SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, JULY 14, 2021

5:00 p.m. Regular Session

TO BE HELD VIA ZOOM VIDEOCONFERENCE

To Participate Via Zoom Videoconferencing
use the link below:

https://sonomavalleyhospital-org.zoom.us/j/98847031323?pwd=MktBTGJneDFqTkpVTExCMWlGRGduQT09

and Enter the **Meeting ID: 988 4703 1323**
Passcode: 700258

To Participate via Telephone only, dial:
1-669-900-9128 or 1-669-219-2599
and Enter the **Meeting ID: 988 4703 1323**
Passcode: 700258

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	*Mainardi*	
2. PUBLIC COMMENT SECTION *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.*	*Mainardi*	
3. CONSENT CALENDAR • Minutes 05.26.21	*Mainardi*	Action
4. QUALITY COMMITTEE WORK PLAN FOR 2021	*Kidd*	Action
5. DEPARTMENT PI PROJECT: ED MANAGEMENT OF SEPSIS	*Schmidt/Brown*	Inform
6. QUALITY PERFORMANCE INDICATORS/SCORECARD REVIEW FOR MAY 2021	*Jones*	Inform
7. PATIENT CARE SERVICES DASHBOARD FOR 2ND QUARTER 2021	*Kobe*	Inform
8. REVIEW OF POLICIES AND PROCEDURES	*Jones*	Inform
9. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report		

10. REPORT OF CLOSED SESSION	*Mainardi*	Action
11. ADJOURN	*Mainardi*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
May 25, 2021 5:00 PM
MINUTES
Via Zoom Teleconference

Members Present	Members Present cont.	Excused	Public/Staff
Michael Mainardi, MD, via Zoom Howard Eisenstark, MD, via Zoom Susan Kornblatt Idell via Zoom Carol Snyder via Zoom	Cathy Webber via Zoom Andrew Solomon, MD via Zoom	Ingrid Sheets	Sabrina Kidd, MD, CMO, via Zoom Danielle Jones, RN, via Zoom Mark Kobe, CNO, via Zoom John Hennelly, CEO, via Zoom

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Mainardi*	
	5:01 pm	
2. PUBLIC COMMENT	*Mainardi*	
	None	
3. CONSENT CALENDAR	*Mainardi*	
• QC Minutes, 04.28.21		**MOTION:** by Eisenstark to approve, 2nd by Kornblatt Idell. All in favor.
4. QUALITY INDICATOR PERFORMANCE AND PLAN FOR APRIL 2021	*Jones*	
	Ms. Jones reviewed the quality indicator performance for the month of April 2021.	
5. QUALITY COMMITTEE MEETING SCHEDULE	*Kidd*	
	A discussion was held regarding moving the monthly Committee meeting so the Medical Staff meetings are held prior to Quality. The Chair suggested moving the meeting to the second Wednesday of the month; members present agreed that was doable. The next meeting will be the second week of July.	**MOTION:** by Webber, 2nd by Snyder. All in favor.

AGENDA ITEM	DISCUSSION	ACTION
6. POLICIES AND PROEDURES DISCUSSION	*Jones*	
	The Chair proposed that the policies and procedures item on the agenda be an inform/discussion item rather than action. Dr. Kidd had reviewed the Committee charter which calls for a "review" of the policies. Policies reviewed may be moved on to the Board for approval or passed back down to the author for further review/revision. If significant changes were made, the policy would come back to Quality Committee again. Insignificant changes would be made and go directly to the Board. Dr. Eisenstark suggested asking the Board their opinion. Ms. Kornblatt Idell asked for more time to consider this issue. Dr. Mainardi suggested this might be a good topic for the Board retreat.	
7. REVIEW OF POLICIES AND PROCEDURES	*Jones*	
	The policies and procedures below were reviewed with no action taken. **<u>Changes Made</u>:** Admission Criteria to the ICU Autopsy Electrosurgical Units Safety Gowning and Gloving Implantation of a Medical Device Latex Allergy Precautions On Call, Surgery Pacemaker IDC – Care of Patients Undergoing Surgery Pathology Handling Cultures and Specimens Patient Safety in the Operating Room Sales Representative in the Operating Room Staffing Ratio Criteria for 1 to 1 Staffing Ratio in the ICU **<u>No Changes</u>:** Charging for Surgical Services Fasting Guidelines Prior to Surgery Loaner Instrument Trays from Outside the Facility, Care and Handling Radiological Safety **<u>Retired</u>:**	

AGENDA ITEM	DISCUSSION	ACTION
	Arterial Line Setup Fluid Warmer Use Implant Reimbursements, Protocol for Surgical Observers-visitors-vendors in OR	
	Mr. Hennelly announced the restructure of hospital Quality, which needs an ultimate person to accept responsibility and normally that person is the CMO. Therefore, Dr. Kidd will be overseeing hospital Quality as of June 1, 2021.	
8. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report		
9. REPORT OF CLOSED SESSION	*Mainardi*	
	The Medical Staff credentialing report was approved.	**MOTION:** by Eisenstark, 2nd by Kornblatt Idell. All in favor.
10. ADJOURN	*Mainardi*	
	5:46 pm	

