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SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, JULY 22, 2020
5:00 p.m. Regular Session

(Closed Session will be held upon adjournment of the Regular Session)

TO BE HELD VIA ZOOM VIDEOCONFERENCE

To Participate Via Zoom Videoconferencing use the link below:

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and enter the Meeting ID: 987 9208 0549
Password: 932037

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Password: 932037

AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a District meeting, please contact the District Clerk, Vivian Woodall, at vwoodall@sonomavalleyhospital.org or 707.935.5005 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 06.24.20	*Hirsch*	Action
4. SVH QUALITY INDICATOR PERFORMANCE AND PLAN	*Jones*	Inform
5. UTILIZATION MANAGEMENT	*Jones*	Inform
6. PATIENT CARE SERVICES DASHBOARD	*Kobe*	Inform
7. COVID-19 UPDATE	*Kidd*	Inform
8. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report b. Government Code §54956.9(d)(2): Discussion Regarding Two Incidents of Significant Exposure to Litigation	*Hirsch* *Jones*	Action Inform
9. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
10. ADJOURN	*Hirsch*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
June 24, 2020 5:00 PM
MINUTES
Via Zoom Teleconference

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch via Zoom Susan Idell via Zoom Ingrid Sheets via Zoom Cathy Webber (late via Zoom)	Howard Eisenstark, MD via Zoom Michael Mainardi, MD via Zoom Carol Snyder via Zoom		Sabrina Kidd, MD, CMO, via Zoom Danielle Jones, RN, Chief Quality Officer via Zoom Dr. Judith Bjorndahl via Zoom

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Called to order at 5:00 p.m. Ms. Hirsch asked Dr. Kidd to give a brief COVID-19 update. Many states are seeing surges as they have opened up and people are relaxing precautions. The Bay Area is doing well. There has been a care facility outbreak in Sonoma which is being handled by the County EMS, and SVH.	
2. PUBLIC COMMENT	*Hirsch*	
	None	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 05.26.20		**MOTION:** by Eisenstark to approve, 2nd by Sheets. All in favor.
4. SVH QUALITY INDICATOR PERFORMANCE AND PLAN	*Jones*	Inform
	Ms. Jones reviewed quality indicator performance for the month of May.	
5. PROPOSED QUALITY COMMITTEE CHARTER	*Jones*	
	The Committee reviewed and discussed further changes to the charter. The Committee requested seeing a clean copy and would vote by email.	No action taken.

AGENDA ITEM	DISCUSSION	ACTION
	Ms. Jones indicated utilization management would be an additional standing agenda item beginning in July.	
6. POLICIES AND PROCEDURES	*Jones*	
	The Compliance Committee had previously approved and forwarded the Compliance Program Plan to the Quality Committee. A discussion ensued regarding whether the Quality Committee was the correct body to review the document since it was not strictly a policy or procedure. Ms. Hirsch and Ms. Jones would review and decide who the owner of this plan should be.	No action was taken.
7. CLOSED SESSION	*Hirsch*	
a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	Called to order at 6:03 pm.	
8. REPORT OF CLOSED SESSION	*Hirsch*	
	Medical Staff credentialing was reviewed.	**MOTION:** by Idell to approve credentialing, 2nd by Sheets, all in favor.
9. ADJOURN	*Hirsch*	
	6:10 pm	

Quality Indicator Performance & Plan

July2020

Data for June 2020

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MORTALITY

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Scorecard Summary
Mortality

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Autopsies Mortalities					
▼	Acute Care Mortality Rate (M)	1.6%	15.3%		Jun 2020
—	Congestive Heart Failure Mortality Rate |M|	0.0%	11.5%		Jun 2020
—	COPD Mortality Rate |M|	0.0%	8.5%		Jun 2020
—	Ischemic Stroke Mortality Rate |M|	0.0%	13.8%		Jun 2020
—	Pneumonia Mortality Rate |M|	0.0%	15.6%		Jun 2020
Quality > Process of Care > Sepsis Care					
—	Sepsis, Severe - Mortality Rate (M)	0.0%	25.0%		Jun 2020
—	Septic Shock - Mortality Rate (M)	0.0%	25.0%		Jun 2020

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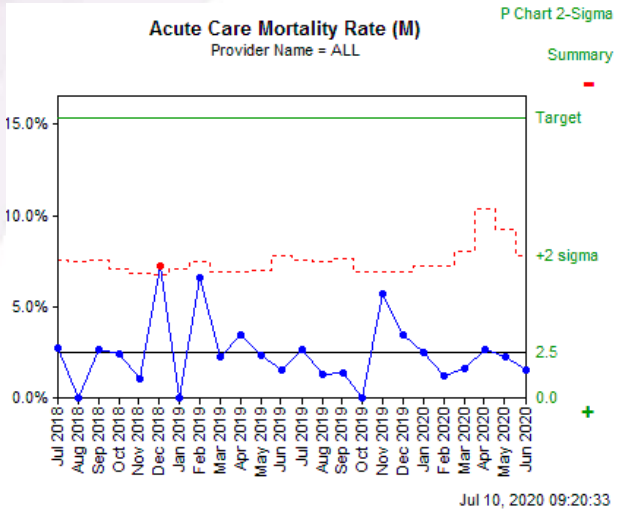
Acute Care Mortality Rate

