SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING AGENDA
Wednesday, June 26, 2013
5:00 p.m. Open Session
(Closed Session will be held upon adjournment of the Open Session)

Location: Schantz Conference Room
Sonoma Valley Hospital – 347 Andrieux Street, Sonoma CA 95476

AGENDA ITEM	RECOMMENDATION	
MISSION STATEMENT *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER	Nevins	
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.*	Nevins	
3. CONSENT CALENDAR: A. Quality Committee Minutes, 5.22.13	Nevins	Inform/Action
4. ANNUAL INFECTION CONTROL REPORT	McMahon	Inform
5. QUALITY REPORT AND BUILDING ACTIVATION TIMELINE	Lovejoy	Inform
6. ORGANIZATIONAL MATERIALS MANAGEMENT POLICIES AND PROCEDURES	Lovejoy	Inform/Action
7. REPORT FROM QUALITY INDICATIORS SUBCOMMITTEE AND DASHBOARD	Hirsch	Inform
8. CLOSING COMMENTS	Nevins	Inform
9. ADJOURN	Nevins	
10. UPON ADJOURNMENT OF THE REGULAR OPEN SESSION	Nevins	Inform
11. CLOSED SESSION: Calif. Health & Safety Code § 32155 – Medical Staff Credentialing & Peer Review Report	Smith/Amara	Inform/Action
12. REPORT OF CLOSED SESSION	Nevins	Inform

3.

CONSENT CALENDAR

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
Wednesday, May 22, 2013
Schantz Conference Room

Committee Members Present	Committee Members Absent	Community Members	Administrative Staff Present
Sharon Nevins, Chair Dr. Paul Amara John Perez Joel Hoffman Leslie Lovejoy Brenda Epperly Dr. Jerome Smith Dr. Howard Eisenstark Dr. Jerome Smith Susan Idell	Jane Hirsch Dr. Robert Cohen, CMO		Mark Kobe Gigi Betta, Board Clerk

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
MISSION AND VISION STATEMENTS	*The mission of the SVHCD is to maintain, improve and restore the health of everyone in our community.* *The vision of the SVHCD is that SVH will be a nationally recognized, compassionate place of healing known for excellence in clinical quality. We serve as the guide and indispensable link in our community members' health care journey.*		
1. CALL TO ORDER/ANNOUNCEMENTS	*Nevins*		
	5:03 PM Ms. Nevins proposed (and it was widely accepted) that in future QC Agenda Packages and any other materials for meetings, will be brought by the Committee Members (either on an electronic device or as a hardcopy). The Board Clerk will bring only a few hardcopies for distribution. This in an effort to go green and reduce paper waste. Further, it was requested the Board Clerk REMIND Committee Members to bring their own meeting materials before each meeting.		
2. PUBLIC COMMENT	*Nevins*		
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	No public comment.		

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.			
3. CONSENT CALENDAR	*Nevins*	**Inform/action**	
A. QC Meeting Minutes, 1.23.13 B. QC Meeting Minutes, 2.27.13		**MOTION** by Perez to approve both A&B and second by Amara. All in favor and none opposed.	
4. QUALITY INDICATORS SUBCOMMITTEE	*Perez*	**Inform/action**	
	Mr. Perez on behalf of the Quality Indicators Subcommittee, presented in two parts: **Part I:** BOARD QULAITY COMMITTEE DASHBOARD 2013 and **Part II:** QUALITY REPORT CARD. Formatting, wording, errors and missing data discussed in an effort to find the best way to represent data overall with an eye to educating public and SVH Board of Directors. **Part I Decisions:** There was no official Motion or a Second however, it was decided that Part I would be revised and brought back to the next QC meeting in June. It will not go to the Board at this time. **Part II Decisions:** There was no official Motion or a Second however, Part II was approved by all and it was agreed that the next steps are to present it to the Board for approval to post it on the SVH website.		
5. QUALITY REPORT	*Lovejoy*	**Inform**	
	Ms. Lovejoy presented a lengthy report this month mainly due to the mock survey and the (relatively minor) issues the survey uncovered. Ms. Lovejoy gave the Quality Report and talked about department priorities for May 2013. Priorities included regulatory compliance, departmental changes and the *Good Catch Program.* The Committee was very impressed with the Good Catch Program, a program which publicly recognizes staff members, issues them a thank you letter signed by the CEO and the Chairman of the Board, and awards a pewter pin in the shape of a catcher's mitt. The Committee suggested that this Program be presented at the next Regular Board meeting.		

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
6. ANNUAL PERFORMANCE IMPROVEMENT AND RISK MGMT PROGRAM EVALUATION REPORTS	*Lovejoy*	**Inform**	
	Ms. Lovejoy talked about the Performance Improvement Plan and the Risk Management Program with an accompanying PowerPoint presentation. It was decided that the Risk Management Report will continue to be treated as a confidential document. Although these reports were not presented as official action items, there was an unofficial motion by Dr. Amara and a 2nd by Mr. Perez to approve the reports.		
7. CLOSING COMMENTS	*Nevins*		
	The SVH Quality Committee will immediately advise the Medical Staff know whenever a Regular SVH Board Meeting is cancelled or not planned for any given month. Dr. Smith requested a 60-90 day advance notice if possible.	.	
8. UPON ADJOURNMENTOF THE REGULAR OPEN SESSION	*Nevins*		
	Opening of closed session.		
9. CLOSED SESSION	*Smith/Amara*	**Inform/action**	
	Medical Staff Credentialing & Peer Review Report was presented by Dr. Smith and approved by the Committee. There is one item that requires *expedition* from the SVH Board Chairman, Bill Boerum. Nancy Iredale, Medical Staff Assistant will contact Mr. Boerum for the *expedition* in email format (done on 5/24/13).		
10. REPORT OF CLOSED SESSION/ADJOURN	*Nevins*		
	6:35PM		

4.

