIR), which is the ratio of observed-to-expected infections during the measure period. SIRs below 1.00 indicate that the observed number of infections during the measure period was lower than would be expected under normal conditions, whereas values above 1.00 indicate that the observed number of infections was higher than expected. Limitation: Some, but not all patient-specific risk factors are included in the adjustment of the SIR for these types of infections. However, not all relevant risk factors are included (e.g., trauma, emergency procedures). Hence, the SIRs for hospitals performing more complex procedures or with larger volumes of trauma or emergency procedures may not be adequately adjusted to account for those patient-specific risk factors.</p> <p>NTSV - Nulliparous, Term, Singleton, Vertex Cesarean Birth Rate: The percentage of cesarean (surgical) births among first-time mothers who are at least 37 weeks pregnant with one baby in a head down position (not breech or transverse). Lower values indicate that fewer cesareans were performed in the hospital among primarily low risk, first-time mothers. Limitation: NTSV rates do not take into account certain obstetric conditions, such as placenta previa, that may make Cesarean delivery the safer route for both mother and infant.</p> <p>Sepsis Mortality: Percent of patients, with a severe infection, who die in the hospital. Most sepsis cases (over 90%) start outside the hospital. Lower percentage of death indicates better survival. Limitation: Use of discharge/administrative data is limiting since such data has lower specificity for diagnoses than clinical data. In addition, without risk adjustment for differences in patient-specific factors, comparing rates among hospitals is difficult.</p> <p>VTE - Venous thromboembolism: The measure of patients who develop deep vein clots who had not received potentially preventive treatment. Limitation: Although not adjusted to account for patient-specific risk factors, this rate is helpful in distinguishing a hospital's adherence to the best practice of administration of appropriate VTE prophylaxis to all appropriate patients.</p>										
Hospital Comments:										

1

2

3

4

Model QT Dashboard: Outcome Measures



1

Outcome Measures:	CLABSI	Lower is Better	Colon SSI	Lower is Better	NTSV	Lower is Better	Sepsis Mortality	Lower is Better	VTE	Lower is Better
ABC Hospital		0.89		0.93		24.0%		19.9%		2.0%
California Level		0.89		0.92		25.0%		18.3%		2.0%
National Level		1.00		1.00		25.7%		25.0%		2.0%
Measure Period	04/01/2016-03/31/2017		04/01/2016-03/31/2017		01/01/2016-12/31/2016		01/01/2014-12/31/2014		04/01/2016-03/31/2017	

1. **CLABSI** - Central line-Associated Blood Stream Infection Standardized Infection Ratio (SIR)
2. **Colon SSI** - Colon Surgical Site Infection SIR
3. **NTSV** - Nulliparous, Term, Singleton, Vertex Cesarean Birth Rate
4. **Sepsis Mortality** Rate
5. **VTE** - Potentially Preventable Venous thromboembolism Incidence (VTE-6)

• California Level

• National Level

• Measure Period⁸

Model QT Dashboard: Program Status

Program Status:	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	This hospital has a Maternity Safety Program in place. A maternity safety program provides a coordinated approach and emergency response to risks associated with pregnancy and childbirth.
<input type="checkbox"/> Yes <input type="checkbox"/> No	This hospital has a Sepsis Protocol in place. A sepsis protocol provides guidance for a coordinated approach to identification and treatment of an infection and inflammatory response which is present throughout the body.
<input type="checkbox"/> Yes <input type="checkbox"/> No	This hospital has a Respiratory Monitoring program in place. Respiratory monitoring provides guidance for assessment of risk of respiratory depression, and includes continuous monitoring of breathing and functioning of the lungs and circulatory system when indicated.