2021 Quality Committee Work Plan

January 1/27	February 2/24	March 3/24	April 4/28
▪ Quality Indicator Performance and Plan ▪ Patient Care Services Dashboard 4th Qtr ▪ Policies and Procedures ▪ Credentialing	▪ Quality Indicator Performance and Plan ▪ Policies and Procedures ▪ Credentialing	▪ Quality Indicator Performance and Plan ▪ Annual Quality Department Review ▪ Policies and Procedures ▪ Credentialing	▪ Quality Indicator Performance and Plan ▪ Patient Care Services Dashboard 1st Qtr ▪ Discussion – Nurse Leaders Attending QC ▪ Policies and Procedures ▪ Credentialing
May 5/26	**June No Meeting**	**July 7/14**	**August 8/11**
▪ Quality Indicator Performance and Plan ▪ QC Meeting Schedule ▪ Discussion – Policies and Procedures ▪ Policies and Procedures ▪ Credentialing		▪ ED Sepsis Metrics/PI Work: Philip Brown & Dr. Schmidt ▪ Quality Indicator Performance and Plan ▪ Patient Care Services Dashboard 2nd Qtr ▪ Policies and Procedures ▪ Credentialing	▪ Communication about Medications: Chris Kutza & Jessica Winkler ▪ Quality Indicator Performance and Plan ▪ Policies and Procedures ▪ Credentialing
September 9/08	**October 10/13**	**November 11/10**	**December 12/08**
▪ Surgery/Central Sterile Project: Dana Fry ▪ Quality Indicator Performance and Plan ▪ Policies and Procedures ▪ Credentialing	▪ Med-Surg/ICU QAPI Plan for Inpatient Services: Jessica Winkler ▪ Quality Indicator Performance and Plan ▪ Patient Care Services Dashboard 3rd Qtr ▪ Policies and Procedures ▪ Credentialing	▪ QAPI Plan for Imaging (or PI Project): Dave Young ▪ Quality Indicator Performance and Plan ▪ Policies and Procedures ▪ Credentialing	▪ Lab QAPI Plan: Lola (Shukurat Baruwa) ▪ Quality Indicator Performance and Plan ▪ Policies and Procedures ▪ Credentialing

Updated 07.08.21

Emergency Services

Emergency Scorecard: ED Nursing Documentation Audits EDIT

Status	Indicator	Current Value	Target	SPC Alert	Updated
	ED 01 DC Instructions Correct (rate) (M)	100.0%	100.0%		May 2021
	ED 03 Continuous Observation for Psych Pt (rate) (M)	77.8%	100.0%		May 2021
	ED 04 NIHSS Dated and Timed (rate) (M)	94.1%	100.0%		May 2021
	ED 05 NIHSS Disposition Accurate (rate) (M)	100.0%	100.0%		May 2021

CIHQ QAPI measures

Sepsis Action Items

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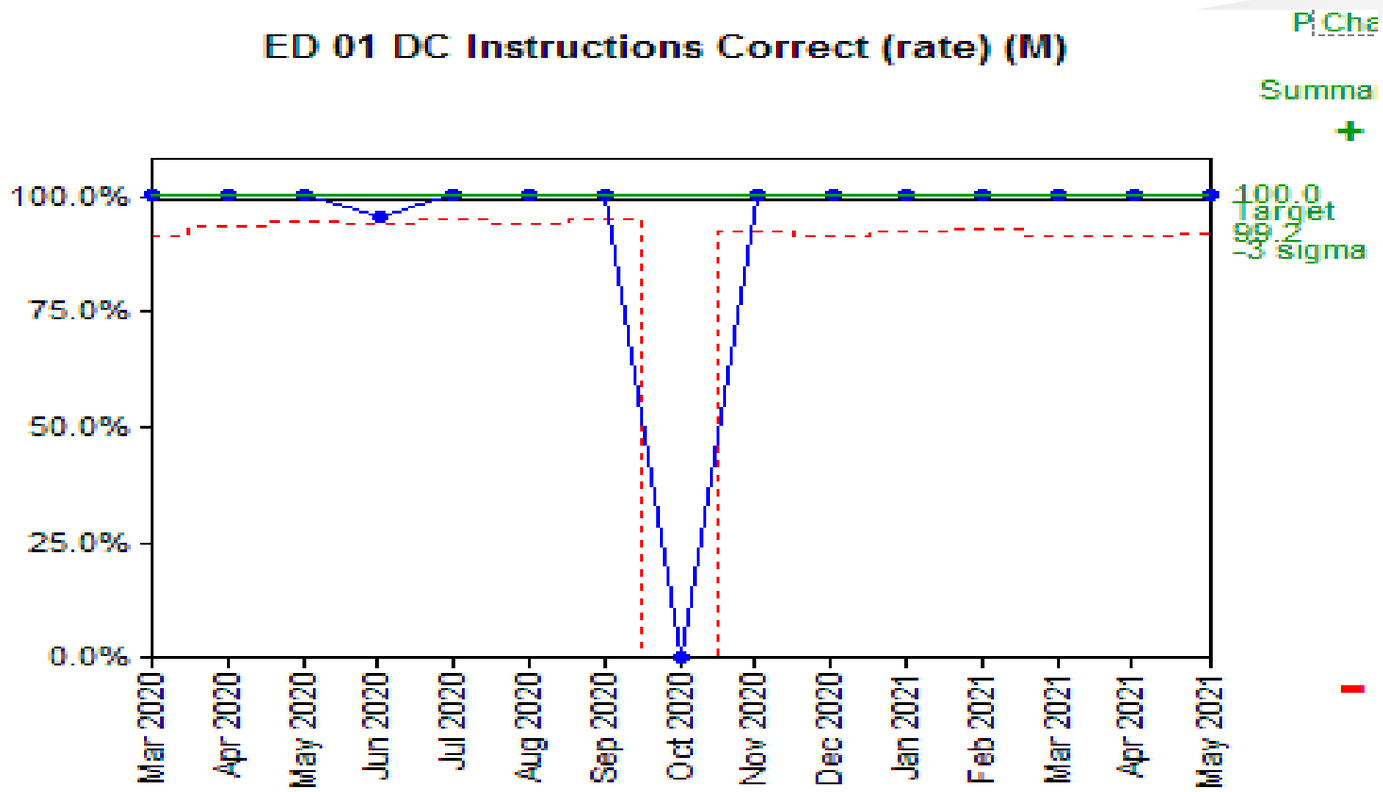
Emergency Services

