SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING AGENDA
Wednesday, September 25, 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, 8.28.13	Nevins	Action
4. DISCUSSION TOPIC: PROPOSED CHANGE OF VENDORS FOR SVH ACCREDITATION	Lovejoy	Inform/Action
5. QUALITY REPORT FOR SEPTEMBER 2013	Lovejoy	Inform
6. BOARD QUALITY DASHBOARD REPORT FOR 2nd QUARTER 2013	Lovejoy	Inform/Action
7. CLOSING COMMENTS/ANNOUNCEMENTS	Nevins	
8. ADJOURN	Nevins	
9. UPON ADJOURNMENT OF THE REGULAR OPEN SESSION	Nevins	
10. CLOSED SESSION: Calif. Health & Safety Code § 32155 – Medical Staff Credentialing & Peer Review Report	Amara	Action
Calif. Health & Safety Code § 32155 – Report from Hospital Staff	Lovejoy	Inform/Action
11. REPORT OF CLOSED SESSION	Nevins	Inform

3.

CONSENT CALENDAR

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
Wednesday, August 28, 2013
Schantz Conference Room

Committee Members Present	Committee Members Absent/Excused	Guests	Administrative Staff Present
John Perez Leslie Lovejoy Howard Eisenstark Susan Idell Robert Cohen Jane Hirsch Paul Amara Joel Hoffman	Brenda Epperly Jerome Smith Sharon Nevins Mark Kobe		Gigi Betta

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	*Hirsch*		
	5:04 PM		
2. PUBLIC COMMENT	*Hirsch*		
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	No public comment.		

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
invited to make comments at the time the item comes up for Committee consideration.			
3. CONSENT CALENDAR	*Hirsch*	Inform/action	
A. QC Meeting Minutes, 7.24.13		**MOTION:** by Eisenstark to approve (3.A.) and 2nd by Idell. All in favor.	
4. QUALITY REPORT	*Lovejoy*	Inform	
	Ms Lovejoy presented the Quality and Resource Management Report and Priorities touching on Nurse Forums, Midas upgrade to Data Vision, Completion of EHR and Physician Advisor Implementation, Building Activation Team and Nursing Education.		
5. POLICY AND PROCEDURES	*Lovejoy/Kobe*	Inform/Action	
A. Provisions of Care **B.** Medical Imaging		**MOTION:** by Eisenstark and 2nd by Amara to approve both A and B. All in favor.	
6. CLOSING COMMENTS	*Hirsch*		
	The Quality Indicators Subcommittee dashboard was presented to the Board on 8/1/13 and accepted. It has been passed to Bob Kenney who will make the information accessible to the public.		
7. ADJOURN	*Hirsch*		
	5:30 PM	.	
8. UPON ADJOURNMENTOF REGULAR OPEN SESSION	*Hirsch*		
9. CLOSED SESSION	*Amara*	Inform/action	
		MOTION: by Hoffman and 2nd by Hirsch. All in favor.	

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
10. REPORT OF CLOSED SESSION/ADJOURN	*Hirsch*		
	Adjourn 5:35 PM		

4.

PROPOSED CHANGE OF VENDORS FOR SVH ACCREDITATION

Center for Improvement in Healthcare Quality

CIHQ

About CIHQ

- Formed in 1999
- Headquartered in Round Rock, TX
- Member-based organization comprised of over 275 hospitals across the United States
- Originally a small consulting firm helping hospitals with accreditation and certification compliance
- Virtual company – small storefront!

CIHQ

Mission / Vision / Values

Mission

Our mission is to create a regulatory environment that enables healthcare organizations to effectively deliver safe, quality patient care.

Vision

CIHQ will be viewed by its members as an indispensable ally in their accreditation and regulatory compliance efforts.