Period	CDB009 - Acute Care - Mortality Rate (numerator)	CDB009 - Acute Care - Mortality Rate (denominator)	Percent
Jun 2020	1	64	1.6%
May 2020	1	44	2.3%
Apr 2020	1	37	2.7%
Mar 2020	1	61	1.6%
Feb 2020	1	80	1.2%
Jan 2020	2	80	2.5%
Dec 2019	3	86	3.5%
Nov 2019	5	88	5.7%
Oct 2019	0	89	0.0%
Sep 2019	1	72	1.4%
Aug 2019	1	76	1.3%
Jul 2019	2	74	2.7%



- Case Review
  - June 2020
  - One mortality
  - Met with Hospice By The Bay
    - Face to Face hand over with the Hospitalists and Hospice By The Bay admission nurse
    - New ED Hospice patient referral to come from ED physician to coordinate appropriate Hospice admission

Mortality rate among acute care inpatient encounters

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PREVENTABLE HARM EVENTS

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Scorecard Summary
AHRQ Patient Safety Indicators

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Patient Safety > AHRQ Patient Safety Indicators_PSI					
—	PSI 02 (v2019) Death in Low-mortality DRGs - Per 1000 ACA (M)	0.00	0.21		Jun 2020
—	PSI 03 (v2019) Pressure Ulcer - Per 1000 ACA (M)	0.00	0.51		Jun 2020
—	PSI 04 (v2019) Death in Surgical IP w/Ser Comp, Overall - Per 1000 ACA (M)	0.00	146.36		Mar 2020
—	PSI 05 (v2019) Retained Surgical Item/Device Fragment - Per 1000 ACA (M)	0.00	0.00		Jun 2020
—	PSI 06 (v2019) Iatrogenic Pneumothorax - Per 1000 ACA (M)	0.00	0.21		Jun 2020
—	PSI 07 (v2019) Central Venous Catheter-related BSI - Per 1000 ACA (M)	0.00	0.12		Jun 2020
—	PSI 08 (v2019) In Hospital Fall with Hip Fracture - Per 1000 ACA (M)	0.00	0.08		Jun 2020
—	PSI 09 (v2019) Perioperative Hemorrhage or Hematoma - Per 1000 ACA (M)	0.00	2.29		Jun 2020
—	PSI 10 (v2019) Postop Acute Kidney Injury Requiring Dialysis - Per 1000 ACA (M)	0.00	0.73		Jun 2020
—	PSI 11 (v2019) Postoperative Respiratory Failure - Per 1000 ACA (M)	0.00	5.53		Jun 2020
—	PSI 12 (v2019) Perioperative Pulmonary Embolism or DVT - Per 1000 ACA (M)	0.00	3.45		Jun 2020
—	PSI 13 (v2019) Postoperative Sepsis - Per 1000 ACA (M)	0.00	4.05		Jun 2020
—	PSI 14 (v2019) Postoperative Wound Dehiscence - Per 1000 ACA (M)	0.00	0.69		Jun 2020
—	PSI 15 (v2019) Accidental Puncture or Laceration - Per 1000 ACA (M)	0.00	1.06		Jun 2020
—	PSI 90 (v2019) Midas Patient Safety Indicators Composite, ACA (M)	0.00	1.00		Jun 2020

The Patient Safety Indicators (PSIs) provide information on potentially avoidable safety events that represent opportunities for improvement in the delivery of care.

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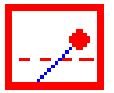
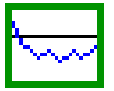
Scorecard Summary
Patient Falls
Preventable Harm

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Patient Safety > Falls					
	RM ACUTE FALL- NO INJURY (M) per 1000 patient days	8.40	3.75		Jun 2020
	RM ACUTE FALL- WITH INJURY (M) per 1000 patient days	0.00	3.75		Jun 2020
	Falls with injury % of all Acute falls |M|	0.0%	0.0%		Jun 2020