Correct Discharge Instructions

–	ED 01 DC Instructions Correct (rate) (M)	100.0%	100.0%		May 2021



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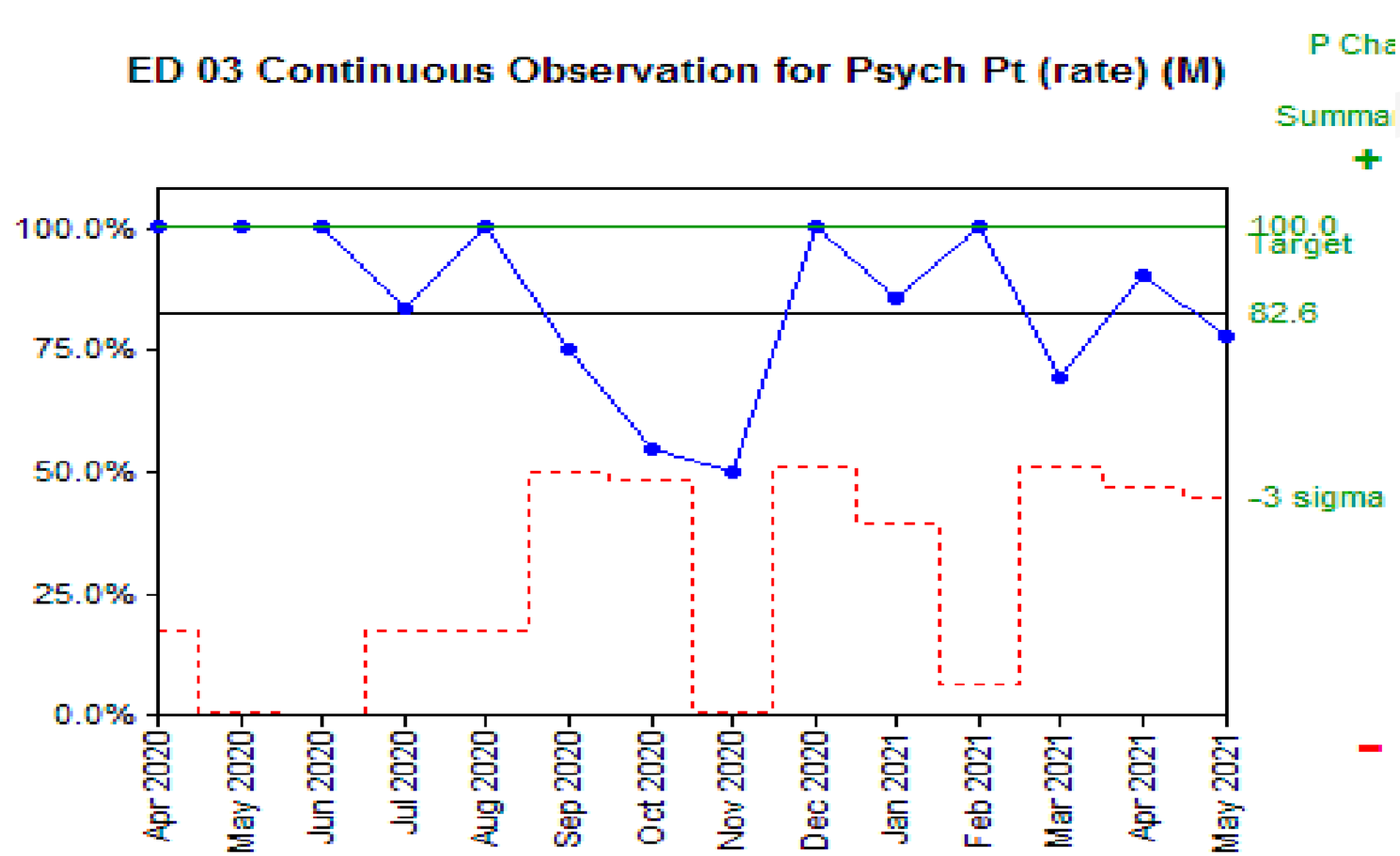
Emergency Services

Continuous Observation for Psych Pt

	ED 03 Continuous Observation for Psych Pt (rate) (M)	77.8%	100.0%		May 2021



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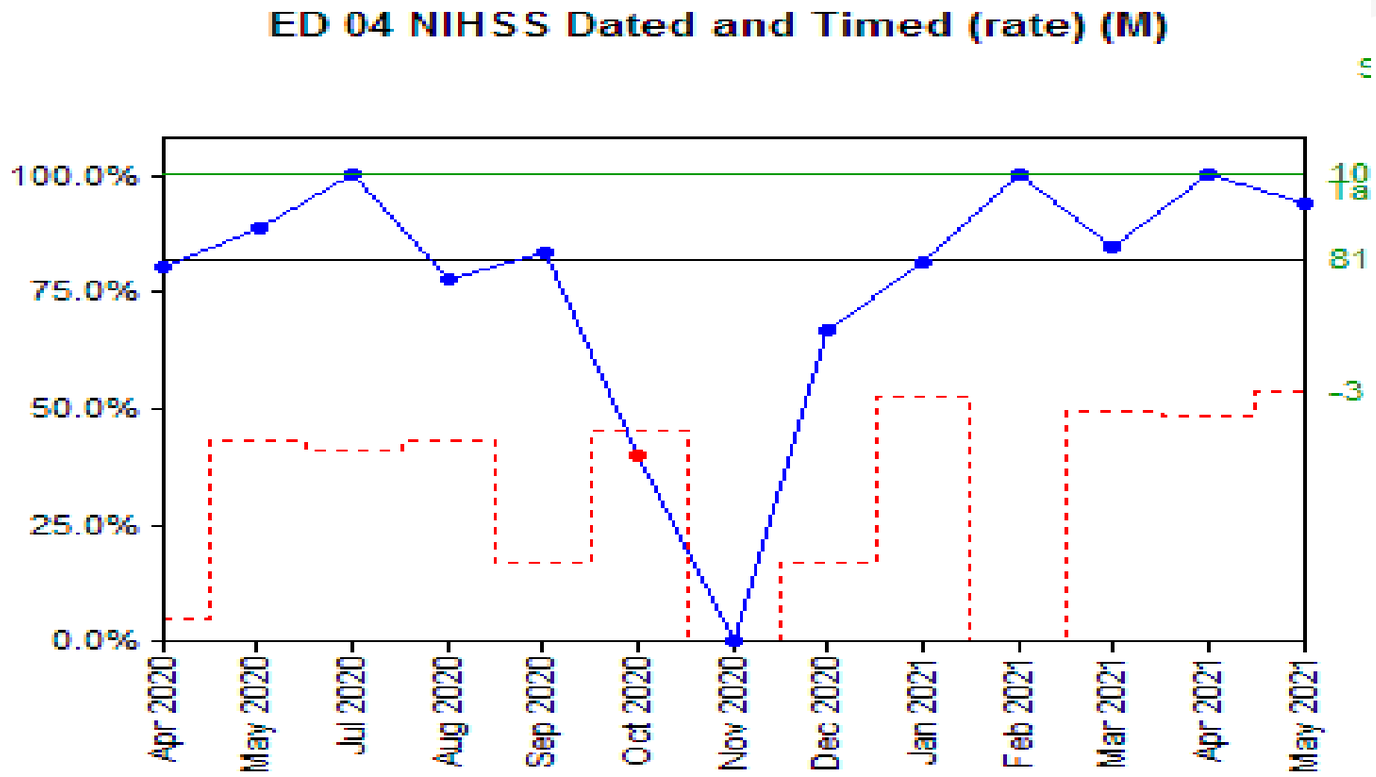
Emergency Services

