SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, April 24, 2024

5:00 pm Regular Session

Held in Person:

SVH Administrative Conference Room

To Participate Via Zoom Videoconferencing
use the link below:
https://sonomavalleyhospital-org.zoom.us/j/97100197319

Meeting ID: 971 0019 7319

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AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a District meeting, please contact the Board Clerk, Whitney Reese, at wreese@sonomavalleyhospital.org, 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	*Bjorndal*	
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.*	*Bjorndal*	
3. CONSENT CALENDAR • Minutes 03.27.24	*Bjorndal*	Action
4. INFECTION PREVENTION ANNUAL RISK ASSESSMENT / PLAN	*Montecino*	Inform
5. QUALITY COMMITTEE CHARTER	*Bjorndal*	Action
6. QUALITY INDICATOR PERFORMANCE & PLAN	*Cooper*	Inform
7. POLICIES AND PROCEDURES	*Cooper*	Inform
8. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	*Bjorndal*	Action
9. ADJOURN	*Bjorndal*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
Wednesday, March 27, 2024, 5:00 PM
MINUTES
Via Zoom Teleconference

Members Present – In Person	Excused	Public/Staff – Via Zoom
Carl Speizer, MD Carol Snyder Howard Eisenstark, MD Ingrid Sheets, EdD, MS, RN Kathy Beebe, RN PhD Michael Mainardi, MD Susan Kornblatt Idell		Denise Kalos, via zoom Judith Bjorndal, MD via zoom Paul Amara, MD, FACOG, via zoom Kylie Cooper, RN BSN CPHQ MBA, Quality and Risk Mgmt. Sabrina Kidd, MD, Interim Chief Medical Officer Jessica Winkler, DNP, RN, NEA-BC, CCRN, Chief Nursing Officer

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Kornblatt Idell*	
	Kornblatt Idell thanked Ingrid Sheets for her service on the Quality Committee for ten years, as this is her last meeting on the committee. Sheets expressed her joy at being so involved with SVH and her appreciation for everything that the hospital does.	
2. PUBLIC COMMENT SECTION	*Kornblatt Idell*	
	No public comments	

3. CLOSED SESSION: a. Calif. Government Code §54956.9: Conference with Legal Council – Anticipated Litigation	*Kornblatt Idell*	INFORM
		Susan Kornblatt Idell announced there was a closed session that took place
4. CONSENT CALENDAR • Minutes 02.28.24	*Kornblatt Idell*	ACTION
	Edits were suggested and made before presenting to the Board of Directors	*Motion to approve Speizer, 2nd by Sheets*
5. ANNUAL QUALITY DEPARTMENT REVIEW	*Cooper*	INFORM
	Cooper presented the Quality department's 2023 data, emphasizing a focus on equity metrics. The department consists of three members: Kylie Cooper, Director of Quality & Risk Management, Cindi Newman, Quality Systems & Analytics, and Stephanie Montecino, Infection Prevention/Employee Health • Emergency room statistics revealed 9222 visits, with 54% being female, 31% over 70, 10% under 10 years old, 43% single, and 81% predominantly spoke English, and. • Inpatient admissions totaled 827, with 54% female and 64% over 70. • Length of stay analysis showed non-Hispanic patients stayed longer than Hispanics, prompting further investigation. • Readmission demographics highlighted a majority aged 70-100, 63% female, and 87% non-Hispanic. • Quality achievements included: mortality rates below benchmark, zero falls with injury incidents, improvement in Sepsis measures vs 2022, significant improvement in Blood Culture contamination rates, successful accreditation survey as Stroke Ready Hospital with excellent stroke care, CMS accreditation survey by the Center of Improvement in Healthcare Quality (CIHQ)	*Kylie Cooper presented the Quality department's 2023 data*

	• Goals for 2024 include reducing length of stay, readmission rates, and improving Sepsis Bundle compliance. • Director of Quality performs weekly reviews of readmissions, hospital acquired infections, surgical site infections, frequent ER visits, and unanticipated events. Peer reviews is robust. • Risk management protocols address patient grievances and staff-reported events, aiming for resolution within seven days. • A health analytics system, MIDAS, tracks and manages risk events, with 90% categorized as no harm or minimal temporary harm in 2023. • Emphasis is placed on staff reporting to foster a culture of safety, with recognition given through a high five system.	
6. QUALITY COMMITTEE CHARTER	*Kornblatt Idell*	ACTION
	Discussion focused on ensuring clarity, consistency, and relevance in the committee's charter. Specific changes include: • Add word under responsibilities: "To oversee **that** quality assurance…" • Add voting member: Vice Chief of Medical Staff • Take off the staff from the voting section.	*Susan Kornblatt Idell to make changes and bring back to committee to review/approve at next meeting.*
7. QUALITY INDICATOR PERFORMANCE & PLAN	*Cooper*	INFORM
	Cooper presented data for February 2024. • Mortality Rate: 4.8%, below benchmark, with three patients in the hospital. • Patient Safety Indicator Events: A spike occurred, largely related to post-operative complications. No Sentinel or adverse events reported. • Blood Products: No transfusion reactions or significant medication errors noted. • Readmissions: Spike observed, particularly among patients with chronic conditions, prompting a focus on reducing readmissions.	*Kylie Cooper presented the Quality department's February 2024 data*