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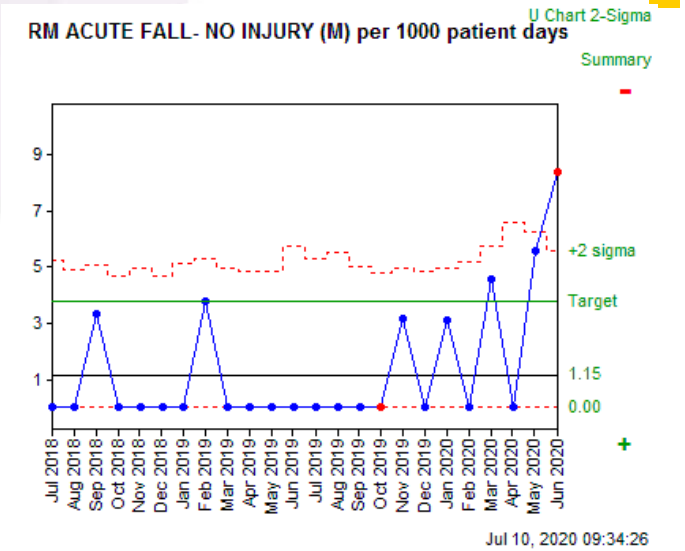
Acute Fall Rate

Period	C-RM Event: Fall-NO Injury: Acute only (numerator)	S-FS-SVH ADJUSTED PATIENT DAYS: Acute	Rate
Jun 2020	2	238	8.40
May 2020	1	179	5.59
Apr 2020	0	156	0.00
Mar 2020	1	218	4.59
Feb 2020	0	286	0.00
Jan 2020	1	321	3.12
Dec 2019	0	336	0.00
Nov 2019	1	319	3.13
Oct 2019	0	351	0.00
Sep 2019	0	312	0.00
Aug 2019	0	240	0.00
Jul 2019	0	269	0.00



- Case Review
  - June 2020
  - Two falls
    - Toileting, call light, pain medication
    - Physical therapy

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MEDICATION EVENTS

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Scorecard Summary
Adverse Drug Events

Quality > Pharmacy > Adverse Drug Events					
▲	Rx-ADEs-Administration Errors Per 10,000 Doses	1.19	1.00		May 2020
▼	Rx-ADEs-High Risk Med Errors Per 10,000 Doses	0.24	1.13		May 2020
—	Rx-Adverse Drug Reactions	4	n/a		Q1-2020
—	Rx-Adverse Drug Reactions-Antibiotics	25%	n/a		Q1-2020
▲	Rx-Adverse Drug Reactions-Anticoagulants	25%	n/a		Q1-2020
—	Rx-Adverse Drug Reactions-Cardiovascular	25%	n/a		Jan 2020

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CORE MEASURES

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Scorecard Summary
Core Measures

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Core Measures					
▼	Core OP-18b - Median Time ED Arrival to ED Departure - Reporting Measure (M)	129.50	140.00		Jun 2020
–	Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)	100.0%	72.0%		Jun 2020
Quality > Core Measures > HOP Measures > HOP Colonoscpy					
▲	Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M)	75.0%	89.0%		Mar 2020
Quality > Core Measures > Sepsis					
▲	SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock (M)	71.4%	81.0%		Jun 2020
▲	SEPa - Severe Sepsis 3 Hour Bundle (M)	85.7%	94.0%		Jun 2020
▲	SEPb - Severe Sepsis 6 Hour Bundle (M)	100.0%	100.0%		Jun 2020
▼	SEPc - Septic Shock 3 Hour Bundle (M)	83.3%	100.0%		Jun 2020
–	SEPd - Septic Shock 6 Hour Bundle (M)	100.0%	100.0%		Jun 2020
–	SEP1aa - severe sepsis - initial lactate management (as of 1/20) (M)	100.0%	94.0%		Jun 2020
▼	SEP1ab - severe sepsis - broad spectrum antibiotic (as of 1/20) (M)	85.7%	94.0%		Jun 2020
▲	SEP1ac - severe sepsis - blood culture collection (as of 1/20) (M)	100.0%	100.0%		Jun 2020
▲	SEP1b - severe sepsis - repeat lactate level measurement (as of 1/20) (M)	100.0%	100.0%		Jun 2020
▼	SEP1c - septic shock - resuscitation w/ crystalloid fluids (as of 1/20) (M)	83.3%	100.0%		Jun 2020
–	SEP1da - septic shock - vasopressors (as of 1/20) (M)	100.0%	100.0%		Jun 2020
–	SEP1db - septic shock - repeat volume status/tissue perfusion assess (as of 1/20) (M)	100.0%	100.0%		Jun 2020

