SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, April 24, 2019
5:00 p.m. Regular Session
(Closed Session will be held upon adjournment of the Regular Session)

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

AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a Quality Committee meeting, please contact the District Clerk, Stacey Finn, at sfinn@svh.com or 707.935.5004 at least 48 hours prior to the meeting.		
MISSION STATEMENT The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.		
1. CALL TO ORDER/ANNOUNCEMENTS	*Mainardi*	
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.*	*Mainardi*	
3. CONSENT CALENDAR • Minutes 03.27.2019	*Mainardi*	Action
4. LABORATORY ANNUAL REPORT	*Valenzuela*	Inform
5. CNO QUARTERLY PATIENT CARE DASHBOARD	*Kobe*	Inform
6. PRIME GRANT UPDATE	*Lovejoy*	Inform
7. CEO DASHBOARD	*Jones*	Inform
8. GOOD CATCH	*Jones*	Inform
9. QUALITY AND RESOURCE MANAGEMENT REPORT	*Jones*	Inform
10. POLICIES AND PROCEDURES	*Jones*	Inform/Action
11. CLOSED SESSION: a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Mainardi*	Inform
12. REPORT OF CLOSED SESSION	*Mainardi*	Inform/Action
13. ADJOURN	*Mainardi*	

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
March 27, 2019 5:00 PM
MINUTES
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch Carol Snyder Michael Mainardi, MD Ingrid Sheets Susan Idell Howard Eisenstark, MD via telephone Cathy Webber			Danielle Jones, RN Sabrina Kidd, MD Kelly Mather, CEO Mark Kobe, CNO

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS		
	Called to order at 5:00 pm	
2. PUBLIC COMMENT		
	None	
3. CONSENT CALENDAR		Action
• QC Minutes, 02.27.19		**MOTION:** by Idell to approve, 2nd by Sheets. All in favor.
4. STRATEGIC PLAN AND FINANCIAL STABILITY	*Mather*	
	Ms. Mather gave an overview of the 2020 strategic plan. This included a review of the SWOT analysis (Strengths, Weaknesses, Opportunities, and Threats) and the four core key initiatives. She also reviewed the fiscal year 2020 draft baseline budget.	
5. QUALITY AND RESOURCE MANAGEMENT REPORT	*Jones*	
	Ms. Jones spoke about the CIHQ stroke readiness survey on April 15th – 16th.	

AGENDA ITEM	DISCUSSION	ACTION
	She also gave an overview of the current status of the CMS 5 star plan.	
6. HQI DASHBOARD	*Jones*	
	Ms. Jones reviewed the HQI dashboard data.	
7. POLICIES AND PROCEDURES	*Jones*	
	Revisions Attendance HR8610-211 Hazardous Material Spill Response CE8610-144 Hostage Active Shooter, Code Silver CE8610-147 Infant Pediatric Security, Code Pink & Purple CE8610-148 **Review/No Changes** Safety Rounds CE8610-174 Patient Controlled Analgesia (PCA) MM8610-154 **Departmental** Medical Records Release of Information – Patient Requests 8700-161	**Motion**: by Mainardi to approve 2nd by Sheets. All in favor
8. CLOSED SESSION	*Hirsch*	
	Called to order at 6:08pm	
9. REPORT OF CLOSED SESSION	*Hirsch*	
	Medical Staff Credentialing reviewed.	**MOTION:** by Mainardi to approve credentialing, 2nd by Sheets. All in favor.
10. ADJOURN	*Hirsch*	
	6:10 pm	

Quality Assurance & Performance Improvement
Summary Report 2018

Department: LABORATORY

DEPARTMENT MISSION STATEMENT: To provide laboratory test results in a timely and accurate manner and deliver those results to the physicians promptly.

DEFINITIONS:

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

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

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

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

QUALITY ASSURANCE/QUALITY CONTROL MONITORING

Indicator Name	Goal/ Threshold	Data Outcome					Percentage					Analysis	Plan
		Q1	Q2	Q3	Q4	Aggregate	Q1	Q2	Q3	Q4	Aggregate		
BLOOD ADMINISTRATION													
Indicator Name	Goal/ Threshold	Data Outcome					Percentage					Data Outcome	Plan
		Q1	Q2	Q3	Q4	Aggregate	Q1	Q2	Q3	Q4	Aggregate		
Crossmatch & Blood Administration form Return Audit Page	100%	65/72	51/58	69/77	71/91	256/ 298	90%	88%	90%	78%	85.9 %	Threshold not met	Continue to Monitor
Effectiveness of Transfusion (% IP follow up H&H documented.	90%	15/15	20/20	22/22	29/30	86/87	100%	100%	100%	97%	98.9%	Threshold met	Continue to monitor. Physician education has shown a great improvement
Massive Transfusion Protocol (MTP)	100%	1 Event	No Event	No event	No Event	1 Event	NA	NA	NA	NA	NA	1 Events	Continue to monitor for appropriate use, documentation and outcome.
Blood Administration Audit	100%	2/2	2/2	2/2	2/2	8/8	100%	100%	100%	100%	100%	Threshold met	Continue to Monitor
Physician Signature for Uncrossmatched Transfusion *New Indicator 2nd Q	100%	1/1	None	0/1	None	1/2	100%	NA	0%	NA	50%	Threshold not met	Continue to Monitor

Indicator Name	Goal/ Threshold	Data Outcome					Percentage					Data Outcome	Plan
		Q1	Q2	Q3	Q4	Aggregate	Q1	Q2	Q3	Q4	Aggregate		
PREANALYTICAL													
Specimen redraw	95%	????/ 3617	3625/ 3629	3833/ 3841	4008/ 4023	11,466/ 11,493	No Data	99.8%	99.8%	99.6%	99.8%	Threshold met	Continue to monitor Based on Q2, Q3, & Q4
Time to Amended Report	Within 24 hours	5/6	2/2	3/3	6/6	16/17	83%	100%	100%	100%	94.1%	Threshold not met	Continue to monitor CLS education
Outpatient wait times: Order to Collected	< 20 min	20	24.5	20.4	16.4	20.3	NA	NA	NA	NA	NA	Threshold met	Continue to monitor. Longer times in 2nd Q correlate with under staffing & new staff.
NPSG—2 identifiers used	100%	29/30	30/30	30/30	30/30	119/120	97%	100%	100%	100%	99%	Threshold not met	Continue to monitor
Laboratory Policy & Procedure Review Due in 2019	100% 1. P&P 2. Manuals	No Data	No Data	No Data	No Data	No Data	NA	NA	54%	86%	86%	Threshold not met	Continue to monitor Date extended to Jan 31, 2018 due to Wildfires & staffing issues..
Ordering Practices CPOE	100%	9/9	15/15	15/15	15/15	20/20	100%	100%	100%	100%	100%	Threshold met	Continue to monitor
ER-Urinalysis TAT—Order to Received	Order to Received <75 min	69 min	59 min	65 min	60 min	62 min	NA	NA	NA	NA	NA	Threshold met	Continue to Monitor
Indicator Name	Goal/ Threshold	Data Outcome					Percentage					Data Outcome	Plan
		Q1	Q2	Q3	Q4	Aggregate	Q1	Q2	Q3	Q4	Aggregate		
ANALYTICAL													
ER Troponin-I Received to Final Report	<60 min 95%	372/ 400	445/ 462	378/ 422	405/ 420	1600/ 1704	93%	96%	90%	96%	93.8%	Threshold met	Continue to monitor
Instrument downtime AU 480 #1 1. Routine 2. Not Routine	1. 47 hrs 2. 4 hrs	1. 47 hrs 2. 0 hrs	1. 47 hrs 2. 0 hrs	1. 47 hrs 2. 0 hrs	1. 47 hrs 2. 0 hrs	1. 188 hrs 2. 0 hrs	NA	NA	NA	NA	NA	Threshold met	Continue to monitor 2. PM, water & printer
Blood culture contamination 1. Lab draw 2. RN draw	1. <3% Lab draw 2. <5% RN draw	1. 2/ 251 2. 4/ 167	1. 0/225 2. 2/165	1. 1/ 237 2. 2/ 188	1. 3/ 246 2. 8/177	1. 6/ 959 2. 16/ 697	1. 0.8% 2. 2.4 %	1. 0% 2. 1.0%	1. 0.4% 2. 1.0%	1. 1.2% 2. 4.5%	1. 0.6% 2. 2.3%	1. Threshold met 2. Threshold met	1. Continue to monitor 2. Continue to monitor
Competency Assessment of Lab Staff	100%	No Data	No Data	No Data	CLS 3/11 Lab Assist 0/9	10% Lab staff	NA	NA	NA	10%	10%	Threshold not met	Continue to Monitor Delayed due to staffing, training, CLIA & vacations