2

Evidence-Based Quality of Care Practices in Place:

1. Maternal Safety Program – Yes/No or N/A
2. Sepsis Protocol - Yes/No
3. Respiratory Monitoring Program - Yes/No

• Self-response completed by each hospital

Model QT Dashboard: Measure Definitions

3

Measure Definitions:

CLABSI - Central line-Associated Blood Stream Infection: A serious infection that occurs when germs enter the bloodstream through a central line. A central line is a special intravenous catheter (IV) that allows access to a major vein close to the heart and can stay in place for weeks or months. The value shown above is a Standardized Infection Ratio (SIR), which is the ratio of observed-to-expected infections during the measure period. SIRs below 1.00 indicate that the observed number of infections during the measure period was lower than would be expected under normal conditions, whereas values above 1.00 indicate that the observed number of infections was higher than expected. **Limitation:** In the calculation of the Standardized Infection Ratio (SIR), the CDC adjusts for differences between hospitals. However, patient risk factors are not taken into account. These patient-specific variables (e.g., poor skin integrity, immunosuppression) can increase the risk of developing a central line infection. Hence, the SIR for hospitals that care for more medically complex or immunosuppressed patients may not be adequately adjusted to account for those patient-specific risk factors.

Colon SSI - Colon Surgical Site Infection: An infection (usually bacteria) that occurs after a person has colorectal surgery that occurs at the body site where the surgery took place. While some involve only the skin, others are more serious and can involve tissues under the skin, organs, or implanted material. The value shown above is a Standardized Infection Ratio (SIR), which is the ratio of observed-to-expected infections during the measure period. SIRs below 1.00 indicate that the observed number of infections during the measure period was lower than would be expected under normal conditions, whereas values above 1.00 indicate that the observed number of infections was higher than expected. **Limitation:** Some, but not all patient-specific risk factors are included in the adjustment of the SIR for these types of infections. However, not all relevant risk factors are included (e.g., trauma, emergency procedures). Hence, the SIRs for hospitals performing more complex procedures or with larger volumes of trauma or emergency procedures may not be adequately adjusted to account for those patient-specific risk factors.

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Sepsis Mortality: Percent of patients, with a severe infection, who die in the hospital. Most sepsis cases (over 90%) start outside the hospital. Lower percentage of death indicates better survival. **Limitation:** Use of discharge/administrative data is limiting since such data has lower specificity for diagnoses than clinical data. In addition, without risk adjustment for differences in patient-specific factors, comparing rates among hospitals is difficult.

VTE - Venous thromboembolism: The measure of patients who develop deep vein clots who had not received potentially preventive treatment. **Limitation:** Although not adjusted to account for patient-specific risk factors, this rate is helpful in distinguishing a hospital's adherence to the best practice of administration of appropriate VTE prophylaxis to all appropriate patients.

Definition of each outcome measure

- Easy to understand, public-friendly explanation
- Simple guidelines to interpret value

Limitations of each outcome measure

- Context & caveats

Model QT Dashboard: Hospital Comments

Hospital Comments:

4

Optional open-ended comments (section expands)

- Responses about outcome measure performance
- Details about program status responses
- Explanation of progress
- Steps and initiatives implemented
- Future plans

• Self-response completed by each hospital

Recap of When: Your Hospital Should have received an Excel file from HQI COB 2/16/18

What should hospitals do with the Excel files?

- Review data for accuracy
- Provide yes/no information about their evidence-based quality of care practices
- Provide optional comments about performance and initiatives
- **Share model dashboard or equivalent on your hospital's public-facing website**
- **Goal:** Quality Transparency Dashboard posted on every California hospital's website by the end of 2018

We did not receive the email with Excel File Attachment

Excel file emails were sent to:

- **Individual Hospitals:** Hospital CEO, Quality/Patient Safety Leaders, and Government Relations executives
- **Hospital Systems:** Corporate CEO, Quality/Patient Safety Leaders, and Government Relations executives

Check with these leaders at your hospital or system

Still can't locate? Email the HQI Analytics Team at: HQIanalytics@HQInstitute.org and let us know!

Q&A – Known Questions

1. Do hospitals *have* to participate in this effort?

A: Participation is encouraged, but voluntary. We don't tell hospitals what to do; we facilitate and support what they do to improve.

2. How were the dashboard measures chosen?

A: From the universe of publicly-available measures, those that fit with PSMF areas of focus, broadly reflective of quality, understandable to public, and were frequently available

3. Can we display additional/other measures?

A: The dashboard contains what is considered a minimum set of measures. Excel files are completely modifiable. Hospitals can do more and many are!

Q&A – Known Questions

4. When should we have measures posted on our website?

A: Implementation through the year. Ask all to be onboard with transparency (voluntary and responsible) by year end.

5. My hospital's dashboard shows ABC Hospital.

A: Open the Excel file and click “Enable Editing” to refresh data from the data tab.