	• Insurance Coverage and Readmissions: Discussion on insurance coverage affecting follow-up care post-discharge. • Blood Culture Contamination: A slight increase in contamination noted, mainly from registry and traveler staff. • Stroke Certification Measures: Met and exceeded targets. • Utilization Management: Complexity of illness remained steady, with observed versus expected ratio below benchmark. • Colonoscopy Follow-up Documentation: Maintained at 100% compliance. • ED Turnaround Time: Experienced a slight increase, with minimal cases of extended wait times. • Outpatient CTs for Strokes: Achieved 100% compliance within 45 minutes. • Sepsis: Five cases met severe sepsis diagnosis, with improvements planned in education and staff training. • Infection Prevention: One catheter-associated urinary tract infection reported, with a review indicating appropriate care. • Direct Observation Compliance: Working towards continuous compliance, with notable progress. • Patient Satisfaction Data: Positive scores reported across emergency room, inpatient, and patient surgery, prompting discussion on publicizing data to address negative perceptions from general public and as expressed by the Community Health Center board.	
8. POLICIES AND PROCEDURES	*Cooper*	INFORM
	Discussion and recommendations were made for the following policies and procedures, to be amended and then presented for approval to the Board of Directors: • Admission to the Hospital from the ED • Infection Control Mandatory Reporting • NEW: Imaging Vascular Access and Use of Vascular Lines and Ports for Contrast Administration	*The committee discussed and made recommendations for edits*

	• Nuclear Medicine Safety Measures • Retire: Central Lines, PICC Lines 7630-115 • Retire: Central Venous Catheters Power Injection 7630-117 • RETIRE: Misadministration of Radioisotopes • Trophon Environmental Probe Reprocessor (EPR)	
9. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	*Kornblatt Idell*	ACTION
		Motion to approve Mainardi, second by Eisenstark
10. ADJOURN	*Kornblatt Idell*	
	Meeting adjourned at 6:13pm	

Infection Prevention

Sonoma Valley Hospital

Board Quality 2024

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What topics will we be looking at today

- What does an Infection Preventionist do?
- Infection Prevention 2023 Quality Metrics
- Key Concepts to an (ICRA)
- The updated ICRA with No Mitigation recommendation changes for 2024
- What microorganisms are identified as a threat during construction

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What does an Infection Preventionist (IP) Do?

Empowers all hospital staff to prevent hospital acquired infections by providing education, training, and recommendations (policy and practice), as well as tracking epidemiological trends in both the hospital and community.

An IP monitors, tracks and reports infections.

An IP also completes all the required public reporting regarding hospital acquired infections: CDPH,CDC, regulatory bodies.