NIHSS Scoring Sheet Dated & Timed

	ED 04 NIHSS Dated and Timed (rate) (M)	94.1%	100.0%		May 2021



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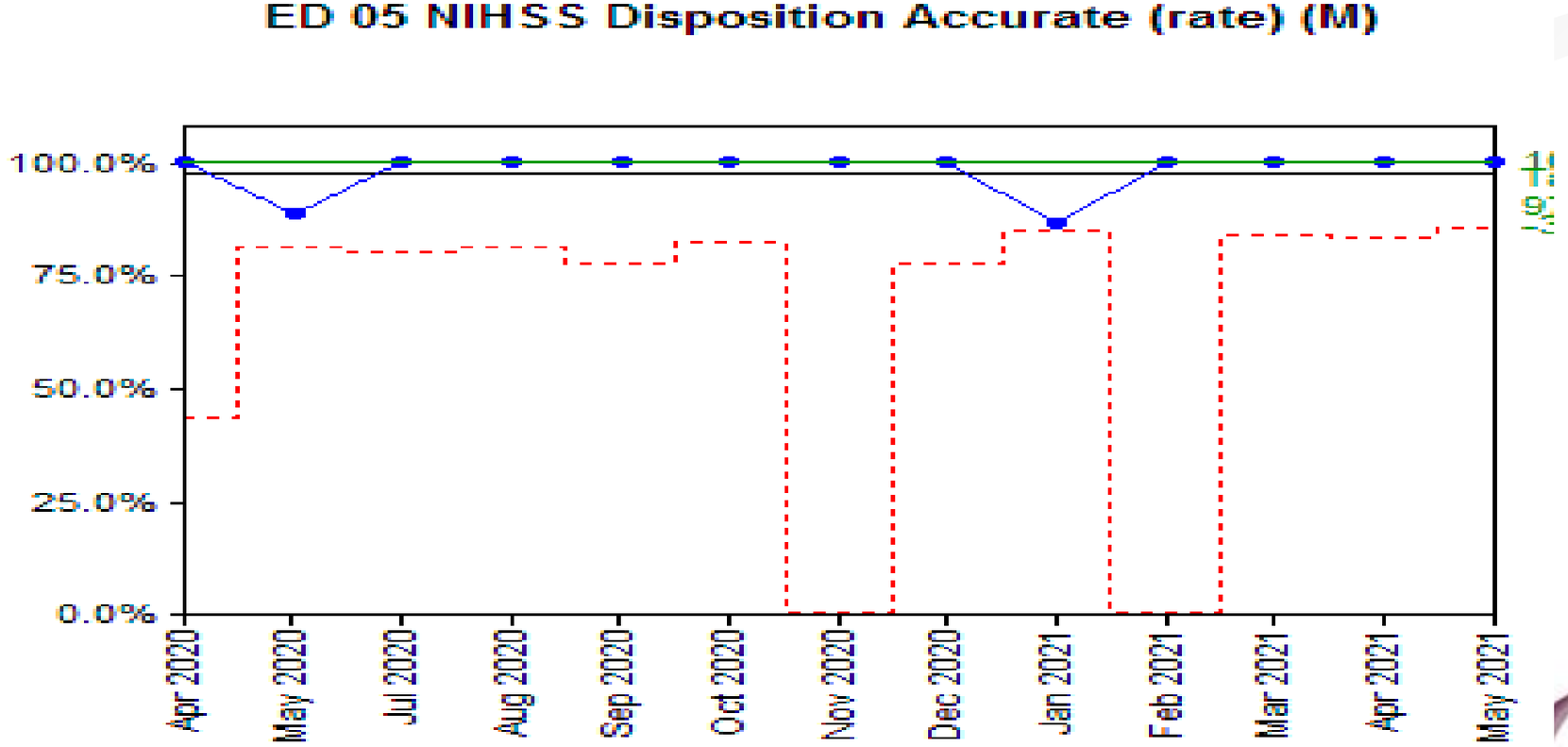
NIHSS Disposition Accuracy

–	ED 05 NIHSS Disposition Accurate (rate) (M)	100.0%	100.0%		May 2021



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Emergency Services

Sepsis Action Items

- Collaborative weekly review of sepsis cases & objective auditing
- Quicker review with staff for opportunities of improvement
- Ownership and remediation for all clinical staff
- 100% of Sepsis cases are reviewed

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Quality Indicators Performance Data

July 2021

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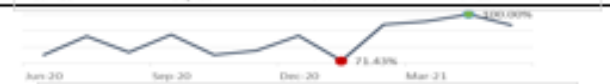
Scorecard Summary
Clinical Outcomes

