

## SVHCD QUALITY COMMITTEE

### AGENDA

**WEDNESDAY, JANUARY 22, 2025**

**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/99901004530?from=addon>

Meeting ID: 999 0100 4530

One tap mobile

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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 <a href="mailto:wreese@sonomavalleyhospital.org">wreese@sonomavalleyhospital.org</a> , at least 48 hours prior to the meeting.		
<b>MISSION STATEMENT</b> <i>The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.</i>		
<b>1. CALL TO ORDER/ANNOUNCEMENTS</b>	<i>Daniel Kittleson, DDS</i>	
<b>2. PUBLIC COMMENT SECTION</b> <i>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.</i>	<i>Daniel Kittleson, DDS</i>	
<b>3. CONSENT CALENDAR</b> • Minutes 12.11.24	<i>Daniel Kittleson, DDS</i>	Action
<b>4. EMERGENCY DEPARTMENT REPORT</b>	<i>Marylou Ehret, MSN, RN OCN</i>	Action
<b>5. LEAPFROG SURVEY EXAMINATION</b>	<i>Jessica Winkler, DNP, RN, NEA-BC, CCRN</i>	Inform
<b>6. QUALITY INDICATOR PERFORMANCE &amp; PLAN</b>	<i>Jessica Winkler, DNP, RN, NEA-BC, CCRN</i>	Inform
<b>7. POLICIES AND PROCEDURES</b>	<i>Jessica Winkler, DNP, RN, NEA-BC, CCRN</i>	Inform
<b>8. CLOSED SESSION:</b> a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	<i>Daniel Kittleson, DDS</i>	Action
<b>9. ADJOURN</b>	<i>Daniel Kittleson, DDS</i>	



**SONOMA VALLEY HEALTH CARE DISTRICT  
QUALITY COMMITTEE**

**Wednesday, December 11, 2024, 5:00 PM**

**MINUTES**

**Via Zoom Teleconference**

<b>Members Present</b>	<b>Excused/Not Present</b>	<b>Public/Staff – Via Zoom</b>
Wendy Lee Myatt (chair sub) Daniel Kittleson, DDS, via zoom Kathy Beebe, RN PhD Carol Snyder Howard Eisenstark, MD Susan Kornblatt Idell Carl Speizer, MD Paul Amara, MD, FACOG, via zoom	Michael Mainardi, MD	Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, SVH CNO Whitney Reese, SVH Board Clerk Chris Kutza, PharmD John Hennelly, SVH CEO

<b>AGENDA ITEM</b>	<b>DISCUSSION</b>	<b>ACTION</b>
<b>1. CALL TO ORDER/ANNOUNCEMENTS</b>	<i>Wendy Lee Myatt &amp; Daniel Kittleson, DDS</i>	
	Lee Myatt called meeting to order at 5:00pm.	
<b>2. PUBLIC COMMENT SECTION</b>	<i>Wendy Lee Myatt</i>	
	No public comments	
<b>3. CONSENT CALENDAR</b> Minutes 10.23.24	<i>Wendy Lee Myatt</i>	<b>ACTION</b>
*name edit made	<i>Motion to approve by Kornblatt Idell, 2<sup>nd</sup> by Snyder</i>	
<b>4. PT/OT QA/PI</b>	<i>Chris Kutza, PharmD</i>	<b>INFORM</b>
Kutza presented that the pharmacy department monitors various quality measures, including adverse drug events, antimicrobial stewardship, controlled substance usage, and IV room compliance, all under stringent regulatory requirements. Significant updates include revising the Title 22-mandated medication error reduction plan (MERP) and adapting smart pump guardrails to enhance patient safety. Monitoring metrics include		

<p>high-risk medication errors, near misses, antimicrobial days of therapy, and pharmacy service turnaround times. Despite external challenges like IV fluid shortages, the department remained unaffected due to strong supplier partnerships. Ongoing updates and collaborations ensure compliance, safety, and continuous improvement across all pharmacy operations.</p>		
<b>5. 2024 YEAR IN REVIEW</b>	<i>Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, SVH CNO</i>	INFORM
<p>Winkler provided an overview of departmental achievements for 2024 and goals for 2025. Highlights included advancements in emergency department protocols, such as nurse-initiated orders and collaborative drills with fire and police departments, and surgical improvements like implementing an age-friendly health system and robotics programs. Quality and risk management efforts emphasized compliance, readiness for inspections, and fostering a culture of safety. Infection prevention saw progress in tracking metrics and reducing hospital-acquired infections. Other departments, including pharmacy, lab, imaging, and physical therapy, showcased enhancements in staffing, equipment, and patient care protocols. Looking ahead, priorities include expanding age-friendly initiatives, reducing patient wait times, and refining interdepartmental collaborations. The overall focus remains on improving patient outcomes, operational efficiency, and readiness for regulatory compliance.</p>		
<b>6. 2025 WORK PLAN: QUALITY COMMITTEE</b>	<i>Daniel Kittleson, DDS</i>	INFORM
<p>Discussed and confirmed pending meeting dates.</p>		
<b>7. QUALITY INDICATOR PERFORMANCE &amp; PLAN</b>	<i>Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, SVH CNO</i>	INFORM
<p>Winkler presented in October, SVH achieved positive outcomes in mortality rates, infection prevention, and stroke metrics, with only a few challenges. Improvements were implemented, such as updates to Epic for continuity in lab orders. HCAHPS scores reflected strong communication and care quality, though discharge medication teaching was behind state and national averages, it prompted efforts to involve pharmacists and standardize nurse communication. Discussions highlighted the stringent scoring criteria for patient satisfaction, the separation of ER and inpatient statistics, and how CMS aggregates performance metrics to determine reimbursements. Real-time feedback systems were praised for offering actionable insights faster than traditional reporting, underscoring the hospital's commitment to addressing gaps and enhancing care quality.</p>		
<b>7. POLICIES AND PROCEDURES</b>	<i>Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, SVH CNO</i>	INFORM
	<p>Winkler presented for approval to the Board of Directors:</p> <ul style="list-style-type: none"> <li>NEW_ NPO in the Emergency Department</li> </ul>	<p>Recommendations were made before submitting to BOD</p>
<b>8. CLOSED SESSION:</b> a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	<i>Lee Myatt</i>	ACTION
<p><i>Credentialing will be approved virtually prior to January 2025 Board of Directors meeting</i></p>		
<b>9. ADJOURN</b>	<i>Kornblatt Idell</i>	
<p>Meeting adjourned at 5:50 pm</p>		

# Emergency Department *Report to the Board Quality*

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JANUARY 2025

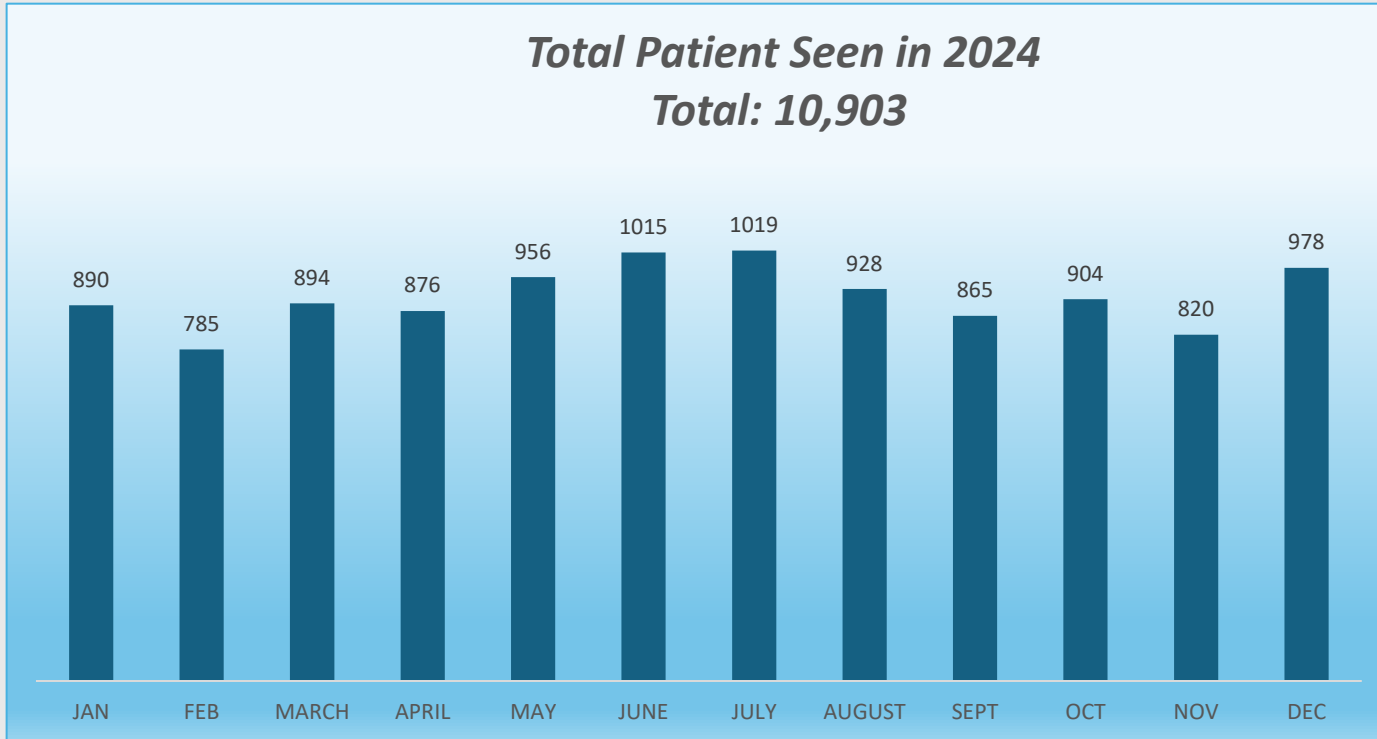
MARYLOU EHRET, MSN, RN

JESSICA WINKLER, DNP, RN, NEA-BC, CCRN

# Looking Back: ED Volume: 2024

Volumes are up – LWBS is down!