6. My Web Team wants to create the look and feel that matches our existing website.

A: We encourage hospitals to retain the transparency message while meeting your own web appearance needs.

Q&A – Known Questions

7. A key contact was not included in the emails sent 2/16.

A: Send the contact information to HQanalytics@HQInstitute.org. Specify the person's job role and all hospitals for which this person has that responsibility.

8. How will HQI know if/when we post the dashboard or equivalent on our hospital website?

A: We will be conducting another survey of hospital websites, but make sure you're counted by letting us know at HQanalytics@HQInstitute.org

Q&A – Known Questions

9. Are customized consultation/ webinars/ in person meetings available?

A: Yes – Contact us at HQIanalytics@HQInstitute.org to arrange

10. Will there be any publicity surrounding the launch of the Quality Transparency Dashboards?

A: Yes - HQI/CHA/PSMF will issue a joint press release at 8:00AM on 2/26/18 (moved from 2/23)

11. How often will these data get updated?

A: Quarterly, coinciding with data released from the sources

Q&A – Known Questions

12. Where did these data originate?

A: HQI extracted CLABSI and Colon SSI data from CMS Hospital Compare HAI files; NTSV C-section rates from CMQCC; VTE from CMS Hospital Compare Timeliness and Effectiveness of Care; and Sepsis Mortality rate calculated from OSHPD inpatient discharge files.

13. How can I share these measures on my hospital's website?

A: Many hospitals have a web development team, while others may lack such resources. The simplest approach might be to capture the Excel presentation tab and post it as a graphic image. Other approaches may involve reformatting the information for display in a web browser.

Q&A – Known Questions

14. Is there a plan to obtain more recent data for display?

A: Yes – look for announcements about the upcoming launch of our web-based, member benefit quality data reporting system for hospitals – The Hospital Quality Intelligence Initiative (HQI²) .

15. Why do the CLABSI and/or Colon SSI values display as “Not Available” for my hospital?

A: NHSN presently only calculates standardized infection ratios (SIRs) when the expected number of infections during the specified time period is at least 1. If this changes in the future (e.g., NHSN begins to calculate SIRs for expected values of at least 0.2), we will show the expanded values in the dashboards.

New Questions and Answers:

Use the Chat function or raise your hand to request that the operator unmute your line, or email for an answer offline. We will share the questions and answers.



More questions later? Send your questions to:

HQIanalytics@hqinstitute.org

Reminder Upcoming Event:

HQI/CHA/PSMF press release scheduled for 2/26/18 at 8 am

HQI Celebrates Patient Safety Week!

March 12-16

Featured Webinars

March 12 – The HCRO Journey to High Reliability

- Gudrun Moll, RN, MSN, MBA, NEA-BC, San Antonio Regional Hospital
- Lisa Ramthun, RN, MSN, CPRHM, FASHRM, SG Collaborative Solutions

March 13 – Reliable Safety Event Response

- Rory Jaffe, MD, MBA, CHPSO Patient Safety Organization, a division of HQI

March 14 – The Promise of OpenNotes

- Sigall Bell, MD, Harvard Medical School & Boston Children's Hospital
- Jan Walker, RN, MBA, Harvard Medical School & Beth Israel Deaconess Medical Center
- Liz Salmi, OpenNotes

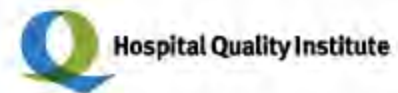
March 15 – Medication Safety

- Kathy Ghomeshi, PharmD, MBA, BCPS, CPPS, UCSF School of Pharmacy

March 16 – The Transgender Care Experience

- Maurice Garcia, MD, MAS, Cedars-Sinai Medical Center

<http://www.chpso.org/event/hqi-hosts-free-webinars-patient-safety-week>



Thank You!