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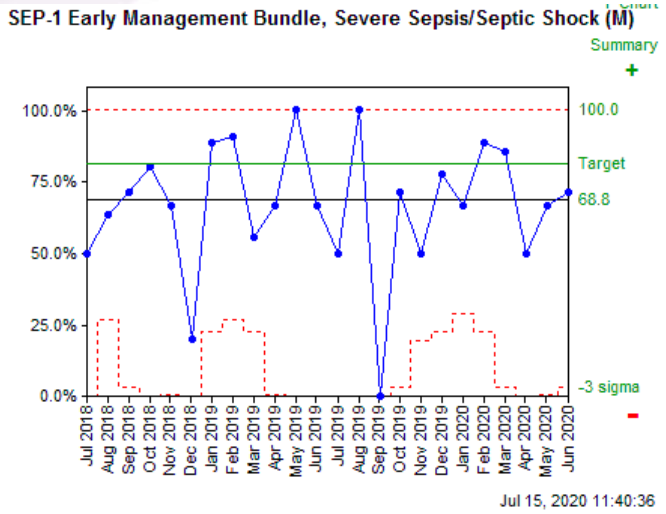
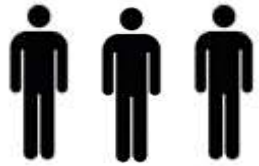
Sepsis Core Measure

Period	Numerator	Denominator	Percent
Jun 2020	5	7	71.4%
May 2020	4	6	66.7%
Apr 2020	1	2	50.0%
Mar 2020	6	7	85.7%
Feb 2020	8	9	88.9%
Jan 2020	8	12	66.7%
Dec 2019	7	9	77.8%
Nov 2019	4	8	50.0%
Oct 2019	5	7	71.4%
Sep 2019	0	3	0.0%
Aug 2019	1	1	100.0%
Jul 2019	2	4	50.0%



- Case Review
  - June 2020
  - 3 fallouts



    - Target volume of fluids not administered, sepsis order set not used by ED physician. Rule out COVID
    - Monotherapy antibiotics not administered within three hours, sepsis order set not used by ED physician
    - Target volume of fluids not administered by ED RN within three hours

This measure focuses on patients with a diagnosis of severe sepsis or septic shock. Consistent with Surviving Sepsis campaign guidelines, it assesses measurement of lactate, obtaining blood cultures, administering broad spectrum antibiotics, fluid resuscitation, vasopressor administration, reassessment of volume status and tissue perfusion, and repeat lactate measurement. As reflected in the data elements and their definitions, the first three interventions should occur within 3 hours of presentation of severe sepsis, while the remaining interventions are expected to occur within 6 hours of presentation of septic shock.

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READMISSION

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Scorecard Summary
Readmissions

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Readmissions					
● ▼	30-DV Inpatients - % Readmit to Acute Care within 30 Days (M)	4.8%	15.3%		Jun 2020
● –	COPD, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0.0%	19.5%		Jun 2020
● –	HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0.0%	21.6%		Jun 2020
● ▲	Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	25.0%	4.0%		Jun 2020
● –	PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0%	17%		Jun 2020
● ▼	Sepsis, Severe - % Readmit within 30 Days (M)	0.0%	12.0%		Jun 2020
● ▼	Septic Shock - % Readmit within 30 Days (M)	0.0%	13.3%		Jun 2020

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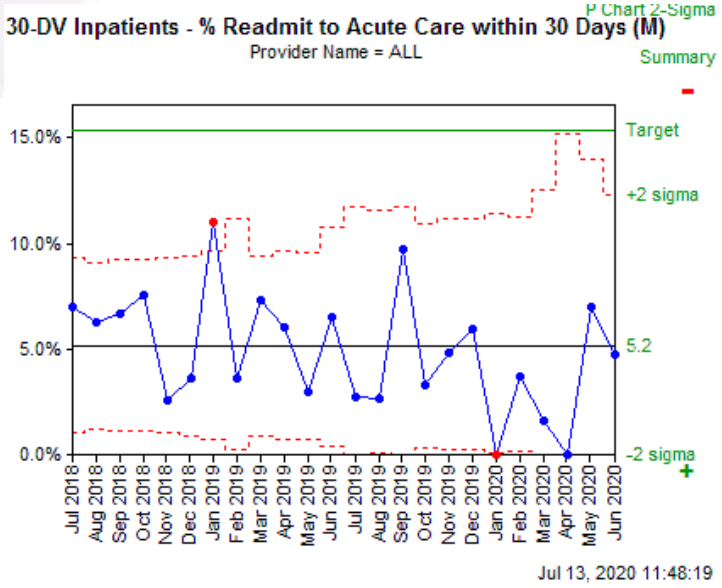
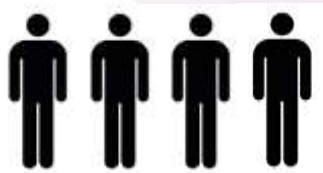
All Cause Readmission Rate

Period	CDB919 - Inpatients - % Readmit to Acute Care within 30 Days (numerator)	CDB919 - Inpatients - % Readmit to Acute Care within 30 Days (denominator)	Percent
Jun 2020	3	63	4.8%
May 2020	3	43	7.0%
Apr 2020	0	37	0.0%
Mar 2020	1	60	1.7%
Feb 2020	3	80	3.8%
Jan 2020	0	78	0.0%
Dec 2019	5	84	6.0%
Nov 2019	4	83	4.8%
Oct 2019	3	90	3.3%
Sep 2019	7	72	9.7%
Aug 2019	2	75	2.7%
Jul 2019	2	72	2.8%