ER-Urinalysis TAT Received to Final average	Received to Final <30 min	21 min	21 min	21 min	20 min.	20.75 min	100%	NA	NA	NA	NA	Threshold met	Continue to Monitor

Indicator Name	Goal/ Threshold	Data Outcome					Percentage					Data Outcome	Plan
		Q1	Q2	Q3	Q4	Aggregate	Q1	Q2	Q3	Q4	Aggregate		
POST ANALYTICAL													
Results final after discharge faxed to PCP if available (unable to fax to Kaiser, no PCP given, NSH, unknown physician)	90%	84/84	105/ 105	128/ 128	83/83	400/ 400	100%	100%	100%	100%	100%	Threshold met	Continue to monitor
Manual entry tests	< 5 errors/Q	1	2	1	0	4	NA	NA	NA	NA	NA	Threshold met	Continue to monitor
Critical values: 1. Called within 30 min 2. Documented/policy	100%	1. 348/ 348 2. 348/ 348	1. 328/ 328 2. 328/ 328	1. 363/ 364 2. 364/ 364	1. 364/ 364 2. 361/ 364	1. 1403/ 1404 2. 1402/ 1404	1. 100% 2. 100%	1. 100% 2. 100%	1. 99% 2. 100%	1. 100% 2. 99%	1. 99.9% 2. 99.8%	Threshold met	Continue to monitor
Reference Lab Tests Scanned into EHR	100%	8/10	6/6	15/15	13/13	40/42	95%	100%	100%	100%	100%	Threshold met	Continue to monitor

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Lois Valenzuela, Lab Manager Date

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Frederick Kretzschmar, MD, Lab Director Date

SONOMA VALLEY HOSPITAL
CLINICAL LABORATORY ANNUAL EFFECTIVENESS SUMMARY REPORT
2018

SCOPE OF SERVICES:

Sonoma Valley Hospital Laboratory has been responsive to the needs of the Sonoma Valley Health Care District to provide accurate, reliable and timely laboratory services on a routine and STAT basis. Services are provided 24 hours/day, 7 days/week, including holidays. Testing in the areas of Hematology, Coagulation, Chemistry, Microbiology, Urinalysis, Serology and Blood Bank is provided. STAT testing is available within 1 hour; most routine testing is available the same day. Services include the following:

- Collection of specimens
- Home draws for bed bound patients when requested by a physician
- Physician Office specimen collection
- Reference laboratory specimen preparation/processing
- Clinical laboratory testing
- Transfusion service
- Clinical laboratory results reporting, including timely critical value communication
- Routine physician office results per fax, internet or interface.
- Maintenance/service/repair for optimal equipment/instrumentation use
- Compliance with all state, federal and accreditation requirements
- Anatomic & Clinical Pathology services & consults
- STAT testing for Quest patients
- Weekend, holiday & night testing for Sonoma Developmental Center
- Microbiology & Coagulation testing for Sonoma Developmental Center
- Collection and processing of Kits brought to the lab by patients

The Clinical laboratory services noted a volume of approximately 500,000 tests performed on patient specimens. Significant clinical, reporting and contractual/business relationships include the following:

1. County of Sonoma Public Health Lab
2. Santa Rosa Memorial Hospital
3. Blood Centers Of The Pacific—Irwin Center
4. Marin Medical Laboratory
5. Marin General Hospital
6. Quest Diagnostics
7. Queen of the Valley Hospital
8. Sonoma Developmental Center
9. ARUP

Budgetary Impact:

Fiscal Year	Gross Revenue*	Total Expenses**	Total UOS***	ER UOS****	Outpatient, Drop offs, House Call*****	
FY2018	$27,196,134	$2,392,968	142,492	26,680	17,571	
FY2017	$27,758,218	$2,434,385	146,980	28,321	17,571	

*Gross revenue is down due to the decrease in UOS.
** Expenses are down due to the decrease in UOS. The laboratory makes an on-going effort to investigate and implement expense efficiencies. The laboratory works closely with our vendors and Materials Management to assure the best pricing for reagents and supplies.
*** UOS are Units of Service which are billable tests or groups of tests reported together. The decrease in UOS is reflective of a decrease in volume.
**** ER volume is down.
***** Outpatients are patients who came to the lab for services, Drop offs are specimens collected in a physician office or other facility and brought to the lab. House Calls are visits to a patient's home to collect a specimen.

MEASURES ASSESSED		FINDINGS, IMPROVEMENTS MADE
PRE—Preanalytical, A—Analytical, POST—Post analytical		
Staff Competency, Performance and Development *Personnel have received the tools and education needed for doing the job and performed expectations well.*		
• *All CLS participate in Proficiency Surveys*	***A***	All CLS participate in the Proficiency Survey. Results were: • Microbiology, 1st event 94%, 2nd event 100% & 3rd event 92% • Hematology, 1st, 2nd, & 3rd event 100% • Chemistry, 1st, 2nd & 3rd event 98% • Blood Bank, 1st, 2nd & 3rd event 100%
• *CLS have annual competencies on all tests performed in the laboratory*	***PRE***	Annual competency assessment for CLS includes competency on all instruments and every test performed in the lab. The primary tools used for assessment are direct observation and verbal discussion. The target date was extended to February 15, 2019 due to new instruments being set up and validated during the 4th Q. All CLS were found fully competent; no follow up training was indicated.
• *2 CLS retired in 2018*	***PRE A POST***	Fortunato Gunita, CLS and Dan Ryan, CLS both retired in 2018. Dan was our Microbiology Supervisor. Dan has stayed on to train his replacement and complete some Microbiology projects.