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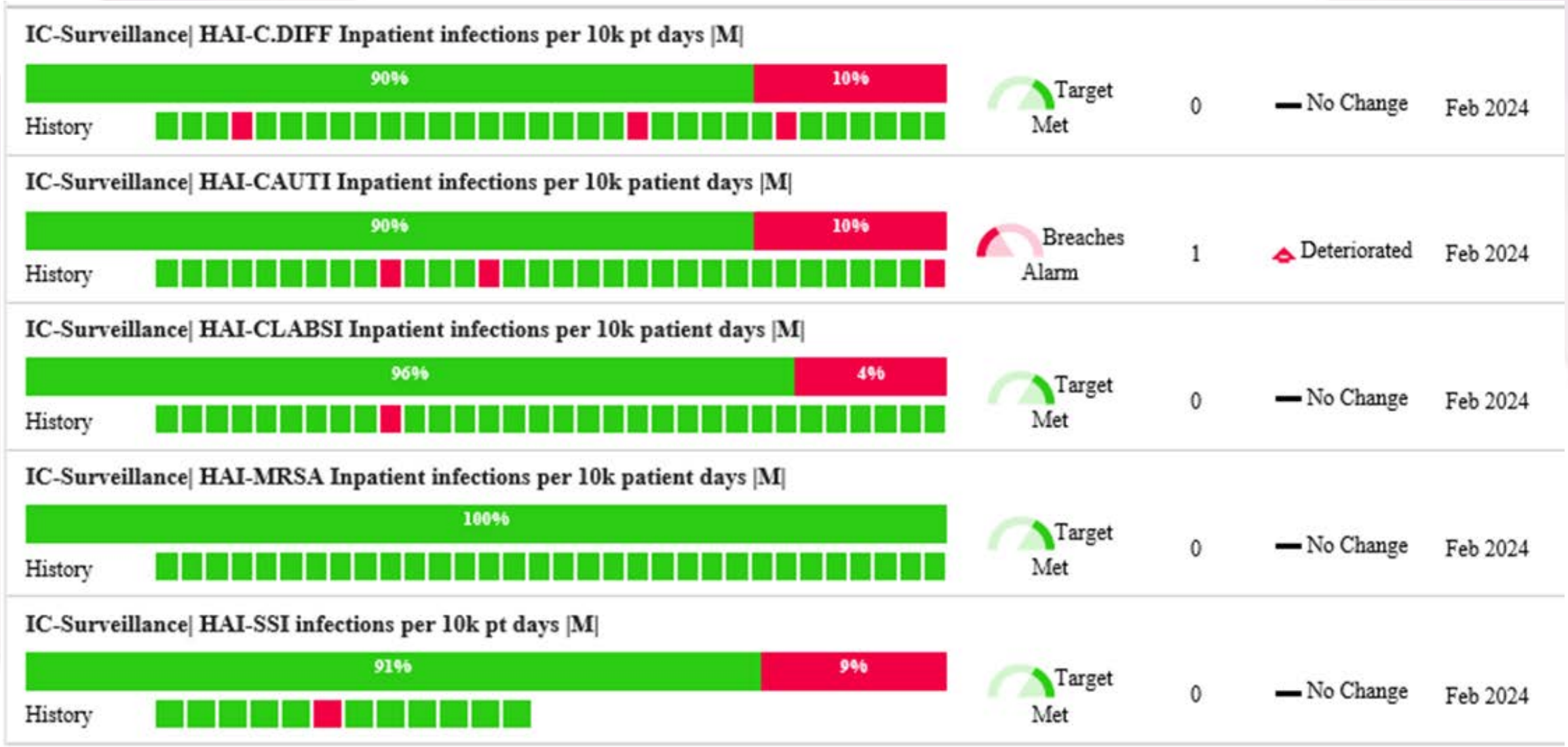
Infection Prevention Quality Metrics 2023



Infection Prevention Metrics Compared

Hospital Acquired Infections 2023

2 HAI C-diff Infections

0 HAI CAUTI

0 HAI CLABSI

1 Surgical Site Infection

0 HAI MRSA Infection

Hospital Acquired Infections 2024

0 HAI C-diff infections

1 HAI CAUTI

0 HAI CLABSI

0 Surgical Site Infection

0 HAI MRSA Infection

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Key Concepts to an (ICRA)

- An Infection Control Risk Assessment or (ICRA) is completed once a year and updated annually.
- The ICRA conducts a Risk Assessment for transmission of Infectious Agents and the Mitigation Recommendations (ICRMR) *no changes have been Identified for 2024 ICRA
- Inpatient, Ambulatory Care and Outpatient Services
- These settings are given a risk setting
- Next slide: example of the Construction Area of the ICRA

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Risk Designation – Enter the Level of Assessed Risk for Each Care Setting:

L = Low risk (1 point)

M = Medium Risk (5 points)

H = High Risk (10 points)

Prioritized Risk Description	Risk Assessment			Mitigation Strategies	Goals/How the Effectiveness of the Strategies is Evaluated
	I	A	O		
Infection Prevention and Control involvement in construction activities **15 points**	M	M	M	Infection Prevention Risk Assessment complete for all construction activities 2023. Construction workers educated on Infection Prevention practices during safety orientation.	Goal: 100% compliance with Infection Control Risk Assessment (ICRA) and compliance checklist completed before initiating any construction projects. Documentation kept in Engineering.

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Mitigation Changes to 2024 ICRA

- Once the IP and other interdisciplinary team members have identified the need for mitigation, the changes are made to that years ICRA.

- Although, we made no changes to the ICRA score this year our focus will be on mitigation efforts for construction and renovation due to construction in the hospital and out-patient settings

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Construction and What Is IP looking for?

- Construction, renovation, demolition, excavation, or maintenance activities that involve cutting, drilling, or grinding, disruption of ventilation or plumbing systems and the impact to patients, staff and or visitors
- Prioritizes the identified risks due to construction
- IP is concerned with environmental contaminants to air systems causing possible airborne pathogens exposures

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ICRA Mitigation Recommendations

- Portables Hand Washing Stations
- Hand Hygiene Gel Sanitizers
- HVAC Air Supply/Hepa Filtration: Ventilation
- Air Containment Partition/Walls
- Installed Foot Sticky Pads
- Ante Room (if needed)

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SUBJECT: Quality Committee Charter

DEPARTMENT: ORGANIZATIONAL

EFFECTIVE: 09.03.20

REVISED: 03.27.24

PURPOSE:

The Board Quality Committee is responsible for guiding and assisting the Executive Leaders, Medical Staff, and the Governing Board in fulfilling their responsibility to oversee safety, quality, and effectiveness of care at Sonoma Valley Hospital; and to meet or exceed standards and regulations that govern health care organizations.