	Quality & Safety	FY20 Baseline # of events	Month (May '21)	FY21TD (May '21)	FY21 Benchmark	Trendline Summary Green/Red Dot: Best/Worst Monthw/in 12-month Trend	
Clinical Outcomes	COPD Mortality	0% (n=21)	0% (n=2)	0% (n=8)	8.4%		Lower Is Better
	AMI Mortality	25% (n=4)	NA (n=0)	0% (n=1)	12.7%		Lower Is Better
	Heart Failure Mortality	3.33% (n=30)	0% (n=1)	5% (n=20)	11.3%		Lower Is Better
	Pneumonia Mortality	10% (n=20)	33.33% (n=3)	10% (n=20)	15.4%		Lower Is Better
	Ischemic Stroke Mortality	0% (n=8)	NA (n=0)	0% (n=11)	13.6%		Lower Is Better
	30-day All-Cause Readmissions per monthly discharges. Lower is better	3.927% (n = 30)	3.6265 (n = 2)	6.874% (n = 42)	<15.5%		Lower Is Better
	Advance Care Planning IP with LACE Score 10 or greater	51.5% (n=167)	93.33% (n=15)	86.42% (n=162)	75%		Higher Is Better
RM Reports	Preventable Harm Events harm events/all events reported	44.00% 99/224	16% 4/16	29.77% 81/272	0		Lower Is Better

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Scorecard Summary
AHRQ Patient Safety Indicators (April)

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

Patient Safety Indicators	FY20 Baseline # of events	April 2021	FY21TD	FY20 Rate	FY21TD Rate	FY21 Goals	Trendline Summary of Rate Green/Red Dot: Best/Worst Month w/in 12-
Falls With Injury (Per 1000 Pt Days)	1	0	1	0.31	0.37	0.00	
All Falls (Per 1000 Pt Days)	7	1	5	2.17	1.87	3.75	
PSI 6-Iatrogenic Pneumothorax (Per 1000 ACA)	0	0	0	0.00	0.00	0.23	
PSI 8-Fall with Hip Fracture (Per 1000 ACA)	0	0	0	0.00	0.00	0.10	
PSI 9-Perioperative Hemorrhage or Hematoma (Per 1000 ACA)	0	0	0	0.00	0.00	2.55	
PSI 10-Postoperative Acute Kidney Injury Requiring Dialysis (Per 1000 ACA)	0	0	0	0.00	0.00	1.42	
PSI 11-Postoperative Respiratory Failure (Per 1000 ACA)	0	0	0	0.00	0.00	5.03	
PSI 12-Perioperative Pulmonary Embolism or Deep Vein Thrombosis (Per 1000 ACA)	0	0	0	0.00	0.00	3.63	
PSI 13-Postoperative Sepsis (Per 1000 ACA)	0	0	0	0.00	0.00	4.90	
PSI 14-Postoperative Wound Dehiscence (Per 1000 ACA)	0	0	0	0.00	0.00	0.86	
PSI 15-Unrecognized Abdominopelvic Accidental Puncture or Laceration Rate (Per 1000 ACA)	0	0	0	0.00	0.00	1.20	
PSI 90	1	0	0	0.67	0.00	1.00	
Reportable Safety Events (Sentinel)	1	0	0	0.00	0.00	0	
Pharmacy (Per 10,000 doses dispensed	**FY20 Baseline # of events**	**Month April 2021**	**FY21TD # of events that reached**	**FY20 Rate**	**FY21TD Ratio**	**FY21 Goals**	**Trendline Summary Quarterly Volume Green/Red: Best/Worst Qtr w/in 3 FY Trend**
Adverse Drug Event (in High Risk Meds) that reached the patient	16	0.27	6	0.26	0.19	1.12	

Patient Safety Indicators (May)

Iatrogenic Pneumothorax with Venous Cath - Per 1000 ACA (Q)	4.81	0.00		Q2-2021	
Total CMS Hospital Acquired Conditions - Per 1000 ACA (Q)	4.81	0.00		Q2-2021	
Cardiac Arrest-NPOA per 1000 ACA (M)	14.49	0.00		Jun 2021	
Cardiogenic Shock NPOA per 1000 ACA (M)	14.49	0.00		Jun 2021	

Period	Numerator	Denominator	Rate
Q2-2021	1	208	4.81
Q1-2021	0	187	0.00
Q4-2020	0	171	0.00
Q3-2020	0	190	0.00
Q2-2020	0	143	0.00

Period	Numerator	Denominator	Rate
Q2-2021	1	208	4.81
Q1-2021	0	187	0.00
Q4-2020	0	171	0.00
Q3-2020	0	190	0.00
Q2-2020	0	143	0.00

Period	CDB1334 - Cardiac Arrest, NPOA - Per 1000 ACA (numerator)	CDB1334 - Cardiac Arrest, NPOA - Per 1000 ACA (denominator)	Rate
Jun 2021	1	69	14.49
May 2021	2	68	29.41
Apr 2021	0	71	0.00
Mar 2021	1	67	14.93
Feb 2021	1	61	16.39
Jan 2021	1	58	17.24
Dec 2020	1	64	15.62
Nov 2020	0	52	0.00
Oct 2020	1	55	18.18
Sep 2020	1	56	17.86
Aug 2020	1	65	15.38
Jul 2020	1	69	14.49

Period	CDB826 - Cardiogenic Shock, NPOA - Per 1000 ACA (numerator)	CDB826 - Cardiogenic Shock, NPOA - Per 1000 ACA (denominator)	Rate
Jun 2021	1	69	14.49
May 2021	0	68	0.00
Apr 2021	0	71	0.00
Mar 2021	0	67	0.00
Feb 2021	0	61	0.00
Jan 2021	0	59	0.00
Dec 2020	1	64	15.62
Nov 2020	0	52	0.00
Oct 2020	0	55	0.00
Sep 2020	0	56	0.00
Aug 2020	0	65	0.00
Jul 2020	0	69	0.00

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Patient Safety Indicators (May)