		Cephas Andoh, CLS was terminated for not meeting performance expectations.
• *3 CLS were hired in 2018*	***PRE***	Tom McHugh, CLS was hired to help cover some weekend shifts. He has worked at several hospitals in Sonoma County as a lab manager. He retired but wanted to keep in touch with the lab world. Kenent "Kiko" Pasion, CLS was hired to cover Microbiology and work in the main lab as a Generalist. He worked at a small hospital in Willows as a Generalist. He also worked in Microbiology in Maine several years ago. Joyce Vinluan,CLS was hired to cover a night shift.
• *CLS are trained on new procedures and instruments before reporting results.*	***PRE***	CLS are trained on new tests and instruments before they can report patient results. CLS were trained on the following: • Body Fluid Cell Count on the DxH • Procalcitonin on the AU480 • C. diff Chek Complete Microbiology CLS only • Extending the life of Blood Bank specimen • Verigene system for Microbiology CLS only • ABL90 Plus blood gas instrument
• *Competency Assessment for Laboratory Assistants*	***PRE***	Competency Assessment for Laboratory Assistants was completed. Their Assessment covers all tasks and Customer Service skills required by the lab. All Lab Assistants were assessed and found competent.
• *Monthly report for each department*	***PRE***	The monthly Quality report for each department gives an analysis of what happened in each department during the month. The reports are reviewed monthly by the Laboratory Technical Supervisor, Laboratory Manager and the Laboratory Medical Director.
• *Individualized Quality Control Plan (IQCP)*	***A***	An Individualized Quality Control Program (IQCP) has to be researched & written for any test or test system that doesn't have Quality Control run on each day of use. An IQCP was written for: • Verigene Molecular Test System • Verigene Enteric Pathogens Assay • Verigene Gram Negative • Verigene Gram Positive • Alere C. difficile Complete Assay

• *Critical Values*	***POST***	Critical Values were reviewed and updated to reflect the current standard operating practice. There were no changes to Critical Values in 2018.
• *Staff Satisfaction*		The laboratory received an outstanding score on the Staff Satisfaction Survey. The Laboratory Staff Engagement score was 4.39, Laboratory Manager score was 4.29 out of a possible 5.0. Opportunities for Improvement: Benefits Career development
• *Staff Awards Luncheon*		Gus Cerame, CPT-1 received his 5 year award.
• Policies & Procedures (P&P)		Laboratory Organizational Policies are reviewed every 2 years. The lab has a total of 90 policies which were reviewed. There were major and minor changes needed. These policies are reviewed by hospital committees then sent to the Board of Directors for approval.
• Blood Management	***A POST***	Data from 2018 was reviewed to determine if the goals of the Blood Management project have been maintained. The review showed that the goals have been maintained. The primary focus of the project was to reduce unnecessary transfusions. The criteria for transfusion are: Hemoglobin is ≤ 7.0 or ≤ 8.0 for a cardiac patient.
• CLIA inspection	***PRE A POST***	The CLIA inspection was due on 07/28/2018. The CLIA agency was unable to inspect in a timely manner. SVH lab was issued a “Delayed Inspection” letter which allowed us to continue operating. The CLIA inspection was scheduled for November 27, 2018. The inspection went very well. The inspector was very thorough. She commented our Competency was very good, she liked our IQCP format, we are running a good lab and she saw nothing that concerned her. We had 5 or 6 items to fix, all comparatively minor.
• Staff Performance Evaluations & HealthStream	***A POST***	All staff received their yearly Performance Evaluation and completed their HealthStream assignments in a timely manner.

Plant, Equipment, Supplies *There were no facility, equipment or supply problems.*		
• *IS, Faxing and Ordering Issues*	***PRE POST***	There were many lab problems created by the 14.1 Paragon upgrade in October, 2017. Some of the problems were: every Chemistry test having its own label, some labels not printing, reflexes quit reflexing. These were very disruptive to the labs workflow, productivity and turnaround time. A second upgrade to address these problems took place in April, 2018. There was some improvement but all problems were not solved. A new & improved patient portal for patients to view their lab results was implemented. An interface with Athena for physician offices was built the plan being that physicians could order from the SVH Compendium. This didn't work out as hoped. Athena comes with its own set of lab orders. It wasn't possible to take those orders out & replace them with SVH lab orders. Redwood Med Net was down for a month. RWM is our interface to Quest and most physician offices. This meant the lab received many calls for results from offices. There were also 300 Quest results that didn't cross into Paragon. Physician ordering in CPOE has many issues. It creates work for the lab assistants trying to interpret the order. We are working with IS on physician education and making CPOE more user friendly.
• *2nd Access 2*	***A***	Our Access 2 was down for 3 days. This caused problems for ER and the lab. The lab was unable to provide ER with Troponin results in a timely manner and all outpatient Immunoassay testing had to be held. A persuasive strategy was applied to our Beckman sales rep to find a way to get us another Access. Our strategy was effective and Beckman gave us a new Access 2. Our contract was extended for 2 years at no increase in cost. Beckman did the install and validation. The timeline for implementation of the instrument was delayed because we were unable to immediately interface with Paragon. The 2nd Access will be used exclusively for ER tests in order to improve the Turnaround Time. The new Access was interfaced on December 5. Since the implementation the following changes to TAT have been observed: • Troponin: reduced by 12 minutes. • BNP: reduced by 6 minutes • TSH: reduced by 24 minutes

• *ABL 90, blood gas instrument*	***A***	After 5 years of outstanding performance the ABL 90's warranty was running out in January 2019. We faced either paying $5,500 a year for a warranty or purchasing a new instrument. A grant proposal was submitted to the Foundation Board to purchase a new ABL 90. The Foundation approved the grant. A new instrument was received on December 5.
• *Molecular testing for pathogenic organisms*	***A***	The Microbiology Department brought in Molecular testing for Enteric Pathogens. It detects bacteria, viruses, and toxins that commonly cause acute diarrhea. It replaces the stool culture. Stool cultures are less sensitive than molecular methods. Molecular testing detects almost three times as many infections in the same set of samples. Results are available within 1 day compared to 3-4 days for a stool culture. Molecular testing for Enteric Pathogens is a significant improvement over the traditional stool culture. The Microbiology department completed Procedures, IQCP, validation and comparisons before reporting results. Verigene for Enteric Pathogens was validated and we began reporting results on Nov 12, 2018.There were 20 Enteric Pathogen tests run identifying 2 Salmonella sp., a Norovirus and an Enteropathogenic E. coli.
• *Microscan computer failure*	***A***	The Microscan computer, (our instrument for reading sensitivity and identification for pathogenic organisms in Microbiology) failed. We were able to buy a Microscan computer from SDC it was installed by SVH IS staff. Beckman support downloaded our programs and data, installed our "alerts" and updated the computer. Disaster was averted. Microbiology was down for 2 days. There was minimal impact to patient care, five reports were delayed 24 hours.

