SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, May 22, 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	*Hirsch*	
2. PUBLIC COMMENT SECTION *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less, Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.*	*Hirsch*	
3. CONSENT CALENDAR • Minutes 04.24.19	*Hirsch*	Action
4. SNF ANNUAL REPORT	*M. Evans*	Inform
5. PRIME GRANT UPDATE	*Lovejoy*	Inform
6. CEO REPORT AND DASHBOARD	*Jones*	Inform
7. CIHQ ACUTE STROKE READY SURVEY FINDINGS	*Jones*	Inform
8. QUALITY AND RESOURCE MANAGEMENT REPORT	*Jones*	Inform
9. CLOSED SESSION: a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Hirsch*	Inform
10. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
11. ADJOURN	*Hirsch*	

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
April 24, 2019 5:00 PM
MINUTES
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Carol Snyder Michael Mainardi, MD Susan Idell Howard Eisenstark, MD Cathy Webber		Jane Hirsch Ingrid Sheets	Danielle Jones, RN Mark Kobe, CNO Lois Valenzuela Frederick Kretzscmar, MD

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, 03.27.19		**MOTION:** by Idell to approve, 2nd by Eisenstark. All in favor.
4. LABORATORY ANNUAL REPORT	*Valenzuela/Kretschmar*	
	Ms. Valenzuela gave the annual Laboratory report for 2018. She reported that while the volumes in the lab were down, the proficiency testing was very good. She spoke about the cost saving measures that were done, new instrumentation purchases, as well as improved diagnostic testing. She spoke about the CLIA inspection in November of 2018. All findings were corrected and accepted. Dr. Kretzschmar reviewed the Pathology Quality Improvement Program for 2018. This included review of intradepartmental consultations, peer review and external consultations.	

AGENDA ITEM	DISCUSSION	ACTION
5. CNO QUARTERLY PATIENT CARE DASHBOARD	*Kobe*	
	Mr. Kobe reviewed the quarterly patient care dashboard. Per the committee request the medication scanning errors were included on the dashboard. Mr. Kobe spoke to the barriers that have been identified with decreased medication scanning in the ED. He said that this process is continually being monitored for improvements.	
6. PRIME GRANT UPDATE	*Lovejoy*	
	Deferred	
7. CEO DASHBOARD	*Jones*	
	Ms. Jones reviewed the CEO dashboard. She said that SVH just completed and passed the stroke readiness survey. Other items she spoke about were the staff satisfaction survey, the patient access center plans, the Outpatient Diagnostic Center, Ensign in SNF and the right sizing of the hospital.	
8. GOOD CATCH REPORT	*Jones*	
	Ms. Jones reviewed four good catche awards.	
9. QUALITY AND RESOURCE MANAGEMENT	*Jones*	
	Ms. Jones spoke about the CIHQ stroke ready survey and certificate, Medical staff peer review process and policy revision, STATIT goals of increasing data accessibility and standardization, Barcode override report for each department and department QAPI plans & quality monitoring with department leaders.	
10. POLICIES AND PROCEDURES	*Jones*	

AGENDA ITEM	DISCUSSION	ACTION
	Revised: Code Management for Patient Emergency Code Blue QS8610-106 Code Stroke Paging NS8610-124 **Retire:** Code Neonate PC8610-174 **Departmental:** Surgery/Central Sterile Allografts and Tissue; Procurement for Surgical Procedures Requiring Grafting 7420-102 On Cal, Surgery 7420-135 Staff Scheduling Practices, Surgery 7420-154 Flexible Endoscopes, Reprocessing of 7471-114 Laboratory Department Manual	**Motion:** by Eisenstark to approve 2nd by Idell . All in favor
11. CLOSED SESSION	*Mainardi*	
	Called to order at 6:10pm	
12. REPORT OF CLOSED SESSION	*Mainardi*	
	Medical Staff Credentialing reviewed.	**MOTION:** by Idell to approve credentialing, 2nd by Eisenstark. All in favor.
13. ADJOURN	*Mainardi*	
	6:12pm	

2018-2019 Skilled Nursing Facility Annual Quality Review

Introduction: The Skilled Nursing Facility, (SNF) is a 27- bed, Distinct Part, (DP) SNF located within the hospital grounds. The goal of the SNF is to provide post-acute care so that our patients may be restored to their prior level of function. Our Key Health care services are; Physical Therapy, Occupational Therapy, Speech Therapy, post-operative care, post-stroke and cardiac surgery care, frequent antibiotic infusions, and wound care.