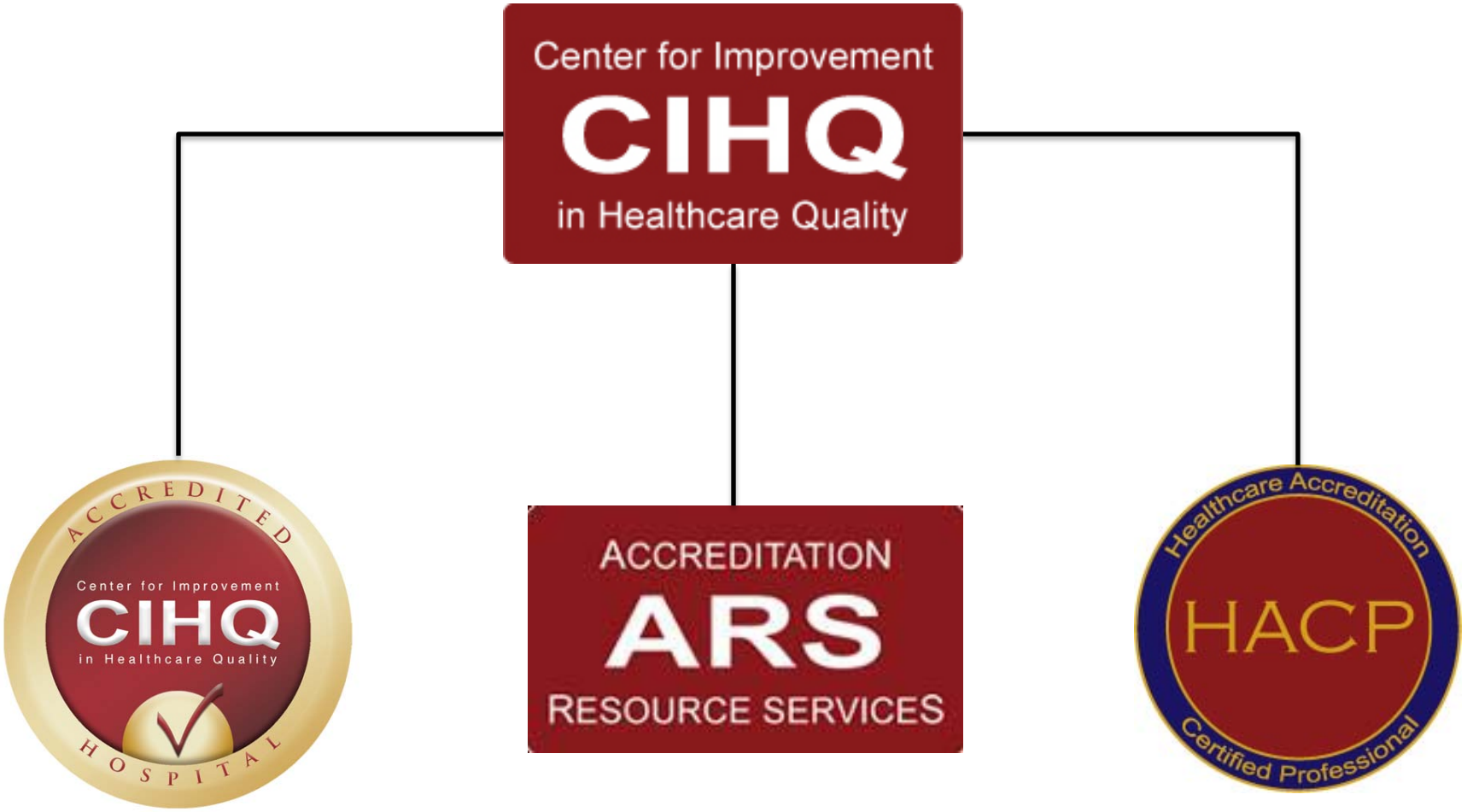
Values

CIHQ seek to fulfill its Mission and Vision through living the following values:

- Integrity
- Accountability
- Collegiality and Openness
- Stewardship

CIHQ

Three Companies… One Organization



Okay…let's move on!

Hospital Accreditation Program

CIHQ

Our Approval by CMS

We have been approved by CMS to deem general acute care hospitals to be in compliance with the Medicare Conditions of Participation under 42CFR.

- We are not currently approved to accredit free standing psychiatric hospitals or critical access hospitals
- We also do not accredit home health, lab, long-term care, or ambulatory surgery centers.

CIHQ

Types of Surveys

Initial Surveys

Triennial Surveys

Mid-Cycle Survey

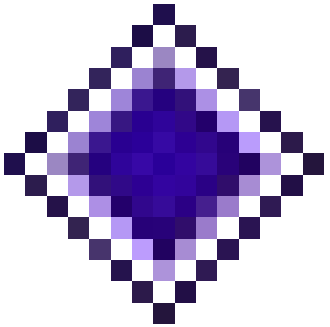
Complaint Surveys

Follow-Up Surveys

Disease Specific Certification

Certification offered in three areas:

- Primary Stroke Center
- Heart Failure
- Hip & Knee Surgery



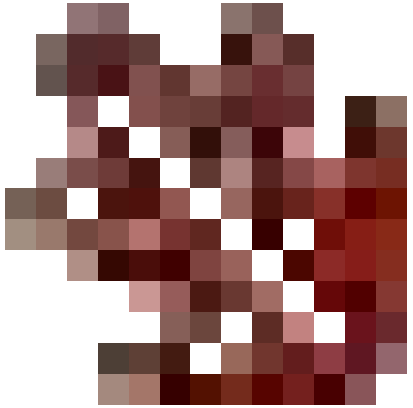
Certification assessments are woven into the initial or triennial accreditation surveys

- Not a separate survey
- Must be accredited by CIHQ to apply for disease specific certification
- No adverse effect on accreditation status if certification is not obtained

Resources to Assist You

CIHQ provides on-line organization-wide access to the following resources at no additional charge:

- Standards interpretation and interpretive guidance
- Accreditation & disease specific standards and requirements (cross-walked to CMS)
- Resource library linked to specific standards
- Reference library
- Monthly audio conferences
- Alert archive
- Staff training library
- Continuing education center



Annual Summit

Each accredited hospital may send two members free of charge to CIHQ's annual Accreditation & Quality Summit

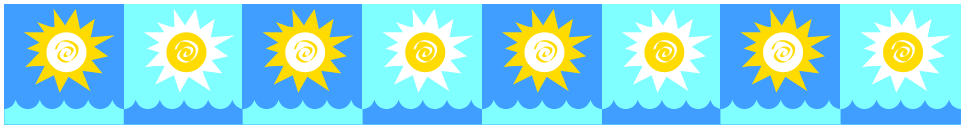
- Hospital pays only travel expenses
- Held once each year in late spring
- Special session devoted to updates on CIHQ policies, survey process, and standards