Business Initiatives, Service Opportunities *Describe entertained or implemented service ventures.*		
• Procalcitonin		Procalcitonin was moved from the MiniVidas to the AU480. The test was validated and comparisons were run between the AU480 and the MiniVidas. They were found to be acceptable. Dr. Kretzschmar signed off for the change. This resulted in a savings of $11,000 a year.
• direct LDL		Direct LDL is a measurement of LDL. This test was being run on all Lipid Panels. It was decided to report a calculated LDL unless a Direct is ordered by the physician. Comparisons were run between Direct and calculated. The results were within an acceptable range. This is a cost savings of $12,000 a year.
• Microbiology—Flu A&B		The 2017 Flu season was very busy. We spent around $50,000 on Flu kits. The 2018 flu season has started out much milder.
• Quest Diagnostics/ARUP Reference labs		We met with Quest & ARUP to determine the best choice of a reference lab for SVH. Quest prices the Top 30 tests ordered at or below Medicare reimbursement but the pricing for all other tests, which is the majority of tests ordered, can be 10 to 100 times Medicare reimbursement. Looking at the big picture Quest ends up being very expensive. ARUP uses Medicare reimbursement for the basis of their pricing & prices follow Medicare pricing whether it goes up or down. We investigated ARUP pricing and found they do follow Medicare pricing very closely and lower prices when Medicare lowers reimbursement. ARUP was also found to be very good with handling patient specimens. An ROI was completed and it was decided that ARUP would be the best choice for us. The agreement was signed and the interface was completed. This is a project for 2019.
• Quest STAT testing agreement		This agreement is for Partnership patients. They have to go to Quest for all lab work but Quest cannot provide STAT testing. We have an agreement with Quest to draw their patients, run the STAT tests, bill Quest and Quest will pay us for the tests. Accounting and Lab had many meetings with Quest this year to try to resolve some issues with the agreement: • Quest hadn't paid SVH since the agreement was implemented. This issue was resolved and by the end of the year they were up to date. • Quest wants SVH to limit STAT testing to what Quest considers a STAT test. This is an unresolved issue. SVH considers anything a physician orders

		as a STAT a STAT. We cannot have one policy for SVH outpatients and a different policy for Partnership patients. • Quest wants SVH to call all the results to Quest. We have refused to do this because we call all critical values to the physician. We do not have available staff to make calls to Quest.
• SDC		SDC business has steadily declined this year. On December 31, 2018 the facility was closed. SVH was doing Microbiology, Chemistry and Coagulation when they closed.
• SDC Courier		SDC requested a morning courier pick up in September to accommodate their needs for more testing. The courier we were using was unable to do a morning run and Vern's Taxi was too expensive. The laboratory picked up the courier service from October till the facility closed.
• Wellness draws		There were about 320 Wellness draws this year. There was some additional Lab Assistant staffing. It was challenging but successful.
• Physician Requisitions		Many physicians are sending lab orders on requisitions printed from their EHR. The physician requisition provided by SVH is not used as much as it was in the past. It was a duplicate form and it was last updated in 2014. We changed to a physician requisition in Form Fast which can be updated easily. We email it to the physician's office as a PDF. They are able to print copies as needed. This is cost effective for SVH.
• House Calls		It was decided to discontinue doing House Calls. Lab staff would go to a patient's house to collect a specimen for bed bound patients. This has become increasingly difficult with staff reductions and concerns about liability. A letter was sent to all local physicians that as of Jan 1, 2019 SVH lab will no longer do House Calls.

National Patient Safety Goals *The Clinical Laboratory is committed to safe patient care by the following activities:* • *Patient identification (use 2 identifiers)* • *Blood check out procedure compliance* • *Critical values called & read back using 2 identifiers within 30 minutes.*		Patient identification was monitored and there was 100% compliance using 2 identifiers (name & DOB). There have been no events of misidentified patients or mislabeled specimens. 100% of Blood products were checked out with 2 signatures (RN & CLS). The Transfusion/Gann (signed consent) form was available for 100% of the transfusions. The Transfusion/Gann form is not required for an ED transfusion. 99.8% of critical values were called and read back within 30 minutes and properly documented.
Sentinel or Adverse Events *Sentinel Events (TJC List) or Significant Adverse Event (CMS List) or "near miss" are investigated for improvement.*		There have been no Sentinel or Significant Adverse Events

Patient and Customer Satisfaction *Significant or repeat customer (patient, family, staff, physician, payer, vendor, etc.) complaints are acknowledged and investigated for improvement.*		
• *Physician and patient complaints*	***POST***	All significant complaints were investigated and handled appropriately.
• Lab Assistants	***PRE***	The Lab Assistants have received many compliments for doing a great job. Their customer service skills are outstanding. The compliments are from patients and physician's office staff. They have a hard job and they provide excellent patient care. We are fortunate to have such a skilled and caring staff.
• Pre-Op patients' Blood Bank draws.	***PRE***	There has been dissatisfaction with the policy of drawing pre-op patients on the morning of surgery in order to have an in date specimen for Blood Bank. We surveyed local hospitals & found the Standard of Practice (SOP) for Sonoma County is to extend the life of the pre-op Blood Bank specimen beyond 3 days if specified criteria are met. It was decided to extend our specimen to 15 days. P&P and a Questionnaire to determine eligibility for extending the life of the specimen were written. After going through committees & receiving approvals the change was implemented on June 15, 2018. This has met with great success: • The lab staff doesn't have to go to surgery to draw a blood bank specimen the morning of surgery. • The OR staff doesn't have to draw any specimens the morning of surgery. • Surgeries are not delayed waiting for results. • There is always a blood bank specimen available for a crossmatch.
• Glucose reference range		In response to a request from a Santa Rosa Endocrinologist the Lab Director investigated the reference range for Glucose. The Glucose reference range was changed to 70-99 mg/dL. This is in line with SOP for local hospitals and it is the range accepted by the American Diabetes Association.
• Interfaced ESR		ESR was a manual entry test. It was the test which had the most entry errors. The ESR instrument was interfaced and manual entry was eliminated.

• *Slide Review binder*		When a patient's hematology slide requires a Pathology slide review the results are filed in a Slide Review binder where they are kept for a year. Before a slide is sent out for review the binder would be checked to see if there is already a review on file. The binder had become cumbersome and challenging to use. David Long, CLS suggested scanning all the reviews into a computer file where they would be readily available for anyone to find. David took on the project. All CLS are happy with the slide reviews being on the computer.
• *Blood Culture Preliminary Reports*		Responding to a request from a Hospitalist physician; Microbiology began sending daily preliminary reports on no growth blood cultures.
• Physicians write in Notes a cancellation order		The lab attended a Medicine Committee meeting to discuss several issues with physician ordering practices. One being that they will write in Notes an order to cancel a test when the result reaches a certain level. But, it doesn't get canceled because nursing doesn't read the Notes. The lab was given permission to cancel these orders when appropriate.
• Urine cultures not being set up		Microbiology was having a problem with Urine cultures not being set up. A report was created by IS listing all cultures which are in Received status which the CLS can check against the culture log book to make sure they are set up. The CLS do this every night. There have been no instances of urine cultures being missed since this was started.
• Epithelial cell contamination as a criteria for urine culture		The lab had a policy of not setting up urine cultures on specimens that demonstrate Epithelial cell contamination. ER and Hospitalist physicians requested a urine culture be set up based on the results of the dipstick and Microscopic exam, disregarding Epithelial cells. It was decided the only reasonable way to do this was to disregard Epithelial cells as a criteria for rejection for all urine cultures, inpatient, ED and outpatient.
• Clostridium difficile testing changed to a 2 step test		Cdiff was changed to a 2 step test. The first step is a slide test for the toxin and antigen. The result of this test will determine if the result is negative, positive or will reflex to molecular testing. This was changed for a financial savings of about $4000 a year.
• Office Staff Luncheon		The hospital has a yearly Office Staff Luncheon. Local physician office staff are invited so we can communicate face to face to maintain or build relationships. The lab attended and introduced the new physician requisition form. We were able to discuss some specific issues with staff. It was beneficial.