The Future: As a result of the SNF Task Force recommendations in conjunction with approval from the Board of Directors, the unit will be managed by a larger company to create a viable, sustainable service for our community. The future of the SNF will involve new management and sub-acute patients including long term tracheostomy and ventilated patients. In addition, the new Patient Driven Payment Model (PDPM) of reimbursement will begin October 1st, 2019.

Patient Driven Payment Model: Under the current payment system, Resource Utilization Group (RUG-IV), most patients are classified into a therapy payment group, which uses primarily the volume of therapy services provided to the patient as the basis for payment classification. This creates an incentive for SNF providers to furnish therapy to SNF patients regardless of the patient's unique characteristics, goals, or needs. The PDPM consists of five case-mix adjusted components, Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP), Nursing, and a non- therapy ancillary (NTA) component which includes patient comorbidities to calculate payment.

Stakeholders: Primary stakeholders of the SNF are the patients, physicians, our workforce, the community, and our new management group who will partner with us.

Regulatory Requirements: Sonoma Valley Hospital's D/P SNF is regulated by the California Department of Public Health Licensing Division, (CDPH), Life Safety Code Division, Office of Statewide Hospital Planning and Development (OSHPD), Title 22 California Code of Regulations, and the Centers for Medicare and Medicaid Services, (CMS).

Key Sources of Competitive and Comparative Data: Key sources of competitive and comparative data from within the post-acute care profession come from; the CA Department of Public Health annual Licensing recertification surveys, CMS certification surveys every two years, CASPER reports, (Certification and Survey Provider Enhanced Reports), Medicare's 5- Star rating system, Medicare.gov website, and the American Health Care Association's (AHCA) Long Term Care Trend Tracker. Data from outside the long-term care profession

would include our own Quality/ Performance Improvement initiatives, Post Discharge Patient Satisfaction surveys, daily patient rounding, and employee satisfaction and retention data.

Department Mission: To restore, maintain or improve the health and *function* of our patients so that they may return to the community.
Leadership Team: Medical Director, SNF Administrator, Director of Nursing. Soon the Leadership team will expand to include a larger management group, a new Executive Director as well as regional and state directors and resources from this company.
Workforce Profile: Ten Registered Nurses, one Director of Nursing, one Medical Director, two "SNFists", two MDS Nurses, 12 Certified Nursing Assistants, one Activities Director, one Unit Secretary, one Intake Coordinator and Social Worker, and one Pharmacist and Dietician consultant. The SNF is also supported by the medical staff, Rehabilitation Services, Nutritional Services, the laboratory, the Medical Imaging Department, and Environmental Services.
Quality Metrics: Key Elements of our performance improvement system include quality monitoring for high-risk-high volume, high- risk-low volume, and problem-prone patients. Our plans are based on regulatory guidelines, industry standards, and best practices. They are revised quarterly based on results.

Performance Goal	Objective	Metric	Actual Results	CA & National Results
Service Excellence	Highly Satisfied Patients 90% or > satisfied	Per Discharge Call Back Questionnaire, "Did you get help as soon as you needed it"	2018 = 93% of our patients were satisfied with prompt response to call lights when asked about their experience.	Goal Met
People	High Employee Satisfaction/ Engagement 80th % ile or >	Per Press Ganey Staff Satisfaction / Engagement survey	2016 = 4.44/5.0 2017 = 4.32/5.0 2018 = 4.41/5.0 2019= pending	SNF Staff Action Planning Readiness (goal met): 2016= 96% ile 2017= 96% ile 2018= 98% ile 2019= pending
Finance	Volume > Expenses 0% variance from budget Revenue 0 % variance From budget	Per Monthly SNF Financials – (not including attributable costs).	Volume (Pt Days) FY 18 = 6,361 FY 17 = 6,553 FY 16 =7312 FY 15= 7350 FY 14 =7565 FY 13 = 7624 FY 12 =7470	FY 18 Gross = Revenue = $13,408,434 on a budget of $13,076,397 (+$332,037 over budget). (FY 17 Gross Revenue = $12,733,584) FY 18 Expenses = $2, 879,607 on a budget of $2,590,415 (-$289, 192) over budget (FY 17 Expenses = $2,642,634) FY 18 Contribution Margin = +$42,845
Quality Measures	Reduce Falls	Midas Risk Report and CASPER Reports, (Certification and Survey Provider Enhanced Reports)	2019 1st quarter = 0.111/1000 days 2018 = 0.151/1000 patient days. 2017= 0.181/1000 patient days, (3rd Quarter Data)	CA Average = 1.7% Nation. Average =3.3% (goal met)