CIHQ

And finally….the cost

Accreditation Fee

- Flat fee billed annually or quarterly (up to you)
- Based on licensed bed capacity
- Includes travel expenses for triennial and mid-cycle surveys
- No increase in fees during your survey year
- Pricing information posted on CIHQ's website



CIHQ

Pros & Cons

- CIHQ: **SVH a charter member, has a history with CIHQ**
- **Easily accessible, website resources, someone**
- **to talk to; no hidden fees**
- **Not well known & doesn't have the status of TJC**
- **Will need to find other accreditation bodies for HC, SNF**
- **& Lab (State, CLIA?)**
- TJC: **Well known and respected**
- **Surveys can have CMS following; more expensive**
- **website cumbersome and resources difficult to**
- **access; lots of busywork standards not related to**
- **CMS**

Center for Improvement
CIHQ
in Healthcare Quality

INDICATOR	CIHQ	TJC	DNV	AOA
1. Approved Deemed Status Program	Acute Care	Acute Care	Acute Care	Acute Care
2. Disease Specific Certification	Primary Stroke Heart Failure Hip / Knee Surgery	Generic Multiple Advanced - Primary Stroke & Comprehensive Stroke - Heart Failure -Lung Volume, etc.	Primary & Comprehensive Stroke	Multiple Stroke Programs
3. Basis for Standards (Regulatory basis for the content of standards/requirements)	CMS Conditions of Participation 42CFR	CMS Conditions of Participation 42CFR	CMS Conditions of Participation 42CFR	CMS Conditions of Participation 42CFR
4. Base Survey Cycle	Triennial	Triennial	Triennial	Triennial
5. Other Routine Survey Assessments	Mid-Cycle Survey One Day	Annual Internal Assessment	Annual Survey Full	None
6. Complex Organization Policy (Requires survey of components of an applicant due to their functional / organizational relationship)	No	Yes	No	No
7. Acceptance of Other Deeming Authority Accredited Programs (Will accept accreditation from other CMS approved deeming authorities for components of an organization; e.g. lab, rehab units, home health, etc.)	All	Few	All	All
8. Accreditation Outcome	Pass / Fail	Complex Rules	Pass / Fail	Pass / Fail
9. Time Frame for Submitting a Plan of Correction Following Survey	10 Calendar Days*	45 – 60 Calendar Days	10 Calendar Days*	30 Calendar Days

INDICATOR	CIHQ	TJC	DNV	AOA
10. Submission of Evidence that Plans of Correction Have Been Implemented	Yes – Random Sample	Yes – Random Sample	Yes – Random Sample	Yes – Random Sample
11. Sentinel Event Policy / Review of Root Cause Analysis	No	Yes	No	No
12. Submission of Core Measure Data to the Accrediting Organization in Addition to CMS	No	Yes	No	No
13. Support Services (Availability of support services such as standards interpretation, access to on-line standards, audio conferences, resource and reference libraries, annual conferences, etc.)	Full Services – No Additional Charge	Full Services – Additional Charge	Limited Service – No Additional Charge	Little Service – No Additional Charge
ADDITIONAL SURVEY REQUIREMENTS				
14. Follow-Up Surveys (Required when an organization sustains a CMS-Based Condition Level Deficiency)	Yes – No Additional Fee. Travel Expenses Only	Yes – Additional Fee and Travel Expenses	Yes – Additional Fee and Travel Expenses	Yes – Additional Fee and Travel Expenses
15. Complaint Surveys (Required when a substantial compliant is received about an accredited organization)	Yes – No Additional Fee for First Two Complaint Surveys in a Calendar Year. Travel Expenses Only	Yes – Additional Fee and Travel Expenses	Yes – Additional Fee and Travel Expenses	Yes – Additional Fee and Travel Expenses

* The 10 calendar day submission does not require full implementation of the plan of correction. The plan of correction may refer to actions that will be taken versus actions that have been implemented.

5.

QUALITY REPORT
SEPTEMBER 2013

To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 9/25/2013
Subject: Quality and Resource Management Report

September Priorities:
1. New Building Construction and Activation Plan
2. Second Quarter Quality Measures
3. Policies and Procedures Process

1. New Building Construction and Activation Plan

The official and formal report of the new wing construction, building activation and the permanent closure of seven acute care licensed beds was sent to the California Department of Public Health. The construction is on time and the Building Activation Team is now meeting weekly to prepare for the OSHPD Substantial Completion Certification inspection slated for October 25th. We are awaiting response and next steps regarding the application and subsequent licensing visit. Administration has set the community open house for the 1th of November and we plan, provided we obtain the approvals for a move in just prior to the holidays in December.

2. Second Quarter Quality Core Measures

Attached please find our Hospital Compare data through first quarter 2013. Also attached is an education piece entitled: Is your hospital ready for value based purchasing. Of particular interest are the last three pages that outline the changes each performance period and the weighting.