• Queen of the Valley reference lab		We have been using Queen when our instruments are down and for running Anti-Xa. We have had many issues with Queen around TAT, specimen rejection and customer service. It was decided to return to using Santa Rosa Memorial for these services.
• PSA ordering		PSA ordering has been challenging for the lab assistants because they had to be ordered as Diagnostic or Screening. We did not have the information to make the correct choice. IS was able to put a fix in place so the lab can just order a PSA. The correct CPT code will be determined in the background based upon the patients ICD-10 codes.
• Blood Bank inventory		Reduced the Blood Bank stock levels in order to adjust to our declining usage of blood products.

Opportunities for Improvement *The Laboratory is constantly striving to improve the quality of the testing performed.*		
• *Blood Bank Module*		The lab is working with Quality to develop a Blood Bank Module for collecting data and statistics. This will change Blood Bank data collection from a manual method to a computerized method. The goal is to make Blood Bank data more useful and easily accessible.
• *Testosterone*		*Testosterone is sent to Quest. It is our highest volume send out test. We have attempted to bring this test in house. It has proven to be challenging. We are waiting until we change reference labs to move ahead with this.*
• *Supply charges*		Charges for supplies are monitored to maintain our savings in supply cost.
• *ARUP*		It is our plan to complete the change from Quest to ARUP as soon as possible this year. ARUP will be a great benefit and it is a priority.
• *Auto Verification*		We started working on Autoverification in 2018. There was a bug in the system. A ticket was sent to McKesson. The project was stopped at this point. Autoverification will allow tests within parameters set by the lab to be resulted without being reviewed by a CLS. It is an involved process to set this up because Rules have to be decided on, built in Paragon then tested in multiple situations.
• *Molecular testing for Blood Cultures*		Microbiology began developing this testing in 2018. This is complicated due to the number of organisms it identifies and it has resistant markers that also need to be reported. We will be able to identify the causative organism of sepsis within 1 day compared to 2 – 4 days with a traditional culture and sensitivity. Rapid results improve patient outcomes. It minimizes the use of inappropriate or unnecessary drugs which will shortening the patient's hospital stay.
• *Other Molecular testing*		There are several Molecular tests available and in development which could benefit us. These tests include a Respiratory panel, Ova & Parasites panel and a Clostridium difficile panel. These tests will be investigated to determine their appropriateness for our Microbiology department.

PATHOLOGY QUALITY IMPROVEMENT PROGRAM
JANUARY 1st – December 31st, 2018
FINAL REPORT
MARIN GENERAL HOSPITAL, SONOMA VALLEY HOSPITAL, MARIN MEDICAL LABORATORIES

Intradepartmental consultations, peer review, and external (outside) consultations continued with appropriate documentation in order to assure accuracy of diagnoses.

Retrospective external consultations on surgical pathology cases were reviewed for 186 cases from January 1st through December 31st, 2018. The concordance rate was 96.8%. The 3.2% discordant cases included 6 type A, 0 type B, and 0 type C cases. The overall and individual concordant rates remain very high. There was no evidence of a negative trend among individuals or the group.

Surgical Pathology Peer Review for January 1st through December 31st, 2018 of 380 cases found no cases with a significant diagnostic discrepancy. There was no evidence of a negative trend among individuals or the group.

Autopsy Pathology Peer Review included all 6 cases for the year 2018. There were agreements with all diagnoses, good clinicopathologic correlations and timely reporting. There was no evidence of a negative trend among individuals or the group.

As a quality assurance activity, we conduct an ongoing audit of 10% of synoptic reports every quarter to ensure required data elements (RDE) are included in at least 90% of the eligible surgical pathology reports.

In 2018, we participated in CAP's HER2 and ER/PR immunohistochemistry challenge surveys and scored 100% on HER2, ER and PR graded samples. We are participating in these surveys again in 2019.

Frozen section TATs continue to average 7-10 minutes.

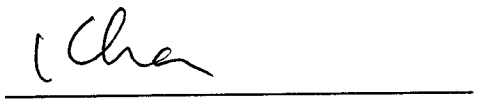
The pathologists have continued to serve special needs of the medical community. More than 865 cases were presented at more than 120 weekly or bi-weekly tumor boards in 2018.

During 2018, the pathologists have continued to participate in the College of American Pathologists APEX Performance Improvement Program in Surgical Pathology, and CAPs Performance Improvement Programs in Non-Gyn Cytopathology and Gyn Cytology. All cytopathologists passed the CLIA mandated proficiency tests in Gyn Cytopathology in Fall, 2018. Also, all pathologists continued to satisfy and exceed CME requirements.

The College of American Pathologists completed their biannual on-site survey in August 2017. Their findings were excellent, and determined full certification and accreditation of Marin General Hospital Clinical Laboratories, Marin Medical Laboratories at MGH (the Pathology Department), and Marin Medical Laboratories (independent Histology, Cytology and Clinical Laboratory services in Novato, CA).

All of these activities and reports were discussed at the hospital Laboratory/Pathology Quality Improvement meetings, and these results were discussed among the pathologists.

These quality improvement activities with continue through the year 2019 and beyond.



Imok Cha, MD
Pathologist, Director of Pathology
Final Report: 01/14/2019

SURGICAL PATHOLOGY QUALITY IMPROVEMENT REPORT:

RETROSPECTIVE EXTERNAL CONSULTATIONS FOR MARIN GENERAL HOSPITAL, SONOMA VALLEY HOSPITAL, AND OUTPATIENT SURGICAL PATHOLOGY CASES FOR MARIN MEDICAL LABORATORIES

January 2018 through December 2018

Retrospective external consultations are surgical cases that have been signed out by Marin Medical Laboratories, and then are subsequently sent out for consultation at the request of someone external to MML/MGH/SVH Pathology Departments. Most of the consultations were from UCSF, Stanford, Johns Hopkins, and MD Anderson.

All retrospective external consultations received from January 2018 through December 2018 were collected and reviewed. A total of 186 retrospective external consultations were identified for the time period (182 cases from MGH and 4 case(s) from SVH). The cases break down by Marin Medical Laboratories pathologist as follows:

			Disagree				
	Agree		A	B	C	Total Discordance	
Dr. Cha	97.7%	42	1	0	0	1 / 43	2.3%
Dr. Kim	100.0%	54	0	0	0	0 / 54	0.0%
Dr. Kretzschmar	92.2%	47	4	0	0	4 / 51	7.8%
Dr. Prasad	97.4%	37	1	0	0	1 / 38	2.6%
TOTALS	96.8%	180	6	0	0	6 / 186	3.2%
			3.2%	0.0%	0.0%		

There was agreement on 180 out of 186 cases (overall 96.8% concordance). There were minor disagreements with no significant impact on patient health in 6 out of 186 cases. There were 0 cases of significant disagreement without serious impact on patient care (overall 3.2% discordance).