	Remain a Restraint – free unit	CASPER Reports	0 % Restraint rate x7 years	CA Average = 0.5% Nation. Average = 0.3% (goal met)
	Excellent survey results	Per CMS/CDPH Federal and Recertification Surveys	10/26/2018 Recertification Survey = 6 deficiencies: "Lack of Advanced Directives on patient record." "Lack of Social Services to assists patient with legal matters." "Lack of palatable, attractive food." "Expired vegetables in kitchen." "Lack of accurate information on face sheets about Advanced Directives." "IV tubing change dates were missing."	CA Average = 12.3 Nation. Average = 7.8 (goal met)
Short Stay Measures from the CMS Quality Measure Provider Rating Report	% of residents who made improvement in function	CMS Provider Rating Report	=53.7% long and short stay measures count equally in calculation (we have two long-term patients with brain injuries, paralysis and contractures)	CA= 68.8% National = 66.7%
	% of residents who self-report moderates to severe pain	CMS Provider Rating Report	=37.6 % (D/P SNF with many post-op patients).	CA = 6.2% National = 14.7%
	Newly received antipsychotic medication	CMS Provider Rating Report	= 2.1 % (acute delirium and Hospitalists' who practice on acute units write admission orders for SNF).	CA = 1.4% National = 1.8%
	New or worsened pressure ulcers	CMS Provider Rating Report	=0.5 %	CA= 1.0% National = 1.7% (goal met)
	% of patients who successfully returned home	CMS Provider Rating Report	= 72.6%	CA= 48.5% National = 48.6% (goal met)
	Re-hospitalized after SNF admission within 30 days	CMS Provider Rating Report	= 11.0 %	CA= 22.8% National = 22.9% (goal met)

	% with outpatient emergency room visit within 30 days.	CMS Provider Rating Report	= 7.3%	CA= 10.1% National = 10.7% (goal met)
FY 19 VBP score:	The Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) is used in the SNF VBP Program. The SNFRM estimates the risk-standardized rate of unplanned readmissions within 30 days.		=100%, Rank 1 = 1% increase in Medicare Part A payments effective Oct. 1, 2018. (Based on readmission rates from January 1, 2017, through December 31, 2017, and the baseline period, January 1, 2015, through December 31, 2015).	CA= 22.8% National =22.9% (goal met)

Strategic Challenges and Advantages: The SNF at Sonoma Valley Hospital has all of the services of the acute care hospital available to its patients. There is 24/7 physician coverage and on-site medical imaging, laboratory, pharmacy and ER services. The unit's small size, frequent physician visits, and skilled nurses are attractive to our patients. However, due to challenges with recruiting and retaining therapy staff, low patient volumes and the high cost of nursing staff, the unit has been threatened with closure.

Conclusion: In summary, the Sonoma Valley Hospital DP/ SNF continues to receive excellent survey results and high ratings for post-acute care. The community supports the SNF, and our patients enjoy frequent physician visits and an all RN staff. The patients in our SNF are initially "sicker" than in a community-based SNF due to our proximity to the acute care hospital, but they require shorter lengths of stay. Due to the increased cost of staffing, decreased RUGS reimbursement, and high turnover of therapy staff, it has become necessary to implement strategic measures to increase profitability to remain viable. The future of the SNF will involve new management and acquisition by a larger parent company, obtaining a sub-acute license, a change in the staffing model and partnering with local, regional and state leaders from a larger management group who specialize in post-acute and sub-acute care.

Questions?