**Total Patient Seen in 2024**  
**Total: 10,903**



**Admits: 8.77% (n=944)**  
(2023: 872, 8.6%)

**Transfer to Higher Level of Care (HLOC): 9% (n=951)**  
(2023: 750; 7%)

**Left Without Being Seen (LWBS): 1% (n=147)** (2023: 226; 2%)

**Against Medical Advice (AMA): 1% (n=67)** (2023: 87, 1%)

n.b. Total patients 2023: 10,098

# Quality Metrics Tracked

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Stroke

Sepsis

Throughput

ED Wait Times

Patient Satisfaction



Blood Culture Contaminations

# ED Visit Times

## Median Initial Evaluation Times

 **11m** Arrival to Provider  
MTD

 **6m** Arrival to Roomed  
MTD

		Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	MTD
 Arrival to Triage Start	Goal 10 or less	9m	9m	8m	8m	8m	8m	8m
 Triage Time	Goal 10 or less	4m	5m	4m	4m	4m	4m	4m
 Arrival to Provider	Goal 35 or less	10m	12m	9m	11m	9m	10m	11m
 Triage End to Provider	Goal 15 or less	7m	6m	5m	4m	3m	6m	7m
 Arrival to Roomed	Goal 30 or less	6m	6m	5m	5m	4m	5m	6m
 Arrival to Depart	Goal 150 or less	148m	139m	140m	140m	140m	139m	155m

*n.b. The MTD score is January 2025*

# Q-Reviews Survey 2024

## Total Score

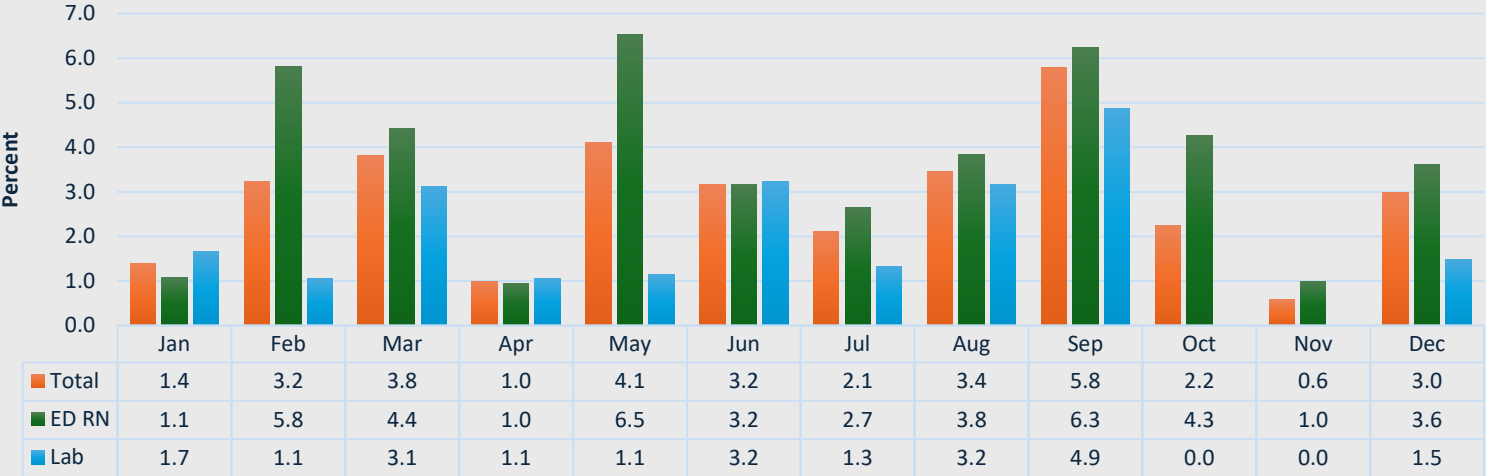
Location	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Department: Emergency Department	4.609	4.647	4.546	4.707	4.611	4.772	4.725	4.786	4.720	4.718	4.700	4.875

## By Question

Question	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Overall, how would you rate your experience with us?	4.596	4.600	4.467	4.673	4.553	4.769	4.731	4.788	4.705	4.701	4.623	4.915
How would you rate the courtesy of the staff in the registration area?	4.615	4.767	4.778	4.830	4.843	4.874	4.831	4.819	4.813	4.776	4.843	4.932
How would you rate the waiting time at the Emergency Department?	4.337	4.411	4.371	4.580	4.559	4.602	4.568	4.635	4.661	4.591	4.717	4.761
How would you rate the cleanliness of the Emergency Department?	4.642	4.739	4.633	4.795	4.755	4.889	4.792	4.835	4.811	4.811	4.843	4.923
How would you rate the courtesy of your doctor?	4.734	4.733	4.589	4.795	4.608	4.924	4.800	4.856	4.795	4.789	4.701	4.907
How would you rate the time your doctor spent with you?	4.667	4.644	4.456	4.685	4.544	4.744	4.605	4.779	4.721	4.622	4.561	4.750
How helpful was your nurse?	4.674	4.722	4.663	4.725	4.738	4.718	4.783	4.865	4.721	4.811	4.766	4.914
How likely are you to recommend us to a friend or loved one?	4.613	4.622	4.483	4.645	4.485	4.767	4.714	4.796	4.686	4.762	4.625	4.949
How well were your tests, treatments, and medications explained to you?	4.645	4.633	4.478	4.655	4.544	4.692	4.723	4.779	4.664	4.680	4.689	4.821
How well were your discharge instructions explained to you?	4.574	4.600	4.544	4.682	4.485	4.741	4.706	4.709	4.623	4.643	4.629	4.880



# QAPI: Blood Culture Draws 2024



Blood Culture Report - Monthly for 2024	Month												YTD
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Total Blood Cultures Processed	214	186	210	200	195	221	189	145	121	179	174	234	2268
Total Contamination Cultures	3	6	8	2	8	7	4	5	7	4	1	7	62
<b>Total Contamination Rate (percent)</b>	<b>1.4</b>	<b>3.2</b>	<b>3.8</b>	<b>1.0</b>	<b>4.1</b>	<b>3.2</b>	<b>2.1</b>	<b>3.4</b>	<b>5.8</b>	<b>2.2</b>	<b>0.6</b>	<b>3.0</b>	<b>2.7</b>
<i>ED RN Contamination Rate (percent)</i>	<i>1.1</i>	<i>5.8</i>	<i>4.4</i>	<i>1.0</i>	<i>6.5</i>	<i>3.2</i>	<i>2.7</i>	<i>3.8</i>	<i>6.3</i>	<i>4.3</i>	<i>1.0</i>	<i>3.6</i>	<i>3.6</i>
<i>Lab Contamination Rate (percent)</i>	<i>1.7</i>	<i>1.1</i>	<i>3.1</i>	<i>1.1</i>	<i>1.1</i>	<i>3.2</i>	<i>1.3</i>	<i>3.2</i>	<i>4.9</i>	<i>0.0</i>	<i>0.0</i>	<i>1.5</i>	<i>1.7</i>
Acceptable Contamination Rate ≤3.0%	Yes	Yes	No	Yes	Yes	No	Yes	No	No	Yes	Yes	Yes	YES

# QAPI: Documenting Observation of High-Risk Patients

*Recommendations from CIHQ findings*

Audit bundle consists of 3 components: MD order, finding and utilizing specific flow sheet, documenting every hour or more

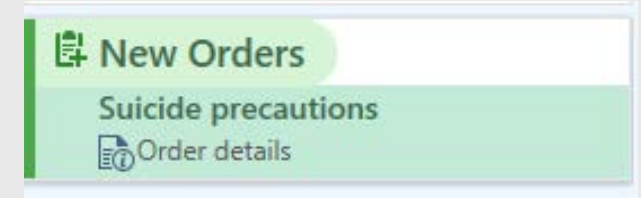
Overall: 74%

## Bundle Breakdown:

MD order compliance: 84%

Correct flow sheet: 93%

Every 1hr obs documented: 89%



	1145	1200	1215
<b>Suicide-Psych Observations</b>			
Type	q 15 min checks	q 15 min checks	Other (Com...)
Reasons for Observation	Suicide precau...	Suicide precau...	Suicide precau...
Behavior	Compliant	Compliant	Compliant
Affirms Safety	Yes	Yes	Yes
Mental Status	Oriented X3	Oriented X3	Oriented X3
Answers Questions	Yes	Yes	Yes
Activity/Location	In room	In room	In room
RN/Therapist Assessment q2h	Done	Done	Done
RN/Therapist Assess Next Due			
<b>RN/Therapist Only</b>			
Thought Process	Organized	Organized	Organized
Thought Content	Non-psychotic	Non-psychotic	Non-psychotic
Mood	Euthymic	Euthymic	Euthymic