The overall and individual concordance rates remain very high. The rate of disagreement continues to be well below the thresholds of acceptability (25% for type A, 10% for type B, and 0% for type C). There is no evidence of a significant negative trend. These finding were discussed among the pathologists and reported to the MGH Laboratory QI meeting.

Imok Cha, MD
Pathologist / Director of Surgical Pathology
January 3, 2019

SURGICAL PATHOLOGY QUALITY IMPROVEMENT REPORT:
MARIN MEDICAL LABORATORIES SURGICAL PATHOLOGY PEER REVIEW
MARIN GENERAL HOSPITAL AND SONOMA VALLEY HOSPITAL

January 2018 - December 2018

Surgical pathology cases from Marin General Hospital and Sonoma Valley Hospital are reviewed during the two weeks following the verification of the report by Drs. Frederick Kretzschmar (K), Che Prasad (P), Imok Cha (C), and Christopher Kim (CK).

A total of 380 cases were reviewed from January 2018 through December 2018:

293 cases from Marin General Hospital: 71-K, 75-P, 66-C, 81-CK

87 cases from Sonoma Valley Hospital: 15-K, 21-P, 25-C, 26-CK

Reviewers were evenly divided between pathologists. There were 0 cases with a significant discrepancy from Marin General Hospital or Sonoma Valley Hospital (0.0%).

Overall, no negative trends are found. The rates of discrepancies remain very low and within acceptable limits. These findings were discussed among the pathologists and reported to the Laboratory/Pathology/Nuclear Medicine QI Committee. This study will continue as an ongoing QA/PI activity.

Imok Cha, MD
Pathologist / Director of Surgical Pathology
January 3, 2019

PATHOLOGY QUALITY IMPROVEMENT PROGRAM
SUMMARY OF AUTOPSY PATHOLOGY PEER REIVEW FOR 2018
MARIN GENERAL HOSPITAL & SONOMA VALLEY HOSPITAL

A total of 6 autopsies were performed in 2018 for Marin General Hospital; 2 performed by Dr. Cha, 1 by Dr. Kretzschmar, 0 by Dr. Prasad and 3 by Dr. Kim.
There were no autopsies for Sonoma Valley Hospital.

All autopsies met hospital criteria for performance. All autopsies were reviewed by MML pathologists, and the reviewing pathologists agreed with the original pathologic diagnoses on all cases. The reports were complete with appropriate descriptions of the clinical history, gross and microscopic autopsy findings, and anatomic diagnoses, and correlative summaries appeared appropriate. Provisional diagnoses were made in 48 hours in 5 of the 7 cases. Final reports were completed in 9-49 days.

This peer review finds that autopsies were performed in an appropriate manner, and there were no diagnostic discrepancies. The College of American Pathologists suggests that routine autopsies should be final within 60 days.

The findings were discussed at the Laboratory/Pathology Quality Improvement meeting and discussed among the pathologists.

I Cha

Imok Cha, MD
Pathologist/Director of Pathology
Final Report: 01/14/2019

2018 CORRECTED/AMENDED REPORTS (ANP. 12185)

In 2018, a total of 9,024 specimens were accessioned and reported by the Pathology Department. Out of 9,024 reports, 31 cases were amended (0.3%).

Review of amended reports show corrections of:

- Significant primary diagnosis change or errors
- Significant diagnostic information changes
- Patient identification errors
- Specimen source identification errors

In all 31 cases, clinicians were promptly notified. There was no significant clinical impact on patient care.

Imok Cha, MD
Director of Pathology
01/03/19

GUIDELINES/AUDIT OF CANCER PROTOCOLS WITH REQUIRED DATA ELEMENT (RDE) 2018

For compliance, Cancer Protocols are updated annually with the latest current version.

As a quality assurance activity, we will conduct an ongoing audit of 10% of synoptic reports every quarter to ensure required data elements (RDE) are included in at least 90% of the eligible surgical pathology reports.

In 2018, there were a total of 266 cases eligible for review. 10% were audited (29 reports). Of 29 reports audited, none were missing required data elements.

These results were discussed among the pathologists and discussed at the hospital's Laboratory/Pathology Quality Improvement Meeting.

I Cha

Imok Cha, MD
Pathologist, Director of Pathology
January 16, 2019

Guidelines for synoptic reports w/RDE.2019

Patient Care Services Dashboard 2019

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT

Medication Scanning Rate	2018-19				
	Q2	Q3	Q4	Q1	Goal
Acute	83.0%	85.0%	84.0%	82.0%	≥90%
ED	84.0%	78.0%	77.0%	90.0%	≥90%
Preventable med errors R/T Med Scanning				1 (n=48)	

Falls (Per 1000 days) 2018-19					
	Q3-Q2	Q4-Q3	Q1-Q4	Q2-Q1	50th %tile
Acute	2.80	2.90	2.00	2.70	3.75
ED				0.0	

Hospital Acquired Pressure Ulcer Incidents (Per 1000 admissions)	2018-19				
	Q2	Q3	Q4	Q1	National
Acute	0.0	0.0	1.2	0.0	3.68

Nursing Turnover	2018-19 RNs/Quarter				
# of RNs	Q2	Q3	Q4	Q1	Goal
Acute (n=65)	5	2	3	0	≤6

Patient Experience (CAHPS)	2018				
	Q1	Q2	Q3	Q4	Goal
HCAHPS					
Would Recommend				76.5	
Quietness of Hosp Environment				51.4	
OASCAHPS					
Care of Patients (MD/RN respect)	97	94.6	93.8	88.2	97.1
Would Recommend	85.4	77.6	75	87.5	88.6
RATE MY HOSPITAL - ED					
Overall score	4.7	4.7	4.8	4.8	≥4.5

Nurse Staffing Effectiveness: Transfers r/t staffing/beds					
2018-19	Q2	Q3	Q4	Q1	Goal
	0	0	0	0	≤0

Green = Goal Met Yellow = Below goal Red = Continues below goal or significantly below goal

2013 Hospital falls std from J Amer Med, AHRQ & PubMed

Indicator	DY12Final	DY13MY	DY13Final	DY14MY	DY14Final	PRIMEOne Benchmarks 25th /min.(%)	90th /Top perf%
2.2.1 – DHCS All-Cause Readmissions (ACR) Over 21	18.67%	11.39%	11.21%	10.92%		16.00%	11.86%
Num	14	9	12	13			
Den	75	79	107	119			
LOWER IS BETTER VISIT BASED: final PRIME Population 21 yo or older: minus L&D , cancer, exp, etc							
2.2.2 - NQF 0166: H-CAHPS – Care Transition Metrics: Understanding Your Care When You Left The Hospital	52.38%	53.80%	52.64%	Mode adj. 54.3%		44.00%	62.00%
Num	99	92	94	71			
Den	189	171	178	130			
USE HCAHPS VENDOR/Midas HCAHPS process focus results Note We do not currently use Mode adjustment since we utilize only 1 mode for the survey instrument-- cn							
2.2.4 - NQF 0646: Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) ALL AGES	22.90%	53.05%	89.42%	85.27%		24.90%	98.00%
Num	60	148	245	249			
Den	262	279	274	292			
USE Report Track -PRIME Focus report							
2.2.5 - NQF 0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) *18 Yrs and older*	0.87%	15.29%	17.60%	18.03%		2.00%	96.30%
Num	2	37	44	53			
Den	229	242	250	294			
USE Report Track -PRIME Focus report							
2.2.3 - NQF 0097: Medication Reconciliation – 30 days	1.40%	29.32%	23.96%	24.70%		32.60%	93.30%
Num	2	39	23	41			
Den	143	133	96	166			
USE Report Track -PRIME Focus report (SVCHC population only due to MOU)							