INFECTION AND PREVENTION CONTOL ANNUAL REPORT

Infection Prevention and Control

Annual Board Quality Committee Report

Courtney McMahon RN, BSN, CIC
Infection Control Coordinator

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2013 Goals

Limit unprotected exposure to pathogens throughout the hospital

- Standard and Transmission based precautions, respiratory hygiene stations in waiting areas, construction rounds

Enhance hand hygiene

- It's Ok to Ask information, IC 'spies' on each unit, evaluation of products

Minimize the risk of transmitting infections with the use of procedures, medical equipment and medical devices

- Quarterly meetings with Central Sterile, Surgery, and Engineering.

Maintain a sanitary environment to avoid sources and transmission of infections and communicable diseases

- Quarterly meetings with EVS and Nutritional Services

Ensure that the hospital-wide quality assurance and training programs address problems identified by infection control personnel, and that subsequent corrective action plans are successfully implemented

- Performance Improvement Committee

Implement Hospital Acquired Infection (HAI) prevention measures in accordance with SB 739, TJC National Patient Safety Goals (NPSG), and SB 1058.

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Comply with the MRSA active surveillance culturing requirements of SB 158.

Comply with Cal/OSHA regulations including Bloodborne Pathogen and Aerosol Transmissible Disease Standards.

Implement a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel including Central Line Associated Bloodstream Infection (CLABSI), Ventilator Associated Events(VAE), Symptomatic Urinary Tract Infection (SUTI), Catheter Associated Urinary Tract Infection (CAUTI), Surgical Site Infections (SSI) and Multi-drug Resistant Organism (MDRO) in accordance with California Department of Public Health (CDPH), National Health and Safety Network (NHSN), and The Joint Commission (TJC) requirements.

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Central line-Associated Bloodstream Infection Prevention 'Bundle'

1. Hand Hygiene
2. Maximal Barrier Precautions
3. Chlorhexidine skin antisepsis
4. Optimal catheter site selection
5. Daily review of line necessity with prompt removal of unnecessary lines
6. Biopatch (Chlorhexidine disk)

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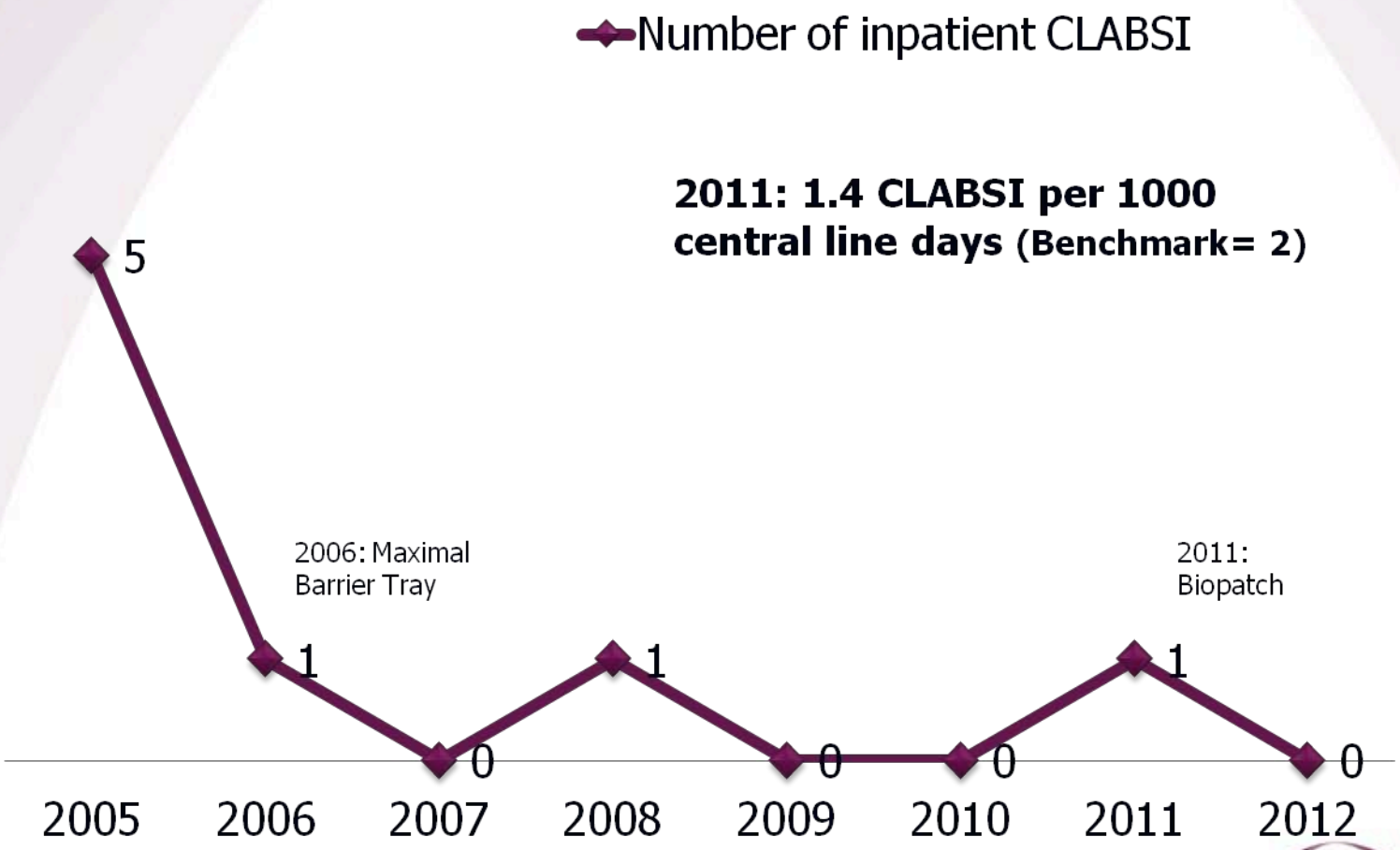
CLABSI Infection Rate



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Prevention of Catheter-Associated UTIs