# QAPI: Documenting Observation of High-Risk Patients 2024

**81** patients needing continuous observation for safety

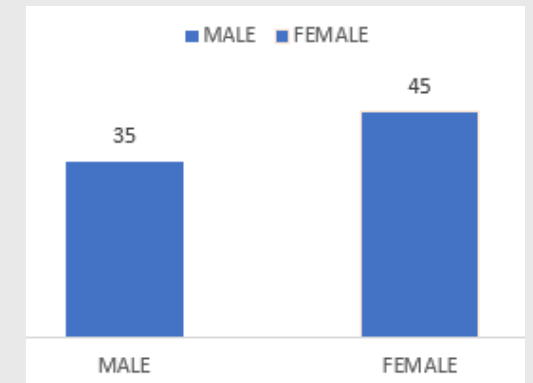
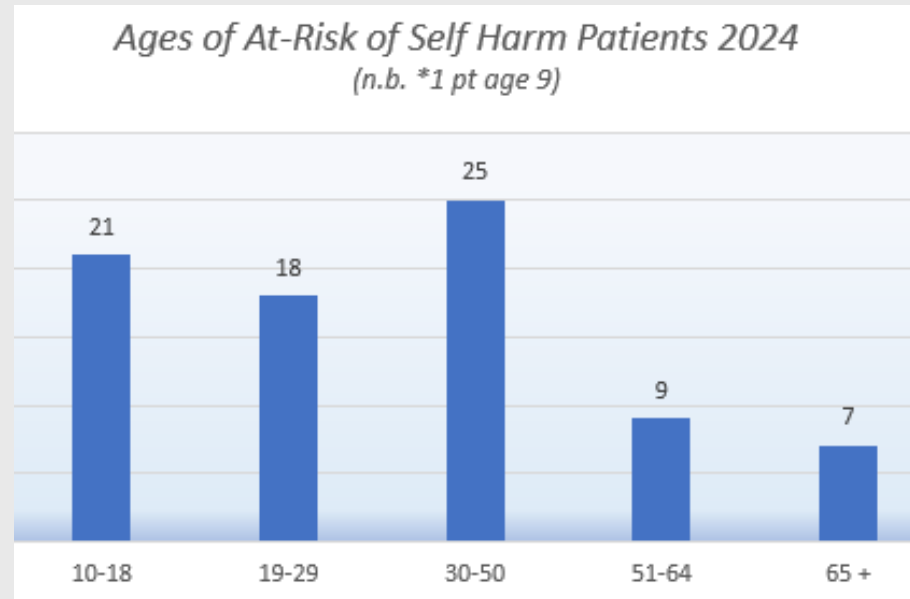
Age range: **9 – 80**

**LOS in ED:** 2 hours – 4 days.

Average LOS 22hrs\*

18 pts stayed >24hrs

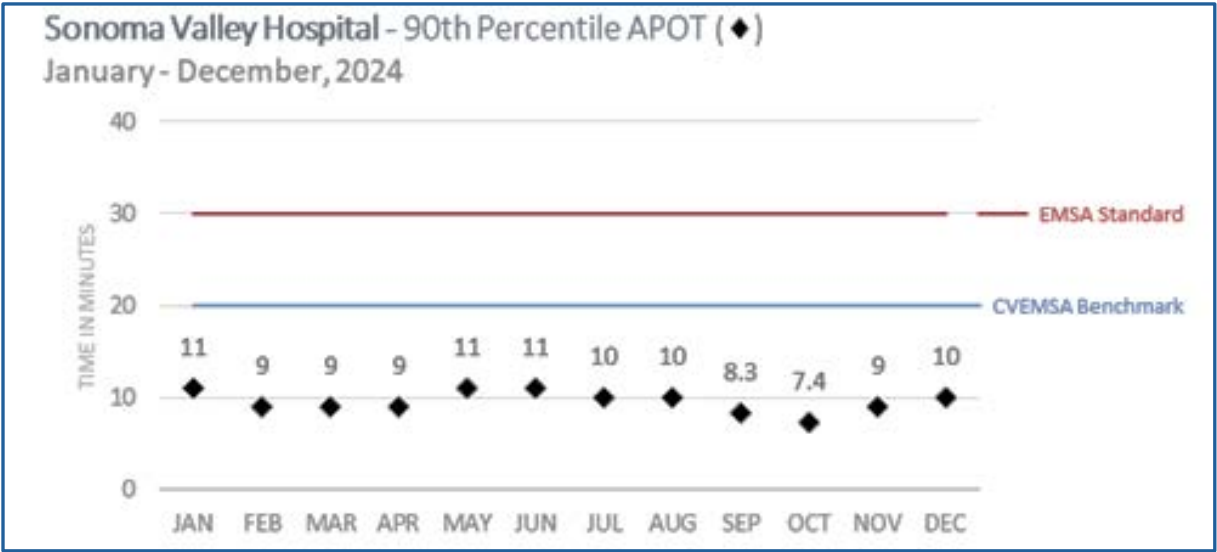
(\*One outlier: 1 pt stayed 9.6 days\* Not included in average)



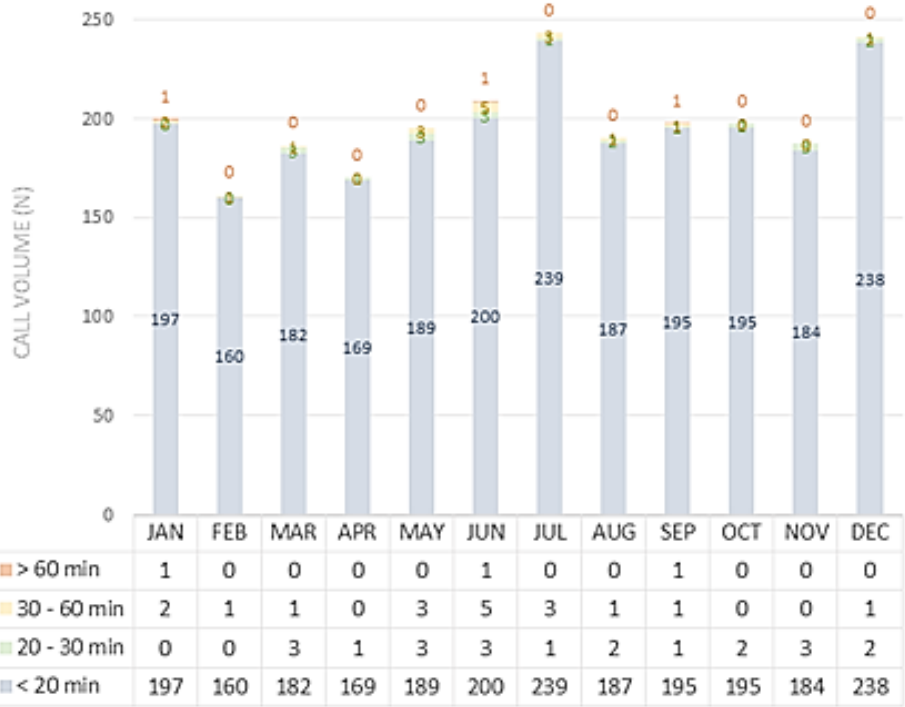
(n.b. one non-binary patient)

# Ambulance Patient Off-load Time (APOT)

Assembly Bill 40 requires all hospitals submit a protocol to the Emergency Medical Services (EMSA) Authority that addresses APOT. Data is tracked by Coastal Valley EMSA and submitted. SVH has consistently low wait times for our first responders.

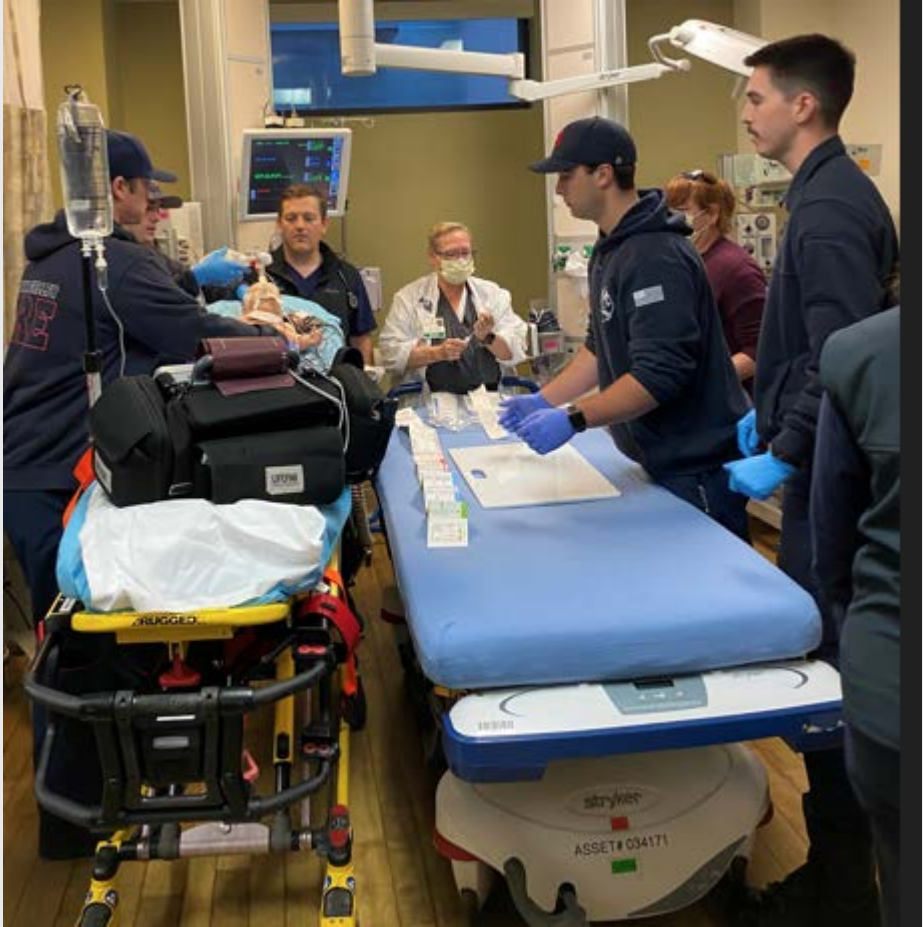


**Sonoma Valley Hospital - Call Volume by Ambulance Patient Offload Time (APOT)**  
January - December, 2024



Working with our First Responders: Coordinated Medical Emergency Drills (Spring and Fall, 2024)