PRIME Reporting Information System | CALIFORNIA DEPARTMENT OF Health Care Services

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Log out | Sign in as different user

DY14 - 2019 - MidYear - Sonoma Valley Hospital, Sonoma Metrics Performance

Metric	Pay for Performance?	High Performance?	Performance
2.2.2 H-CAHPS: Care Transition Metrics (3)	Yes	Yes	75% ☆
2.2.3 Medication Reconciliation – 30 days	Yes	Yes	
2.2.4 Reconciled Medication List Received by Discharged Patients	Yes	Yes	
2.2.5 Timely Transmission of Transition Record	Yes	Yes	

SVH Prime Account Summary							
Thru FY 19							
	Prime Grant Account	5880-3000					
	Prime Grant Receivable	1063-0000					
Date	Description	Gross Amount	Matching Fee	Net			
06/30/2016	Prime Grant	375,000.00	187,500.00	187,500.00			
10/31/2016	Prime Grant	1,125,000.00	562,500.00	562,500.00			
05/25/2017	Prime Grant	150,000.00	75,000.00	75,000.00			
10/13/2017	Prime Grant	1,350,000.00	675,000.00	675,000.00			
03/21/2018	Prime Grant	750,000.00	375,000.00	375,000.00			
11/15/2018	Prime Grant	600,000.00	300,000.00	300,000.00			
		4,350,000.00	2,175,000.00	2,175,000.00			
Calendar Year							
2016	750,000	75.00 expedite fee					
2017	750,000						
2018	675,000	(75,000.00)	pay for performance take back				
2019	Pending						
	Total: 2,175,000.00						
8363 Care Transitions Operating costs							
FY2016	None						
FY2017	76,029						
FY2018	269,913						
FY 2019 YTD	145,915						
	Total: 491,857						
SVH Gain	1,683,143						

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

To: **SVHCD Board of Directors**
From: **Kelly Mather**
Date: **3/28/19**
Subject: **Administrative Report**

Summary
Changes continue this fiscal year as we reinvent our hospital. The new FY 2020 strategic plan will be ready for review and approval in May. The FY 2020 budget is underway with significant expense reductions targeted for July 1st. Due to the shrinking of our volumes that we traditionally relied upon, we must reduce overhead.

Strategic Update from FY 2019 Strategic Plan:

Strategic Priorities	Update
Highest levels of health care safety, quality and value	➢ The 5 Star hospital plan and the move to the 3rd floor went very well. We are changing the culture of Inpatient Care. ➢ We expect the "Stroke Ready" certification on April 16th. Tele-neurology with UCSF started in March. ➢ We are looking at a new safety self-assessment tool to be completed with the leaders. ➢ The Staff Satisfaction survey will go out this month.
Be the preferred hospital for patients, physicians, employers and health plans	➢ The Patient Access Center plans to start the new service with Medical Imaging by May. This will include upgrading our phone system. ➢ I have meet with several physicians and stakeholders to get their input on our strategic plan. ➢ Several better I.T. solutions for radiology are underway.
Implement new and enhanced revenue strategies as measured by increased direct margins in each service	➢ The Outpatient Diagnostic Center project is going well. We have submitted Project 1 (CT/Imaging/Hospitality) to OSHPD. We will bring Project 2 (Cardiology/North Entrance/Lab) to the board in June. We are still raising funds for Project 3 (MRI.) ➢ Discussing the need for another Primary Care Physician and/or Geriatrician for Sonoma. ➢ Enhancing the CEO dashboard to look at every single service such as Speech Therapy, Wound Care and revenue by type of Surgery.
Continue to improve financial stability as measured by EBDA	➢ We are shrinking the hospital expenses to less than $4.2 million per month going forward. This means we are restructuring and will unfortunately mean layoffs in July. ➢ Ensign starts their assessment and consulting on April 1st in the SNF. We plan to transition staff to Ensign on July 1st. ➢ The South Lot housing project is expected to be complete this summer. Selling a portion of this lot will pay down our line of credit.
Lead progress toward becoming a Healthier community	➢ Re-prioritizing some of the community outreach due to less resources. But, we will keep events that bring a return on the investments such as physician talks. ➢ Fundraising for the Outpatient Diagnostic Center continues and we are at $16.7 million raised.

FEBRUARY 2019

Patient Experience	Current Performance	FY 2019 Goal	National Benchmark
Would Recommend Hospital	78th	> 60th percentile	50th percentile
Inpatient Overall Rating	51st	>60th percentile	50th percentile
Outpatient Services	4.9	Rate My Hospital	4.5
Emergency	4.6	Rate My Hospital	4.5
Quality & Safety	**YTD Performance**	**FY 2019 Goal**	**Benchmark**
CLABSI	0	<1	<.51
CAUTI	0	<1	<1.04
SSI – Colon Surgery	0	<1	N/A
SSI – Total Joint	0	<1.5%	N/A
MRSA Bacteremia	0	<.13	<.13
C. Diff	1	3.5	7.4/10,000 pt days
PSI – 90 Composite	1	<1	<1
Heart Failure Mortality Rate	12.5%	TBD	17.3%
Pneumonia Mortality Rate	18.1%	TBD	23.6%
Stroke Mortality Rate	14.7%	TBD	19.7%
Sepsis Mortality Rate	10.2%	<18%	25%
30 Day All- Cause Readmissions	9.50%	< 10 %	< 18.5%
Serious Safety Events	0	0	0
Falls	2	< 2.3	2.3
Pressure Ulcers	0	<3.7	3.7
Injuries to Staff	11	< 10	17
Adverse Drug Events with Harm	0	0	0
Reportable HIPAA Privacy Events	0	0	0
SNF Star Rating	4	4	3
Hospital Star Rating	4	4	3
Our People	**Performance**	**FY 2019 Goal**	**Benchmark**
Staff Satisfaction Survey	61st percentile	75th percentile	50th percentile
Turnover	9.4%/14.1%	< 10%	< 15%
Financial Stability	**YTD Performance**	**FY 2019 Goal**	**Benchmark**
EBDA	-.1%	1%	3%
FTE's/AOB	4.44	4.3	5.3
Days Cash on Hand	4.6	20	30
Days in Accounts Receivable	43	49	50
Length of Stay	3.8	3.85	4.03
Funds raised by SVHF	$16.7 million	$20 million	$1 million
Strategic Growth	**YTD Performance**	**FY 2019 Goal**	**Benchmark**
Inpatient Discharges	697/1045	1000	1000
Outpatient Visits	35,542/53,178	53,000	51,924
Emergency Visits	6601/9901	10,000	11,040
Surgeries + Special Procedures	1929/2893	2500	2,568
Community Benefit Hours	740/1110	1200	1200