3. Policies and Procedures Process

For the past two years we have been using a web based policy and procedure management database that tracked each step in the approval process and mapped out responsibilities. We changed our policy and procedure on policies and procedures and started this process after very lengthy training of leadership. It has not worked well and I will not be renewing the contract in March of 2014. The program is cumbersome and too big for a small hospital. Starting in January, we will be going back to a policy and procedure committee process as part of a Clinical Operations Meeting. Clinical Operations will meet monthly and consists of all leaders who directly provide patient care. We are in the process of creating a tracking structure and defining responsibilities. It will be the responsibility of the Quality Assistant to track, post and monitor progress. The process will be rolled out at the January Leadership meeting.

Topic for discussion: Change in Accreditation Vendor

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Clinical Process Measures: Second Quarter 2012 through First Quarter 2013 Discharges

050090-SONOMA VALLEY HOSPITAL

Address: 347 ANDRIEUX ST
City, State, ZIP: SONOMA, CA 95476
Phone Number: (707) 935-5000
County Name: SONOMA

Type of Facility: Short-term
Type of Ownership: Government - Hospital District or Authority
Emergency Service Provided: Yes

Structural Measures (SM)		
SM-1	Participates in a Systematic Database for Cardiac Surgery	Does Not Have a Program
SM-2	Participates in a Systematic Clinical Database Registry for Stroke Care	No
SM-3	Participates in a Systematic Clinical Database Registry for Nursing Sensitive Care	No
SM-4	Participation in a Systematic Clinical Database Registry for General Surgery	No

	Hospital Quality Measures	Your Hospital Performance Aggregate Rate for All Four Quarters	10% of All Hospitals Submitting Data Scored Equal to or Better Than	State Performance	National Performance
Acute Myocardial Infarction (AMI)					
AMI-2	Aspirin Prescribed at Discharge	100% of 4 patients(1,3)	100%	99%	99%
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	N/A(3,7)	100%	79%	61%
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	N/A(3,7)	100%	94%	95%
AMI-10	Statin Prescribed at Discharge	80% of 5 patients(1,3)	100%	98%	98%
Heart Failure (HF)					
HF-1	Discharge Instructions	88% of 24 patients	100%	94%	94%
HF-2	Evaluation of LVS Function	100% of 35 patients	100%	99%	99%
HF-3	ACEI or ARB for LVSD	89% of 9 patients(1)	100%	97%	97%
Stroke (STK)					
STK-1	Venous Thromboembolism (VTE) Prophylaxis	88% of 8 patients(1)	100%	92%	92%
STK-2	Discharged on Antithrombotic Therapy	100% of 6 patients(1)	100%	98%	99%
STK-3	Anticoagulation Therapy for Atrial Fibrillation/Flutter	100% of 2 patients(1)	100%	95%	95%

Hospital Performance

Reporting Period for Clinical Process Measures: Second Quarter 2012 through First Quarter 2013 Discharges

050090-SONOMA VALLEY HOSPITAL

	Hospital Quality Measures	Your Hospital Performance Aggregate Rate for All Four Quarters	10% of All Hospitals Submitting Data Scored Equal to or Better Than	State Performance	National Performance
Stroke (STK)					
STK-4	Thrombolytic Therapy	N/A(7)	100%	64%	60%
STK-5	Antithrombotic Therapy By End of Hospital Day 2	88% of 8 patients(1)	100%	97%	97%
STK-6	Discharged on Statin Medication	100% of 5 patients(1)	100%	93%	93%
STK-8	Stroke Education	100% of 2 patients(1)	100%	85%	85%
STK-10	Assessed for Rehabilitation	100% of 6 patients(1)	100%	97%	97%
Venous Thromboembolism (VTE)					
VTE-1	Venous Thromboembolism Prophylaxis	98% of 44 patients(2)	99%	79%	82%
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	83% of 12 patients(2)	100%	90%	90%
VTE-3	Venous Thromboembolism Patients with Anticoagulation Overlap Therapy	N/A(2,7)	100%	91%	91%
VTE-4	Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol or Nomogram	N/A(2,7)	100%	94%	96%
VTE-5	Venous Thromboembolism Warfarin Therapy Discharge Instructions	N/A(2,7)	100%	69%	70%
VTE-6	Hospital Acquired Potentially-Preventable Venous Thromboembolism	N/A(2,7)	50%	13%	11%
Pneumonia (PN)					
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital	100% of 61 patients	100%	97%	98%
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	97% of 34 patients	100%	96%	95%
Surgical Care Improvement Project (SCIP)					
SCIP-Inf-1	Prophylactic Antibiotic Received Within 1 Hour Prior to Surgical Incision	97% of 102 patients	100%	99%	99%
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	100% of 102 patients	100%	99%	99%

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Clinical Process Measures: Second Quarter 2012 through First Quarter 2013 Discharges