1. Use only when medically necessary...NOT for nursing convenience.
2. Remove promptly when no longer necessary
3. Insert with strict aseptic technique
4. Secure catheter to minimize movement of catheter
5. Keep bag below level of bladder at all times but not on floor
6. Maintain good hygiene
6. Clean your hands before touching the catheter
7. Maintain closed drainage system (minimize irrigations)

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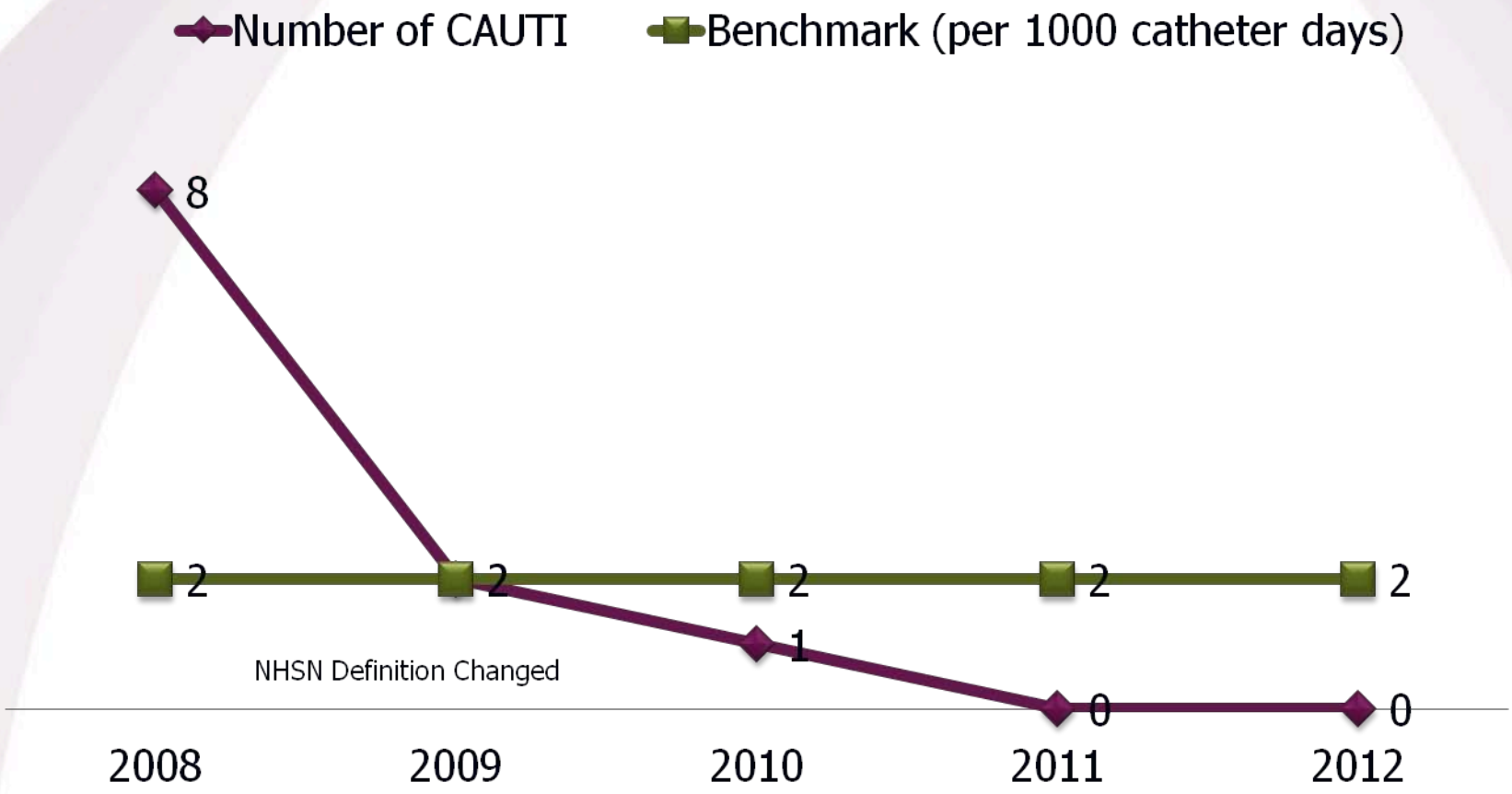
CAUTI Data (Acute/SNF)



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CAUTI Prevention 2013

- Urinary catheter utilization

Inpatient	2011	2012
Catheter days	1548	1491

SNF	2011	2012
Catheter days	592	798

- Bladder scanner

Catheter Usage

2011: 0/1548=0 per 1000 catheter days

Prevention of Surgical Site Infections

1. Appropriate use of antibiotics and timing
2. Appropriate hair removal (clippers not razors)
3. Postoperative normothermia
4. Postoperative glucose control
5. 2011: Total Joint Protocol (CHG showers and mupirocin in nose)
6. Removal of urinary catheter by post-op day 2