	RM ACUTE FALL- All (M) per 1000 patient days	0.00	3.75		May 2021
	RM ACUTE FALL- All (Q) per 1000 patient days	1.89	3.75		Q2-2021
	RM ACUTE FALL- NO INJURY (M) per 1000 patient days	0.00	3.75		May 2021
	RM ACUTE FALL- NO INJURY (Q) per 1000 patient days	1.89	3.75		Q2-2021
	RM ACUTE FALL- WITH INJURY (M) per 1000 patient days	0.00	3.75		May 2021
	RM ACUTE FALL- WITH INJURY (Q) per 1000 patient days	0.00	3.75		Q2-2021

Period	C-RM Event: All FALLS: Acute only (numerator)	S-FS-SVH ADJUSTED PATIENT DAYS: Acute	Rate
May 2021	0	247	0.00
Apr 2021	1	281	3.56
Mar 2021	2	309	6.47
Feb 2021	0	243	0.00
Jan 2021	0	230	0.00
Dec 2020	0	294	0.00
Nov 2020	0	230	0.00
Oct 2020	0	239	0.00
Sep 2020	0	212	0.00
Aug 2020	0	314	0.00
Jul 2020	2	324	6.17
Jun 2020	2	238	8.40

Period	C-RM Event: Fall-NO Injury: Acute only (numerator)	S-FS-SVH ADJUSTED PATIENT DAYS: Acute	Rate
May 2021	0	247	0.00
Apr 2021	1	281	3.56
Mar 2021	2	309	6.47
Feb 2021	0	243	0.00
Jan 2021	0	230	0.00
Dec 2020	0	294	0.00
Nov 2020	0	230	0.00
Oct 2020	0	239	0.00
Sep 2020	0	212	0.00
Aug 2020	0	314	0.00
Jul 2020	1	324	3.09

Period	C-RM Event: Fall-with Injury: Acute only (numerator)	S-FS-SVH ADJUSTED PATIENT DAYS: Acute	Rate
May 2021	0	247	0.00
Apr 2021	0	281	0.00
Mar 2021	0	309	0.00
Feb 2021	0	243	0.00
Jan 2021	0	230	0.00
Dec 2020	0	294	0.00
Nov 2020	0	230	0.00
Oct 2020	0	239	0.00
Sep 2020	0	212	0.00
Aug 2020	0	314	0.00
Jul 2020	1	324	3.09
Jun 2020	0	238	0.00

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Blood Culture Contamination

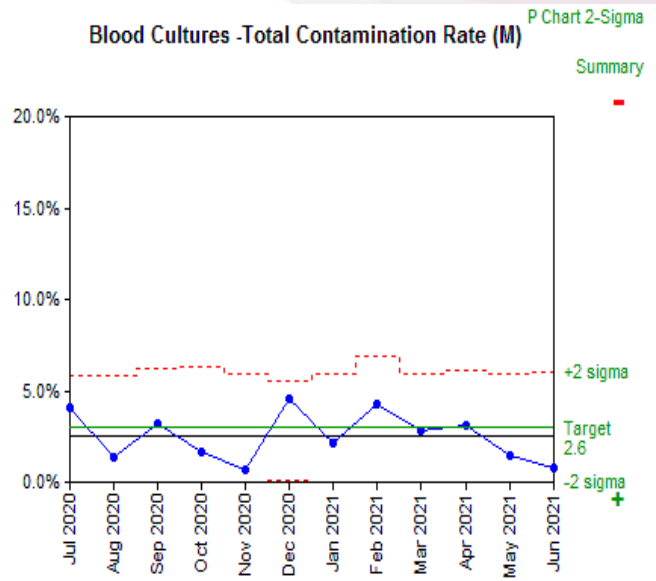
All Indicators Scorecard: Blood Contamination Indicators

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Blood Utilization					
	Blood Cultures -Total Contamination Rate (M)	0.8%	3.0%		Jun 2021
	Blood Cultures -Contamination Rate |LAB| (M)	1.5%	3.0%		Jun 2021
	Blood Cultures -Contamination Rate|RN| (M)	0.0%	3.0%		Jun 2021

Month	Total Contaminated Cultures (num)	Total Blood Cultures Processed (den)	Percent
Jun 2021	1	130	0.8%
May 2021	2	135	1.5%
Apr 2021	4	127	3.1%
Mar 2021	4	140	2.9%
Feb 2021	4	93	4.3%
Jan 2021	3	137	2.2%
Dec 2020	8	173	4.6%
Nov 2020	1	134	0.7%
Oct 2020	2	119	1.7%
Sep 2020	4	124	3.2%
Aug 2020	2	145	1.4%
Jul 2020	6	146	4.1%

Month	Lab-Contaminated Culture Reports (num)	Blood Cultures Drawn by Lab (den)	Percent
Jun 2021	1	65	1.5%
May 2021	1	63	1.6%
Apr 2021	0	67	0.0%
Mar 2021	0	55	0.0%
Feb 2021	0	50	0.0%
Jan 2021	1	48	2.1%
Dec 2020	0	43	0.0%
Nov 2020	0	41	0.0%
Oct 2020	0	38	0.0%
Sep 2020	1	37	2.7%
Aug 2020	0	32	0.0%
Jul 2020	0	26	0.0%

Month	RN-Contaminated Culture Reports (num)	Blood Cultures Drawn by RN (den)	Percent
Jun 2021	0	65	0.0%
May 2021	1	72	1.4%
Apr 2021	4	60	6.7%
Mar 2021	4	85	4.7%
Feb 2021	4	43	9.3%
Jan 2021	2	89	2.2%
Dec 2020	8	130	6.2%
Nov 2020	1	93	1.1%
Oct 2020	2	81	2.5%
Sep 2020	3	87	3.4%
Aug 2020	2	112	1.8%
Jul 2020	6	120	5.0%



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Hospital Acquired Infections/Conditions