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Quality Transparency Dashboard

Outcome Measures:	CLABSI <small>Lower is Better</small>	Colon SSI <small>Lower is Better</small>	NTSV <small>Lower is Better</small>	Sepsis Mortality <small>Lower is Better</small>	VTE <small>Lower is Better</small>
Sonoma Valley Hospital	Not Available	Not Available	22.5%	10.0%	Not Available
California Level	0.89	0.92	25.0%	18.3%	2.0%
National Level	1.00	1.00	25.7%	25.0%	2.0%
Measure Period	04/01/2016-03/31/2017	04/01/2016-03/31/2017	01/01/2016-12/31/2016	01/01/2014-12/31/2014	04/01/2016-03/31/2017

Program Status:	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	This hospital has a Maternity Safety Program in place. A maternity safety program provides a coordinated approach and emergency response to risks associated with pregnancy and childbirth.
<input type="checkbox"/> Yes <input type="checkbox"/> No	This hospital has a Sepsis Protocol in place. A sepsis protocol provides guidance for a coordinated approach to identification and treatment of an infection and inflammatory response which is present throughout the body.
<input type="checkbox"/> Yes <input type="checkbox"/> No	This hospital has a Respiratory Monitoring program in place. Respiratory monitoring provides guidance for assessment of risk of respiratory depression, and includes continuous monitoring of breathing and functioning of the lungs and circulatory system when indicated.

Measure Definitions:

CLABSI - Central line-Associated Blood Stream Infection: A serious infection that occurs when germs enter the bloodstream through a central line. A central line is a special intravenous catheter (IV) that allows access to a major vein close to the heart and can stay in place for weeks or months. The value shown above is a Standardized Infection Ratio (SIR), which is the ratio of observed-to-expected infections during the measure period. SIRs below 1.00 indicate that the observed number of infections during the measure period was lower than would be expected under normal conditions, whereas values above 1.00 indicate that the observed number of infections was higher than expected. **Limitation:** In the calculation of the Standardized Infection Ratio (SIR), the CDC adjusts for differences between hospitals. However, patient risk factors are not taken into account. These patient-specific variables (e.g., poor skin integrity, immunosuppression) can increase the risk of developing a central line infection. Hence, the SIR for hospitals that care for more medically complex or immunosuppressed patients may not be adequately adjusted to account for those patient-specific risk factors.

Colon SSI - Colon Surgical Site Infection: An infection (usually bacteria) that occurs after a person has colorectal surgery that occurs at the body site where the surgery took place. While some involve only the skin, others are more serious and can involve tissues under the skin, organs, or implanted material. The value shown above is a Standardized Infection Ratio (SIR), which is the ratio of observed-to-expected infections during the measure period. SIRs below 1.00 indicate that the observed number of infections during the measure period was lower than would be expected under normal conditions, whereas values above 1.00 indicate that the observed number of infections was higher than expected. **Limitation:** Some, but not all patient-specific risk factors are included in the adjustment of the SIR for these types of infections. However, not all relevant risk factors are included (e.g., trauma, emergency procedures). Hence, the SIRs for hospitals performing more complex procedures or with larger volumes of trauma or emergency procedures may not be adequately adjusted to account for those patient-specific risk factors

NTSV - Nulliparous, Term, Singleton, Vertex Cesarean Birth Rate: The percentage of cesarean (surgical) births among first-time mothers who are at least 37 weeks pregnant with one baby in a head down position (not breech or transverse). Lower values indicate that fewer cesareans were performed in the hospital among primarily low risk, first-time mothers. **Limitation:** NTSV rates do not take into account certain obstetric conditions, such as placenta previa, that may make Cesarean delivery the safer route for both mother and infant.

Sepsis Mortality: Percent of patients, with a severe infection, who die in the hospital. Most sepsis cases (over 90%) start outside the hospital. Lower percentage of death indicates better survival. **Limitation:** Use of discharge/administrative data is limiting since such data has lower specificity for diagnoses than clinical data. In addition, without risk adjustment for differences in patient-specific factors, comparing rates among hospitals is difficult.

VTE - Venous thromboembolism: The measure of patients who develop deep vein clots who had not received potentially preventive treatment. **Limitation:** Although not adjusted to account for patient-specific risk factors, this rate is helpful in distinguishing a hospital's adherence to the best practice of administration of appropriate VTE prophylaxis to all appropriate patients.

Hospital Comments:

Release Date: 01/31/2018

7.

QUALITY REPORT



To: Sonoma Valley Healthcare District Board Quality Committee
From: Danielle Jones
Date: 2/28/2018
Subject: Quality and Resource Management Report

January Priorities:

1. Department development of 2018 Performance Improvement projects
2. 2018 Quality Measures
3. MedMined

Department Development of 2018 Performance Improvement projects

The focus for February has been on the current year's Performance Improvement projects. I have included the list for review.

2018 Quality Measures

One of the functions of the Quality Department is to monitor and communicate publically reported quality data related to Hospital Inpatient Quality Reporting (IQR) Program, Hospital Value-Based Purchasing (VBP) Program, Hospital Readmissions Reduction Program and Hospital-Acquired Condition (HAC) Reduction Program. I have included the current 2018 Quality metrics for review.

MedMined

We currently use MedMined advanced analytics in the Pharmacy for our antimicrobial stewardship program. SHV has a contract that includes modules for Infection Prevention which includes surveillance, reporting of NHSN, and best practices. The Quality & Resource Management team is working to determine which modules will benefit our practice and create a plan for implementation. Our contract with MedMined also includes a Care Transitions (Medication Reconciliation) module that we are investigating.

Sonoma Valley Hospital

2018 Performance Improvement

Department	Project	Type	NOTES	
1	Safety Committee	Standardize Code Policies	Organizational	Multiple code policies live in multiple locations and are not easily accessible to the staff
2	Clinical Informatics Committee	Clinical Forms Bin	Organizational	The clinical orders, used during computer downtime, do not accurately reflect the electronic order sets for patient care
3	Infection Prevention & Nursing	Hospital Acquired Pneumonia	Organizational	Partner with SNF. Based on Sutter data from APIC, nurse protocol driven. 5 non vent related hospital acquired pneumonias in last 12 months
4	Infection Prevention & Nursing	Clostridium Difficile Infection	Organizational	In response to letter from CDPH indicating SVH has a significantly high incidence of CDI
5	Surgery	ATD charting surgery patients	Departmental	approximately five different ways of admitting and discharging patients from PACU. Plan to work with clinical nurse IS to consolidate, standardize and streamline assessments within Paragon to be able to us for all patients and eliminate all paper charting in the unit
6	Surgery	Standardized SCU discharge instructions	Departmental	Currently 30 discharge instructions with varied format and information
7	Materials Management	Non patient care contract revamp	Departmental	
8	Revenue Cycle Team	MSP collection from Medicare patients	Departmental	Medicare just completed an audit and found us to be very out of compliance. We received a strong warning and put a process into place to correct the issue. This takes place in Admitting whereby each Medicare patient should be questioned each time they register so we know if their Medicare benefits are primary or secondary. The process has not been adhered to and the next time we undergo an audit, we will be fined \$2k per missed MSP
9	Pharmacy	Pyxis stock out	Departmental	
10	Information Systems	Standing Orders/protocols	Organizational	Define terms, protocol, standing order, order sets. List evidence based practice references in protocol. Implement archival process. CMS482.24(c)(3) refer to CIHQ COP for medical record services
11	Nutritional Services	Tray Line Optimization	Departmental	In response to RCA related to anaphylactic shock secondary to patient food allergy
12	Medical Records/Medical Imaging	MRI HIM access	Organizational	
13	Emergency Department	CIHQ Stroke Certification	Organizational	Stroke care based on the latest recommendations for the establishment of acute stroke ready hospitals by the Brain Attack Coalition, American Heart Association/American Stroke Association
14	Pharmacy, Med/Surg, Hospitalists, ED	Medication Reconciliation	Organizational	The objective of this project is to develop a process that will ensure that an accurate list of all patients' medications are collected and then compared to the physicians' admission, transfer and/or discharge orders. This process will also create an improved and safer system by increasing communication between settings of care through a common medication history process and therefore reducing the potential for medication errors at these patient transition points.
15	Admitting & Medical Imaging	Pre-registration of Medical Imaging Accounts	Organizational	Reduce denials by checking for authorization prior to service, minimize last minute cancelations, capturing upfront revenue and increase patient satisfaction
16	Skilled Nursing	Nurse Retention	Departmental	Continuation of last year's PI project.
17	Healting at Home	Home Health Conditions of Participation	Departmental	Ensure compliance with CMS Home Health Conditions of Participation that take effect Jan 2018. Significant adjustments to processess and resources will be required to comply tieh COPs for patient rights, care planning, quality assessment and performance improvement, and Infection Prevention and Control.