Indicator	DY12Final	DY13MY	DY13Final	DY14MY	DY14Final	PRIMEOne Benchmarks 25th /min.(%)	PRIMEOne Benchmarks 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)							

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: **4/29/19**
Subject: **Administrative Report**

Summary
We are now stroke certified! After many changes have been made in this fiscal year, things are starting to come together. The FY 2020 budget is almost complete and ready for review at the May 30th special meeting. The strategic plan is coming to the board this month for review and approval.

Strategic Update from FY 2019 Strategic Plan:

Strategic Priorities	Update
Highest levels of health care safety, quality and value	➢ The 5 Star hospital plan continues with a strong focus on patient experience. The new hospitalist group will be key to this achievement as well. They begin in June. ➢ We now have the stroke certification. ➢ The Staff Satisfaction survey went out today and will be a great tool for us to assess the culture.
Be the preferred hospital for patients, physicians, employers and health plans	➢ The Patient Access Center start this week. This will include upgrading our phone system which is part of the Outpatient Diagnostic Center project. ➢ The strategic plan is complete and represented many different stakeholder views and concerns. ➢ Canopy Health is partnering with us to provide free telehealth visits this summer to their members in Sonoma Valley.
Implement new and enhanced revenue strategies as measured by increased direct margins in each service	➢ The Outpatient Diagnostic Center project has run into a few snags with power due to our old building. We hope to break ground by the end of 2019. ➢ We have a potential Geriatrician interested in joining our hospital team. ➢ A new "Management Information System" previously called "Cost Accounting" will be rolled out in June to include direct margins on all services, even small.
Continue to improve financial stability as measured by EBDA	➢ The FY 2020 budget reflects a smaller level of overhead due to the reductions in services this past year. ➢ Ensign will present at the May board meeting. The final contract is almost complete. 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	➢ Met with a community member who would like to help lead more conversations about the hospital in people's homes. ➢ The Advanced Health Care Directive or POLST program at Vintage house was a huge success with double the attendees. ➢ Fundraising for the Outpatient Diagnostic Center continues and we are at $16.8 million raised.

MARCH 2019

Patient Experience	Current Performance	FY 2019 Goal	National Benchmark
Would Recommend Hospital	83rd	> 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	0	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	2.7	< 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	11.1%/13.3%	< 10%	< 15%
Financial Stability	**YTD Performance**	**FY 2019 Goal**	**Benchmark**
EBDA	3.9%	1%	3%
FTE's/AOB	4.15	4.3	5.3
Days Cash on Hand	4.6	20	30
Days in Accounts Receivable	44	49	50
Length of Stay	3.8	3.85	4.03
Funds raised by SVHF	$16.8 million	$20 million	$1 million
Strategic Growth	**YTD Performance**	**FY 2019 Goal**	**Benchmark**
Inpatient Discharges	784/1045	1000	1000
Outpatient Visits	40,347/53,796	53,000	51,924
Emergency Visits	7459/9945	10,000	11,040
Surgeries + Special Procedures	2183/2910	2500	2,568
Community Benefit Hours	891/1188	1200	1200

Note: Colors demonstrate comparison to National Benchmark

Center for Improvement
CIHQ
in Healthcare Quality
P.O. Box 3620, McKinney, TX 75070
866-324-5080

NOTIFICATION OF DISEASE SPECIFIC CERTIFICATION SURVEY RESULTS
ACUTE STROKE READY HOSPITAL

April 18, 2019

Ms. Kelly Mather
Chief Executive Officer
Sonoma Valley Hospital
347 Andieux Street
Sonoma, CA 95476

Dear Ms. Mather:

A disease specific certification survey for Acute Stroke Ready Hospital was conducted on April 16, 2019. The final report appears below. An electronic version of this report will appear on your CIHQ intranet site within 24 to 48 hours.

As a result of this survey activity, deficiencies have been identified that require a corrective action plan (CAP). The CAP must be completed and returned to CIHQ within 10 calendar days from the date this report was sent to your organization. The CAP is to be submitted electronically via your organization's CIHQ intranet site. Submission will be available once your electronic report has been posted.

If you require assistance in the submission process, please contact Traci Curtis at tcurtis@cihq.org

Please do not include any supporting documentation with your submission. You will be contacted if supporting documentation is required.

If the CAP is not accepted, then you will be able to submit necessary revisions. Please be advised that CIHQ will not be able to extend disease specific certification to your organization until an acceptable CAP is submitted. Please also be advised that your organization must obtain / maintain its hospital accreditation by CIHQ in order for this certification to remain in good standing.