- Case Review
  - June 2020
  - Four readmissions
    - Retained foreign body
    - Substance use disorder, noncompliant, benefit from palliative care consult
    - Inability to pay for medications, inadequate discharge plan, Home Health and primary physician follow up delays
    - Complicated cholecystitis, GI bleed, cholecystostomy drain, scheduled cholecystectomy in 2 months



Percentage of encounters for which the patient was readmitted to the same facility within 30 days among all inpatient encounters

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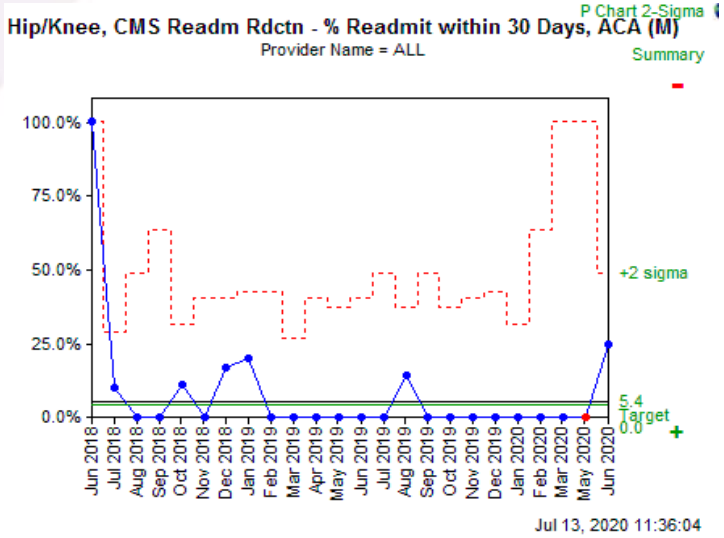
Hip & Knee Readmission Rate

Period	CDB1735 - Hip/Knee Arthroplasty, Total, CMS - % Readmit w/in 30 Days, Same Server, ACA (numerator)	CDB1735 - Hip/Knee Arthroplasty, Total, CMS - % Readmit w/in 30 Days, Same Server, ACA (denominator)	Percent
Jun 2020	1	4	25.0%
May 2020	0	1	0.0%
Mar 2020	0	1	0.0%
Feb 2020	0	3	0.0%
Jan 2020	0	9	0.0%
Dec 2019	0	5	0.0%
Nov 2019	0	6	0.0%
Oct 2019	0	7	0.0%
Sep 2019	0	4	0.0%
Aug 2019	1	7	14.3%
Jul 2019	0	4	0.0%



- Case Review
  - June 2020
  - One readmission
    - Retained foreign body

Percentage of encounters with an unplanned readmission to any facility on the same server within 30 days among adult acute care inpatient encounters with a principal discharge procedure of total hip arthroplasty or total knee arthroplasty

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INFECTION PREVENTION

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Q1 2020 Infection Prevention