Note: Colors demonstrate comparison to National Benchmark

Jae Ann Jeys (Respiratory Therapy) RM 19-328	*Need to remove all simple o2 masks from the hospital—there is a chance of patients rebreathing their own co2 at low flow. Potential for patient harm.*	***PI Project for Respiratory Therapy Revamp*** ***Simple o2 masks removed. No patient harm***
Nicole Medieros (Emergency) RM 19-184	*ED back doors have been zip tied causing doors to not lock appropriately. Potential safety/security issue.*	***The doors have been repaired and zip ties removed. No Harm***
Tyler Swift (SCU) RM 19-33	*Sterilization indicator was missing from a tray of surgical supplies when beginning a case. Procedure was rescheduled in order to ensure all tools and supplies properly sterilized.*	***Equipment sterilized and patient procedure safely completed. No patient harm.***
Darriel Arnott (SCU) RM 19-147	*An unclear medication order for eye drops.* *RN practiced behavior based tool of* ***STAR (Stop. Think. Act. Review).***	***Correct dose delivered, no patient harm.***

To: Sonoma Valley Healthcare District Board Quality Committee
From: Danielle Jones
Date: 4/24/19
Subject: Quality and Resource Management Report

April Priorities: CIHQ Stroke Ready Certification, Medical Staff Peer Review Process, STATIT, QAPI

CIHQ Stroke Ready Certification
Completed on April 16th. SVH will officially receive certification after our minimal plan of corrections are submitted and approved.

Medical Staff Peer Review Process
Updated Peer Review Policy that establishes guidelines for external, routine, and expedited peer review processes. The new policy establishes time frame for review process completion and combines three policies into one. The new policy establishes monthly performance data review Created work flow for new peer review process.

STATIT
The goal is to increase data accessibility and standardization through the use of control charts for various indicators throughout the organization. Additionally, STATIT will support actionable performance improvement projects based on relevant benchmarks and standards. Currently, the Quality Department has created indicator templates in excel to aggregate the data until it migrates STATIT. The initial focus has been on Utilization Management and Medical Staff Performance Improvement and Quality Committee of the Board.

Barcode override report
A barcode override report was created for each unit so that managers can track overrides per unit per nurse. The quality assistant has been trained on how to extract data and enter into template reports for nursing leaders to provide monthly and quarterly data aggregation.

Department QAPI plans & quality monitoring
In April I have been meeting with department leaders to update the quality assurance performance improvement plans. We reviewed the departments workflow processes based on high risk, high volume, low volume and problem prone areas to establish quality assurance indicators, focused studies and performance improvement projects.

Policy and Procedures – Summary of Changes
Board Quality Committee, April 24th, 2019

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

REVISIONS:

Code Management for Patient Emergency Code Blue QS8610-106
Updated Code team members, clarified Code Team Response to 'outside locations' and overhead code page response protocol, and removed OB neonatal response.

Code Stroke Paging NS8610-124
Updated to provide a consistent emergency overhead paging protocol for all codes

RETIRE:

Code Neonate PC8610-174
No longer appropriate responders due to closure of OB

DEPARTMENTAL

Surgery / Central Sterile

Allografts and Tissue; Procurement for Surgical Procedures Requiring Grafting 7420-102
update with CIHQ requirements for documentation, minor format changes/spelling changes. Aligned policy with what we are doing.

On Call, Surgery 7420-135
Create standardized, minimal call requirements, response times, and after case recovery changed for OR nurse to remain for 1 hour to assist PACU RN per 2 RN requirements. This will provide for 2 RN coverage in PACU for recovery of post-surgical patients during after- hours. The guidelines were previously unclear.

Staff Scheduling Practices, Surgery 7420-154
Revised to provide a minimum requirement of availability for per diem employees; clarified different shift possibilities to allow for some commitment from per diem staff

Flexible Endoscopes, Reprocessing of 7471-114

Revised to include a broad comprehensive overview of how we provide high quality in the critical area of scope care and cleaning and high level disinfection per recommendations from SGNA (Society of Gastroenterology Nurses and Associates) to ensure all regulations and guidelines are observed and followed for reprocessing and storing endoscopes d/t the highly detailed nature of these processes and the high risk for inadequate cleaning of such

Laboratory Departmental Manual

Table of Contents includes description of changes

POLICIES/PROCEDURES MANUAL
Department-Laboratory
TABLE OF CONTENTS

LB8610-116	**Part 4-Administration Guidelines**
LB8610-118	**Part 5-Post Transfusion**
LB8610-120	**Part 6-Massive Transfusion**
7500-36	Organization Chart Sonoma Valley Hospital and Laboratory
~~**7500-38**~~	~~**Out Patient and Pre-Op Urine Collection**~~ **delete procedure**
7500-40	**Outpatient Service**
LB8610-122	**Pathology Specimen Handling- Organizational Remove reference to "Pathology Department" Update handling of specimens with no preservative.**
7500-42	**Personnel Responsibility and Accountability**
	PICC Line Access **Organizational**
LB8610-124	**Placenta Disposition- Organizational**
LB8610-126	**Point of Care Testing (POCT)- Organizational delete Home Care & OB**
7500-46	**Policy or Procedure Changes**
7500-48	**Pre-Operative Testing**
7500-50	**Priority Lab Work**
7500-52	**Proficiency Testing**
~~**7500-54**~~	~~**PTO/Time Off Requests**~~ **delete procedure, subject to change**
7500-56	**Reagent and Supply Handling—Dating and Visual Inspection**
~~**PCLB8610-113**~~	~~**Record Thermometer Documentation, Failure & Backup- Organizational**~~ **delete, no in the file. Remove from Tof C**
7500-58	**Reflex Testingupdate changes to include PSA reflex**
LB8610-130	**Release of Blood Products to Nursing- Organizational**
7500-60	**Release of Information**
7500-62	**Requests for Laboratory Tests update for CPOE**
7500-64	**Results Reporting updated per Paragon changes**
7500-66	**Retention of Clinical Laboratory Records**
7500-68	**Retention of Clinical Laboratory Specimens**
7500-70	**Retention of Pathology Records**
7500-72	**Retention of Records—Cease of Operation**
7500-74	**Review of Patient Results and Quality Control**
7500-78	**Self-Referral Testing**
~~**7500-82**~~	~~**Specimen Collection 24 Hour Urine**~~ **delete procedure**
7500-84	**Specimen Collection and Processing**
7500-86	**Specimen Rejection**
7500-88	**Specimens Collected at Outside Sites**
7500-90	**Staffing and Service Availability**
~~**7500-91**~~	~~**Synovial Fluid Exam**~~ **delete procedure**
PR8610-114	**Facsimile (Fax) Confidentiality and Security—Organizational**
7500-94	**Temperature Control in the Laboratory**
7500-96	**Temperature Daily Checks**
7500-98	**Venipuncture**

APPROVALS:

Policy & Procedure Team: 3/19/19
Medicine Committee: 4/11/19
Medical Executive Committee: 4/18/19
Board Quality Committee:
The Board of Directors: