SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, NOVEMBER 18, 2020

5:00 p.m. Regular Session

TO BE HELD VIA ZOOM VIDEOCONFERENCE

To Participate Via Zoom Videoconferencing
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https://zoom.us/j/98792080549?pwd=VjIzS3lYM01rTGVwNm1EeVQ2MWhTUT09

and enter the Meeting ID: 987 9208 0549
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Passcode: 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 09.23.20	*Hirsch*	Action
4. INTRODUCE NEW INFECTION PREVENTIONIST	*Jones/Heinrich*	Inform
5. QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PROGRAM REVIEW 2019	*Jones*	Inform
6. COVID-19 UPDATE	*Kidd*	Inform
7. ADJOURN	*Hirsch*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
September 23, 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 via Zoom	Howard Eisenstark, MD via Zoom Michael Mainardi, MD via Zoom Andrew Solomon, MD via Zoom	Carol Snyder	Sabrina Kidd, MD, CMO, via Zoom Danielle Jones, RN, CQO via Zoom Mark Kobe, CNO, via Zoom Dr. Judith Bjorndahl via Zoom Janine Clark, Perioperative Services Manager, via Zoom

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Called to order at 5:05 p.m.	
2. PUBLIC COMMENT ON CLOSED SESSION		
	None	
3. CLOSED SESSION: a. Calif. Government Code §54956.9(d)(2): Discussion Regarding Significant Exposure to Litigation (One Case) b. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report		
4. REPORT ON CLOSED SESSION		
	A discussion was held regarding one item of significant exposure to litigation. No action was taken. Medical Staff credentialing was reviewed.	**MOTION:** by Mainardi to approve credentialing, 2nd by Eisenstark, all in favor.
5. PUBLIC COMMENT	*Hirsch*	
	None	
6. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 08.26.20		**MOTION:** by Eisenstark to approve, 2nd by Idell. All in favor.

AGENDA ITEM	DISCUSSION	ACTION
4. SVH QUALITY INDICATOR PERFORMANCE AND PLAN	*Jones*	Inform
	Ms. Jones reviewed quality indicator performance and utilization management metrics for the month of August.	New Infection Preventionist to join either Oct. or Nov. meeting.
5. POLICIES AND PROCEDURES	*Jones*	Inform
	Policies Reviewed Human Resources: Bulletin Boards Compensatory Time Dress Code Leaves – Medical & Family Care (FMLA & CFRA) Orientation Period Required Certifications Tuberculosis Screening Governance and Leadership Policies: Code of Conduct Medication Management Policies: Piperacitin-Tazobactam Extended Infusion Dosing Remote Pharmacist Services Temperature Monitoring of Medication Storage Vaccine Screening-Pneumococcal and Influenza Vancomycin Protocol	**MOTION:** to approve by Mainardi, 2nd by Eisenstark. All in favor.
7. COVID-19 UPDATE	*Kidd*	Inform
	Dr. Kidd said things were much quieter in September than August as far as COVID patients. Sonoma wide the last week has seen a decline in hospitalizations. Nationwide we are beginning to see signs of a fall surge, especially in the Midwest. Los Angeles County has seen a rebound after Labor Day. Colleges and universities have also seen increased numbers. SVH is attempting to stockpile PPE and putting all surge plans into writing. The Hospital has in-house PCR testing with limited supplies so far (not enough to open to the community). Survival rates are increasing compared to last spring. Hospital stays for COVID patients vary widely from 0 to 30 days.	
9. ADJOURN	*Hirsch*	
	6:09 pm	

Quality Assurance/Performance Improvement
Program Review 2019

Purpose

The Quality Department, in cooperation with the Medical Staff Performance Improvement Committee and Administrative Leadership, has completed an appraisal of the Performance Improvement Program.

The purpose of this appraisal is to:

- Evaluate the comprehensiveness and scope of the program.
- Assess the effectiveness of the FOCUS / PDSA model.
- Measure the extent of interdisciplinary collaboration.
- Assure that all key functions and dimensions of performance have been addressed.
- Provide the Governance, Administration and Medical Staff leaders with the results of prior year activities to assist in development of priorities for improvement.
- Determine the extent to which the Performance Improvement Program supported the mission and vision.

Scope and Applicability

This is an organization-wide program. It applies to all settings of care and services provided by Sonoma Valley Hospital.

Quality Assurance Performance Improvement (QAPI) Purpose Statement
The purpose of QAPI at Sonoma Valley Hospital is to take a proactive approach to continually improving the way we care for and engage with our patients, physicians and employees and other partners so that we may realize our vision to be a trusted resource for compassionate, exceptional care. To do this, all employees will participate in ongoing QAPI efforts which support our mission by continually working to restore, maintain and improve the health of everyone in our community.

QAPI Guiding Principles

1. Sonoma Valley Hospital uses quality assurance and performance improvement to make decisions and guide our day-to-day operations.
2. In Sonoma Valley Hospital, QAPI includes all employees, all departments and all services provided.
3. QAPI focuses on systems and processes. The emphasis is on identifying system gaps rather than on blaming individuals.

Findings

The Leaders devoted 2019 to developing their quality assurance performance improvement projects into professional posters that could be presented at conferences. Poster presentations are excellent opportunity that showcase our work in a very concise overview of a topic that is easily understood by community members.

Each department identified the complexity of workflow processes and opportunities to improve based on a prioritization process that included considerations of high risk, high and low volume activities and areas that are problem prone.

Leaders have improved in their workflow process, analysis, and the identification of potential performance improvement activities by including their departmental staff in the development of QAPI plans.

The Quality Department identified that Sonoma Valley Hospital leadership team has an opportunity to expand performance improvement beyond regulatory or compliance concerns and move towards topics that are proactive in increasing safety, efficiency and patient experience.

The Administrative Team performed a formal organization-wide Performance Improvement Project prioritization process and continued the 100-Day Workout productivity cycle. The goal of this process is to achieve efficient gains through rapid cycle Plan, Do, Study, Act in hospital performance while sustaining productivity and patient safety.

In 2019 Sonoma Valley Hospital undertook multiple performance improvement projects with representatives from each department; both clinical and non-clinical. These projects were aligned with Sonoma Valley Hospital Strategic Priorities 2019-2021 which outlined five priorities:

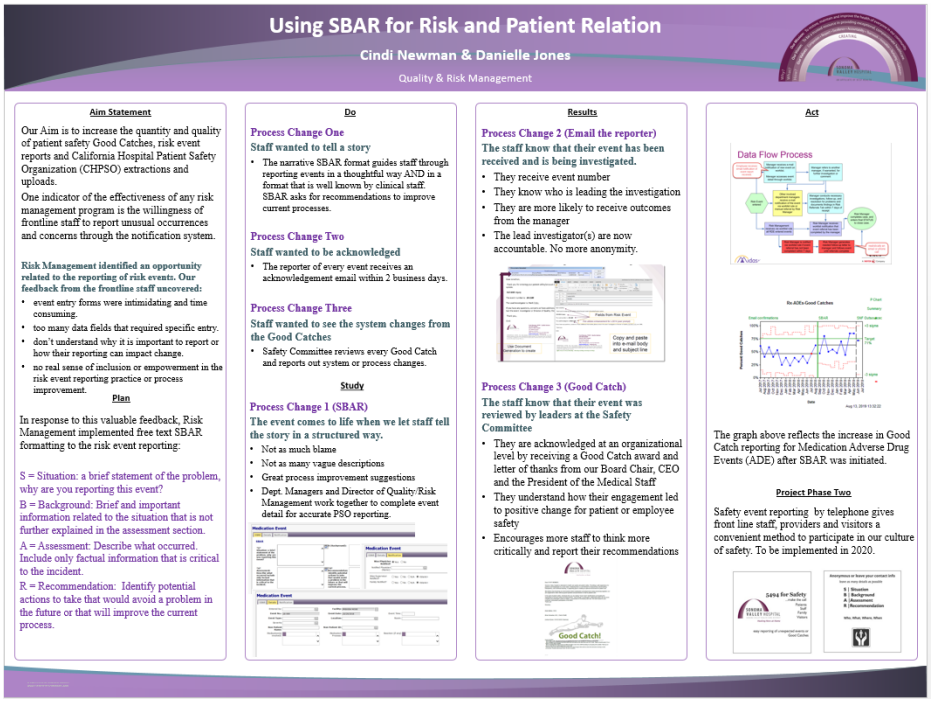
1. Achieve the highest levels of health care safety, quality and value
2. Be the preferred hospital for patients, physicians, employers and health plans
3. Implement new and enhanced revenue strategies and services
4. Continue to improve financial stability
5. Lead progress toward being a healthier community

Sonoma Valley Hospital's focus on quality care, patient safety and improved efficiencies was featured during our Performance Improvement Showcase in February 2019 where the community was invited to attend a self-guided tour of the posters and hospital.

The Performance Improvement Showcase, now in its fifth year, was organized by the Hospital's Quality Department and the Sonoma Valley Health Care District's Quality Committee to recognize initiatives developed by hospital staff, departments, and multidisciplinary teams that have identified opportunities for improving the Hospital's patient care, safety, and performance.
The 2019 Performance Improvement Showcase highlights nine projects. All teams followed the Plan-Do-Study-Act (PDSA) process promoted by the Institute for Healthcare Improvement. PDSA is a

powerful and reliable tool of change in the healthcare environment to improve processes and outcomes. Sonoma Valley Hospital has been utilizing the PDSA protocol method since 2011.

Performance Improvement projects are designed to support innovative approaches that get results, whether by enhancing patient care and safety, or streamlining operations for maximum effectiveness and potential reduced cost savings.



Aim Statement: To increase the quantity and quality of patient safety Good Catches, risk event reports and California Hospital Patient Safety Organization (CHPSO) extractions and uploads.

Broadcast & Notification System

Fe Sendaydiego, Lynn McKissock, Celia Kruse de la Rosa, Veronica Loza

Information Systems, Human Resources, Community Outreach, Mammography

Introduction SMART goal

During the North Bay Fires of 2017, we realized we did not have a system in place to contact all hospital staff with important information pertaining to the condition of the hospital and/or staffing needs (similar to the county-wide Nixle system). Simultaneously, we saw an opportunity to improve our appointment reminder process utilizing available technology to remind patients of their appointments via text, email and/or phone call.

GOAL: Implementation of a notification system capable of various methods of reaching both staff and patients with important communication before the end of the 2019 calendar year.

Plan

Upon identification of a system that meets our needs, we will run a pilot with a small group first, and upon success will expand use for other purposes.

One Call Now

Do

Identified One Call Now as the cost-effective system that met our needs.

Selected Mammography as the pilot program for appointment reminders. Working with the scheduler, created a report to capture appointments by patient within the scheduling system. Implemented a process to import the electronic report into the One Call Now system and began testing the various contact methods. After a week of successful testing, the appointment reminder portion of the system was activated.

After a successful pilot program, we began research and testing for employee notifications. Again, utilizing a small group for piloting, we tested various rounds of notifications and developed training materials for employees to follow for self-enrollment. After three weeks of successful testing, we introduced the new notification system to all employees in October, 2019.

As each employee enrolls, we assign them to a "sub-group" for targeted message distribution. The primary sub-groups include All Staff, Leadership, Administrative Team, and Emergency Preparedness Team. We also created a couple of additional distribution groups for community organizations and specific departments within this hospital.

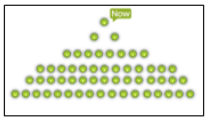
Study

Appointment Reminders: Within the pilot group we observed that there did seem to be a reduction in "no shows" for appointments and an increase in patients calling in to reschedule appointments they were no longer able to meet. We believe the appointment reminders prompted the individuals to reschedule, rather than just not showing.

Employee Notifications: While some employees reported enthusiasm for having such a system in place and found the self-enrollment instructions very easy to follow, there remains a majority of staff that have not yet registered (as of November 2019, only 16% of our total population have registered).

Upon further research, we learned that some employees have concerns of getting inundated with messages on their personal phones – particularly messages that are not emergency-related. Additional feedback also included responses indicating a lack of urgency in the need of signing up – it appeared to be presented more as an option, if desired.

So, while we met our implementation goal, we have yet to reach our goal of having all staff enrolled.



Act

Appointment Reminders: With the pilot program being successful, we feel ready to expand this functionality to additional departments, such as Patient Access. We will target this to begin after the first of the new year.

Employee Notifications: We see an opportunity to further promote and better communicate the importance of this notification tool. We will enhance our communication to stress the emergency aspect and benefits of receiving notifications and alleviating the perception of message inundation.

Overall, we see this as an excellent additional method of reaching a greater population with important messages, alerts, and notifications that we should continue to grow.

Aim Statement: To implement a notification system capable of various methods of reaching both staff and patients with important communication.

Verigene®

Nicolaos Hadjiyanni CLS (MT-ASCP), Dawn Kuwahara RN BSN, and David Long CLS (MT-ASCP)

Laboratory

Introduction SMART goal

Background

Enteric diseases are infections caused by viruses and bacteria; primarily as a result of eating, drinking and digesting contaminated foods or liquids. Cholera, typhoid fever, salmonella and Escherichia coli, infections are some of the most common enteric diseases.

Stomach pain, diarrhea, nausea and vomiting are the typical side effects of enteric diseases. Diarrhea and nausea could cause severe dehydration. An enteric disease could last for days, weeks, months or even years, leading to constant malnutrition and poor absorption of medicines.

Plan

In an effort to identify Enteric Pathogen (EP) organisms faster, the Laboratory is recommending implementing a rapid direct detection system. This will allow us to identify these organisms and drug resistant markers in a 2 to 5 hour process instead of the traditional culture and sensitivity (C&S) process of 2 days (or more) resulting in faster patient treatment and improved outcomes.

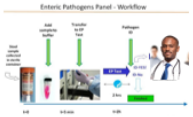
Traditional C&S Process:

Rapid detection and molecular technology is found to be the standard of practice in most hospitals. It enables physicians to make decisions about timely, targeted therapy.

Do

Contacting various molecular testing vendors, SVH Laboratory choose and contracted with Verigene® to implement their system. The contract was signed in August 2018, the equipment was delivered a month later. A "go live" date targeted for Nov. 5, 2018 for Enteric Pathogens.

Propose Verigene® Molecular Process:



The testing process with Verigene® takes about 2 hours with positive genera identification. With this faster testing time should result in faster patient treatment and improved outcomes. There are possible net revenue gains of $5-6,000.00 due to shorten length of stay, pharmaceutical costs, and lower testing costs.

To execute the project, the laboratory did the following to meet regulatory requirements for new tests.

- Validation of instrument
- Writing policy and procedures
- Staff Training
- Proficiency and parallel testing
- Communication with Physicians & Pharmacy

Progress will be measured by monitoring patient outcomes, length of stay, and pharmaceutical costs

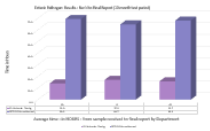
Study

What was observe?

As shown above, recovery rates for the bacterial culture method are low. Compared with the Verigene® that detects bacteria, viruses, and toxins recovery rates improved.

Comparing the recovery rate percentages:

Finally, results are available much sooner, within less than 1 day as compared with traditional stool diagnostics that require an incubation time of 3-4 days.



Act

The Laboratory found that since implementation of molecular testing for Enteric Pathogens that the recovery rate of the causative organism did increase as well as the turn-around-time (TAT) did decreased as expected.

At this time the lab is unable to determine cost savings by length-of-stay or pharmacology improvement due to the low number of positive patients. Further review will be needed to verify those parameters.

Additional training of staff should help in to decrease the TAT, especially with ED and In-patient areas.

Results

Results were as expected showing improved recovery rate and lower TATs.

2nd Phase

Verigene® offers additional molecular testing platforms for direct testing of blood cultures (recovery of gram positive and negative organisms) as well for *C difficile*. The lab will be adding this capability to their test menu. Additional staff training with emphasis on ED and In-patient specimens should even further reduce the TAT for those patients.

Acknowledgements:

Nicolaos Hidjiyanni, CLS Laboratory Manager; Dawn Kuwahara BSN, RN, Chief of Ancillary Services; Dan Ryan, CLS and Dennis Mangan CLS, for the man hours to implement, parallel study; to bring the methodology to SVH. David Long CLS, & Danielle Jones for design work

Aim Statement: To identify Enteric Pathogen organisms faster, the Laboratory is implementing a rapid direct detection system. This will allow us to identify these organisms and drug resistant markers in a 2 to 5 hour process instead of the traditional culture and sensitivity process of 2 days resulting in faster patient treatment and improved outcomes.

Respiratory Therapy Supply Reorganization

Ellen Shannahan, Kimberly Drummond, James Dugger & Jessica Winkler

Materials Management, Facilities, Respiratory Therapy, Medical/Surgical and ICU

Introduction SMART goal

RT Supplies were scattered in multiple locations and were not managed by one person. This lead to over stocking of supplies, expired product, and next-day shipping costs due to expired/lost supplies.

Specific: Eliminate expired product in RT's active inventory.

Measurable: 100% reduction of outdated products.

Achievable: With buy-in from all stakeholders.

Relevant: $885 worth of expired product located in RT supplies.

Time-Bound: 4-months

Plan

Create an automated process to reorder RT supplies, reduce supply locations, reduce supplies, gain buy-in from stakeholders, and improve supply management by eliminating hoarding.

Outcome: No expired product located in supplies.

Do

- Meet with key stakeholders.
- Identify supplies and locations
- Update Item Files in Paragon
- Update Min/Max levels for reordering
- Eliminate old locations
- Create Barcodes for scanning
- Stock high moving supplies in Materials to reduce supplies on floors (consolidation).
- Install new shelving units for supplies
- Label, barcode, and begin new system.

The work to setup this system took longer than anticipated because of preparatory work in Paragon database.

RT's input was vital to the success and identification of supplies to keep, to eliminate, and usage.

Study

Organizing the RT supplies created efficiency, improved workflow, eliminated waste, and improved patient care by allowing RT's to focus on patients rather than supplies.

- RT Supply locations have been reduced down to 2 nursing locations on the 3rd floor.
- Materials Management is now scanning RT supplies.
- Supply usage and flow is easier to track.
- Expirations not occurring
- Overnight shipping cost reduced.
- Supplies reduced for RT by 40%
  - **171 items down to 104**

Act

We now have a well established system for ordering and stocking RT supplies. Supply outdates are checked on a regular basis. Over ordering has been dramatically reduced. This system replenishes stock as needed in specified area that is easily maintained.

By engaging clinical staff, we were able to establish cost-saving habits, discourage hoarding, and empower providers by allowing them to focus on patient care rather than supplies.

Supply Area 1 - ICU

Supply Area 2 – Med/Surg

Aim Statement: To eliminate expired products from Respiratory Therapy's active inventory with 100% reduction of outdated products ensuring that the right tools are available at the right time.

RENOVO Clinical Engineering Program Renewal

Grigory Gatenian, Kimberly Drummond, Jessica Winkler, Janine Clark, Mark Kobe

Facilities, Surgery, Med/Surg, Emergency Department, Lab, Skilled Nursing Facility & Medical Offices

Introduction SMART goal

Background - In 2019, the hospital reinvented itself and refocused its services based on Community needs. The closure of OB and transferring the management of the Skilled Nursing and Home Health reduced the amount of clinical equipment in the hospital inventory.

The hospital also consolidated nursing services onto the 3rd Floor with ICU. Med/Surg, Respiratory Therapy, Physical Therapy; Case Management and Satellite Pharmacy departments were moved to the 3rd Floor from different locations in the hospital. With all clinical services located on the same floor it increased efficiency, improved communication and patient care coordination and allowed for a consolidation of clinical equipment.

These major changes coincided with the renewal of RENOVO Clinical Engineering contract. The RENOVO renewal was presented to the hospital at $235,133 and was based on previous full operations.

Goal - Reduce the cost of Clinical Engineering program and right size the inventory based on current operations in FY2020.

Plan

1. Reduce overall cost of the Clinical Engineering program
2. Reduce (right size) the clinical equipment inventory in each department.
3. Reduce on site presence of biomedical engineer based on reduced inventory.
4. Renegotiate biomed services contract with Renovo based on the new hospital structure.

Do

We worked with several department managers (Med/Surg, Emergency Department, Lab, Skilled Nursing Facility, Medical Offices) to review the inventory and determine which equipment can be removed due to reduced services. As a result, some of the equipment was completely removed from inventory, some was re-assigned to Plant Operations to maintain and some specialty equipment was replaced with equipment that could be maintained as routine Biomed equipment.

We worked with RENOVO to bid on 3 different Clinical Engineering platforms.

Full Clinical Engineering – Existing full service, scheduling & documentation program. After hours calls – Labor included.

Hybrid Clinical Engineering – Same as Full CE but SVH to maintain Beds/Gurneys, After hours calls and Time &Materials.

Biomed/Specialty Engineering w/documentation – Same as Hybrid – but SVH take over scheduling for Preventative Maintenance on Facility Direct Contract equipment (i.e. CT, MRI, etc.)

We met with our Financial Department to review contract options presented by RENOVO.

Full Clinical Engineering – $148,425.15

Hybrid Clinical Engineering – $129,954.35

Biomed/Specialty & data base documentation – $125,954.35

After extensive study of presented option details we selected **Hybrid Clinical Engineering** as it provided the best value with Renovo still retaining documentation of all Clinical Equipment included the beds/gurneys. Savings of **$105K annually** comparing to the original renewal proposal.

Study

We right sized the physical inventory of the equipment covered by the Renovo contract from 856 to 715 units.

We reduced the on-site presence of the Biomedical Engineer from 5 to 3.6 days per week on average.

Changing After hour call coverage to time & materials reduced the monthly premium and allows us to pay for the Biomed Engineers time as used.

Some equipment in the Specialty Equipment category was switched to time and materials based on the age of the equipment. Full-service coverage was no longer necessary as the equipment will be replaced if significant repairs (over 50% of its value) are required. By switching to time & materials, we achieved a significant price reduction for specialty equipment supported by Renovo.

The new contract was signed mid-July. We received a credit in August of 2019 as the previous contract pricing had been billed. The graph below illustrates the reduction in monthly payments after implementing the changes to the program.

Act/Next Steps

In the Hybrid Clinical Engineering program, Plant Operations is maintaining patient beds/gurneys, which were removed from Renovo contract. Renovo continues to document service in our Clinical Engineering database.

Some equipment from Skilled Nursing Facility, OB and the Home Care was completely removed from the inventory, some was re-assigned to other departments. Equipment that was not re-assigned is being evaluated for sale, donation or disposal based on its age and condition.

A monthly meeting has been established with Plant Operations, Biomed Engineer and Materials Management. The goals for this meeting are to monitor the inventory, review service contract needs for equipment that is maintained by the manufacturer, trending repairs on equipment and make replacement plans for equipment deemed end of life by the manufacturer.

Next steps – Review all service contracts for equipment that is being maintained by the Manufacturer. Determine overall spend for this equipment and evaluate areas to reduce costs.

Aim Statement: To reduce the cost of the Clinical Engineering program and right size the inventory based on current operations in FY2020.

MEDICATION ADMINISTRATION ELECTRONIC SCANNING

Mark Kobe, Jessica Winkler, Chris Kutza, Andrea O'Donnell

Emergency Department, Pharmacy, Information Systems, Nursing Informatics & Quality

Introduction SMART goal

By April 1, 2019 compliance to medication administration scanning by Emergency Department RNs will be 90% or greater.

Plan

Quarter 4 2018 medication administration scanning by Emergency Department RNs had fallen to 77% compliance. To improve performance we plan to:

1. Publish scanning compliance by RN in the Emergency Department
2. Re-validate compliance expectations with Emergency Department RNs
3. Solicit information from ED RNs as to obstacles/barriers to successful compliance to medication scanning.

Do

We published scanning compliance by RN in the Emergency Department and solicited perceived barriers to successful compliance from the RNs.

What did you observe? We immediately learned there were many barriers related to successful scanning of medications that were related to the pharmacy and information system protocols:

1. Monthly downtime protocols from IS lasting 5 hours where RN is unable to scan medications, but medications given during that time were counted against their compliance.
2. Immediately identified 4 medications that would never scan properly and Pharmacy unable to correct due to manufacturer: Tylenol, Solumedrol, Saline Flushes & 500 milliliter bags of Normal Saline.

Study

What did you learn?

1. Night pharmacy response times were frequently well beyond contract obligations (>10 minutes) causing Emergency Department RNs to override scanning in order to give meds for safe patient care
2. New hires in Emergency Department without adequate medication administration scanning training
3. Medications ordered in the Emergency Department not available in the department's Pyxis
4. Pharmacy process for changing medication vendors and not upgrading bar codes
5. Bar code scanning programming in the Pharmacy differed from programming on Emergency Department computers causing errors for RNs
6. More medications routinely not scanning properly: Probiotics, Bentyl, Tramadol, Magnesium oxide

Did you meet your measurement goal?

Yes, January scanning compliance increased to 88% overall, February increased to 91% and March showed a dip back to 89%. Further investigation warranted. Current overall compliance is **93.5%**

Act

What will you put into place?

1. We continued to gather information from RNs on obstacles to successful scanning
2. Increased monitoring of offsite pharmacy contract compliance
3. Created generic barcode for Probiotics to scan successfully
4. Pharmacy re-designed process for upgrading bar codes with vendor changes.
5. Roll out of learnings from this to Inpatient Nursing experiencing same issues

What did not work?

1.Some medication bar codes will not scan

2.Downtime protocols lasting 5 hours and not able to decrease length at this time

3. After hours pharmacy continues to need frequent monitoring

4. When a medication is held because of parameters and medication charted as not given, this creates non-compliance for RN. Currently working on a fix for this.

5.When we administer a patient's own meds, there is no bar code to scan.

Acknowledgments

Chris Kutza, Director of Pharmacy
Jessica Winkler, Patient Care Services Director
Ernie Torrento, Information Systems
Andrea O'Donnell, Nurse Informatics
Laura Gallmeyer, Quality

Aim Statement: To improve compliance in medication administration scanning by Emergency Department Registered Nurses.

Perioperative Services Optimization Project

Leslie Lovejoy, Janine Clark

Perioperative Services, Medical Staff

Introduction SMART goal

Background. In light of a dramatic shift from inpatient to outpatient surgical procedure volumes, Leadership determined the need to once again look at the current perioperative services model and determine its overall efficiency.

Goal: Increase the efficiency and direct margin in Perioperative Services by developing and implementing best practice strategies that maximize efficiencies in both the scale of services provided and in operations.

Phase One: **Late first case start times**

Late case start times, especially when it is the first case of the day can lead to disruption of the schedule for the whole team and may result in pushing elective cases into after hours. Consequently the cost of doing the surgery increases due to the necessity of staffing overtime hours and the use of premium pay..

To improve the "on-time" rate for the first case of the day. Base line data indicated that the first case of the day started on time 3% of the time in FY 2018. The national benchmark is 76%.

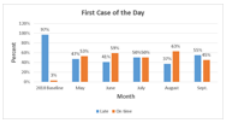
What we planned to do:

1. Develop a format for tracking cases by surgeon;
2. Define the parameters for designating that a case was late;
3. Develop a coding system for determining the reasons for first case delays; and
4. Analyze the reasons for patterns and created a monthly reporting tool for discussion in Surgery Committee.

Plan

Do

We collected data for FY2019; analyzed the reasons for the late case start and created a perioperative metrics dashboard that included % of late first cases, the reason codes for lateness and performance by surgeon. The data was presented in Surgery Committee in July, who asked for refinement of the data to make sure that their performance was accurately reflected.

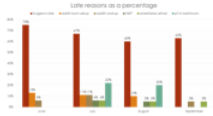


Once refinement was completed, monthly reporting of late first cases prompted improvement by most surgeons. And performance is moving closer to the 76% national benchmark.

We refined the metric dashboard creating two metrics:

1. % of first cases late due to surgeon lateness; and
2. % total late first cases which includes other reasons for lateness.

Study



After analyzing the reasons codes, it was found that the majority of the reasons for lateness is surgeon lateness.

The Committee agreed to the current definitions of " late" to be 7 minutes past the in-room time. This would mean that the surgeon arrives to the pre-op area for patient site marking, History & Physical updates, etc., so that 'wheels in', (the time that the patient enters the operating room), occurs on or before scheduled start time + 7 minutes. Anytime thereafter is deemed to be late.

We also are looking at any patterns within the "other" reasons for a late start to identify any process flow issues that can also be addressed.

Act

This metric will be monitored and reported monthly. The committee's next process is to decide at what point in time and at what percentage does that result in the surgeon losing the privilege of having the "first case of the day" or other measures. This will be added to current perioperative policies and taken through committees.

Surgeons will be notified of the changes in policy and their first case of the day timeliness data .

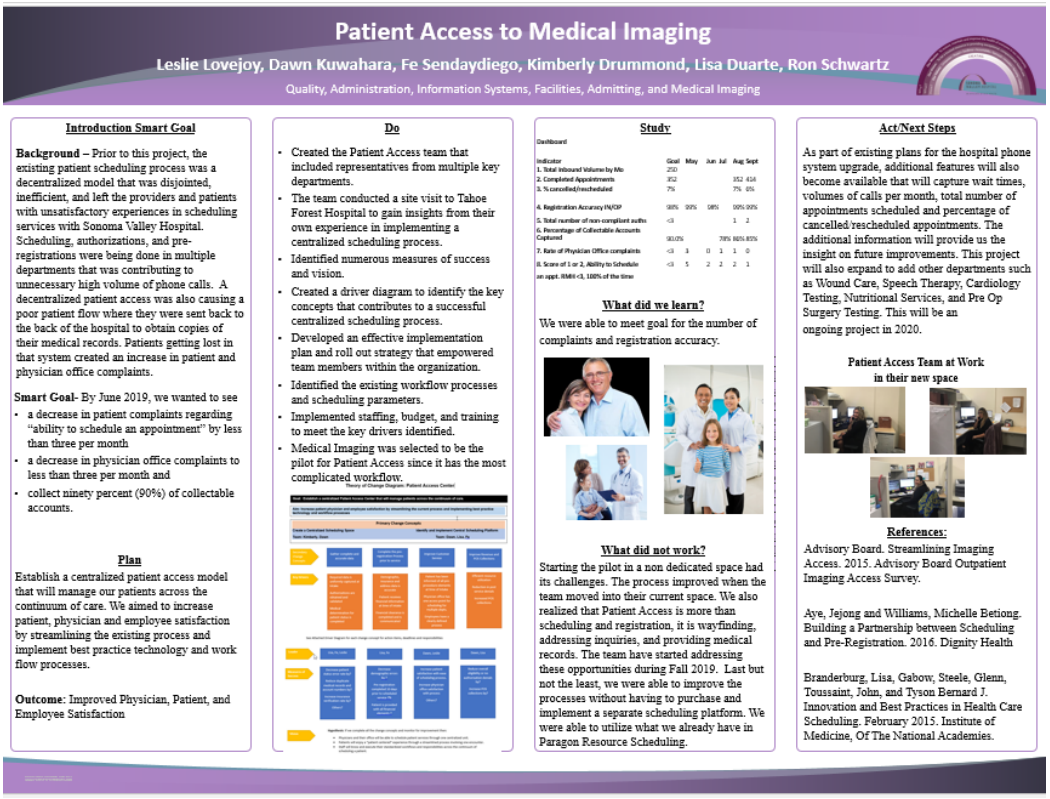
Phase Two: One Medical Passport implementation.

Goal: to reduce the manual pre-operative preparation process by implementing an electronic platform

References

Healthcare Advisory Board
AORN

Aim Statement: To increase the efficiency and direct margin in Perioperative Services by developing and implementing best practice strategies that maximize efficiencies in both the scale of services provided and in operations.



Patient Access to Medical Imaging

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Quality, Administration, Information Systems, Facilities, Admitting, and Medical Imaging

Introduction Smart Goal

Background – Prior to this project, the existing patient scheduling process was a decentralized model that was disjointed, inefficient, and left the providers and patients with unsatisfactory experiences in scheduling services with Sonoma Valley Hospital. Scheduling, authorizations, and pre-registrations were being done in multiple departments that was contributing to unnecessary high volume of phone calls. A decentralized patient access was also causing a poor patient flow where they were sent back to the back of the hospital to obtain copies of their medical records. Patients getting lost in that system created an increase in patient and physician office complaints.

Smart Goal- By June 2019, we wanted to see

- a decrease in patient complaints regarding "ability to schedule an appointment" by less than three per month
- a decrease in physician office complaints to less than three per month and
- collect ninety percent (90%) of collectable accounts.

Plan

Establish a centralized patient access model that will manage our patients across the continuum of care. We aimed to increase patient, physician and employee satisfaction by streamlining the existing process and implement best practice technology and work flow processes.

Outcome: Improved Physician, Patient, and Employee Satisfaction

Do

- Created the Patient Access team that included representatives from multiple key departments.
- The team conducted a site visit to Tahoe Forest Hospital to gain insights from their own experience in implementing a centralized scheduling process.
- Identified numerous measures of success and vision.
- Created a driver diagram to identify the key concepts that contributes to a successful centralized scheduling process.
- Developed an effective implementation plan and roll out strategy that empowered team members within the organization.
- Identified the existing workflow processes and scheduling parameters.
- Implemented staffing, budget, and training to meet the key drivers identified.
- Medical Imaging was selected to be the pilot for Patient Access since it has the most complicated workflow.

Study

Dashboard

Indicator	Goal	May	Jun	Jul	Aug	Sept
1. Total Inbound Volume by Mo	250					
2. Completed Appointments	352				352	414
3. % cancelled/rescheduled	7%				7%	6%
4. Registration Accuracy IN/OP	100%	99%	98%		100%	99%
5. Total number of non-compliant auths	<3				1	2
6. Percentage of Collectable Accounts Captured	90.0%			78%	86%	85%
7. Ratio of Physician Office complaints	<3	3	0	1	1	0
8. Score of 1 or 2, Ability to Schedule an appt. RMH<3, 100% of the time	<3	5	2	2	2	1

What did we learn?

We were able to meet goal for the number of complaints and registration accuracy.

What did not work?

Starting the pilot in a non dedicated space had its challenges. The process improved when the team moved into their current space. We also realized that Patient Access is more than scheduling and registration, it is wayfinding, addressing inquiries, and providing medical records. The team have started addressing these opportunities during Fall 2019. Last but not the least, we were able to improve the processes without having to purchase and implement a separate scheduling platform. We were able to utilize what we already have in Paragon Resource Scheduling.

Act/Next Steps

As part of existing plans for the hospital phone system upgrade, additional features will also become available that will capture wait times, volumes of calls per month, total number of appointments scheduled and percentage of cancelled/rescheduled appointments. The additional information will provide us the insight on future improvements. This project will also expand to add other departments such as Wound Care, Speech Therapy, Cardiology Testing, Nutritional Services, and Pre Op Surgery Testing. This will be an ongoing project in 2020.

Patient Access Team at Work in their new space

References:

Advisory Board. Streamlining Imaging Access. 2015. Advisory Board Outpatient Imaging Access Survey.

Aye, Jejong and Williams, Michelle Betiong. Building a Partnership between Scheduling and Pre-Registration. 2016. Dignity Health

Branderburg, Lisa, Gabow, Steele, Glenn, Toussaint, John, and Tyson Bernard J. Innovation and Best Practices in Health Care Scheduling. February 2015. Institute of Medicine, Of The National Academies.

Aim Statement: To decrease patient complaints regarding ability to schedule an appointment, decrease physician office complaints, and collect ninety percent of collectable accounts in the Medical Imaging Department.

2019 Quality Department Initiatives

The Quality Department partnered with the Emergency Department and the Vintage House to provide Community Stroke Education in a series of discussions titled Let's Talk about Stroke The panel included the SVH Medical Director of Emergency Medicine, Chief Quality Officer, and SVH Stroke Coordinator RN. Topics included; SVH's recent Acute Stroke Ready Hospital Certification, stroke statistics, anatomy and physiology, types of strokes, how to recognize a stroke, treatment, risk factors and preventative measures. 46 members of the public attended and shared that the presentation was "excellent, concise, and informative".

The Quality Department supported and managed the Center for Improvement in Healthcare Quality (CIHQ) Stroke Ready Certification. CIHQ awarded this disease specific certification to Sonoma Valley Hospital as an Acute Stroke Ready Hospital effective from April 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.

Additionally, The Quality Department supported and managed the 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 consisted of a review of nursing and pharmacy as well as identified past compliance concerns. The Quality Department partnered with pharmacy, infection prevention, nutritional services, medical staff, and human resources to prepare for the unannounced survey. SVH successfully completed California Department of Public Health, Life Safety to achieve deemed status of approval.

The Quality Department was instrumental in developing the updated Medical Staff Peer Review Policy that establishes guidelines for peer review processes. The new policy also set up time frames for review process completion and set expectations for monthly performance data review by the newly created Medical Staff Peer Review Committee.

The Quality Department worked tirelessly in 2019 to increase data accessibility and standardization through the use of control charts for various indicators throughout the organization. STATIT has supported actionable performance improvement projects based on relevant benchmarks and standards. The initial focus has been on Utilization Management and Medical Staff Performance Improvement and Board Quality Committee. An incredible 275 total STATIT indicators were built in 2019 that allowed SVH to leverage the power of performance improvement best practice in statistical process control as well as automating labor-intensive work in a reduced workforce environment. STATIT has provided insights to help SVH make objective, sustainable, and defensible decisions while improving clinical quality, patient experience, and satisfaction.

The Quality Department engaged a consultant to help us assess identify our opportunities for improvement and design strategies to improve the experience for our teams, patients, and families. Beginning in November 2019 the Quality Department participated in series of activities aimed at understanding the current gaps in the human experience. Many of our staff, leadership and physicians had the opportunity to provide insights through a pulse survey, interviews, and focus groups. We brought together a multidisciplinary team that helped us to define a shared vision of the Sonoma Valley Hospital Human Experience and core strategies to help achieve it. In addition, we have identified innovative operating systems, team structures, cultural attributes, and tactics to enable our success. The result of this project is an 18-month work plan that will continue into 2020 as we hardwire these new practices.

The Quality Department in collaboration with Board Quality Committee restructured the monthly Board Quality meeting moving from a passive to a structured data driven agenda.

The Quality Department provided monthly education to leadership on the topics of CIHQ standards interpretation and compliance, and Program Beta provided an educational session on the legal implications of documentation.

The Quality Department instituted the Midas Risk/Pt Relations Committee. The expectation is that risk leaders attend twice monthly sessions to collaborate and facilitate best outcomes for organizational risk management. Sonoma Valley Hospital is moving from a silo approach to a holistic view of our systems, processes, and procedures. The goal of Midas Risk/Pt Relations Committee is to recognize and mitigate unsafe conditions, patient harm and serious safety events. The Patient Relations committee reviewed grievances and complaints monthly.

The Director of Quality and Risk attended the Northern California Hospital Quality Symposium and the annual American Society for Healthcare and Risk Management Conference and brought back best practices that are in the process of being adopted.

The Quality Data Analyst attended the annual Midas Symposium bringing back refinements to our use of this database that have improved data gathering and reporting.

An annual review of the budget for Quality, Risk Management, Infection Prevention, Medical Staff Peer Review, Health Information Management and Patient Satisfaction indicates adequate staffing and resources have been allocated to these functions.

The Quality Department provided Anthem Blue Cross with hospital data this year for their Q-HIP program. We also provided healthcare associated infection data to the National Healthcare Safety Network and the Centers for Disease Control for surveillance and benchmarking purposes. We successfully reported quarterly data to our Patient Safety Organization. Lastly, in a combined effort, Information systems and Quality were able to again successfully send Electronic Quality Measures to CMS.

Interdisciplinary collaboration was demonstrated through the following:

Sorry Works	**Culture of Safety Program**	**Good Catch Program**
Safety Committee	Patient Safety Committee	Clinical Informatics Team
Pharmacy and Therapeutics Committee	Departmental and cross departmental performance improvement projects and organization wide performance improvement	Medical Staff Performance Improvement Committee
Grievance Committee	Safety Rounds	Policy & Procedure Committee
Antimicrobial Stewardship	Compliance Committee	Med Staff Committees
IT Steering Committee	Daily Multidisciplinary Patient Care Huddle	Utilization Review Program

Assessment of Performance

The Performance Improvement Program supports the hospital's mission and is well on the way to supporting an organizational Culture of Quality and Safety. The effectiveness of the PI program is measured by its accomplishments. Data was collected and aggregated on performance measures and thoroughly analyzed. Intensive assessments were completed when SVH detected or suspected a significant undesirable performance or variation. Progress was made on the following program goals:

I. ***Quality Department Infrastructure Goals for 2019***

Performance Goal	Outcome
• **Continue to work with department leaders and their staff to revise, refine and improve their department specific QAPI plans including development and reporting of meaningful quality and patient safety indicators.**	Completed
• **Create standardized organizational indicators and dashboards for medical staff committees.**	Completed
• **Continue to define and develop the tools to build a "High Reliability" Organization through expanded use of both Lean principles and further exploration of Human Factors Design.**	
• **Develop and implement standardized Code Stroke dashboard to track and trend performance of process measures.**	Completed
• **Investigate the implementation of the NHSN procedure abstraction process in MedMined**	Completed

II. ***Performance Improvement, Reportable Outcome Measures***
See Attached Dashboards

Assessment of Effectiveness

The Performance Improvement Program, in 2019, met the needs of the Performance Improvement Committee, Medical Executive Committee and Sonoma Valley Hospital.

Objectives for Next Evaluation Period

With input from the medical staff and leadership, the Administrative Team performed an assessment of potential organizational performance improvement activities for 2020 that align with the strategic plan and core strategic initiatives and reflects the scope and complexity of patient care services. In addition to departmental and interdepartmental continuous performance improvement activities, the organization will focus on the following priorities.

A. Prioritized Organizational Performance Improvement Projects for 2020 include the following:
- Palliative Care-to improve the quality of life and wellbeing of our patients by increasing palliative care consults and strengthening the partnership between SVH and community palliative care providers. Director of Patient Care Services, Hospitalists, Chief Quality Officer
- Orthopedic Clinical Care Pathway- standardize and create a pathway for surgical patients beginning the moment there is a decision for surgery all the way through 90 days post-operative (the global period). Surgical Services Director, Chief Medical Officer, Chief Quality Officer

B. Quality Department Infrastructure Goals 2020:

- Policy and Procedure renovation from manual to automated
- Get With the Guidelines Stroke membership
- Case Management department restructure
- Create additional STATIT indicators including Risk, Patient Relations, Medical Records QA/PI, Code Stroke Protocol
- Continue to work with department leaders and their staff to revise, refine and improve their department specific QAPI plans including development and reporting of meaningful quality and patient safety indicators