Department	Project	Type	NOTES	
18	Facilities	Water Management Program	Departmental	To establish a water management program that limit the spread and growth of legionella and other water-borne pathogens in the organization's building.To establish a process to identify and respond to a legionella / water-borne pathogen incident or outbreak. In response to CMS requirements.
19	Quality	Midas Risk/Pt Relations Committee	Organizational	We are moving from a silo approach to a holistic view of our systems, processes and procedures. The goal of Midas Risk/Pt Relations Committee is to recognize and mitigate unsafe conditions, patient harm and serious safety events.

Calendar Year 2018 Measure Table

CMS Hospital Inpatient Quality Reporting Program Measures (HIQR) FY2020 Payment Determination							
NHSN Submission Measures							
Measure	Measure Name	Type	Submit to	Due Date	Comments	Reported on Hospital Compare	Value-Based Purchasing
HAI	Catheter-Associated Urinary Tract Infection (CAUTI)	NHSN	Self- Report NHSN Tool	Q1 2018 due 8/15/2018	Reported out by Infection Prevention	Yes	Safety Domain FY 2018, 2019, 2020
HAI	Clostridium Difficile (CDI)	NHSN	Self- Report NHSN Tool	Q1 2018 due 8/15/2018		Yes	Safety Domain FY 2018, 2019, 2020
HAI	Central Line Associated Bloodstream Infection (CLABSI)	NHSN	Self- Report NHSN Tool	Q1 2018 due 8/15/2018		Yes	Safety Domain FY 2018, 2019, 2020
HAI	Surgical Site Infection (Colon / Hysterectomy)	NHSN	Self- Report NHSN Tool	Q1 2018 due 8/15/2018		Yes	Safety Domain FY 2018, 2019, 2020
HAI	Healthcare Personnel Influenza Vaccination (2017-2018 flu season)	NHSN	Self- Report NHSN Tool	Due 5/15/2018	Data for the 10/1/2017 – 3/31/2018 flu season is due 5/15/2018.	Yes	
HAI	MRSA Bacteremia	NHSN	Self- Report NHSN Tool	Q1 2018 due 8/15/2018		Yes	Safety Domain FY 2018, 2019, 2020

CMS HIQR-Chart-Abstracted Measures

Measure	Measure Name	Type	Submit to	Due Date	Comments	Reported on Hospital Compare	Value-Based Purchasing
ED-1	Median Time from ED Arrival to ED Departure for Admitted ED Patients	Chart-abstracted	Midas XML	Quarterly Harvest	For FY2020 Payment Determination, all 6 chart-abstracted measures must be submitted. eCQM data may not be submitted in lieu of these measures.	Yes	
ED-2	Admit Decision Time to ED Departure Time for Admitted Patients	Chart-abstracted	Midas XML	Quarterly Harvest		Yes	
IMM-2	Influenza Immunization	Chart-abstracted	Midas XML	Quarterly Harvest		Yes	
PC-01	Elective Delivery Prior to 39 Completed Weeks of Gestation	Chart-abstracted	Midas Web-based	Quarterly Harvest		Yes	Safety Domain FY 2018, 2019, 2020
SEP-1	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	Chart-abstracted	Midas XML	Quarterly Harvest		TBD	
VTE-6	Incidence of Potentially Preventable VTE	Chart-abstracted	Midas XML	Quarterly Harvest		Yes	

Claims-Based Outcome Measures

Measure	Measure Name	Type	Submit to	Due Date	Comments	Reported on Hospital Compare	Value-Based Purchasing
Mort-30- COPD	COPD 30-day Mortality Rate	Claims- based				Yes	
Mort-30-HF	Heart Failure (HF) 30-day Mortality Rate	Claims- based				Yes	Clinical Care Domain FY 2018, 2019, 2020
Mort-30-PN	Pneumonia (PN) 30-day Mortality Rate	Claims- based				Yes	Clinical Care Domain FY 2018, 2019, 2020
Mort-30-STK	Stroke (STK) 30-day Mortality Rate	Claims- based				Yes	
Readm-30-COPD	COPD 30-day Risk Standardized Readmission	Claims- based				Yes	