**Advanced Cardiac Life Support (ACLS)**





Working with our First  
Responders: Coordinated  
Medical Emergency Drills (Spring  
and Fall, 2024)

**Pediatric Advanced Life Support  
(PALS)**





## Precipitous Birth and Neonatal Resuscitation Protocol (NRP)



# Looking Ahead.... 2025

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Staffing:

Addition of Clinical Coordinator

Reduction of travel RN use

Follow Up Phone Calls: Checking in on patients after their visit

Supplies Re-organization to improve workflow

Continued work on Quality Metrics

Strengthen relationships with our Fire, EMS and Police

Geriatric Emergency Department Accreditation: Education for RNs on targeted geriatric assessment practices, NPO and foley catheter policy updates



Questions?





SVH  
&  
The Leapfrog Survey  
January 2025

## *Who is Leapfrog?*

In 2000, a group of large employers and purchasers formed Leapfrog to independently assess hospital safety, to “empower purchasers to find the highest-value care”

## *Who does Leapfrog survey?*

- Almost 3,000 hospitals surveyed  
2,200 hospitals voluntarily participated, submitted significant data  
Leapfrog does NOT routinely survey: VA hospitals, specialty hospitals, or critical access

## *What is the Leapfrog Survey*

An extensive survey that includes:

Hospital Profile, Organizational culture; Nursing workforce details

Patient Rights and Ethics

Medication safety and practices

Surgical practices- adult and pediatric; outpatient procedures

Critical Care physician qualifications

# SVH does not participate in the Leapfrog Survey

## It is expensive

- Free to submit data – but there is cost to receive your results and use them in your media
- This is not a transparent cost- not listed on website. One article estimates \$5k-\$12k (Allen, 2024)

## It requires significant resources

- The survey is 330 pages in length
- One study found it took 12 people and 117 hours to complete (Erdmann, Marshall & Lay, 2024)

## Success requires larger volumes of patients and procedures

- Measurements are in terms of “per 1000 procedures” or “per 10000 patient days”

## We are regularly surveyed

- California Dept of Public Health – surprise (randomly) and scheduled (triennial)
- Center for the Improvement in Healthcare Quality (CIHQ)
- The Centers for Medicare & Medicaid Services (CMS)

## We do publicly report our data

- Required metrics (by CMS & CDPH regulations) are posted on SVH & CMS internet sites
- Public is invited to attend Board/BQ meetings, and/or review current & past meeting packets
- And soon, Hospital Quality Institute will make CDPH/CMS data more easily accessed to the public



# If we don't participate, how does Leapfrog rate us?

## Depending on the specific metric:

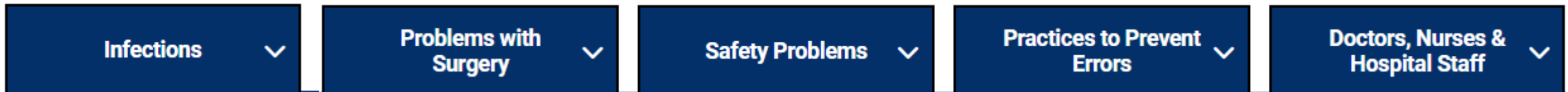
- Uses CMS Data (variable time frames: 2020-2023)
- Imputation Method: Leapfrog decides! Assigns lowest point value if we do not submit anything
- "Not available" or "Declined to report" may or may not have a score assigned to it (low score that is "assumed".)
- Points add up to give overall score

Past  
SVH  
Ratings:



# How did the Leapfrog decide SVH was a "C" ?

## *5 Domains:*



Let's go right to the source to drill in a bit:

[Sonoma Valley Hospital - CA - Hospital Safety Grade](#)

# *Should we try to participate?*

Aside from the significant resources and associated cost with complying, other points to consider are:

SVH still rated a “B” in past reports – without participation.

**Cost : Benefit may not there:**

Consistent low volumes of procedures or patient days for SVH- will we ever meet the metrics?

**Critiques of Leapfrog do exist:**

- “Leapfrog safe practices score as a standalone quality measure may have limited power to distinguish between high-quality and low-quality hospitals” (Quian, et al., 2011)
- “Voluntary Leapfrog SPS skew towards positive self-report with *little association with compulsory Medicare outcomes* and penalties.” (Smith, et al., 2018)
- “Multiple LFG standards do not align perfectly with other accrediting bodies, meaning that specific [clinical/organizational] changes would need to be made in order to score highly on several sections” (Erdmann, Marshall, & Lay, 2024)

# References

- Allen, J. (2024, December 12). What is the leapfrog group (and should you care about their ratings?) *What I've Learned As A Hospital Medical Director*. <https://hospitalmedicaldirector.com/what-is-the-leapfrog-group-and-should-you-care-about-their-ratings/>
- Erdmann, M., Marshall, C., & Lay, M. (2024). Transparency in hospital safety: A field study of “what it takes” for hospital to complete the leapfrog group hospital survey. *Oklahoma State University: Center for Health Sciences*.(8)1. <https://www.okstatedmedicalproceedings.com/index.php/OSMP/article/view/216>
- Qian, F., Lustik, S., Diachun, C., Wissler, R., Zollo, R., G. (2011) Association between leapfrog safe practices score and hospital mortality in major surgery. *Medical Care* 49(12):p 1082-1088
- Smith, S., Reichert, H., Ameling, J., Meddings, J. (2017) Dissecting leapfrog: how well do leapfrog safe practices scores correlate with hospital compare ratings and penalties, and how much do they matter?. *Medical Care* 55(6):p 606-614



# Useful Links












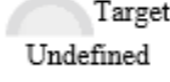




- [Hospital Quality Institute:](#)
  - [Quality Transparency Dashboard - HQI](#)
- [Leapfrog Survey Materials](#)
  - [Survey and CPOE Materials | Leapfrog](#)
- [Leapfrog Methodology](#)
  - [Safety-Grade-Scoring-Methodology-Fall-2024.pdf](#)

# Quality Indicator Performance & Plan

Board Quality Presentation for January 2025

Data For December 2024

# Mortality

Indicator	Performance	Most Recent	Trend	Period	
<b>Acute Care Mortality Rate (M)</b> 	 Target Met	4.6% 3/65	 Deteriorated	Dec 2024	5.0%
<b>COPD Mortality Rate [M]</b> 	 Target Met	0.0% 0/4	 No Change	Dec 2024	8.5%
<b>Congestive Heart Failure Mortality Rate [M]</b> 	 Target Met	0.0% 0/8	 No Change	Dec 2024	11.5%
<b>Pneumonia Mortality Rate [M]</b> 	 Target Met	12.5% 1/8	 Deteriorated	Dec 2024	15.6%
<b>Ischemic Stroke Mortality Rate [M]</b> 	 Target Met	0.0% 0/1	 No Change	Dec 2024	13.8%
<b>Hemorrhagic Stroke - Mortality Rate (M)</b> 	 Target Undefined	n/a		Dec 2024	0.0%
<b>Sepsis, Severe - Mortality Rate (M)</b> 	 Target Met	0.0% 0/3	 No Change	Dec 2024	25.0%
<b>Septic Shock - Mortality Rate (M)</b> 	 Target Met	0.0% 0/1	 No Change	Dec 2024	25.0%

All mortality rates below target threshold

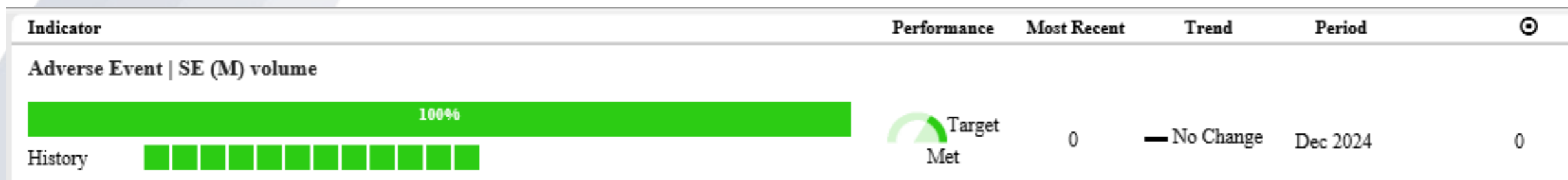
# AHRQ Patient Safety Indicators

Indicator	Performance	Most Recent	Trend	Period	🎯	
PSI 90 (v2023-1) Midas Patient Safety Indicators Composite, ACA (M)	 75% 25%	 Target Met	0.00 0/58	— No Change	Dec 2024	0.00
History						
PSI 90 (v2023-1) Patient Safety Indicators Composite, ACA - Numerator Volume (M)	 75% 25%	 Target Met	0	— No Change	Dec 2024	0
History						