050090-SONOMA VALLEY HOSPITAL

	Hospital Quality Measures	Your Hospital Performance Aggregate Rate for All Four Quarters	10% of All Hospitals Submitting Data Scored Equal to or Better Than	State Performance	National Performance
Surgical Care Improvement Project (SCIP)					
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	97% of 100 patients	100%	97%	98%
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Blood Glucose	N/A(7)	100%	96%	96%
SCIP-Inf-9	Urinary Catheter Removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with Day of Surgery being Day Zero	97% of 120 patients	100%	96%	97%
SCIP-Inf-10	Surgery Patients with Perioperative Temperature Management	100% of 151 patients	100%	100%	100%
SCIP-Card-2	Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period	100% of 24 patients	100%	96%	97%
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	99% of 139 patients	100%	97%	98%
Emergency Department (ED)					
ED-1b	Median Time from ED Arrival to ED Departure for Admitted ED Patients	259 Minutes based on 272 patients(2)	176 Minutes	323 Minutes	275 Minutes
ED-2b	Admit Decision Time to ED Departure Time for Admitted Patients	53 Minutes based on 173 patients(2)	42 Minutes	123 Minutes	97 Minutes
Immunization (IMM)					
IMM-1a	Pneumococcal Immunization	85% of 372 patients(2)	98%	89%	90%
IMM-2	Influenza Immunization	92% of 286 patients(2)	99%	89%	90%
Perinatal Care (PC)					
PC-01	Elective Delivery	0% of 3 patients(1)	N/A	N/A	N/A

Footnote Legend

1. The number of cases/patients is too few to report.
2. Data submitted were based on a sample of cases/patients.
3. Results are based on a shorter time period than required.
4. Data suppressed by CMS for one or more quarters.
5. Results are not available for this reporting period.
7. No cases met the criteria for this measure.

Hospital CAHPS (HCAHPS) Survey

Reporting Period for HCAHPS Measures: First Quarter 2012 through Fourth Quarter 2012 Discharges

050090-SONOMA VALLEY HOSPITAL

Address: 347 ANDRIEUX ST
City, State, ZIP: SONOMA, CA 95476
Phone Number: (707) 935-5000
County Name: SONOMA

Type of Facility: Short-term
Type of Ownership: Government - Hospital District or Authority
Emergency Service Provided: Yes

HCAHPS Survey Completion and Response Rate

Number of Completed Surveys	285
Survey Response Rate	32

HCAHPS Composites and Individual Items

		Your Hospital's Adjusted Score			State Average			U.S. Average		
HCAHPS Composites		**% Sometimes to Never**	**% Usually**	**% Always**	**% Sometimes to Never**	**% Usually**	**% Always**	**% Sometimes to Never**	**% Usually**	**% Always**
Composite 1 (Q1 to Q3)	Communication with Nurses	4	20	76	6	20	74	5	17	78
Composite 2 (Q5 to Q7)	Communication with Doctors	5	15	80	6	16	78	4	15	81
Composite 3 (Q4 & Q11)	Responsiveness of Hospital Staff	7	23	70	13	26	61	9	24	67
Composite 4 (Q13 & Q14)	Pain Management	5	22	73	8	24	68	7	22	71
Composite 5 (Q16 & Q17)	Communication about Medicines	19	21	60	21	18	61	19	17	64
Hospital Environment Items		**% Sometimes to Never**	**% Usually**	**% Always**	**% Sometimes to Never**	**% Usually**	**% Always**	**% Sometimes to Never**	**% Usually**	**% Always**
Q8	Cleanliness of Hospital Environment	15	22	63	10	20	70	9	18	73
Q9	Quietness of Hospital Environment	17	37	46	17	32	51	10	30	60

Discharge Information Composite		**% Yes**	**% No**	**% Yes**	**% No**	**% Yes**	**% No**
Composite 6 (Q19 & Q20)	Discharge Information	88	12	83	17	85	15

Hospital CAHPS (HCAHPS) Survey

Reporting Period for HCAHPS Measures: First Quarter 2012 through Fourth Quarter 2012 Discharges

050090-SONOMA VALLEY HOSPITAL

HCAHPS Global Items

		Your Hospital's Adjusted Score			State Average			U.S. Average		
Q21	**Overall Rating of Hospital**	**% 0 to 6 rating**	**% 7 and 8 rating**	**% 9 and 10 rating**	**% 0 to 6 rating**	**% 7 and 8 rating**	**% 9 and 10 rating**	**% 0 to 6 rating**	**% 7 and 8 rating**	**% 9 and 10 rating**
Overall Rating of Hospital *(0 = Worst Hospital 10 = Best Hospital)*		8	28	64	10	23	67	8	22	70

		Your Hospital's Adjusted Score			State Average			U.S. Average		
Q22	**Willingness to Recommend this Hospital**	**% No: Definitely or Probably Not Recommend**	**% Yes: Probably Recommend**	**% Yes: Definitely Recommend**	**% No: Definitely or Probably Not Recommend**	**% Yes: Probably Recommend**	**% Yes: Definitely Recommend**	**% No: Definitely or Probably Not Recommend**	**% Yes: Probably Recommend**	**% Yes: Definitely Recommend**
Willingness to Recommend this Hospital		6	25	69	7	24	69	5	24	71

Footnote Legend

1. *The number of cases/patients is too few to report.*
3. *Results are based on a shorter time period than required.*
5. *Results are not available for this reporting period.*
6. *Fewer than 100 patients completed the HCAHPS survey. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.*
10. *Very few patients were eligible for the HCAHPS survey. The scores shown reflect fewer than 50 completed surveys. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.*
11. *There were discrepancies in the data collection process.*

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Measures: Third Quarter 2009 through Second Quarter 2012 Discharges

Reporting Period for 30-Day Hospital-Wide Outcome Measures: Third Quarter 2011 through Second Quarter 2012 Discharges