RESPONSIBILITIES:

The Committee has three broad sets of responsibilities.

- To oversee that quality assurance and improvement processes are in place and operating in the hospital.
- To enhance quality across and throughout the patient care, technical, and operation areas of Sonoma Valley Hospital. This encompasses all aspects of the interface and experience between patients, families, and the community. This also includes coordination and alignment within the organization.
- To assure continual learning and skills development for risk surveillance, prevention, and continuous improvement.

The committee examines all activities against the Institute of Medicine's Six Aims for Improvement: safe, effective, patient/family-centered, efficient, timely, and equitable. This also aligns with the strategic plan of Sonoma Valley Hospital.

POLICY:

Oversight

As the governing body, the Governing Board is charged by law and by accrediting and regulatory organizations (e.g., Center for Improvement in Healthcare Quality CIHQ) with ensuring the quality of care rendered by Sonoma Valley Hospital through its various divisions and departments. The Committee has the delegated authority to establish accountability in medical staff and management to assure improvement is occurring and targeted outcomes are achieved. To help meet this responsibility, the Board Quality Committee exists to:

- Develop the quality goals and blueprint (priorities and strategies) for Sonoma Valley Hospital, using an inclusive and data driven-process.

- Review and monitor patient safety, risk mitigation, quality assurance, and improvement plans and progress.

- Have the authority to initiate inquiries, studies, and investigations within the purview of duties assigned to the Committee.

- Perform, on behalf of the Governing Board and Medical Staff Leadership, such other activities as are required by the CIHQ, Centers for Medicaid and Medicare Services (CMS), and other external accrediting and regulatory bodies.

- Render reports and recommendations to the Executive Leadership Committee of Sonoma Valley Hospital and SVH Medical Staff on its activities.

- Review all new and updated hospital patient care policies for adherence to quality and safety priorities.

- Review all Medical Staff credentialing.

Quality Integration

- The Committee monitors the quality assurance and improvement activities of Sonoma Valley Hospital's entities to enhance the quality of care provided throughout the hospital or medical center system and encourage a consistent standard of care. Monitored activities include but are not limited to:
    - Quality Performance Indicator Set
        - Mortality
        - Preventable Harm Events
        - Healthcare Acquired Infections
        - Medication Events
        - Never Events
        - Core Measures
        - Readmissions
        - Utilization Review
    - Patient Experience
    - Accreditation & Regulatory Standards
    - Quality Assurance Performance Improvement
    - Culture of Safety
    - Risk Event Reports
    - Policies & Procedures

- The Committee ensures the coordination and alignment of quality initiatives throughout Sonoma Valley Hospital.

- The Committee conducts annual reviews of the following key areas:
    - Improvement goal achievement
    - Clinical outcomes (priorities and improvement)
    - Patient Safety/Event Analysis/Risk Trending
    - Culture of Patient Safety
    - Accreditation and Regulatory Reviews
    - Emergency Operations Plans

- The Committee monitors the progress of quality assurance and improvement processes and serves as champion of issues concerning quality to other committees.

- The Committee identifies barriers to improvement for resolution and systematically addresses and eliminates barriers and excuses.

PROCEDURE:

All Committee meetings will have a Standard Agenda, which will include:

- Quality Performance Indicator Set
- Clinical Priorities (clinical outcomes/process improvement), including:
    - Quality Assurance Performance Improvement
    - Patient harm
    - Patient safety (adverse event reduction, healthcare acquired infection reduction, risk mitigation)
    - Performance to accreditation and regulatory standards and requirements
    - Patient Experience
    - Culture of Safety
    - Policies and Procedures
    - Medical Staff Credentialing

SUBJECT: Quality Committee Charter

DEPARTMENT: ORGANIZATIONAL

EFFECTIVE: 09.03.20

REVISED: 03.27.24

Rules

Charter Review	Will be reviewed/revised, at a minimum, every three years. Changes will be submitted to the Board of Directors for approval.
Authority to Act	In compliance with the Charter and as directed by Executive Leadership and the District Board
Meeting Schedule	At least ten meetings per year
Voting Members:	The Board Quality Committee shall have at least seven and no more than nine voting members. • Two Board members o One of whom shall be the QC chair, the other the vice-chair • Vice Chief of Staff • At least four and no more than six members of the public are selected by the Governing Board.
Quorum Requirement:	Half plus one member present.
Chair	One of the appointed Board Members
Composition	Voting Committee Members, Presenters, CEO, Chief Medical Officer (CMO) and Chief Nursing Officer (CNO), Director of Quality