- **No PSI 90 events**

- *CMS Patient Safety & Adverse Events Composite is a summary of varying patient safety events across multiple indicators, monitors performance over time, and facilitates comparative reporting and quality improvement.*  
<https://www.cms.gov/priorities/innovation/files/fact-sheet/bpciadvanced-fs-psi90.pdf>

# Adverse Events Reporting



- *No adverse events*

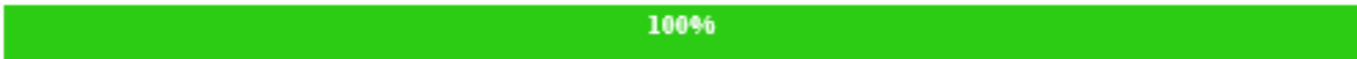



*(Severe/Sentinel events; Not PSI 90 events)*

# Patient Falls

Indicator	Performance	Most Recent	Trend	Period		
RM ACUTE FALL- All (M) per 1000 patient days	 66% 34%	7.60 2/263	Breaches Alarm	Deteriorated	Dec 2024	3.75
History						
RM ACUTE FALL- WITH INJURY (M) per 1000 patient days	 83% 8% 9%	3.80 1/263	Bet. Target & Alarm	Deteriorated	Dec 2024	3.75
History						

- 2 patient falls, one with minor injury.

# Significant Medication Errors: High Risk Meds and Administration Errors

Indicator	Performance	Most Recent	Trend	Period	
<b>Rx-ADEs-High Risk Med Errors Per 10,000 Doses (M)</b>	 100%	0.00 0/78658	— No Change	Dec 2024	1.13
History					
<b>Rx-Administration Errors Per 10,000 Doses Dispensed</b>	 91% 9%	0.76 6/78658	▲ Deteriorated	Dec 2024	1.00
History					

- *No High Risk Medication Errors*
- *Administration Error Rate below target*







# Infection Prevention

Indicator	Performance	Most Recent	Trend	Period	🕒
IC-Surveillance  HAI-C.DIFF Inpatient infections per 10k pt days [M]	 History	Target Met 0.000	— No Change	Dec 2024	1.000
IC-Surveillance  HAI-CAUTI Inpatient infections per 10k patient days [M]	 History	Target Met 0	— No Change	Dec 2024	1
IC-Surveillance  HAI-CLABSI Inpatient infections per 10k patient days [M]	 History	Target Met 0	— No Change	Dec 2024	1
IC-Surveillance  HAI-MRSA Inpatient infections per 10k patient days [M]	 History	Target Met 0	— No Change	Dec 2024	1
IC-Surveillance  HAI-SSI infections per 10k pt days [M]	 History	Target Met 0	— No Change	Dec 2024	1
QA-02   Hand Hygiene Practices Monitored [M]	 History	Target Met 94% 47/50	📉 Deteriorated	Dec 2024	90%

■ No HAI



# Blood Products: Transfusions

Indicator	Performance	Most Recent	Trend	Period	
<b>Lab   Transfusion Effectiveness (M)</b> 	 Target Met	100.0% 7/7	 No Change	Dec 2024	100.0%
<b>Lab   Transfusion Reaction (M)</b> 	 Target Met	0.0% 0/20	 No Change	Dec 2024	0.0%



















- *Transfusions effective; no transfusion reactions*

# Blood Culture Contamination

Indicator	Performance	Most Recent	Trend	Period	📍	
<b>Blood Cultures -Total Contamination Rate (M)</b>	 50% 33% 17%	 3.0%	 Target Met	 Deteriorated	Dec 2024	3.0%
History		7/234				
<b>Blood Cultures -Contamination Rate  LAB  (M)</b>	 66% 25% 9%	 1.5%	 Target Met	 Deteriorated	Dec 2024	3.0%
History		1/67				
<b>Blood Cultures -Contamination Rate  RN  (M)</b>	 33% 25% 42%	 3.6%	 Bet. Target & Alarm	 Deteriorated	Dec 2024	3.0%
History		6/166				

















- *Total of 7 contaminated out of 233 samples*  
*(n.b. the RN rate only reflects RNs in the ED)*

# CIHQ Stroke Certification Measures




















Indicator	Performance	Most Recent	Trend	Period	🔍	
CDSTK-03 Median- Code Stroke Called [M] elapsed time (mins)	 100%	Target Met	8	⬇️ Deteriorated	Dec 2024	10
History						
CDSTK-04 Median- Door to Phys Eval [M] minutes	 100%	Target Met	6	⬇️ Deteriorated	Dec 2024	10
History						
CDSTK-05 Median- Door to CT Scanner [M] elapsed time (minutes)	 100%	Target Met	12	⬇️ Deteriorated	Dec 2024	25
History						
CDSTK-06 Median- Neuro Consult Contacted [M] minutes	 100%	Target Met	25	⬇️ Deteriorated	Dec 2024	30
History						
CDSTK-07 Median- CT Read by Radiology [M] minutes	 100%	Target Met	31	⬇️ Deteriorated	Dec 2024	45
History						
CDSTK-08 Median- Lab Results Posted [M] minutes	 100%	Target Met	23	⬆️ Improved	Dec 2024	45
History						
CDSTK-10 Median- Door to EKG Complete [M] minutes	 100%	Target Met	25	⬆️ Improved	Dec 2024	60
History						
CDSTK-11 Median-Door to tPA Decision [M] minutes	 100%	Target Met	29	⬆️ Improved	Dec 2024	60
History						
CDSTK-12 Median-Door to tPA [M] minutes	 25% 50% 25%	Breaches Alarm	65	⬆️ Improved	Dec 2024	60
History						

Door-tPA(TNK) time: goal is 60 minutes.  
 November (1 case) 75 minutes (problems with order)  
 December (1 case) 65 minutes (family undecided/language barrier)

# Utilization Management

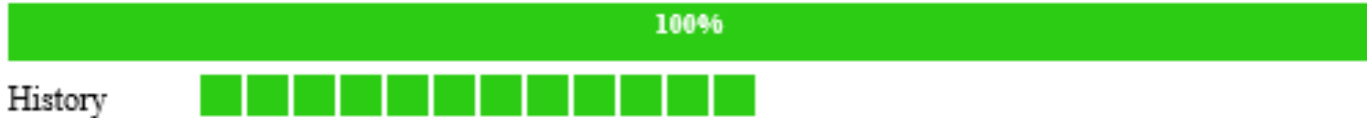





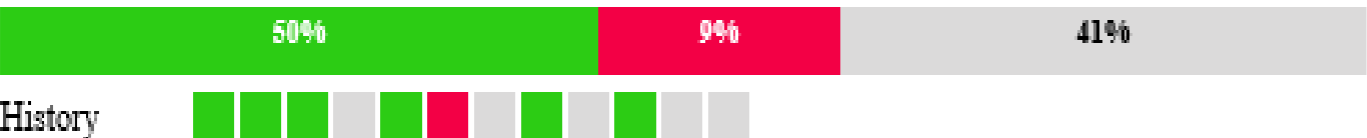

Indicator	Performance	Most Recent	Trend	Period		
MS-DRG Case Mix Index (CMI) [M]		Breaches Alarm	1.30	Improved	Dec 2024	1.55
History						
MS-DRG Case Mix Index (CMI) MEDICARE [M]		Breaches Alarm	1.28	Deteriorated	Dec 2024	1.55
History						
1 Day Stay Rate Medi-Cal [M]		Target Met	0.00% 0/11	No Change	Dec 2024	2.61%
History						
1 Day Stay Rate-Medicare [M]		Target Met	0.00% 0/53	No Change	Dec 2024	8.10%
History						
Acute Care Risk-adjusted Average Length of Stay, O/E Ratio [M]		Target Met	0.87 193/223.56	Deteriorated	Dec 2024	0.99
History						
Inpatients Risk-adjusted Average Length of Stay, O/E Ratio [M]		Target Met	0.90 212/235.15	Deteriorated	Dec 2024	0.99
History						
Medicare Risk-adjusted Average Length of Stay, O/E Ratio [M]		Target Met	0.84 107/127.08	Deteriorated	Dec 2024	0.99
History						
Acute Care - Geometric Mean Length of Stay [M]		Breaches Alarm	3.40 30.9926/9	Deteriorated	Dec 2024	2.75
History						