Readm-30- HF	Heart Failure (HF) 30-day Risk Standardized	Claims- based				Yes	
Readm-30- HWR	Hospital-Wide All-Cause Unplanned Readmission (HWR)	Claims- based				Yes	
Readm-30- PN	Pneumonia (PN) 30-day Risk Standardized	Claims- based				Yes	
Readm-30- STK	Stroke 30-day Risk Standardized	Claims- based				Yes	
Readm-30- THA/TKA	30-day Risk Standardized Readmission Following Total Hip/ Total Knee Arthroplasty	Claims- based				Yes	Clinical Care Domain FY 2018, 2019, 2020
EDAC-HF	Excess Days in Acute Care after Hospitalization for Heart Failure	Claims- based				Yes	
EDAC-PN	Excess Days in Acute Care after Hospitalization for Pneumonia	Claims- based				Yes	
Hip/Knee Complication	Hospital-level Risk- Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty	Claims- based				Yes	
PSI-90 Composite	Complication/Patient Safety for Selected Indicators	Claims- based				Yes	Safety Domain FY 2018
PSI-4	Death Among Surgical Inpatients with Serious Treatable Complications	Claims- based				Yes	

Claims-Based Payment Measures

Measure	Measure Name	Type	Submit to	Due Date	Comments	Reported on Hospital Compare	Value-Based Purchasing
HF Payment	HF Payment per Episode of Care	Claims- based				Yes	
PN Payment	PN Payment per Episode of Care	Claims- based				Yes	
THA/TKA Payment	Primary Elective Total Hip Arthroplasty and/or Total Knee Arthroplasty Payment asoci w/ an Episode-of-Care	Claims- based				Yes	

MSPB	Medicare Spending per Beneficiary	Claims- based				Yes	Efficiency and Cost Reduction FY 2018, 2019, 2020
Cellulitis Payment	Cellulitis Clinical Episode- Based Payment	Claims- based				Yes	
GI Payment	Gastrointestinal Hemorrhage Clinical Episode- Based Payment	Claims- based				Yes	
Kidney/UTI Payment	Kidney/Urinary Tract Infection Clinical Episode- Based Payment	Claims- based				Yes	
Chole and CDE Payment	Cholecystectomy and Common Duct Exploration Clinical Episode- Based Payment	Claims- based				Yes	
SFusion Payment	Spinal Fusion Clinical Episode- Based Payment	Claims- based				Yes	

CMS Electronic Clinical Quality Measures (eCQM)

Measure	Measure Name	Type	Submit to	Due Date	Comments	Reported on Hospital Compare	Value-Based Purchasing
CAC-3	Home Management Plan of Care Document Given to Patient/Caregiver	EHR	Midas/ eCQM Vendor	Due 2/28/2019	Prime Grant	No	
ED-1	Median Time from ED Arrival to ED Departure for Admitted ED Patients	EHR	Midas/ eCQM Vendor	Due 2/28/2019		No	
ED-2	Admit Decision Time to ED Departure Time for Admitted Patients	EHR	Midas/ eCQM Vendor	Due 2/28/2019		No	
PC-01	Elective Delivery	EHR	Midas/ eCQM Vendor	Due 2/28/2019		No	
STK-2	Discharged on Antithrombotic Therapy	EHR	Midas/ eCQM Vendor	Due 2/28/2019		No	
STK-3	Anticoagulation Therapy for Atrial Fibrillation/Flutter	EHR	Midas/ eCQM Vendor	Due 2/28/2019		No	

STK-5	Antithrombotic Therapy by the End of Hospital Day Two	EHR	Midas/ eCQM Vendor	Due 2/28/2019		No	
STK-6	Discharged on Statin Medication	EHR	Midas/ eCQM Vendor	Due 2/28/2019		No	
STK-8	Stroke Education	EHR	Midas/ eCQM Vendor	Due 2/28/2019		No	
STK-10	Assessed for Rehabilitation	EHR	Midas/ eCQM Vendor	Due 2/28/2019		No	
VTE-1	Venous Thromboembolism Prophylaxis	EHR	Midas/ eCQM Vendor	Due 2/28/2019		No	
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	EHR	Midas/ eCQM Vendor	Due 2/28/2019		No	