REFERENCES:

www.ihi.org/improvement-areas/triple-aim-population-health
www.ihi.org/insights/quintuple-aim-why-expand-beyond-triple-aim

Quality Indicator Performance & Plan

Board Quality Presentation April 2024

Data For March 2024

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Mortality

Mortality

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Acute Care Mortality Rate (M)								
History 	Target Met	3.5% 2/57	Improved	Mar 2024	15.3%	n/a	n/a	3.3%
COPD Mortality Rate |M|								
History 	Breaches Alarm	25.0% 1/4	Deteriorated	Mar 2024	8.5%	n/a	n/a	3.2%
Congestive Heart Failure Mortality Rate |M|								
History 	Target Met	0.0% 0/3	No Change	Mar 2024	11.5%	n/a	n/a	0.0%
Pneumonia Mortality Rate |M|								
History 	Target Met	0.0% 0/6	Improved	Mar 2024	15.6%	n/a	n/a	4.8%
Ischemic Stroke Mortality Rate |M|								
History 	Target Met	0.0% 0/1	No Change	Mar 2024	13.8%	n/a	n/a	0.0%
Hemorrhagic Stroke - Mortality Rate (M)								
History 	Target Met	0.0% 0/1	No Change	Jun 2023	0.0%	1.0%	n/a	14.3%

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Sepsis, Severe - Mortality Rate (M)								
History 	Target Met	0.0% 0/5	No Change	Mar 2024	25.0%	n/a	n/a	12.5%
Septic Shock - Mortality Rate (M)								
History 	Target Met	0.0% 0/1	Improved	Mar 2024	25.0%	n/a	n/a	25.0%

AHRQ Patient Safety Indicators

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		x̄
PSI 90 (v2023-1) Midas Patient Safety Indicators Composite, ACA (M)								
75% 25% History	Breaches Alarm	9.80 0.049/0.005	Improved	Mar 2024	0.00	n/a	n/a	4.17
PSI 90 (v2023-1) Patient Safety Indicators Composite, ACA - Numerator Volume (M)								
75% 25% History	Breaches Alarm	1	No Change	Mar 2024	0	n/a	n/a	0

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Adverse Events Reporting

Indicator	Performance	Most Recent	Trend	Period				
Adverse Event | SE (M) volume 100% History	Target Met	0	No Change	Mar 2024	0	1	n/a	0

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Blood Products

Lab | Transfusion Effectiveness (M) 	Target Met	100.0% 5/5	No Change	Mar 2024	100.0%	99.0%	n/a	96.6%
Lab | Transfusion Reaction (M) 	Target Met	0.0% 0/42	No Change	Mar 2024	0.0%	1.0%	n/a	0.8%

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Significant Medication Errors and Adverse Drug Reactions

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Rx-ADEs-High Risk Med Errors Per 10,000 Doses (M) 100% History	Target Met	0.00 0/55987	— No Change	Mar 2024	1.13	2.00	n/a	0.09
Rx-Administration Errors Per 10,000 Doses Dispensed 91% 9% History	Target Met	0.89 5/55987	Deteriorated	Mar 2024	1.00	3.00	n/a	0.40

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Patient Falls

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
RM ACUTE FALL- All (M) per 1000 patient days								
75% 16% 9%	Breaches Alarm	10.42 2/192	Deteriorated	Mar 2024	3.75	4.00	n/a	1.62
History								
RM ACUTE FALL- WITH INJURY (M) per 1000 patient days								
91% 9%	Breaches Alarm	5.21 1/192	Deteriorated	Mar 2024	3.75	4.00	n/a	0.32
History								

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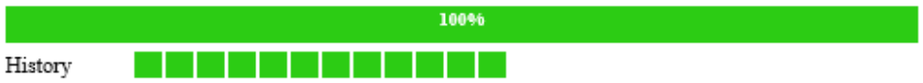
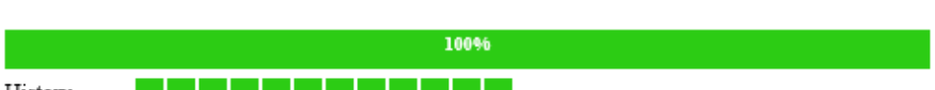
Readmissions