# Readmissions

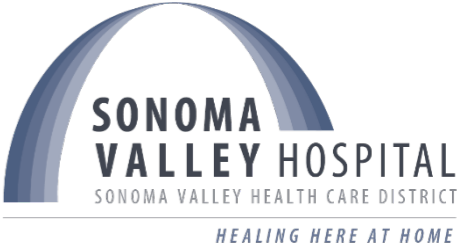
Indicator	Performance	Most Recent	Trend	Period		
30-DV Inpatients - % Readmit to Acute Care within 30 Days (M)	 100%	Target Met	7.69% 4/52	 Deteriorated	Dec 2024	15.30%
History						
COPD, CMS Readm - % Readmit within 30 Days, ACA (M)	 75% 17% 8%	Target Met	0.0% 0/2	 No Change	Dec 2024	19.5%
History						
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	 75% 25%	Target Met	16.7% 1/6	 Deteriorated	Dec 2024	21.6%
History						
Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	 41% 59%	Target Undefined	n/a 0/0		Dec 2024	4.0%
History						
PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	 75% 8% 17%	Target Met	0.0% 0/7	 No Change	Dec 2024	16.6%
History						
Sepsis, Severe - % Readmit within 30 Days (M)	 75% 25%	Target Met	0.0% 0/1	 No Change	Dec 2024	12.0%
History						
Septic Shock - % Readmit within 30 Days (M)	 75% 25%	Target Undefined	n/a		Dec 2024	13.3%
History						

 Readmission rates below target threshold

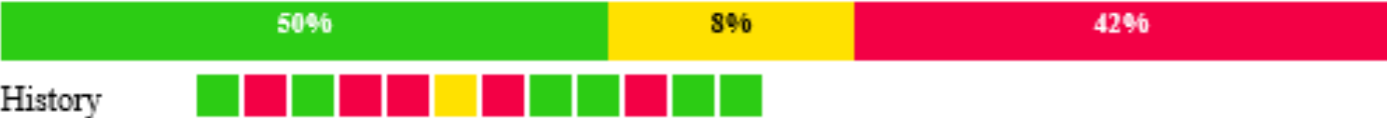





# Core Measures

Indicator	Performance	Most Recent	Trend	Period	
<b>Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M)</b> 	 Target Met	100.0% 6/6	— No Change	Dec 2024	88.0%
<b>Core OP 18b Median Time ED Arrival to ED Departure - Reporting Measure (M)</b> 	 Target Met	128.50	⬇ Deteriorated	Dec 2024	132.00
<b>Core OP 22 ED LWBS Emergency Dept Left Without Being Seen (M)</b> 	 Target Met	0.1% 1/885	⬇ Improved	Dec 2024	2.0%
<b>Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)</b> 	 Target Undefined	n/a		Dec 2024	80.0%

Core Measures target thresholds met in all categories



# Core Measures: Sepsis

Indicator	Performance	Most Recent	Trend	Period	📍
<b>SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock (M)</b> 	 Target Met	100.0% 8/8	— No Change	Dec 2024	81.0%
<b>SEPa - Severe Sepsis 3 Hour Bundle (M)</b> 	 Target Met	100.0% 8/8	— No Change	Dec 2024	94.0%
<b>SEPB - Severe Sepsis 6 Hour Bundle (M)</b> 	 Target Met	100.0% 4/4	— No Change	Dec 2024	100.0%

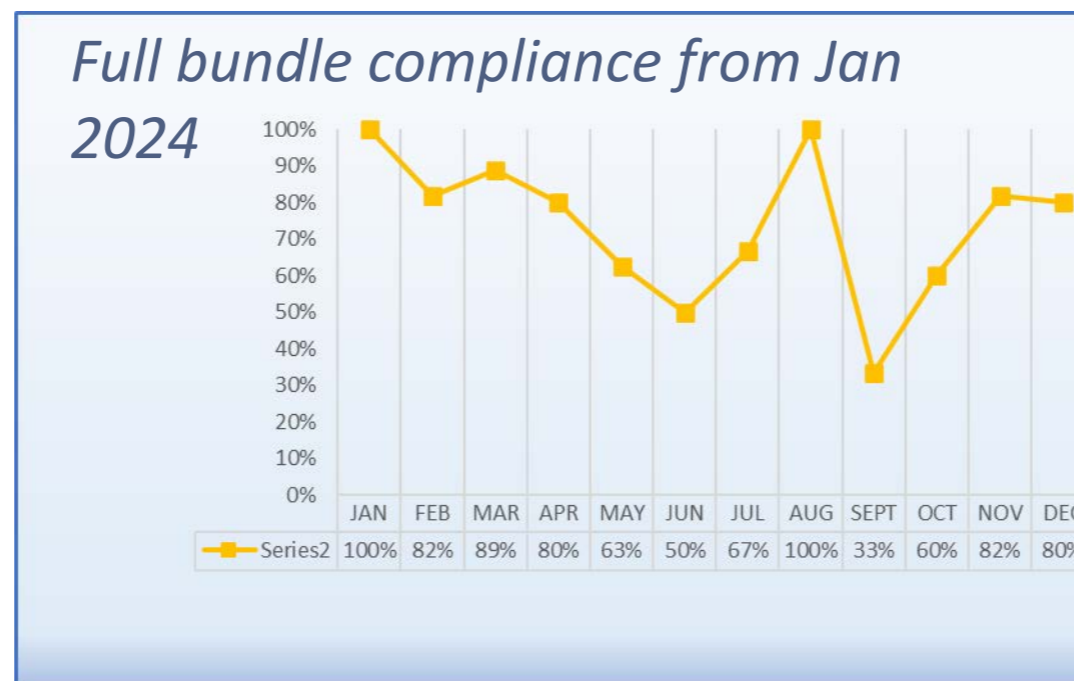
■ Sepsis metrics met

# CIHQ Corrective Action Plan Monthly Compliance Condition Level Findings: Continuous Observation of High Risk of Self Harm Patients

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



▼ Deteriorated Dec 2024 100%



- 5 patients in December
- 1 missed MD order



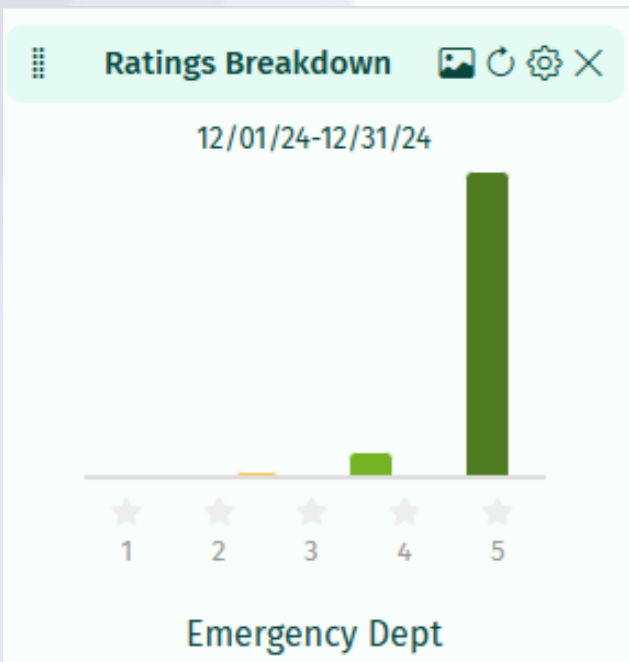
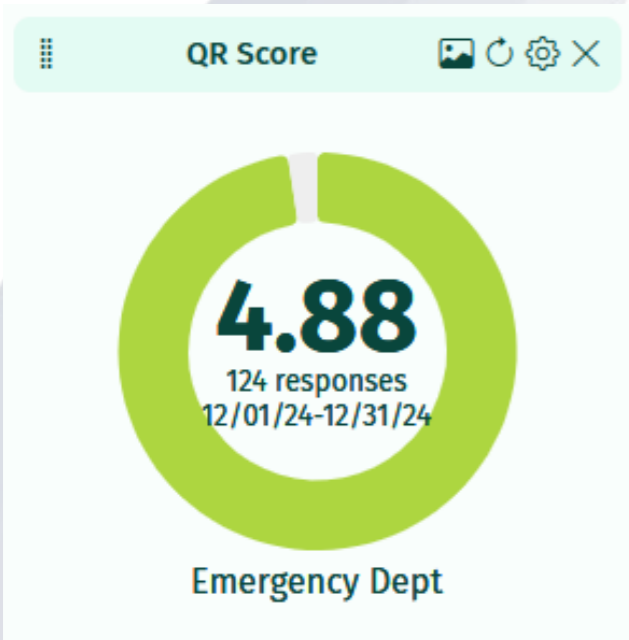