050090-SONOMA VALLEY HOSPITAL

Address: 347 ANDRIEUX ST
City, State, ZIP: SONOMA, CA 95476
Phone Number: (707) 935-5000
County Name: SONOMA

Type of Facility: Short-term
Type of Ownership: Government - Hospital District or Authority
Emergency Service Provided: Yes

30-Day Risk-Standardized Mortality Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Mortality Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	U.S. National Rate		Number of Hospitals...	Better than U.S. National Rate	No Different than U.S. National Rate	Worse than U.S. National Rate	Number of Cases Too Small
Acute Myocardial Infarction (AMI)											
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	Number of Cases Too Small	22	Will Not Be Reported	15.2%		in the **Nation** that Performed ...	77	2579	19	1889
							in the **State** that Performed ...	7	219	1	103
Heart Failure (HF)											
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate	No Different than U.S. National Rate	123	10.2% (7.5%, 13.6%)	11.7%		in the **Nation** that Performed ...	181	3732	139	725
							in the **State** that Performed ...	30	246	10	51
Pneumonia (PN)											
MORT-30-PN	Pneumonia (PN) 30-Day Mortality Rate	No Different than U.S. National Rate	84	10.5% (7.3%, 14.8%)	11.9%		in the **Nation** that Performed ...	203	4014	223	377
							in the **State** that Performed ...	34	244	19	45

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Measures: Third Quarter 2009 through Second Quarter 2012 Discharges

Reporting Period for 30-Day Hospital-Wide Outcome Measures: Third Quarter 2011 through Second Quarter 2012 Discharges

050090-SONOMA VALLEY HOSPITAL

30-Day Risk-Standardized Readmission Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	U.S. National Rate		Number of Hospitals...	Better than U.S. National Rate	No Different than U.S. National Rate	Worse than U.S. National Rate	Number of Cases Too Small
Acute Myocardial Infarction (AMI)											
READM-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	Number of Cases Too Small	22	Will Not Be Reported	18.3%		in the **Nation** that Performed ...	23	2327	29	2085
							in the **State** that Performed ...	1	201	1	122
Heart Failure (HF)											
READM-30-HF	Heart Failure (HF) 30-Day Readmission Rate	No Different than U.S. National Rate	130	18.9% (15.3%, 23.3%)	23.0%		in the **Nation** that Performed ...	120	3876	159	631
							in the **State** that Performed ...	10	280	3	46
Pneumonia (PN)											
READM-30-PN	Pneumonia (PN) 30-Day Readmission Rate	No Different than U.S. National Rate	87	15.7% (12.4%, 19.8%)	17.6%		in the **Nation** that Performed ...	37	4285	135	376
							in the **State** that Performed ...	3	290	5	46

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Measures: Third Quarter 2009 through Second Quarter 2012 Discharges

Reporting Period for 30-Day Hospital-Wide Outcome Measures: Third Quarter 2011 through Second Quarter 2012 Discharges

050090-SONOMA VALLEY HOSPITAL

30-Day Risk-Standardized Readmission Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	U.S. National Rate		Number of Hospitals...	Better than U.S. National Rate	No Different than U.S. National Rate	Worse than U.S. National Rate	Number of Cases Too Small
Hip/Knee											
READM-30-HIP-KNEE	30-Day Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	No Different than U.S. National Rate	56	5.6% (3.8%, 8.1%)	5.4%		in the **Nation** that Performed ...	51	2738	38	665
							in the **State** that Performed ...	8	199	1	90
Hospital-Wide											
READM-30-HOSPWIDE	30-Day Hospital-Wide All-Cause Unplanned Readmission Rate	Better than U.S. National Rate	524	13.8% (12.4%, 15.7%)	16.0%		in the **Nation** that Performed ...	316	3966	369	158
							in the **State** that Performed ...	29	283	17	10

Hospital Performance

Reporting Period for Complication Outcome Measures: Third Quarter 2009 through First Quarter 2012 Discharges

050090-SONOMA VALLEY HOSPITAL

Risk-Standardized Complication Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Complication Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	U.S. National Rate		Number of Hospitals...	Better than U.S. National Rate	No Different than U.S. National Rate	Worse than U.S. National Rate	Number of Cases Too Small
Surgical Complication											
COMP-HIP-KNEE	Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	No Different than U.S. National Rate	51	4.0% (2.4%, 6.6%)	3.4%		in the **Nation** that Performed ...	75	2655	68	687
							in the **State** that Performed ...	7	196	4	89

Footnote Legend

1. The number of cases/patients is too few to report.
4. Data suppressed by CMS for one or more quarters.
5. Results are not available for this reporting period.
7. No cases met the criteria for this measure.
13. Results cannot be calculated for this reporting period.