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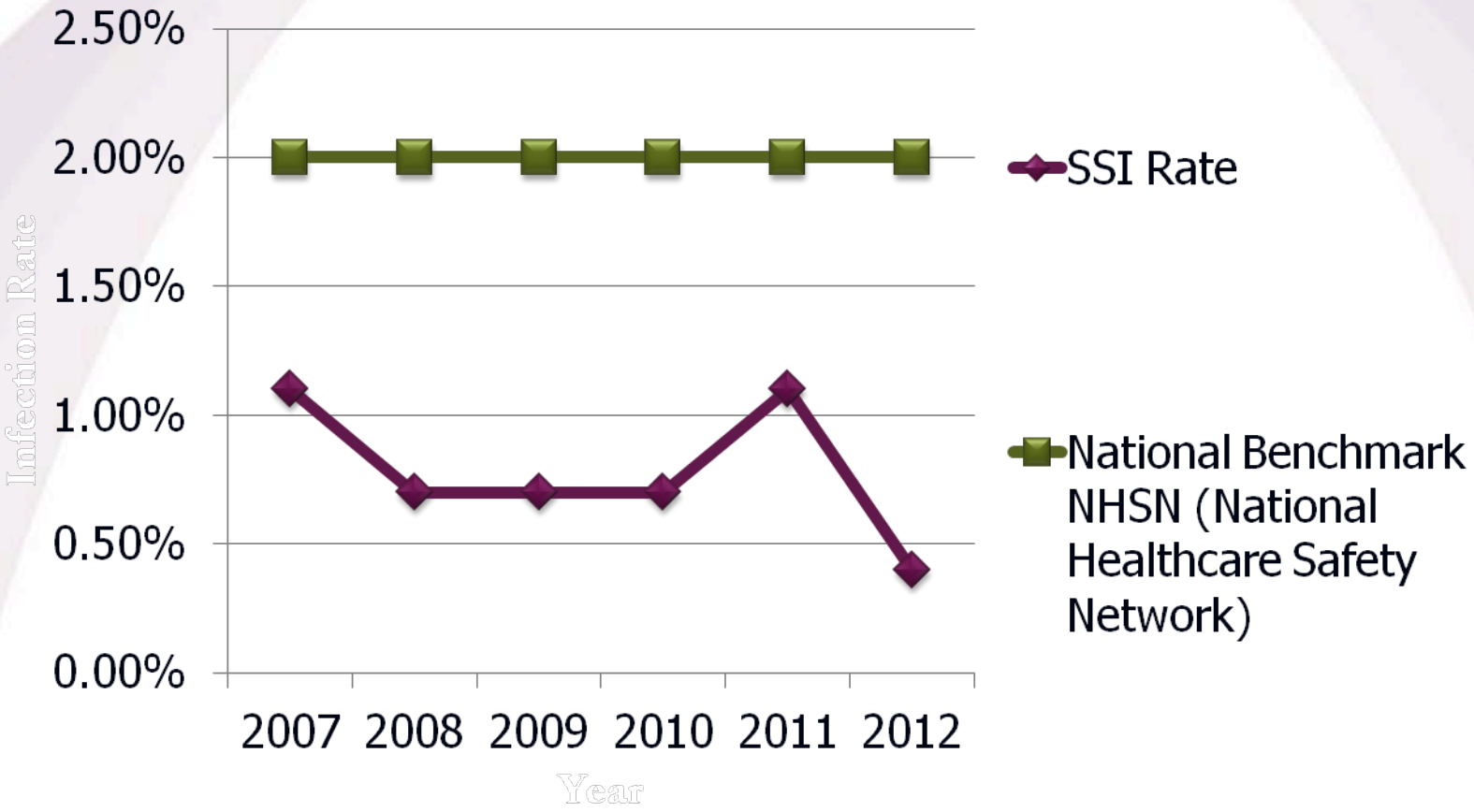
Sonoma Valley Hospital
Surgical Site Infection Rate



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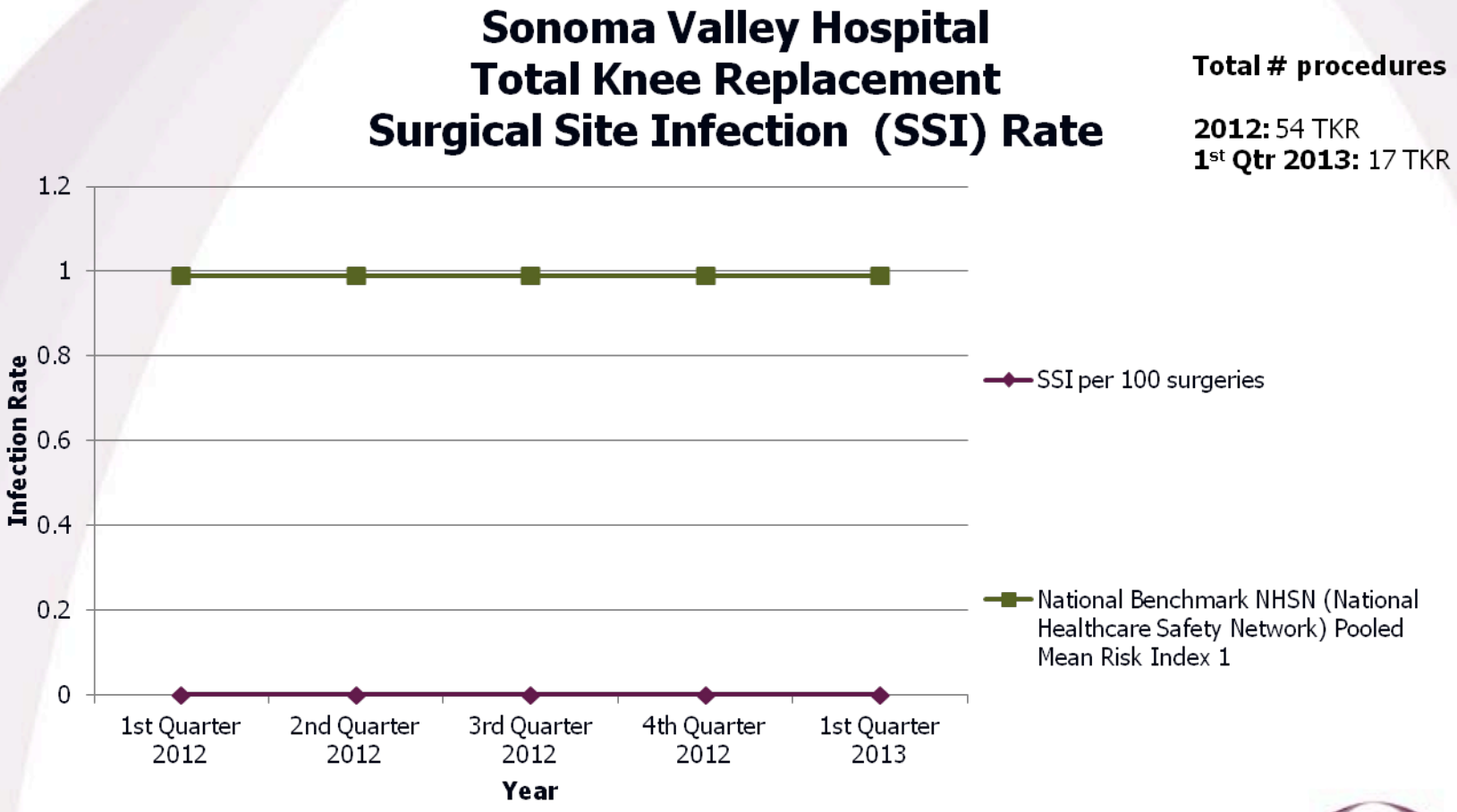
Total Joint Program: Knee