# **HCHAPS Patient Satisfaction: Inpatient Ambulatory Surgery *Reported Quarterly***

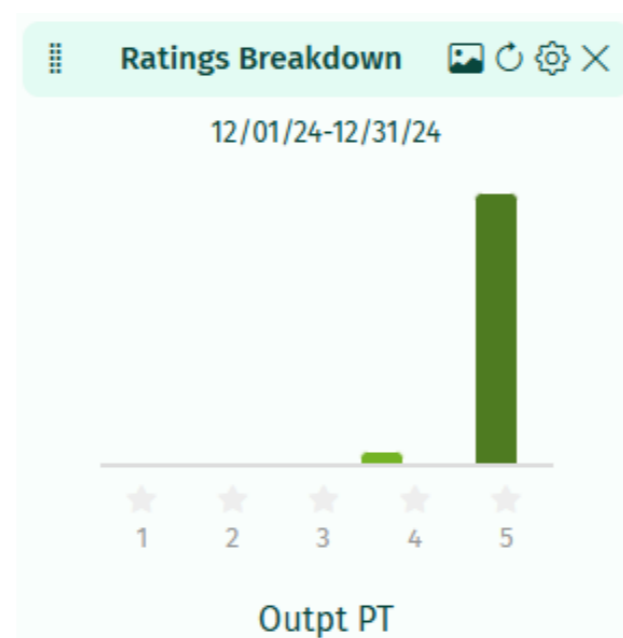
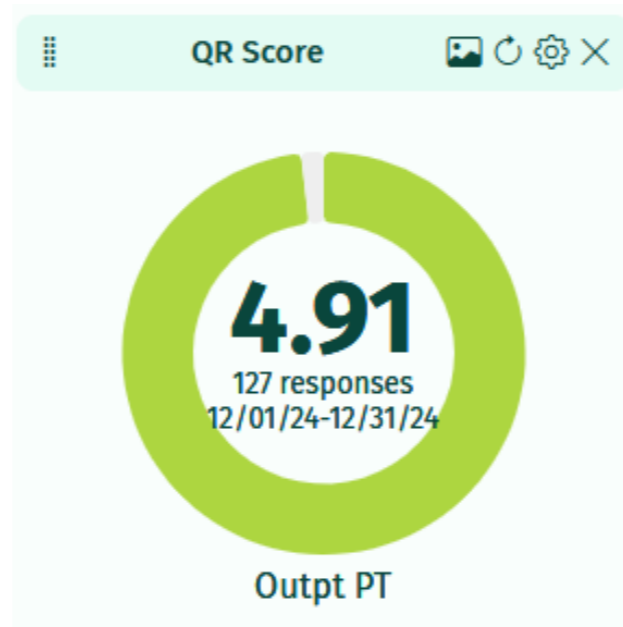
(please refer to August report for Q2 & November report for Q3)

# Q Reviews: Rate My Hospital December 2024

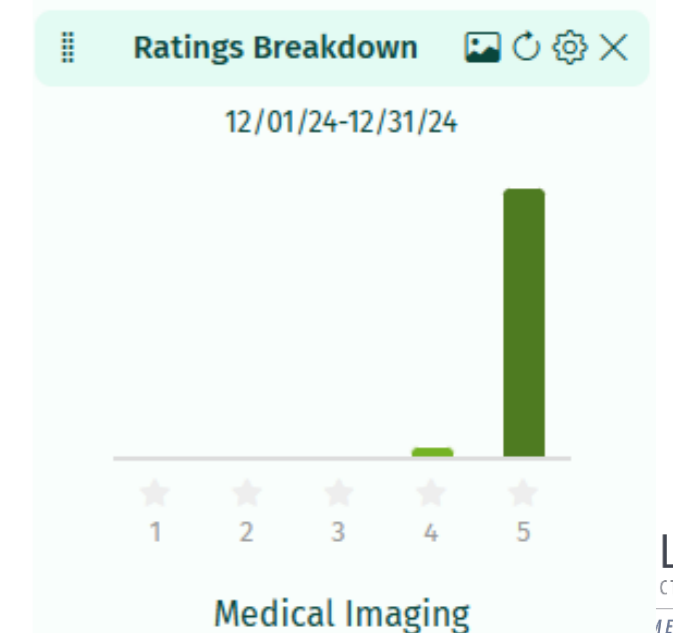
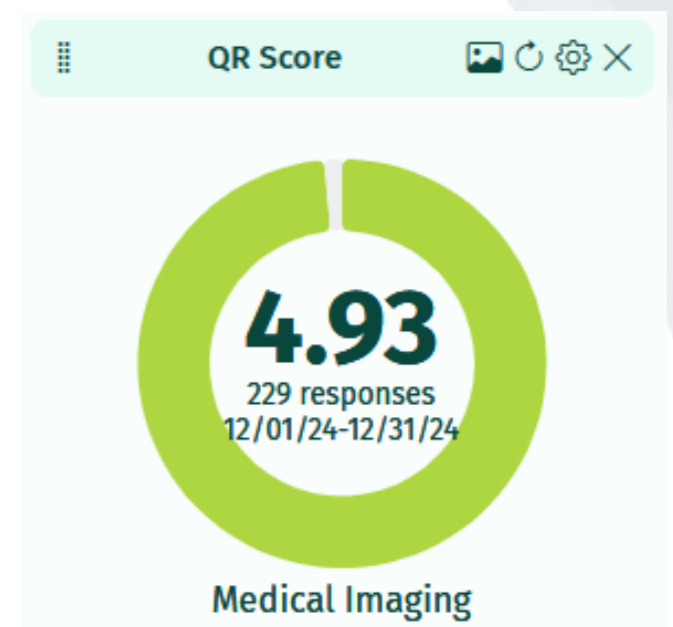
## Emergency Department



## Outpatient Physical Therapy

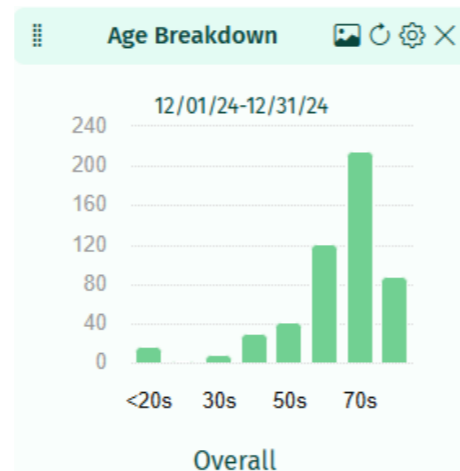
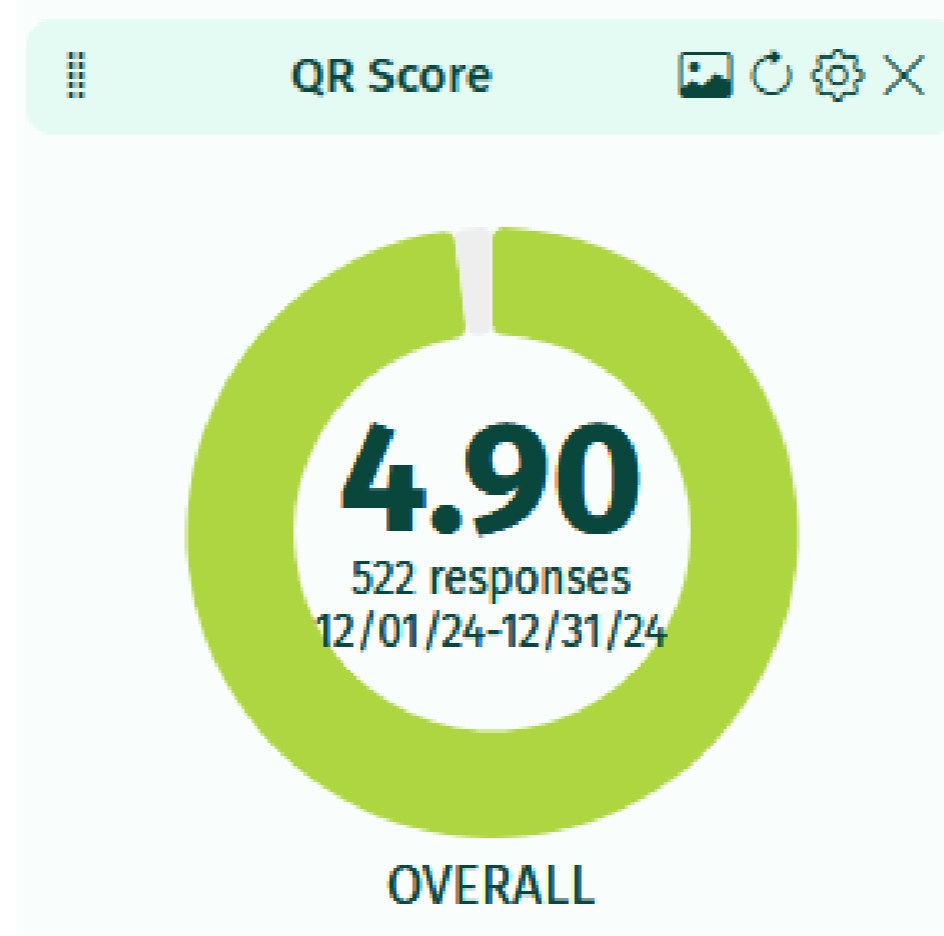
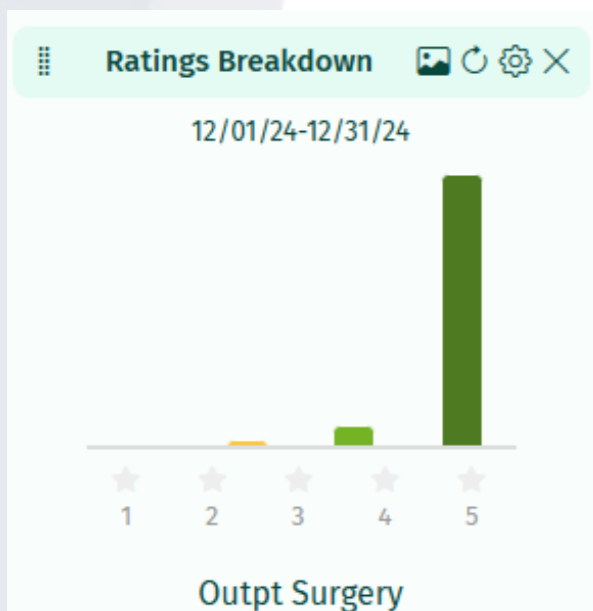
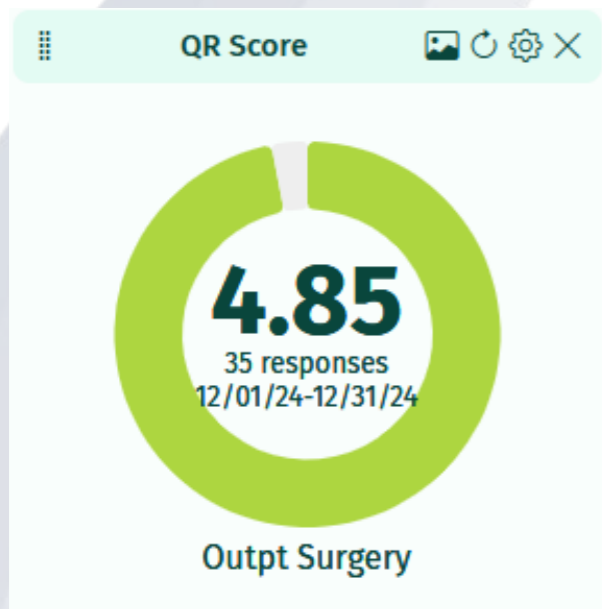