Please let me know if you have any questions. Thank you for allowing CIHQ to partner with you in improving the delivery of healthcare.

Sincerely:

Richard Curtis RN, MS, HACP
Chief Executive Officer
CIHQ

Sonoma Valley Hospital
Disease Specific Certification Survey Final Report

DATES OF SURVEY: April 16, 2019

TYPE OF SURVEY: Acute Stroke Ready Hospital Disease Specific Certification

Level of Deficiency - Standard
Standard
SRH-4: Care of the Stroke Patient in the Emergency Department Stroke patients have access to timely and effective emergency department care B. For ischemic stroke patients who meet criteria for IV thrombolytic therapy (e.g. patients presenting within three (3) hours of symptom onset); • The organization assures 24/7 availability of IV thrombolytic medications, associated supplies, and other necessary items in the emergency department. • Emergency department physicians and nursing staff are trained on the appropriate management of IV thrombolytic therapy – including indications for use, contraindications, administration, monitoring requirements, post-therapy neurologic deterioration, and education to the patient and/or family. • If an eligible ischemic stroke patient does not receive IV thrombolytic therapy, the reason is documented in the patient's medical record.
The Standard Was Not Met as Evidenced by the Following
REQUIREMENT B <u>Observed during Medical Record Review</u> The medical record of a 67 year old male presenting to the Emergency Department on 1/28/19 at 1712 with a facial droop was reviewed. It was noted that the patient received TPA. The TPA was documented as being administered at 1825, which is greater than the 60 minute target window. It is noted that the TPA was ordered at 1757 but took almost 30 minutes to prepare and administer. Staff present confirmed the finding.

Level of Deficiency - Standard
Standard
SRH-5: Availability of Diagnostic Services Stoke patients have timely access to diagnostic services A. Diagnostic brain imaging (e.g. CT, MRI) is available 24/7 for acute stroke patients. A brain image study is performed, preliminarily interpreted, and reported to the requesting practitioner within 45 minutes of order. • Preliminary interpretation can either be performed on-site or through telemedicine services. • The preliminary interpretation must definitively rule out or detect intracranial hemorrhage or other causes of the stroke syndrome • There should be written documentation that such scans were performed and read within the specified times • For facilities without in-house imaging interpretation expertise, tele-radiology systems approved by the Food and Drug Administration (or equivalent organization) are available for timely review of brain computed tomography (CT) and magnetic resonance imaging (MRI) scans in patients with suspected acute stroke B. Laboratory testing is available 24/7 for acute stroke patients. Laboratory studies are obtained, run, resulted, and communicated to the requesting practitioner within 45 minutes of order • Laboratory tests include, but are not necessarily limited to; o Complete blood counts (CBC) o Platelet count o Prothrombin time (PT) o International Normalization Ratio (INR) o Blood chemistries C. ECG and chest x-rays for acute stroke patients are available 24/7. The studies are performed and the results made available to the requesting practitioner within 45 minutes of order
The Standard Was Not Met as Evidenced by the Following
REQUIREMENT A <u>Observed during Medical Record Review</u> The medical record of an 86 year old male who presented to the Emergency Department on 3/29/19 at 0947 was reviewed. It was noted that the CT results were interpreted at 1102, which is outside the 45 minute target window. Staff present confirmed the finding. <u>Observed during Medical Record Review</u> The medical record of a 71 year old male presenting to the Emergency Department on 1/24/19 at 1243 with expressive aphasia was reviewed. It was noted that the CT results were interpreted at 1354, which is outside the 45 minute target window. Staff present confirmed the finding. REQUIREMENT B <u>Observed during Medical Record Review</u> The medical record of an 86 year old male who presented to the Emergency Department on 3/29/19 at 0947 was reviewed. It was noted that lab results were available between 1054 and 1058, which is outside the 45 minute target window. Staff present confirmed the finding. REQUIREMENT C <u>Observed during Medical Record Review</u> The medical record of an 86 year old male who presented to the Emergency Department on 3/29/19 at 0947 was reviewed. It was noted that EKG results were available at 1047, which is outside the 45 minute target window. Staff present confirmed the finding.