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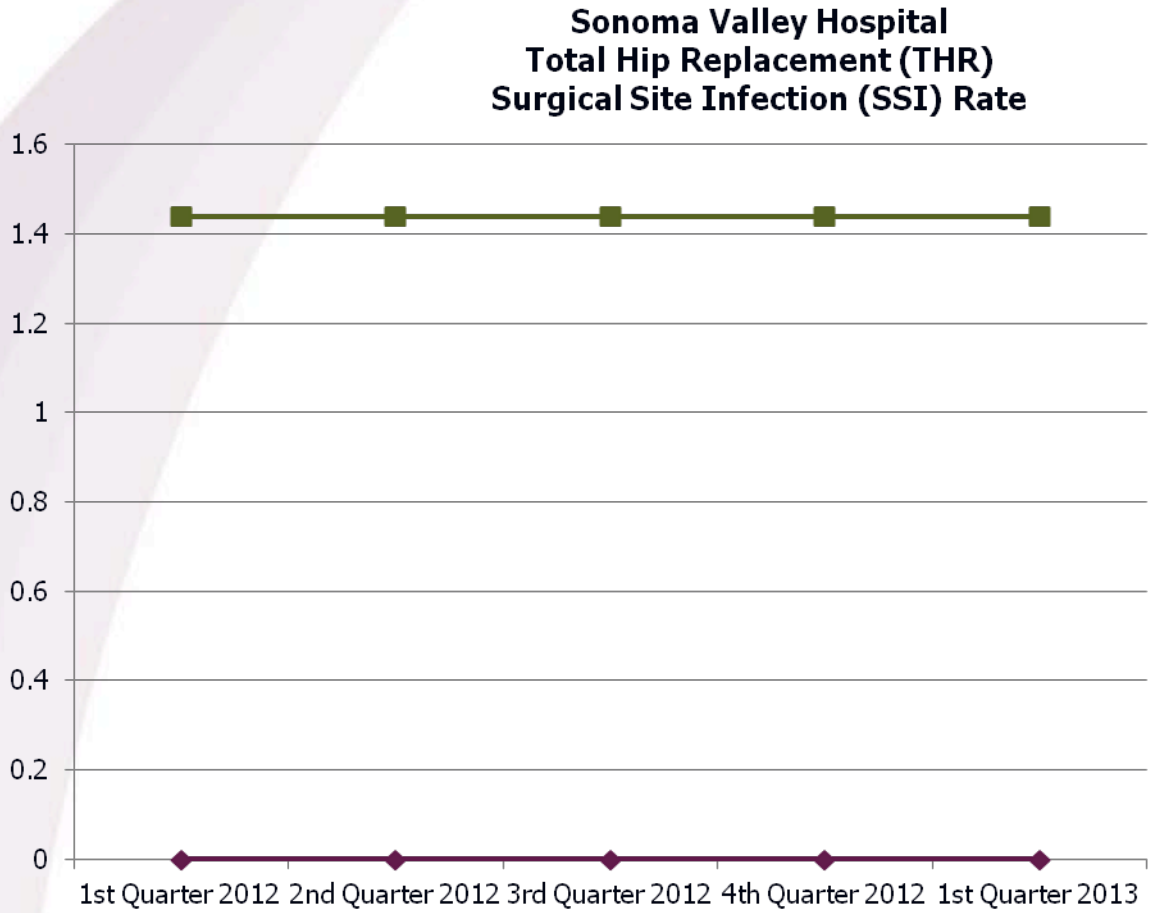
Total Joint Program: Hips



Total # procedures

2012: 54 TKR
1st Qtr 2013: 18 TKR

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Multi-Drug Resistant Organisms (MDRO)

- MRSA, VRE, ESBL - spread by contact/touch
- Isolation for Infection and Colonization
- Patient and family education
- Antimicrobial Stewardship

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MRSA Infections

Year	MRSA HAI	Source
2012	1	SSI (post discharge)
2011	3	SSI (post discharge)
2010	1 1 1 1	SSI (post discharge) Pneumonia (acute) Skin UTI (SNF)
2009	1	UTI (SNF)
2008	2	UTI (SNF)