Specific/Preventable Harm Metrics Hospital Acquired Infection or Condition	FY20 Baseline # of events	# of Harm Events		Rate		FY21 Goals	Trendline Summary of Rate Green/Red Dot: Best/Worst Monthw/in 12-month Trend
		April 2021	FY21TD	FY20	FY21TD		
CLABSI-Central Line Blood Stream Infection (per 10k pt days)	0	0	0	0.000	0.000	0.777	
CAUTI-Catheter Associated Urinary Tract Infection (per 10k pt days)	0	0	0	0.000	0.000	0.734	
MRSA-Methicillin-resistant Staphylococcus aureus (per 10k pt days)	0	0	0	0.000	0.000	0.865	
SSI HYST-Surgical Site Infection Hysterectomy (per 10k pt days)	0	0	0	0.000	0.000	0.944	
SSI COLON-Surgical Site Infection Colon (per 10k pt days)	0	0	0	0.000	0.000	0.863	
C.DIFF- Clostridioides difficile (per 10k pt days)	0	1	1	0.000	3.160	0.554	
HAPI- Hospital Acquired Pressure Injuries (per 10k pt days)	0	0	0	0.000	0.000	0.59	
Surgical Complications HIP/Knee Complication Rate following Total Hip/ Knee Arthroplasty	2	0	0	4.00% (n=50)	0.00% (n=15)	2.40%	

Lower Is Better

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Utilization Management

Acute Care – Risk-adjusted Average Length of Stay, O/E Ratio 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.

Finance > Utillization Management					
	1 Day Stay Rate-Medicare |M|	0.00%	8.10%		Jun 2021
	1 Day Stay Rate Medi-Cal |M|	0.00%	2.61%		Jun 2021
	Acute Care Risk-adjusted Average Length of Stay O/E Ratio |M|	0.85	0.79		Jun 2021
	InterQual Criteria Status Not Met: Admission |M|vol	0	2		Jun 2021
	InterQual Criteria Status Not Met: Continued Stay |M| vol	0	0		Jun 2021

Period	R-ENC-1 Day Stay Medicare rate (numerator)	R-ENC-1 Day Stay Medicare rate (denominator)	Percent
Jun 2021	0	46	0.00%
May 2021	0	45	0.00%
Apr 2021	0	40	0.00%
Mar 2021	0	45	0.00%
Feb 2021	0	41	0.00%
Jan 2021	0	46	0.00%
Dec 2020	0	39	0.00%
Nov 2020	0	31	0.00%
Oct 2020	0	38	0.00%
Sep 2020	0	33	0.00%
Aug 2020	0	41	0.00%
Jul 2020	0	41	0.00%

Period	R-ENC-1 Day Stay Medi-Cal rate (numerator)	R-ENC-1 Day Stay Medi-Cal rate (denominator)	Percent
Jun 2021	0	14	0.00%
May 2021	0	13	0.00%
Apr 2021	0	12	0.00%
Mar 2021	0	15	0.00%
Feb 2021	0	10	0.00%
Jan 2021	0	12	0.00%
Dec 2020	0	12	0.00%
Nov 2020	0	14	0.00%
Oct 2020	0	9	0.00%
Sep 2020	0	14	0.00%
Aug 2020	0	15	0.00%
Jul 2020	0	16	0.00%

Period	Observed Days (num)	Expected Days (den)	Rate
Jun 2021	229	270	0.85
May 2021	246	297	0.83
Apr 2021	287	287	1.00
Mar 2021	267	297	0.90
Feb 2021	204	224	0.91
Jan 2021	174	197	0.89
Dec 2020	197	216	0.91
Nov 2020	146	180	0.81
Oct 2020	179	179	1.00
Sep 2020	179	185	0.97
Aug 2020	246	240	1.02
Jul 2020	234	237	0.99

Period	C-HCM-NOT MET IQ Criteria-Admission
Jun 2021	0
May 2021	0
Apr 2021	0
Mar 2021	0
Feb 2021	0
Jan 2021	0
Dec 2020	0
Nov 2020	0
Oct 2020	0
Sep 2020	1
Aug 2020	3
Jul 2020	4

Period	C-HCM-NOT MET IQ Criteria, Continued Stay
Jun 2021	0
May 2021	0
Apr 2021	0
Mar 2021	0
Feb 2021	0
Jan 2021	0
Dec 2020	0
Nov 2020	0
Oct 2020	0
Sep 2020	0
Aug 2020	0
Jul 2020	0

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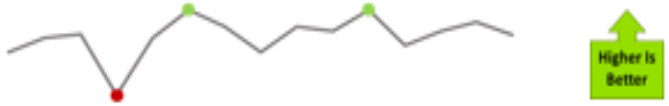
Core Measures

Core Measures	FY20 Baseline	Month (May '21)	FY21TD (May '21)	FY21 Benchmark	Trendline Summary Green/Red Dot: Best/Worst Monthw/in 12-month Trend
HOP Colonoscopy Follow-up for avg risk patients OP 29	80.26% (n=76)	100% (n=10)	100% (n=74)	91%	 Higher Is Better
HOP ED Throughput (Median time in minutes) OP 18	140 minutes (n=335)	110 minutes (n=28)	111.11 minutes (n=308)	114 minutes	 Lower Is Better
HOP Stroke Head CT within 45 minutes OP 23	100% (n=11)	NA (n=0)	100% n=6)	72%	 Higher Is Better
Core Sepsis Sepsis Care Composite	68% (n=75)	85.71% (n=7)	71.70% (n=53)	60%	 Higher Is Better

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Patient Experience: HCAHPS Scores

Patient Experience	FY20	FY21TD (May 2021)		FY21 Goals	FY21TD vs FY20 Baseline Period
Would Recommend the Hospital (IP)	67.19% (n=128)	Hospital	75% (n=88)	>70%	Increase 7.81%
Would Recommend the Hospital (AS)	78.72% (n=376)	Outpatient	82.84% (n=268)	>70%	Increase 4.12%
Physician Communication (IP)	74.57% (n=133)	Hospital	89% (n=89)	>70%	Increase 14.43%
Care Provider Overall (AS)	78.76% (n=365)	Outpatient	82.96% (n=261)	>70%	Increase 4.20%

Likelihood to Recommend

Time Period	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021
n	45	27	27	28	22	12
Top Box Score	60.00%	74.07%	77.78%	64.29%	81.82%	75.00%
Percentile Rank	10	34	47	8	55	22