## Medical Imaging

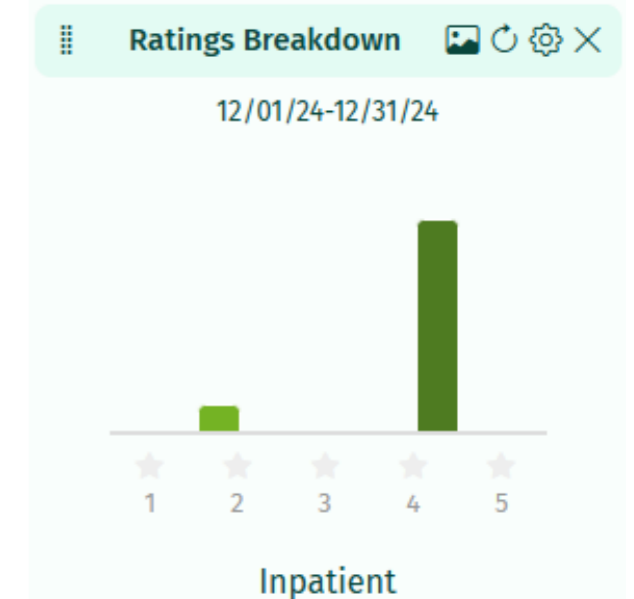
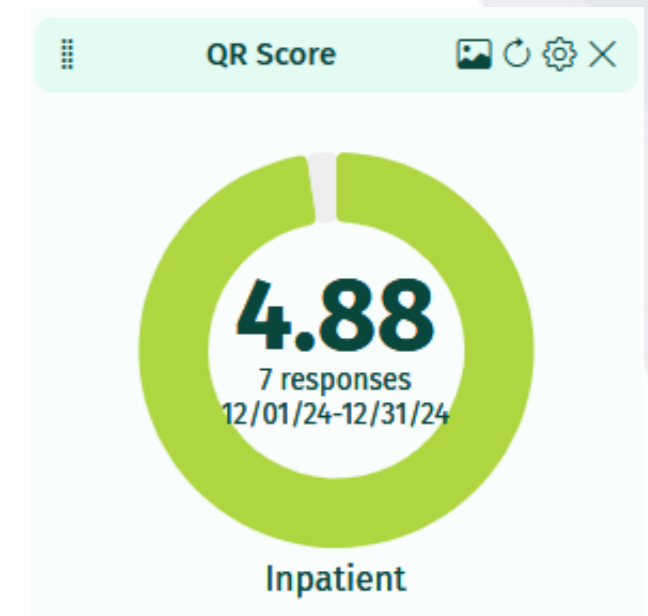


# Q Reviews: Rate My Hospital December 2024

## Outpatient Surgery



## Inpatient Care



Medication Scanning Rate	2024				
	Q1	Q2	Q3	Q4	Goal
Inpatient (ICU/MS)	96%	97%	96%	95%	≥90%
Pre/Post Op	92%	99%	97%	99%	≥90%
ED	85%	82%	83%	83%	≥90%
Preventable med errors R/T Med Scanning	0	0	0	0	≤2

Nursing Turnover	2024 Staff/Quarter				
	Q1	Q2	Q3	Q4	Goal
# of RNs	4	5	3	2	≤5
RNs, >0.5FTE (n=64)	(8.1%)	(10.2%)	(6.3%)	(3.6%)	

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Patient Experience: Q-Reviews	2024				
	Q1	Q2	Q3	Q4	Goal
2024	4.83	4.83	4.85	4.87	

### Quality Indicators (QAPI) 2024

	Q1	Q2	Q3	Q4	Goal
Antibx admin within 30" M/S and ICU	93%	92%	94%	93%	≥90%
Cont. OBS for Psych Pt- ED**New Bundle Q2, May-June	89%	64%	70%	76%	100%
Drug Admin Errors- Pharmacy (per 10000)	0.41 (n=22)	0.6 (n=29)	0.51 (n=71)	0.29 (n=15)	<1

### RATE MY HOSPITAL- PHYSICAL THERAPY

Overall score	4.94	4.91	4.93	4.92	≥4.75
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### RATE MY HOSPITAL-OUTPATIENT SURGERY

Overall Score	4.9	4.9	4.86	4.88	≥4.75
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### RATE MY HOSPITAL - ED

Overall score	4.6	4.7	4.74	4.77	≥4.75
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### RATE MY HOSPITAL - MEDICAL IMAGING

Overall score	4.91	4.88	4.89	4.93	≥4.75
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### RATE MY HOSPITAL-INPATIENT

Overall score	4.78	4.8	4.75	4.85	≥4.75
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### Case Management 2024

	Q1	Q2	Q3	Q4	Goal
Patient Choice Form Completed	91%	92%	94%	94%	90%

Nurse Staffing Effectiveness: Transfers r/t staffing/beds					
2024	Q1	Q2	Q3	Q4	Goal
	0	0	0	1	≤0

Green = Goal Met Yellow = Below goal Red = Continues below goal or significantly below goal

# 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: 01/17/2025 7:38 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: 4

**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
<b>On Call Pharmacist</b> <i>Medication Management Policies (MM)</i>	Pending Approval	12/19/2024	29
Summary Of Changes: <b>Updated hours of operation, minor formatting edits.</b> Moderators: <b>Kutza, Chris (ckutza), Newman, Cindi (cnewman)</b> Lead Authors: <b>Kutza, Chris (ckutza)</b> ExpertReviewers: <b>McKissock, Lynn (lmckissock)</b> Approvers: <b>01 P&amp;P Committee -&gt; 04 MS-Performance Improvement/Pharmacy &amp; Therapeutics Committee - (Committee) -&gt; 05 MS-Medical Executive - (Committee) -&gt; 07 BOD-Quality (P&amp;P Review) - (Committee) -&gt; 09 BOD-Board of Directors - (Committee)</b>			
<b>Patient Controlled Analgesia (PCA)</b> <i>Medication Management Policies (MM)</i>	Pending Approval	12/19/2024	29
Summary Of Changes: <b>Reviewed, no changes</b> Moderators: <b>Kutza, Chris (ckutza), Newman, Cindi (cnewman)</b> Lead Authors: <b>Kutza, Chris (ckutza)</b> ExpertReviewers: <b>Taylor, Jane (jtaylor)</b> Approvers: <b>01 P&amp;P Committee -&gt; 04 MS-Performance Improvement/Pharmacy &amp; Therapeutics Committee - (Committee) -&gt; 05 MS-Medical Executive - (Committee) -&gt; 07 BOD-Quality (P&amp;P Review) - (Committee) -&gt; 09 BOD-Board of Directors - (Committee)</b>			
<b>Pharmacy Staff Competency Assessment</b> <i>Pharmacy Dept</i>	Pending Approval	12/19/2024	29
Summary Of Changes: <b>Reviewed, no changes</b> Moderators: <b>Kutza, Chris (ckutza), Newman, Cindi (cnewman)</b> Lead Authors: <b>Kutza, Chris (ckutza)</b> ExpertReviewers: <b>McKissock, Lynn (lmckissock)</b> Approvers: <b>01 P&amp;P Committee -&gt; 04 MS-Performance Improvement/Pharmacy &amp; Therapeutics Committee - (Committee) -&gt; 05 MS-Medical Executive - (Committee) -&gt; 07 BOD-Quality (P&amp;P Review) - (Committee) -&gt; 09 BOD-Board of Directors - (Committee)</b>			
<b>QAPI Procedures for Sterile Compounding Quality Assurance program</b> <i>Pharmacy Dept\Compounding Related</i>	Pending Approval	12/19/2024	29

## Document Tasks by Committee

Sonoma Valley Hospital

Run by: Reese, Whitney (wreese)

Run date: 01/17/2025 7:38 PM

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

Summary Of Changes: **Reviewed, no changes**

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

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

Approvers: **01 P&P Committee -> 02 MS-Medicine 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)**

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