Infection Prevention Report: 1st Q 2020

Indicator	Comparison Rates: 2014-2019	Q1 2020	Benchmarks/Actions/Comments
Quarterly reporting of National Healthcare Safety Network (NHSN) indicator data is required by CDPH. NHSN provides the predicted number of HAIs based on standardized infection rations (SIRS). ** Indicates public reporting on CDPH website. Green indicates no action indicated, yellow indicates above the predicted number of infections, red indicates action is recommended to reduce infections.			
"CLABSI (NHSN) (CMS Never Event) *# Central Line Associated Bloodstream Infections (CLABSI)/1000 central line days*	0 since 2011	0	NHSN predicts SIR 0.51
"CDI (NHSN) *#Inpatient Hospital Acquired infections due to C. difficile per 10,000 patient days*	7.2 /12/15/ 21.7/7.5/9.9	0	
"MRSA Bloodstream Infections (NHSN) *#bloodstream infections due to MRSA per 1000 pt days*	0 since 2014	0	CDPH predicts SIR 0.5.
"VRE Bloodstream Infections (NHSN) *#Hospital Acquired bloodstream infections due to VRE per 1000 pt. days*	0 x 7 yrs	0	CDPH has no SIR for VRE.
"Hip: Deep or Organ Space Surgical Site Infections (NHSN) *# infections/ # Total Hip Cases x 100*	1.8% / 0 /1.6 / 0 /0	0	
"Knee: Deep or Organ/Space Surgical Site Infections (NHSN) *# infections/ # Total Knee Cases x 100*	1.7% / 2/ 1.4% 1.3%/3.5/ 0	0	
"Overall Surgical Site Infections (SSI) *Total # SSI/Total # surgeries x 100*	0.2%/0.7% (12)/ 0.5% (8)/ 0.4% (8)/ 0.4% (9)	0.3%	
Class I SSI rate	<1% x 5 yrs	1	1001366573 trauma but not open, soft tissue infection.Came back post ORIF for I&D/
Class II SSI rate	< 1.3% x 5 yrs	0	
Total Joint SSI rate	0 / 0.8%/1.9%/1.4%/1.4%	0	No NHSN All Total Joint SSI rate Benchmark. 0.68%-1.6% expected SSI rate for total knee (CDC 2009)
Post discharge surveillance surgeon compliance	90% 0r greater x3 years		2014 Surgery Committee approved SSI reporting by surgeons monthly, to promote accurate SSI rates.
Hand Hygiene Compliance *hand hygiene observations: # opportunities/# hand hygiene procedure observed*	greater than	100%	>90% Surveillance was only done when IC was present. Did not have "secret shoppers" this quarter due to COVID and flexing of staff due to census.
"Ventilator Associated Event (VAE) *# Ventilator Associated Pneumonias or events/ # vent days x 1000*	0 for 4 yrs/41.5% in 2019	0	NHSN Benchmark: 1.1 per 1,000 ventilator days.
"Hospital Acquired Pneumonia (HAP) *# hospital acquired pneumonia/# pt days x 1000 pt days*	0.5/0.5/1.6/ 0.7/1.2	2.6	Benchmark 1.2 cases per 1,000 pt days. HAPPI project implemented 2018 with prevention triggers in EMR and staff education. 1001365641 Patient with multiple comorbidities, COPD and ARF. High risk for HAI.
"Inpatient Hospital Acquired Catheter Associated Urinary Tract Infections (CA-UTI) (CMS Never Event) *# inpatient CAUTI/# catheter days x 1000*	0 / 1.7 1.4/1.6/0.85/4.6	0	NHSN predicts 1.04 CAUTIs per year.
MRSA Active Surveillance Cultures (nares cultures only) *# positives/total screened x 100*	14%, 20%, 26% 9.2%/5.8%	8.8% 6/68	Nares surveillance performed in accordance with California law.
% ESBL (E. coli;K. pneumoniae, K. oxytoca, P. mirabilis)	2% /3%/4.2%/4.1%	5%	ASP monitors antibiogram and updates annually. Note: ESBL in CA reported by MedMined to be 0.8-1.5 per 1000 pt days. 1Q 2020 there were 12 isolates.
# CRE cases	0/0/0/1/2	0.81%	1001357660 Admitting Dx. Pyelonephritis

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UTILIZATION MANAGEMENT

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Utilization Management

Status	Indicator	Current Value	Target	SPC Alert	Updated
Finance > Utillization Management					
▲	1 Day Stay Rate-Medicare |M|	11.11%	8.10%		Jun 2020
–	1 Day Stay Rate Medi-Cal |M|	0.00%	2.61%		Jun 2020
▼	Acute Care Risk-adjusted Average Length of Stay O/E Ratio |M|	0.85	0.79		Jun 2020
–	InterQual Criteria Status Not Met: Admission |M|vol	0	2		Jun 2020
–	InterQual Criteria Status Not Met: Continued Stay |M| vol	0	0		Jun 2020

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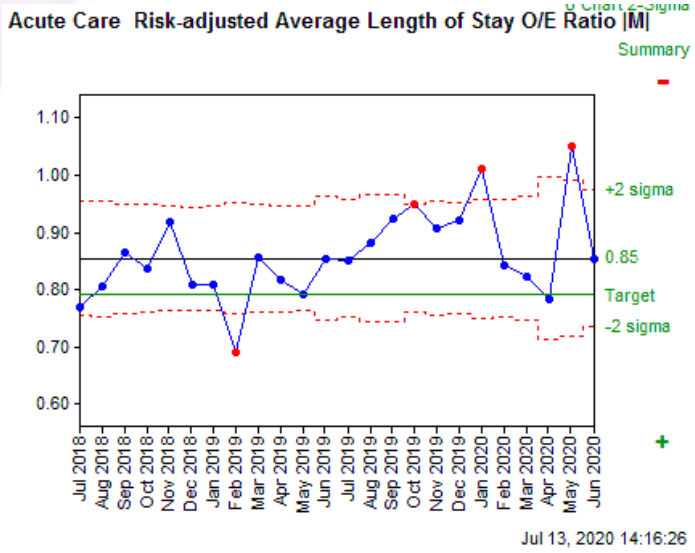
Acute Care Risk Adjusted Length of Stay

Period	Observed Days (num)	Expected Days (den)	Rate
Jun 2020	205	240	0.85
May 2020	190	181	1.05
Apr 2020	132	168	0.78
Mar 2020	244	297	0.82
Feb 2020	270	321	0.84
Jan 2020	320	317	1.01
Dec 2019	328	356	0.92
Nov 2019	310	342	0.91
Oct 2019	364	383	0.95
Sep 2019	258	279	0.92
Aug 2019	246	279	0.88
Jul 2019	271	319	0.85