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Patient Care Services Dashboard 2020-21

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Medication Scanning Rate	2020-21				
	Q3	Q4	Q1	Q2	Goal
Acute	SDE	70.4%	91.0%	96.0%	≥90%
ED	SDE	21.8%	69.0%	74.0%	≥90%
Preventable med errors R/T Med Scanning	SDE	0 (n=0)	0 (n=5)	0 (n=3)	≤2

Falls (Per 1000 days) 2020-21					
	Q3-Q2	Q4-Q3	Q1-Q4	Q2-Q1	50th %tile
Acute	1.30	1.30	0.53	0.61	3.75
ED	0.0	0.0	0.0	0.0	

Hospital Acquired Pressure Ulcer Incidents (Per 1000 admissions)	2020-21				
	Q3	Q4	Q1	Q2	National
Acute (stage III & IV)	0.0	0.0	0.0	0.0	3.68

Nursing Turnover	2020-21 RNs/Quarter				
# of RNs	Q1	Q2	Q3	Q1	Goal
Acute (n=52)	2	3	6	1	≤6

Patient Experience (CAHPS)	2020-21				
	Q3	Q4	Q1	Q2	Goal
HCAHPS (rolling 12 month)					
Would Recommend	66.3	68	82.1	N/A	70.0
Quietness of Hosp Environment	53.9	54.6	55.6	N/A	51.0
OASCAHPS (rolling 12 month)					
Care of Patients (MD/RN respect)	99.2	96.1	84.8	N/A	97.1
Would Recommend	88.9	78.5	86.2	N/A	88.6
RATE MY HOSPITAL - ED	Q3	Q4	Q1	Q2	
Overall score	4.8	4.7	4.7	4.7	≥4.5
RATE MY HOSPITAL - MEDICAL IMAGING	Q3	Q4	Q1	Q2	
Overall score	N/A	N/A	4.8	4.9	≥4.5

Nurse Staffing Effectiveness: Transfers r/t staffing/beds					
2020-21	Q3	Q4	Q1	Q2	Goal
	0	0	0	1	≤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

Document Tasks by Committee

Listing of currently pending and/or upcoming document tasks grouped by committee.

Sonoma Valley Hospital

Run by: Woodall, Vivian (vwoodall)
Run date: 07/09/2021 10:01 AM

Report Parameters

Filtered by: Document Set: all applicable
Committee: 07 BOD-Quality Committee of the Board
Include Current Tasks: Yes
Include Upcoming Tasks: No

Grouped by: Committee

Sorted by: Document Name, Document Location

Report Statistics

Total Documents: 8

Committee: **07 BOD-Quality Committee of the Board**

Committee Members: **Woodall, Vivian (vwoodall)**

Current Approval Tasks (due now)

Document	Task/Status	Pending Since	Days Pending
Accountability and Responsibility GL8750-101 *Case Management/UM Dept*	**Pending Approval**	7/6/2021	3

Summary Of Changes: **Added:Monday through Friday. . Behavioral/Mental Health consultations with a medical staff member or contracted psychiatrist/psychologist/LCSW are initiated by the ordering physician.**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Jones, Danielle (djones)**

Approvers: **Jones, Danielle (djones) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Document	Task/Status	Pending Since	Days Pending
Aggressive Behavior Management *Ancillary Services Dept Policies*	**Pending Approval**	7/6/2021	3

Summary Of Changes: **Retire--use organizational policy and competency (Workplace Violence #xxxxxxxx)**

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Kuwahara, Dawn (dkuwahara)**

Approvers: **Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Document	Task/Status	Pending Since	Days Pending
AIDET-Patient Relations Protocols 8440-01 *EVS Dept Policies*	**Pending Approval**	7/6/2021	3

Summary Of Changes: **Retire, follow organizational protocol.**
Reviewed policy and made minor grammar corrections.

Moderators: **Newman, Cindi (cnewman), Tierney, Pat (ptierney)**

Lead Authors: **Drummond, Kimberly (kdrummond)**

Approvers: **01 P&P Committee -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Document	Task/Status	Pending Since	Days Pending
Care Transitions Program Post Discharge Phone Calls DS8750- 124 *Case Management/UM Dept*	**Pending Approval**	7/6/2021	3

Summary Of Changes: **Retire. This policy was part of the PRIME grant that ends December 31, 2020. It may be that it is reinstated in another format in 2021.**

Moderators:	**Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors:	**Jones, Danielle (djones)**
Approvers:	**Jones, Danielle (djones) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Discharge Referral Process for Home Care DC8750- 107 | **Pending Approval** | 7/6/2021 | 3

Case Management/UM Dept

Summary Of Changes:	**Updated for electronic exchanges of information; added documents that need to be sent; changed the name to reflect all potential discharge referrals and added details for each referral process.**
Moderators:	**Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors:	**Jones, Danielle (djones)**
Approvers:	**Jones, Danielle (djones) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Orientation, Case Manager | **Pending Approval** | 7/6/2021 | 3

Case Management/UM Dept

Summary Of Changes:	**Recommend Retirement--redundant**
Moderators:	**Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors:	**Jones, Danielle (djones)**
Approvers:	**Jones, Danielle (djones) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Protective and Advocacy Services PR8750 -120 | **Pending Approval** | 7/6/2021 | 3

Case Management/UM Dept

Summary Of Changes:	**Spoke to Social WOrker Updating and Maintaining Resource List**
Moderators:	**Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors:	**Jones, Danielle (djones)**
Approvers:	**Jones, Danielle (djones) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Standard Employer Service Rate | **Pending Approval** | 7/6/2021 | 3

Ancillary Services Dept Policies

Summary Of Changes:	**Reviewed, no changes**
Moderators:	**Newman, Cindi (cnewman), Tierney, Pat (ptierney)**
Lead Authors:	**Kuwahara, Dawn (dkuwahara)**
Approvers:	**Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality Committee of the Board - (Committee) -> 09 BOD-Board of Directors - (Committee)**