Patient Experience of Care Survey

Measure	Measure Name	Type	Submit to	Due Date	Comments	Reported on Hospital Compare	Value-Based Purchasing
HCAHPS	HCAHPS Survey	Survey	Self/Survey Vendor	Quarterly Harvest	Midas VBP clients data required for harvest	Yes	Patient-and Caregiver-Centered Experience of Care/Care Coordination (Experience of Care) FY 2018 [8 questions]

Structural Measures

Structural- PSC	Hospital Survey on Patient Safety Culture	Web- based	QNET Web- Based Tool	Submit 4/1/2019- 5/15/2019		Yes	
Registry- SSCL	Safe Surgery Checklist Use	Web- based	QNET Web- Based Tool	Submit 4/1/2019- 5/15/2019		Yes	

Hospital Outpatient Quality Reporting Program (HOQR)

CMS HOQR-Chart-Abstracted

OP-3	Median Time to Transfer to Another Facility for Acute Coronary Intervention	Chart-abstracted	Midas XML	Quarterly Harvest		Yes (3b)	
OP-4	Aspirin at Arrival	Chart-abstracted	Midas XML	Quarterly Harvest	Retired-End Date 3/31/18	Yes	
OP-5	Median Time to ECG	Chart-abstracted	Midas XML	Quarterly Harvest		Yes	
OP-18	Median Time from ED Arrival to ED Departure for Discharged ED Patients	Chart-abstracted	Midas XML	Quarterly Harvest		Yes (18b)	
OP-20	Door to Diagnostic Evaluation by a Qualified Medical Personnel	Chart-abstracted	Midas XML	Quarterly Harvest	Retired-End Date 3/31/18	Yes	
OP-21	Median Time to Pain Mgt. for Long Bone Fracture	Chart-abstracted	Midas XML	Quarterly Harvest	Retired-End Date 3/31/18	Yes	
OP-23	Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival	Chart-abstracted	Midas XML	Quarterly Harvest		Yes	
OP-29	Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients	Chart-abstracted	QNET Web- Based Tool	Submit 1/1/2019- 5/15/2019		Yes	

OP-30	Endoscopy/Polyp surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use	Chart-Abstracted	QNET Web- Based Tool	Submit 1/1/2019-5/15/2019		Yes	
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Claims-Based Measures

Measure	Measure Name	Type	Submit to	Due Date	Comments	Reported on Hospital Compare	Value-Based Purchasing
OP-9	Mammography Follow-up Rates	Claims- based	Submitted via hospital claims			Yes	
OP-10	Abdomen CT - Use of Contrast Material	Claims- based	Submitted via hospital claims			Yes	
OP-11	Thorax CT - Use of Contrast Material	Claims- based	Submitted via hospital claims			Yes	
OP-13	Cardiac Imaging for Preoperative Risk Assessment for Non Cardiac Low Risk Surgery	Claims- based	Submitted via hospital claims			Yes	
OP-32	Facility 7-Day Risk- Standardized Hospital Visit Rate after Outpatient Colonoscopy	Claims- based	Submitted via hospital claims			Yes	

Structural Measures

OP-12	The Ability for Providers w/ HIT to Receive Lab Data Electronically Directly into their ONC Certified EHR System as Discrete Searchable Data	Structural	QNET Web- Based Tool	Submit 1/1/2019-5/15/2019		Yes	
OP-17	Tracking Clinical Results Between Visits	Structural	QNET Web- Based Tool	Submit 1/1/2019-5/15/2019		Yes	

OP-22	Left Without Being Seen	Structural	QNET Web- Based Tool	Submit 1/1/2019- 5/15/2019		Yes	
OP-25	Safe Surgery Checklist	Structural	QNET Web- Based Tool	Submit 1/1/2019- 5/15/2019	Remove CY 2020 payment determination	Yes	
OP-26	Hospital OP Vol. on Selected OP Surg. Procedure	Structural	QNET Web- Based Tool	Submit 1/1/2019- 5/15/2019	Remove CY 2020 payment determination	Yes	
OP-27	Influenza Vaccination Coverage among Healthcare Personnel	NHSN	Self- Report NHSN tool	Submit 1/1/2019- 5/15/2019	Data for the 10/1/2017 – 3/31/2018 flu season is due 5/15/2019	Yes	