- Case Review
  - June 2020
  - 23 our of 63 encounters had a greater observed than expected length of stay
    - Substance use disorder
    - Homeless/Placement issues
    - Unsafe discharge (SVH received admin days from Partnership)
    - Readmissions

Comparison of observed to expected length of stay among acute care inpatient encounters as calculated by the Midas Risk Adjustment Model for all Clinical Clusters

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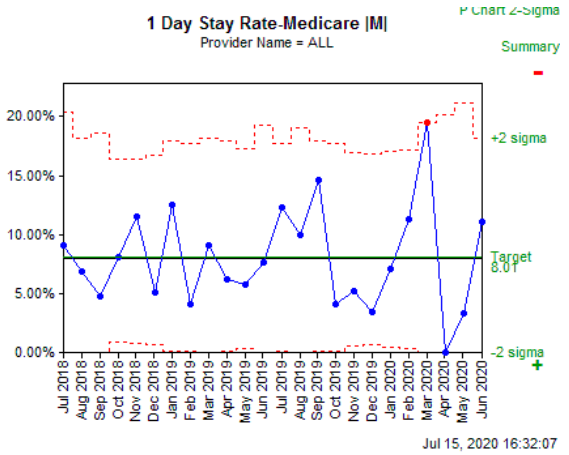
One-Day Stay Medicare

Period	R-ENC-1 Day Stay Medicare rate (numerator)	R-ENC-1 Day Stay Medicare rate (denominator)	Percent
Jun 2020	5	45	11.11%
May 2020	1	30	3.33%
Apr 2020	0	34	0.00%
Mar 2020	7	36	19.44%
Feb 2020	6	53	11.32%
Jan 2020	4	56	7.14%
Dec 2019	2	58	3.45%
Nov 2019	3	57	5.26%
Oct 2019	2	49	4.08%
Sep 2019	7	48	14.58%
Aug 2019	4	40	10.00%
Jul 2019	6	49	12.24%



- Case Review
  - June 2020
  - 5 encounters
    - Hospice
    - Higher level of care
    - 2 patients who rapidly improved
    - 1 fallout-physician documentation indicated observation status and Interqual supported inpatient status
      - Risk for denial and audit

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HUMAN EXPERIENCE

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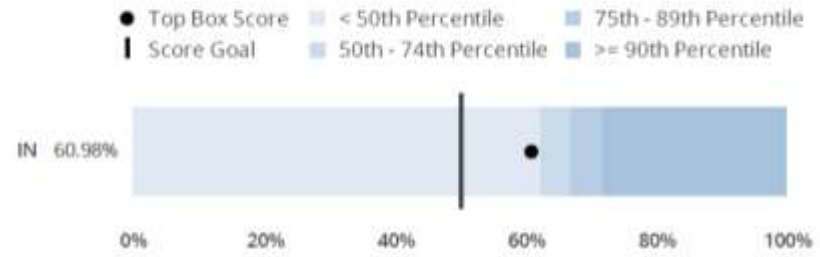
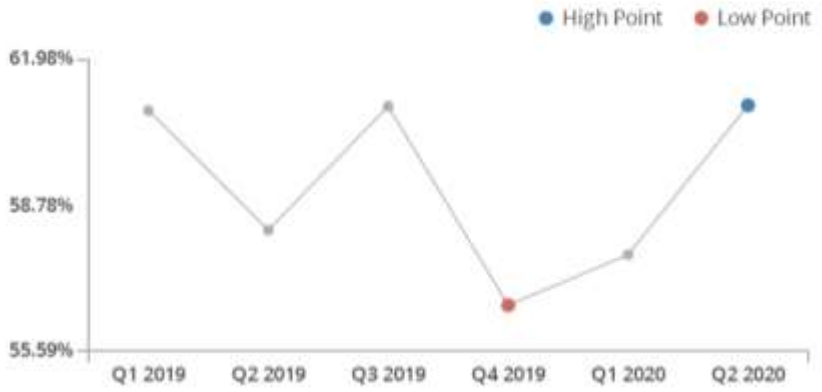
Inpatient Patient Satisfaction

Service Line Performance

PG Overall





n	34
Top Box Score	60.98%
Score Goal	50.00%
Percentile Rank	43

Time Period	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020
n	29	46	42	41	56	34
Top Box Score	60.86%	58.24%	60.95%	56.59%	57.70%	60.98%
Percentile Rank	35	21	33	17	26	43

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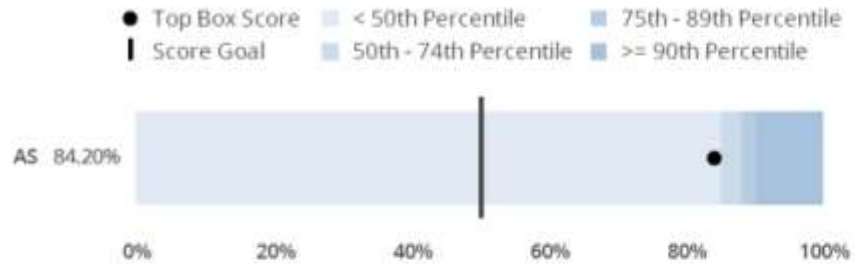
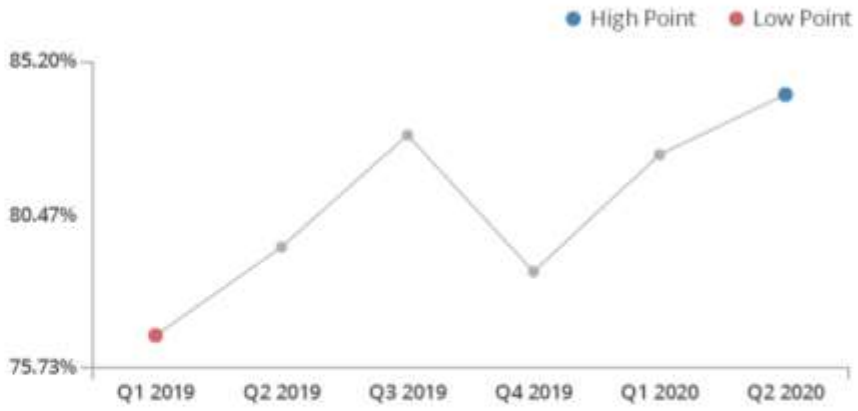
Surgery Patient Satisfaction

Service Line Performance

PG Overall





n	54
Top Box Score	84.20%
Score Goal	50.00%
Percentile Rank	42

Time Period	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020
n	89	198	162	112	127	54
Top Box Score	76.73%	79.47%	82.94%	78.71%	82.33%	84.20%
Percentile Rank	7	14	34	11	25	42

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Rate My Hospital

WEEKLY RATE MY HOSPITAL SCORES AND COMMENTS

Week ending July 10, 2020

Overall score: **4.72**

1191 surveys sent since June 8, 2020.

283 responded (23.8%)

1173 total service recoveries since inception

Average department scores:

ED	4.52
OP Surg	4.78
OP PT	4.89
INPT Care	4.89
Imaging	4.85
Cardiopulm	4.89

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Patient Care Services Dashboard 2019

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Medication Scanning Rate	2019-2020				
	Q3	Q4	Q1	Q2	Goal
Acute	94.0%	91.4%	N/A	N/A	≥90%
ED	90.6%	90.0%	N/A	N/A	≥90%
Preventable med errors R/T Med Scanning	2 (n=12)	2 (n=7)	4 (n=22)	1 (n=9)	≤2

Falls (Per 1000 days) 2019-2020					
	Q3-Q2	Q4-Q3	Q1-Q4	Q2-Q1	50th %tile
Acute	1.50	1.10	1.50	2.30	3.75
ED	0.4	0.1	0.0	0.0	

Hospital Acquired Pressure Ulcer Incidents (Per 1000 admissions)	2019-2020				
	Q3	Q4	Q1	Q2	National
Acute (stage III & IV)	0.0	0.0	4.5*	0.0	3.68
* 1 pt out of 222					

Nursing Turnover	2019-2020 RNs/Quarter				
# of RNs	Q3	Q4	Q1	Q2	Goal
Acute (n=52)	3	0	0	0	≤6

Patient Experience (CAHPS)	2019-2020				
	Q2	Q3	Q1	Q2	Goal
HCAHPS (rolling 12 month)					
Would Recommend	72	72	71	71.4	70.0
Quietness of Hosp Environment	61.3	38	59	62.3	51.0
OASCAHPS (rolling 12 month)					
Care of Patients (MD/RN respect)	97.5	97.9	97.9	97.9	97.1
Would Recommend	83.5	83.5	83.7	87.5	88.6
RATE MY HOSPITAL - ED	Q3	Q4	Q1	Q2	
Overall score	4.7	4.5	4.7	4.7	≥4.5
RATE MY HOSPTIAL-INPATIENT	Q3	Q4	Q1	Q2	
How Do You Feel About Your Stay?	N/A	4.3	4.6	4.9	≥4.5

Nurse Staffing Effectiveness: Transfers r/t staffing/beds					
2019	Q3	Q4	Q1	Q2	Goal
	0	1	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

1. Proparacaine ordered by tetracaine overrode from Pyxis and given 2. Seroquel XR overrode from Pyxis when order already active for Seroquel plain, dose given 3. Senna removed on override from Pyxis when order already active for Senna w/ docusate. Dose given 4. Xopenex neb removed on override from Pyxis by RT and given when albuterol neb ordered