Indicator	Performance	Most Recent	Trend	Period				
30-DV Inpatients - % Readmit to Acute Care within 30 Days (M)								
History 	Target Met	7.69% 4/52	Improved	Mar 2024	15.30%	15.50%	n/a	5.86%
COPD, CMS Readm - % Readmit within 30 Days, ACA (M)								
History 	Target Met	0.0% 0/2	Improved	Mar 2024	19.5%	20.0%	n/a	13.0%
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
History 	Breaches Alarm	33.3% 1/3	Deteriorated	Mar 2024	21.6%	22.0%	n/a	8.8%
Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
History 	Target Undefined	n/a 0/0		Mar 2024	4.0%	5.0%	n/a	9.1%
PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
History 	Bet. Target & Alarm	16.7% 1/6	Deteriorated	Mar 2024	16.6%	17.0%	n/a	1.7%
Sepsis, Severe - % Readmit within 30 Days (M)								
History 	Target Met	0.0% 0/4		Mar 2024	12.0%	13.0%	n/a	0.0%
Septic Shock - % Readmit within 30 Days (M)								
History 	Target Met	1.0% 1/1	Deteriorated	Mar 2024	13.3%	14.0%	n/a	0.2%

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Blood Culture Contamination

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Blood Cultures -Contamination Rate |LAB| (M)								
91% 9% History	Bet. Target & Alarm	3.1% 3/96	Deteriorated	Mar 2024	3.0%	4.0%	n/a	1.3%
Blood Cultures -Total Contamination Rate (M)								
66% 34% History	Bet. Target & Alarm	3.8% 8/210	Deteriorated	Mar 2024	3.0%	4.0%	n/a	2.2%
Blood Cultures -Contamination Rate |RN| (M)								
58% 8% 34% History	Breaches Alarm	4.4% 5/113	Improved	Mar 2024	3.0%	3.1%	n/a	3.0%

Month	RN-Contaminated Culture Reports (num)	Blood Cultures Drawn by RN (den)	Percent
Mar 2024	5	113	4.4%
Feb 2024	5	86	5.8%
Jan 2024	1	93	1.1%
Dec 2023	3	112	2.7%
Nov 2023	2	134	1.5%
Oct 2023	3	122	2.5%
Sep 2023	1	97	1.0%
Aug 2023	5	94	5.3%
Jul 2023	2	89	2.2%
Jun 2023	3	98	3.1%
May 2023	1	111	0.9%
Apr 2023	7	104	6.7%

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CIHQ Stroke Certification Measures

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
CDSTK-03|Median- Code Stroke Called |M| elapsed time (mins)	Target Met	2	Improved	Mar 2024	10	11	n/a	4
CDSTK-04|Median- Door to Phys Eval |M| minutes	Target Met	0	Improved	Mar 2024	10	11	n/a	2
CDSTK-05|Median- Door to CT Scanner |M|elapsed time (minutes)	Target Met	4	Improved	Mar 2024	25	26	n/a	8
CDSTK-06|Median- Neuro Consult Contacted |M| minutes	Target Met	22	Deteriorated	Mar 2024	30	31	n/a	22
CDSTK-07|Median- CT Read by Radiology |M| minutes	Target Met	20	Improved	Mar 2024	45	46	n/a	27
CDSTK-08|Median- Lab Results Posted |M| minutes	Target Met	22	Improved	Mar 2024	45	46	n/a	24
CDSTK-10|Median- Door to EKG Complete |M| minutes	Target Met	30	Deteriorated	Mar 2024	60	61	n/a	35
CDSTK-11|Median-Door to tPA Decision |M| minutes	Target Met	14	Improved	Mar 2024	60	61	n/a	36
CDSTK-12|Median-Door to tPA |M| minutes	Target Met	58		Mar 2024	60	61	n/a	58

Utilization Management

Utilization Management

Indicator	Performance	Most Recent	Trend	Period	◎	🔔		✕
MS-DRG Case Mix Index (CMI) |M| 58% 42% History	Breaches Alarm	1.30	Deteriorated	Mar 2024	1.55	1.40	n/a	1.41
MS-DRG Case Mix Index (CMI) MEDICARE |M| 41% 9% 50% History	Breaches Alarm	1.31	Deteriorated	Mar 2024	1.55	1.40	n/a	1.45
1 Day Stay Rate Medi-Cal |M| 100% History	Target Met	0.00% 0/11	No Change	Mar 2024	2.61%	5.00%	n/a	0.00%
1 Day Stay Rate-Medicare |M| 100% History	Target Met	0.00% 0/38	No Change	Mar 2024	8.10%	10.00%	n/a	0.00%
Medicare Risk-adjusted Average Length of Stay, O/E Ratio |M| 95% 5% History	Target Met	0.78 128/163.2	Improved	Mar 2024	0.99	1.00	n/a	0.85
Acute Care - Geometric Mean Length of Stay |M| 50% 50% History	Breaches Alarm	4.28 42.8047/10	Improved	Mar 2024	2.75	3.23	n/a	3.46