Level of Deficiency - Standard
Standard
SRH-8: Quality Assessment & Performance Improvement The stroke ready program monitors and improves its performance B. At least two relevant, valid, and reliable clinical performance measures are chosen annually to monitor performance. Data is collected, aggregated, benchmarked, analyzed, and acted upon in a timely manner E. A multidisciplinary committee meets at least twice annually, and reviews and monitors stroke care quality benchmarks, indicators, evidence-based practices, and outcomes.
The Standard Was Not Met as Evidenced by the Following
REQUIREMENT B Observed during Document Review The organization has chosen to monitor CT result times as part of its performance improvement efforts. While staff can articulate such efforts, there is little documentation to support that data is collected, aggregated, benchmarked, analyzed, and acted upon in a timely manner. Staff present confirmed the finding. REQUIREMENT E Observed during Document Review The minutes of the stroke committee were reviewed. While the committee did meet, there was little evidence that it reviewed and monitored stroke care quality benchmarks, indicators, evidence-based practices, and outcomes. Staff present confirmed the finding.

---END---

	CMS/CDPH Action Plan	
Citation Section & Deficiency #SRH-4	"The following constitutes the facility's response to the findings of the Department of Health Services and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statements of deficiencies."	
Observed during Medical Record Review The medical record of a 67 year old male presenting to the Emergency Department on 1/28/19 at 1712 with a facial droop was reviewed. It was noted that the patient received TPA. The TPA was documented as being administered at 1825, which is greater than the 60 minute target window. It is noted that the TPA was ordered at 1757 but took almost 30 minutes to prepare and administer. Staff present confirmed the finding.	"The CMS 2567 statement of deficiencies was reviewed by the hospital Chief Executive Officer, Chief Medical Officer and Chief Nursing Officer 4-18-19 face to face in the monthly Stroke Committee Meeting. The senior leaders directed that a POC be developed and implemented." All patients have the potential to be affected by the deficient practice. The following immediate corrective actions and systematic changes have been put into place to ensure that the deficient practice does not happen again. **A. <u>Action Plan</u>** 1. Stroke Coordinator to provide 1:1 tPA demonstration for admixture of and administration of to all ED RNS 2. Beginning 4/23/19 tPA will be mixed and administered aseptically by the ED RNs. 3. Healthstream education for tPA administration is assigned as a refresher to all ED RNs and this module must be completed by June 1, 20109 4. Immediate implementation of 2 RN validation for Medication Administration and documentation on the Medication Administration Record (EMR). 5. Annual skills to include hands on demonstration of tPA mixing and administration. **Responsible Person**: Chief Nursing Officer **<u>B. Monitoring</u>** ED Department QAPI monitoring will include tPA administration times extracted from the EMR. Data will be reviewed monthly at the Stroke Committee and results reported Quarterly to Medical Staff PI Committee	May 16, 2019

STK-5 REQUIREMENT A Observed during Medical Record Review The medical record of an 86 year old male who presented to the Emergency Department on 3/29/19 at 0947 was reviewed. It was noted that the CT results were interpreted at 1102, which is outside the 45 minute target window. Staff present confirmed the finding. Observed during Medical Record Review The medical record of a 71 year old male presenting to the Emergency Department on 1/24/19 at 1243 with expressive aphasia was reviewed. It was noted that the CT results were interpreted at 1354, which is outside the 45 minute target window. Staff present confirmed the finding. REQUIREMENT B Observed during Medical Record Review The medical record of an 86 year old male who presented to the Emergency Department on 3/29/19 at 0947	"The CMS 2567 statement of deficiencies was reviewed by the hospital Chief Executive Officer, Chief Medical Officer and Chief Nursing Officer 4-18-19 face to face in the monthly Stroke Committee Meeting. The senior leaders directed that a POC be developed and implemented." All patients have the potential to be affected by the deficient practice. The following immediate corrective actions and systematic changes have been put into place to ensure that the deficient practice does not happen again. **A. <u>Action Plan</u>** 1. The CT Tech monitors the timing of the Radiologists read of the non-contrast head CT. Immediately on notification, the CT tech will contact the ED MD by face to face communication or by telephone that the CT result is ready. CT tech will document on Stroke Code Flow Sheet time notifying ED MD. 2. The CT tech will flag all stroke non-contrast CT scans as 'Code Stroke' for Radiologist for prioritization of read. 3. Laboratory Stats from ED will have a 30 minute turnaround time beginning April 22, 2019. 4. Immediately upon return from CT, ED tech will perform EKG. 5. Clinical informatics to create a field in Paragon for ED MD to document 'time CT read' **Responsible Person**: Chief Nursing Officer **<u>B. Monitoring</u>** ED Department QAPI monitoring will include monthly OP-23 data, laboratory turnaround times from the ED, time to EKG. Data will be reviewed monthly at the Stroke Committee and results reported Quarterly to Medical Staff PI Committee	May 16, 2019