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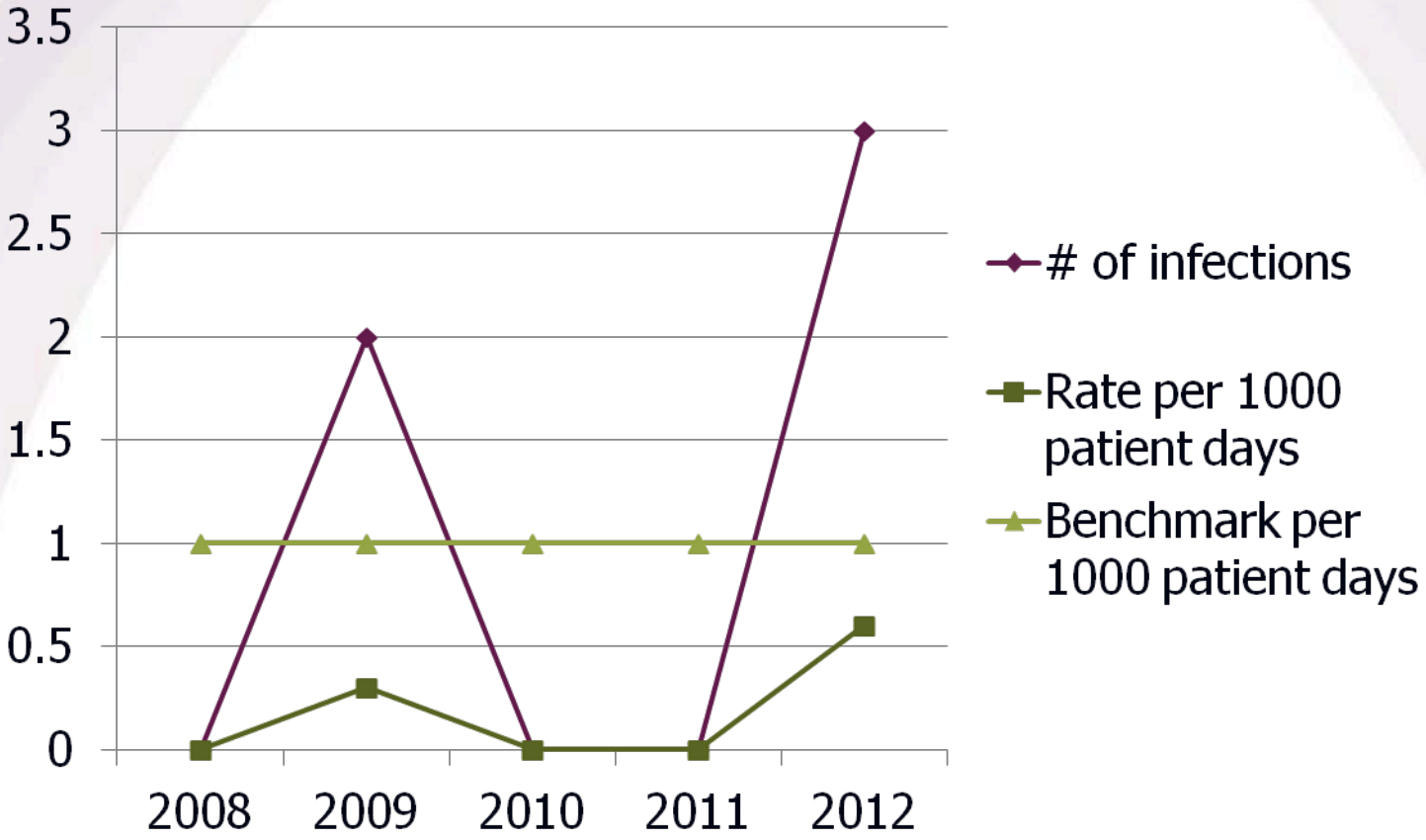
Clostridium difficile Infection: Inpatient



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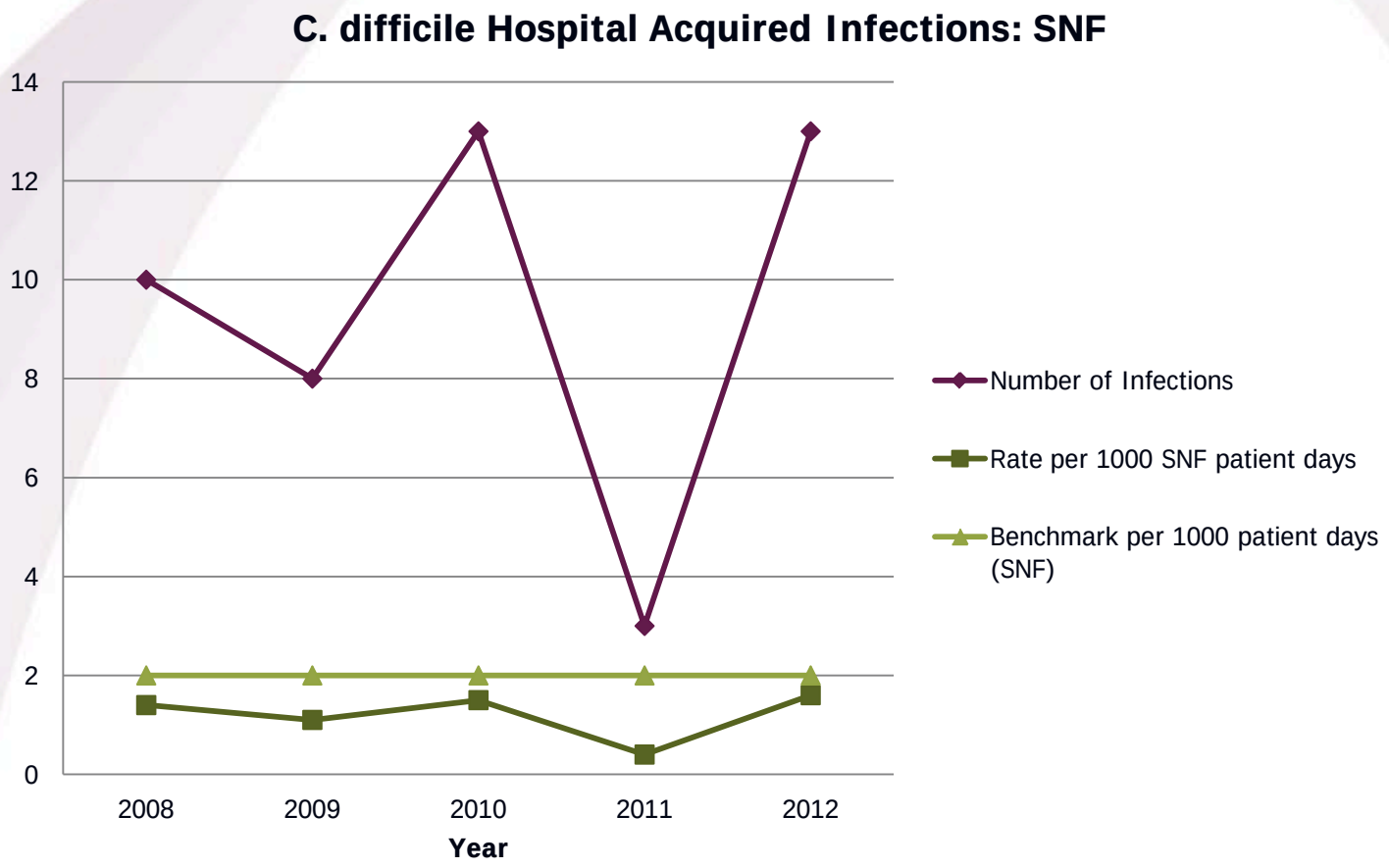
C. Diff Infection Rate: SNF