Hospital Performance

Reporting Period for AHRQ Patient Safety Indicators: Third Quarter 2010 through Second Quarter 2012 Discharges

050090-SONOMA VALLEY HOSPITAL

Address: 347 ANDRIEUX ST
City, State, ZIP: SONOMA, CA 95476
Phone Number: (707) 935-5000
County Name: SONOMA

Type of Facility: Short-term
Type of Ownership: Government - Hospital District or Authority
Emergency Service Provided: Yes

AHRQ Measures - Patient Safety Indicators

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's PSI Rate (Lower Limit, Upper Limit of 95% Confidence Interval)	U.S. National Rate per 1,000	Number of Hospitals...	Better than U.S. National Rate / Value	No Different than U.S. National Rate / Value	Worse than U.S. National Rate / Value	Number of Cases Too Small
Individual Patient Safety Indicators (PSIs)										
PSI-4	Death among surgical inpatients with serious treatable complications	N/A(1)	9	N/A(1)	110.25	in the **Nation** that Performed ...	43	1831	70	1058
						in the **State** that Performed ...	1	164	3	116
PSI-6	Iatrogenic pneumothorax, adult	No Different than U.S. National Rate	1496	0.27 (0.00, 0.68)	0.32	in the **Nation** that Performed ...	9	3366	60	38
						in the **State** that Performed ...	1	302	7	0
PSI-12	Post-Operative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT)	No Different than U.S. National Rate	315	2.49 (0.00, 6.51)	4.14	in the **Nation** that Performed ...	155	2846	203	114
						in the **State** that Performed ...	16	274	8	5

Hospital Performance

Reporting Period for AHRQ Patient Safety Indicators: Third Quarter 2010 through Second Quarter 2012 Discharges

050090-SONOMA VALLEY HOSPITAL

AHRQ Measures - Patient Safety Indicators

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's PSI Rate (Lower Limit, Upper Limit of 95% Confidence Interval)	U.S. National Rate per 1,000	Number of Hospitals...	Better than U.S. National Rate / Value	No Different than U.S. National Rate / Value	Worse than U.S. National Rate / Value	Number of Cases Too Small
Individual Patient Safety Indicators (PSIs)										
PSI-14	Postoperative wound dehiscence	No Different than U.S. National Rate	52	0.80 (0.00, 2.94)	0.92	in the **Nation** that Performed ...	0	2703	42	391
						in the **State** that Performed ...	0	245	2	49
PSI-15	Accidental puncture or laceration	No Different than U.S. National Rate	1534	1.82 (0.00, 3.71)	1.83	in the **Nation** that Performed ...	95	3133	203	42
						in the **State** that Performed ...	7	280	22	1
Composite Patient Safety Indicator (PSI)										
PSI-90	Complication / patient safety for selected indicators (composite)	No Different than U.S. National Rate	N/A	0.51 (0.13, 0.89)	0.61	in the **Nation** that Performed ...	108	3184	182	0
						in the **State** that Performed ...	8	287	15	0

Hospital Performance

Reporting Period for Healthcare Associated Infection Measures: Second Quarter 2012 through First Quarter 2013 Discharges

050090-SONOMA VALLEY HOSPITAL

Healthcare Associated Infection

Hospital Quality Measures	Your Hospital's Reported Number of Infections	Device or Patient Days/Procedures	Your Hospital's Predicted Number of Infections	Ratio of Reported to Predicted Infections (SIR) (Lower Limit, Upper Limit of 95% Interval Estimate)	Your Hospital's Performance	State Standardized Infection Ratio, State Lower Limit, State Upper Limit of 95% Interval Estimate	U.S. National Standardized Infection Ratio
Central Line Associated Bloodstream Infection	0	213	0.320	N/A(13)	N/A	0.513 (0.483, 0.544)	0.545
Catheter Associated Urinary Tract Infections	0	541	0.703	N/A(13)	N/A	1.052 (1.008, 1.098)	1.127
SSI-Colon Surgery	0	10	0.284	N/A(13)	N/A	0.728 (0.671, 0.788)	0.831
SSI-Abdominal Hysterectomy	0	3	0.037	N/A(13)	N/A	0.897 (0.779, 1.029)	0.903
MRSA Bacteremia	0	1509	0.054	N/A(13)	N/A	0.717 (0.616, 0.830)	1.019
Clostridium Difficile (C.Diff)	0	1509	1.059	0.000(--,3.483)(8)	No Different than U.S. National Benchmark	1.092 (1.052, 1.133)	0.966

Hospital Performance

Reporting Period for Healthcare Personnel Influenza Vaccination Measure: First Quarter 2013 through First Quarter 2013

050090-SONOMA VALLEY HOSPITAL

Healthcare Personnel Influenza Vaccination

Hospital Quality Measures	Your Hospital's Reported Adherence Percentage	Your Hospital's Performance	State Reported Adherence Percentage	U.S. National Reported Adherence Percentage
Healthcare Personnel Influenza Vaccination	61%	N/A	73%	75%

Footnote Legend

1. The number of cases/patients is too few to report.
3. Results are based on a shorter time period than required.
4. Data suppressed by CMS for one or more quarters.
5. Results are not available for this reporting period.
7. No cases met the criteria for this measure.
8. The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero.
12. This measure does not apply to this hospital for this reporting period.
13. Results cannot be calculated for this reporting period.