was reviewed. It was noted that lab results were available between 1054 and 1058, which is outside the 45 minute target window. Staff present confirmed the finding. REQUIREMENT C Observed during Medical Record Review The medical record of an 86 year old male who presented to the Emergency Department on 3/29/19 at 0947 was reviewed. It was noted that EKG results were available at 1047, which is outside the 45 minute target window. Staff present confirmed the finding.		
SRH-8 REQUIREMENT B Observed during Document Review The organization has chosen to monitor CT result times as part of its performance improvement efforts. While staff can articulate such efforts, there is little documentation to support that data is collected, aggregated, benchmarked,	"The CMS 2567 statement of deficiencies was reviewed by the hospital Chief Executive Officer, Chief Medical Officer and Chief Nursing Officer 4-18-19 face to face in the monthly Stroke Committee Meeting. The senior leaders directed that a POC be developed and implemented." All patients have the potential to be affected by the deficient practice. The following immediate corrective actions and systematic changes have been put into place to ensure that the deficient practice does not happen again. **A. <u>Action Plan</u>** 1. Clinical performance measures identified as OP-23, ED Head CT results and timing of tPA administration. 2. The identified clinical performance measures will be added to the ED Department QAPI 3. 100% of all fall-outs will be monitored and report monthly to the Stroke Committee.	May 16, 2019

analyzed, and acted upon in a timely manner. Staff present confirmed the finding. REQUIREMENT E Observed during Document Review The minutes of the stroke committee were reviewed. While the committee did meet, there was little evidence that it reviewed and monitored stroke care quality benchmarks, indicators, evidence-based practices, and outcomes. Staff present confirmed the finding.	**Responsible Person**: Chief Nursing Officer **B. Monitoring** All stroke data including core measures, case fall-outs, tPA timing and OP-23 will be reported monthly to the Stoke Committee, Medical Staff Performance Improvement Committee and the Medical Executive Committee	

To: Sonoma Valley Healthcare District Board Quality Committee
From: Danielle Jones
Date: 5/22/19
Subject: Quality and Resource Management Report

May Priorities:

CIHQ Stroke Ready Certification

Center for Improvement in Healthcare Quality (CIHQ) has awarded disease specific certification to Sonoma Valley Hospital as an Acute Stroke Ready Hospital effective from April 16, 2019. Certification as an Acute Stroke Ready Hospital means that SVH has successfully met the requirements outlined in CIHQ's standards. These standards are based on, and consistent with, evidence-based guidelines including those promulgated by the American Heart Association and the American Stroke Association.

Medical Records

I am now overseeing Medical Records. We are working on a project to implement concurrent document scanning. The practice itself ensures that all of the charts and records generated while a person is an inpatient gets scanned into their electronic health record while they are still in the hospital. Prior to concurrent scanning the records and charts are gathered after a person is discharged and then brought down to Medical Records and scanned into the record. This project will increase the efficiency as it will save time on the back end as we will have less information to process once the patient is discharged. Additionally, this will support the intent of the electronic health record as one that is universal and immediately accessible. This project will be piloted for Med/Surg and ICU and will be managed by the Quality Coordinator.

General Acute Care Hospital relicensing survey

We are in the window for our triennial General Acute Care Hospital relicensing survey through the California Department of Public Health. The focus of this accreditation is classified into two categories and is intended to evaluate facility compliance with statutory and regulatory requirements addressed in Title 22 and the Health and Safety Code. Focused on quality of care, the survey will consist of a review of nursing and pharmacy as well as identified past compliance concerns. Quality has been partnering with pharmacy, infection prevention, nutritional services, medical staff, and human resources as we prepare for the unannounced survey.