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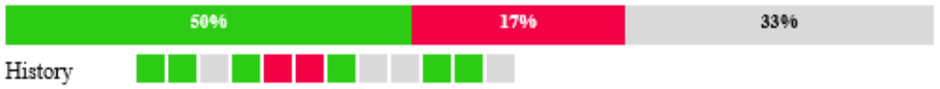
Core Measures

Indicator	Performance	Most Recent	Trend	Period				
Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M)								
History 	Target Met	100.0% 10/10	No Change	Mar 2024	88.0%	50.0%	n/a	100.0%
Indicator	**Performance**	**Most Recent**	**Trend**	**Period**				
Core OP 18b Median Time ED Arrival to ED Departure - Reporting Measure (M)								
History 	Breaches Alarm	177.00	Deteriorated	Mar 2024	132.00	140.00	n/a	149.75
Core OP 22 ED LWBS Emergency Dept Left Without Being Seen (M)								
History 	Target Met	0.2% 2/812	Improved	Mar 2024	2.0%	2.5%	n/a	0.5%
Indicator	**Performance**	**Most Recent**	**Trend**	**Period**				
Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)								
History 	Target Undefined	n/a		Mar 2024	72.0%	70.0%	n/a	80.0%

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Core Measures Sepsis

Indicator	Performance	Most Recent	Trend	Period				
SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock (M)								
50% 50% History	Target Met	100.0% 5/5	Improved	Mar 2024	81.0%	80.0%	n/a	76.9%
SEPa - Severe Sepsis 3 Hour Bundle (M)								
50% 50% History	Target Met	100.0% 5/5	Improved	Mar 2024	94.0%	90.0%	n/a	86.2%
SEPb - Severe Sepsis 6 Hour Bundle (M)								
83% 17% History	Target Met	100.0% 5/5	No Change	Mar 2024	100.0%	90.0%	n/a	95.9%

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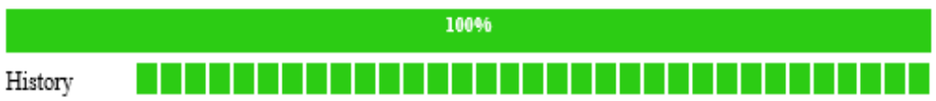
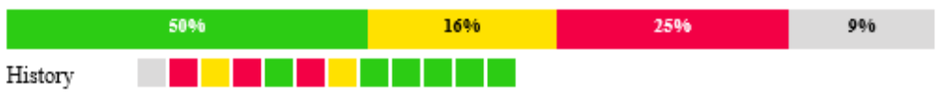
Infection Prevention

Infection Prevention

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
IC-Surveillance| HAI-C.DIFF Inpatient infections per 10k pt days |M|								
	Target Met	0	No Change	Mar 2024	1	1	n/a	0
IC-Surveillance| HAI-CAUTI Inpatient infections per 10k patient days |M|								
	Target Met	0	Improved	Mar 2024	1	1	n/a	0
IC-Surveillance| HAI-CLABSI Inpatient infections per 10k patient days |M|								
	Target Met	0	No Change	Mar 2024	1	1	n/a	0
IC-Surveillance| HAI-MRSA Inpatient infections per 10k patient days |M|								
	Target Met	0	No Change	Mar 2024	1	1	n/a	0
IC-Surveillance| HAI-SSI infections per 10k pt days |M|								
	Target Met	0	No Change	Mar 2024	1	1	n/a	0
QA-02 | Hand Hygiene Practices Monitored |M|								
	Target Met	96% 48/50	Improved	Mar 2024	90%	85%	n/a	86%

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CIHQ Corrective Action Plan Monthly Compliance Condition Level Findings

QS-10 | Documentation: Continuous Observation of High Risk Pts |M|

Breaches Alarm	89% 8/9	Improved	Mar 2024	100%	95%	n/a	58%

DATE	1:1 Observation for High Risk Patie		Percent
Mar 2024	8	9	89%
Feb 2024	9	11	82%
Jan 2024	6	6	100%
Dec 2023	5	8	62%
Nov 2023	4	4	100%
Oct 2023	3	6	50%
Sep 2023	2	6	33%
Aug 2023	2	4	50%
Jul 2023	1	5	20%
Jun 2023	2	6	33%
May 2023	1	9	11%

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CIHQ Corrective Action Plan Quarterly Compliance Standard Level Findings