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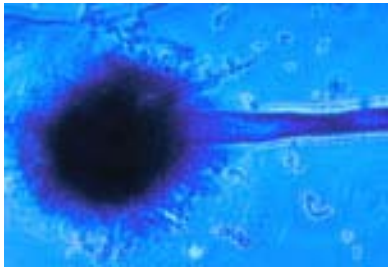
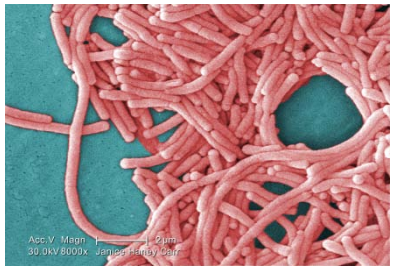
Construction

- Involved in construction planning and risk assessment to keep patients, staff, and visitors safe
- Fungi: Aspergillus



- Bacteria: Legionella



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Antimicrobial Stewardship Program (ASP)

- Recognition for best practice: AHRQ Innovations Exchange website profile

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

- Presented at ID Week October 2012

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5.

QUALITY REPORT AND BUILDING ACTIVATION TIMELINE

To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 6/26/13
Subject: Quality and Resource Management Report

June Priorities:

1. Building Activation Project
2. Utilization Management
3. Clinical Informatics

1. Building Activation Project

The new building is on track to be completed sometime in November. I have attached a timeline outlining the steps that have been and are being completed to ensure timely occupation of the building. I have been in contact with the California Department of Public Health (CDPH) regarding the actual changes to the building which will include a reduction in acute patient beds by seven. The reduction in beds is the result of joining the new building to 2N and the third floor. All policies and procedures that need to be changed or updated will be complete by the end of August. We expect that we will be given the staff and stock permit sometime in September. It is my hope that CDPH will come and do their inspection sometime around Thanksgiving. Should everything go well, the earliest we could activate the building and see patients would be the second week of December.

2. Utilization Management

The hospital has seen increasing activity regarding Medicare RAC audits and denials not only here at the hospital but throughout the nation. The volume significantly increased beginning last fall and has needed greater attention by case management, the business office and medical staff. Dr. Cohen, I and Rick Reid will be presenting the issues at the Finance Committee meeting. In response to the growing need to focus more, the hospital has contracted with a company that specializes in physician to physician communication regarding appropriate use of observation status and will assume the appeal process responsibility. We had our kick-off meeting and have submitted denials this week.

3. Clinical Informatics

One of the 2013-2014 performance improvement goals is to develop a new quality role in the area of informatics. Clinical informatics teams are responsible for ensuring that the electronic record is intuitive, efficient and easy to use for the team. In addition, the Clinical Informatics team helps the organization identify, abstract, and report quality metrics. To that end, the hospital has purchased and will implement additional Midas modules that interact with the electronic health record and other reporting databases so that data may be reported out of one central overarching system. Implementation of the first phase of integration will begin in July. The clinical Informatics team consists of a Nurse Informaticist, the Quality Data Analyst, an Informatics Trainer , the Chief Quality Officer and the CMIO. Dr. Cohen has also formed a Physician Advisory Council to provide feedback for physician related issues with the electronic health record.

Topic for discussion this session:
Annual Performance Infection Control Program Evaluation Quality Committee Quality Dashboard.

Building Activation Team Timeline	March	April	May	June	July	August	Sept	Oct	Nov	Dec
Team Developed & Kick-off										
Budgets for activation completed										
Policy & Procedure review & changes										
Vendor discussions re: move										
Move Plan completed										
Depts room stocking mock-ups										
Staff & Stock approval										
Education on flow for staff & physicians										
Stock Departments										
Request for inspection: CDPH										
Inspections completed & signed off										
Open House: SVH, MD's Ambulance Ser etc										
Open House: Community/Donors										
Move										
PDSA: ED Throughput										
Surgery Throughput										
Med/Surg Obs & Op Throughput										

6.

ORGANIZATIONAL MATERIALS MANAGEMENT POLICIES AND PROCEDURES

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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the following organizational leaders for meeting all of the following criteria. All of these policies and procedures are:

- Consistent with the Mission, Vision and Values of the Sonoma Valley Health Care District
- Consistent with all Board Policy, Hospital Policy and Hospital Procedures
- Meet all applicable law, regulation, and related accreditation standards
- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Organizational – Materials Management	
APPROVED BY: **Director of Materials Management**	DATE: 5-17-13
Director's/Manager's Signature Ellen Shannahan	Printed Name Ellen Shannahan

Richard Reid — 5-20-13

Rick Reid – Chief Financial Officer — **Date**

6/20/13

Jerome Smith, MD
President of Medical Staff — **Date**

Bill Boeurum
Chair, Board of Directors — **Date**

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POLICIES/PROCEDURES MANUAL
Materials / Organizational
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7.

QUALITY INDICATORS SUBCOMMITTEE REPORT

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BOARD QUALITY COMMITTEE DASHBOARD 2013

The following are quality and patient safety indicators selected by the Board Quality Committee for quarterly reporting as part of the oversight mandate for ensuring the the organization has an effective quality assurance and performance improvement program (QAPI).