Indicator	Performance	Most Recent	Trend	Period				
RS-07 | Timely MD Order for Restraint |M| 63% 18% 10% 9% History	Bet. Target & Alarm	86% 6/7	Deteriorated	Mar 2024	90%	85%	n/a	95%
CE-11 | Monitoring Temperature and Humidity Logs|M| 18% 82% History	Breaches Alarm	84.4% 227/269	Improved	Mar 2024	100.0%	95.0%	n/a	70.8%
QA-02 | Hand Hygiene Practices Monitored |M| 50% 16% 25% 9% History	Target Met	96% 48/50	Improved	Mar 2024	90%	85%	n/a	86%
GL-04 | Policies in Compliance for Review |M| 100% History	Breaches Alarm	74% 697/944	No Change	Mar 2024	90%	85%	n/a	68%
RS-07 | Timely MD Order for Restraint |M| 72% 9% 10% 9% History	Target Met	100% 6/6	No Change	Mar 2024	90%	85%	n/a	96%
RS-12 | MedStaff Restraint Policy Review Monitoring |M| 63% 28% 9% History	Bet. Target & Alarm	98% 49/50	No Change	Mar 2024	100%	90%	n/a	76%
QS-07 | Accuracy in Patient Identification |M| 45% 9% 37% 9% History	Target Met	90% 9/10	Deteriorated	Mar 2024	90%	85%	n/a	90%
PR-02 | IMM Signed Within 48 hours |M| 75% 9% 16% History	Target Met	100.0% 44/44	No Change	Mar 2024	90.0%	85.0%	n/a	98.0%
IC-10 | MedStaff Antimicrobial Stewardship Training Monitoring |M| 91% 9% History	Breaches Alarm	33% 10/30	No Change	Mar 2024	100%	90%	n/a	23%

Patient Satisfaction

HCAHPS reported quarterly

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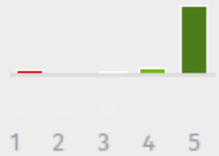
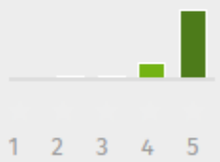
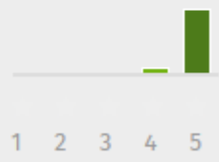
Rate My Hospital
Scale 1-5
March Data

	Question Responses	Average Score	Score breakdown
Sonoma Valley Hospital / Emergency Department	96	4.546 95% CI: 4.477—4.616	

	Question Responses	Average Score	Score breakdown
Sonoma Valley Hospital / Inpatient Care	6	4.500 95% CI: Not enough samples	

	Question Responses	Average Score	Score breakdown
Sonoma Valley Hospital / Outpatient Surgery	40	4.872 95% CI: 4.833—4.911	

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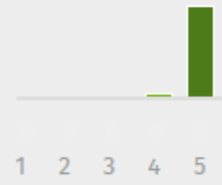
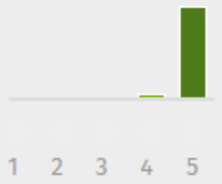
Rate My Hospital
Scale 1-5
March Data

	Question Responses	Average Score	Score breakdown
Sonoma Valley Hospital / Medical Imaging	206	4.917 95% CI: 4.897—4.937	

	Question Responses	Average Score	Score breakdown
Sonoma Valley Hospital / Hand and Physical Therapy	156	4.939 95% CI: 4.923—4.955	

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Document Tasks By Committee

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

Sonoma Valley Hospital

Run by: Reese, Whitney (wreese)
Run date: 04/19/2024 12:00 PM

Report Parameters

Filtered by: Document Set: - All Available Document Sets -
Committee: 07 BOD-Quality (P&P Review)
Include Current Tasks: Yes
Include Upcoming Tasks: No

Grouped by: Committee

Sorted by: Document Title

Report Statistics

Total Documents: 2

Committee: **07 BOD-Quality (P&P Review)**

Committee Members: **Finn, Stacey (sfinn), Newman, Cindi (cnewman), Reese, Whitney (wreese)**

Current Approval Tasks (due now)

Document	Task/Status	Pending Since	Days Pending
AccuChek Inform II Glucose Monitoring System *Laboratory Services Policies (LB)*	**Pending Approval**	4/18/2024	1

Summary Of Changes: **1. Added STAT confirmation with patient glucose result of <50mg/dl and >400mg/dl**
2. Added scanning patient armband and confirming CSN# prior to patient testing

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Kuwahara, Dawn (dkuwahara), Ramos, Karen (kramos), Lugo, Al (alugo)**

ExpertReviewers: **Medical Director-Lab**

Approvers: **Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Document	Task/Status	Pending Since	Days Pending
Clozapine REMS Procedure *Pharmacy Dept*	**Pending Approval**	4/18/2024	1

Summary Of Changes: **Added "- Obtain a REMS Dispense Authorization (RDA)" to step 2**

Moderators: **Kutza, Chris (ckutza), Newman, Cindi (cnewman)**

Lead Authors: **Kutza, Chris (ckutza)**

Approvers: **01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**