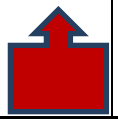
1. Surgical Services Volumes by Service Calendar Year 2013

	2012		1Q13		2Q13		3Q13		4Q13	
SERVICE	**IP**	**OP**	**IP**	**OP**	**IP**	**OP**	**IP**	**OP**	**IP**	**OP**
OB/GYN	64	62	17	16						
Ophthalmology	0	209	0	45						
General	142	118	31	30						
Orthopedics	324	466	55	106						
Pain Management	1	144	0	37						
Breast/Plastics	4	15	0	0						
Spine	4	2	0	0						
Urology	9	32	3	3						
Vascular	2	17	0	3						
Podiatry	4	58	0	0						
Endoscopy	97	331	24	66						
Totals	**651**	**1454**	**130**	**306**	**0**	**0**	**0**	**0**	**0**	**0**

2. Emergency Department Patient Performance

a. **Time from presentation to the ED to time seen by MD based on a sampling of cases.**

Measurement:	Emergency Department Patient Throughput (Lower # is Better)
Category:	Patient Safety
Definition:	Time from arrival in ED to being seen by an MD in minutes (Average)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
25.85	26.36					N/A	25	

b. Time from decision to admit to bed on inpatient unit until patient departure from ED based on a sampling of cases.

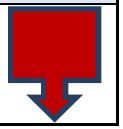
Measurement:	Time from admit decision to depart to bed (Lower # is Better)
Category:	Patient Safety
Definition:	Time from decision to admit patient to departure to assigned bed in minutes (Average)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
72.37	64.93					N/A	TBD	TBD

3. Patient Satisfaction: Quality Patient Experience

Patient satisfaction is measured by the Press Ganey Patient Satisfaction Questionnaire that is mailed to the patient's home two week post discharge. There are many questions of the survey and the hospital has shown a significant improvement over the past two years. We chose 3 questions to focus our attention on.

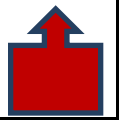
Measurement:	Noise Level in and around rooms (Higher # is Better)
Category:	Patient Satisfaction
Definition:	% of Patients responding to Press Ganey Survey who gave a score of 5 (Very Good)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
75.3%	69.1%					N/A	100.00%	

Measurement:	Explanations re: tests and treatments (Higher # is Better)
Category:	Patient Satisfaction
Definition:	% of Patients responding to Press Ganey Survey who gave a score of 5 (Very Good)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
87.1%	85.3%					N/A	100.00%	

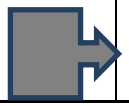
Measurement:	Likelihood to recommend SVH to others (Higher # is better)
Category:	Patient Satisfaction
Definition:	% of Patients responding to Press Ganey Survey who gave a score of 5 (Very Good)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
89.6%	90.6%					N/A	100.00%	

4. Readmissions Rates: Quality Patient Outcomes

Data is captured for patients who return to SVH within 30 days. The hospital focuses on four specific diagnostic groups as they are currently tied to Medicare pay-for-performance.

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days - All Diagnosis

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
8.20%	**8.40%**	0.00%	0.00%	0.00%		**N/A**	**TBD**	**TBD**

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with Same Diagnosis

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
2.40%	**2.00%**	0.00%	0.00%	0.00%		N/A	**TBD**	**TBD**

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with AMI (Heart Attack)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
6.00%	**0.00%**	0.00%	0.00%	0.00%		**N/A**	**TBD**	**TBD**

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with CHF (Congestive Heart Failure)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
2.80%	**0.00%**	0.00%	0.00%	0.00%		N/A	**TBD**	**TBD**

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with PNE (Simple Pneumonia)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
8.50%	**0.00%**	0.00%	0.00%	0.00%		N/A	**TBD**	**TBD**

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with COPD (Chronic Obstructive Pulmonary Disease)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
0.00%	**16.50%**	0.00%	0.00%	0.00%		**N/A**	**TBD**	**TBD**

5. Hospital Acquired Infections: Quality Patient Outcomes and Safety

Infections are tracked for 20 different categories of infections are reported in detail only if quarterly or YTD performance does not meet the benchmark set and therefore potentially merits clinical and management remedial action. The following table summarizes those infection categories being tracked which are within benchmark.

Infection Category	Within Benchmark
Central line associated bloodstream infections	
Hospital acquired Cdiff infections	
Inpatient, MRSA infections	
VRE bloodstream infections	
Hip surgical site infections	
Knee surgical site infections	
Overall surgical site infections	
Class I SSI rate	
Class II SSI rate	
Total Joint SSI rate	
Ventilator Associated Events	
Hospital acquired Pneumonia	
Inpatient Hospital acquired Catheter associated urinary tract infections	
Home Care associated infections	
MRSA Active Surveillance cultures	
Flash sterilization measurements	

Infection categories which do not currently meet benchmarks are reported below:

	Hospital Acquired Infections (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	SNF acquired Catheter Associated Urinary Tract Infections (cases per catheter days)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
?	**2/237 =.84%**	0.0	0.0	0.0		**N/A**	**5/1000 =.50%**	

Measurement:	Hospital Acquired Infections (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	SNF acquired Cdiff Infections (cases per patient days)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
?	**9/2100 =.43%**	0.0	0.0	0.0		**N/A**	**2/1000 =.20%**	

Measurement:	Hospital Acquired Infections (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	SNF Central Lineal Line associated bloodstream infections (cases per central line days)

CALENDAR YEAR 2012	2013 Q1	2013 Q2	2013 Q3	2013 Q4	Q Change	YTD Trend	Benchmark Goal	Benchmark Perform
?	1/199 =.50%	0.0	0.0	0.0		N/A	1/1000 =.10%	

Chart Definitions:	Calendar Year	Average of all quarters previous year
	Q Change	Change from previous quarter/calendar year
	YTD Trend	Change from previous calendar year based on an average of the quarterly values this year
	Benchmark goal	External standard or internally set benchmark for quality performance
	Benchmark Perform	Most recent quarter performance against the benchmark goal
		Red means performance declined or does not meet the benchmark goal
		Green means improved performance or meeting the benchmark goal