Hospital Compare Preview Report: Hospital Performance – Outpatient

Reporting Period for Clinical Process Measures: Second Quarter 2012 through First Quarter 2013 Encounters

Reporting Period for Outpatient Imaging Efficiency Measures: First Quarter 2011 through Fourth Quarter 2011 All Paid Medicare FFS Claims

050090-SONOMA VALLEY HOSPITAL

Address: 347 ANDRIEUX ST
City, State, ZIP: SONOMA, CA 95476
Phone Number: (707) 935-5000
County Name: SONOMA

Type of Facility: Short-term
Type of Ownership: Government - Hospital District or Authority
Emergency Service Provided: Yes

Structural Measures

OP-12	Does/did your facility have the ability to receive laboratory data electronically directly into your ONC certified EHR system as discrete searchable data?	Yes
OP-17	Does your facility have the ability to track clinical results between visits?	Yes
OP-22	Patient left before being seen	86/4742 (2%)

	Hospital Quality Measures	Your Hospital Performance for All Quarters	10% of All Hospitals Submitting Data Performed Equal to or Better Than	State Performance	National Performance
AMI Cardiac Care					
OP-1	Median Time to Fibrinolysis	N/A(7)	19 Minutes	28 Minutes	28 Minutes
OP-2	Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	N/A(7)	100%	62%	57%
OP-3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention-Reporting Rate	45 Minutes based on 6 patients(1)	38 Minutes	60 Minutes	58 Minutes
OP-4	Aspirin at Arrival	96% of 26 patients	100%	97%	96%
OP-5	Median Time to ECG	12 Minutes based on 23 patients	3 Minutes	9 Minutes	7 Minutes
Surgical Care					
OP-6	Timing of Antibiotic Prophylaxis	100% of 24 patients	100%	97%	97%
OP-7	Prophylactic Antibiotic Selection for Surgical Patients	100% of 24 patients	100%	97%	97%

Hospital Compare Preview Report: Hospital Performance – Outpatient

Reporting Period for Clinical Process Measures: Second Quarter 2012 through First Quarter 2013 Encounters

Reporting Period for Outpatient Imaging Efficiency Measures: First Quarter 2011 through Fourth Quarter 2011 All Paid Medicare FFS Claims

050090-SONOMA VALLEY HOSPITAL

	Hospital Quality Measures	Your Hospital Performance for All Quarters	10% of All Hospitals Submitting Data Performed Equal to or Better Than	State Performance	National Performance
Outpatient Imaging Efficiency (OIE)					
OP-8	MRI Lumbar Spine for Low Back Pain	37.5% of 48 patients	N/A	32.9%	36.5%
OP-9	Mammography Follow-up Rates	5.7% of 895 patients	N/A	8.6%	8.8%
OP-10	Abdomen CT - Use of Contrast Material	8.5% of 236 scans	N/A	15.7%	12.7%
OP-11	Thorax CT - Use of Contrast Material	0.6% of 164 scans	N/A	3.4%	3.7%
OP-13	Cardiac imaging for preoperative risk assessment for non-cardiac low-risk surgery	6.0% of 134 patients	N/A	5.7%	5.5%
OP-14	Simultaneous use of brain Computed Tomography (CT) and sinus Computed Tomography (CT)	N/A(1)	N/A	2.1%	2.8%
Emergency Department					
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients	124 Minutes based on 598 patients	92 Minutes	172 Minutes	137 Minutes
OP-20	Median Time from ED Arrival to Provider Contact for ED patients	14 Minutes based on 186 patients	13 Minutes	30 Minutes	27 Minutes
Pain Management					
OP-21	Median Time to Pain Management for Long Bone Fracture	62 Minutes based on 62 patients	38 Minutes	63 Minutes	59 Minutes
Stroke					
OP-23	Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival	18% of 11 patients	99%	46%	51%

Footnote Legend

*OP-1 Measure data displayed on the preview report will be available through the download process and excluded from display on Hospital Compare.

1. The number of cases/patients is too few to report.
3. Results are based on a shorter time period than required.
4. Data suppressed by CMS for one or more quarters.
5. Results are not available for this reporting period.
7. No cases met the criteria for this measure.

VBP

Is Your Hospital Ready for Value-Based Purchasing?

Since October 2012, Medicare rewards hospitals that provide high-quality care for their patients through the new Hospital Value-Based Purchasing (VBP) Program. Hospitals paid under the Inpatient Prospective Payment System (IPPS) are paid for inpatient acute care services based on quality of care—not the volume of services they provide.

The Medicare Quality Improvement Organizations for Florida and California, FMQAI and Health Services Advisory Group of California, offer technical assistance and support for hospitals in those states to be successful in a value-driven environment.

> "Instead of payment that asks, *How much did you do?,* the Affordable Care Act clearly moves us toward payment that asks, *How well did you do?*, and more importantly, *How well did the patient do?*"
>
> Don Berwick

Measures → Points → Domain Score → Domain Weighting → Total Performance Score → Incentive Payment

Measures

The VBP program has 20 measures for FY 2013, 24 for FY 2014, and 26 for FY 2015. Each hospital may earn two scores on each measure—one for *achievement* and one for *improvement*. The final score awarded to a hospital for each measure or dimension is the higher of these two scores.

Points

Achievement Points: Awarded by comparing an individual hospital's rates during the performance period with the 50th percentile (threshold) of all hospitals' performance and the mean of the top decile, which is approximately the 95th percentile (benchmark) during the baseline period:

- Hospital rate at or above benchmark: **10 achievement points**
- Hospital rate below achievement threshold: **0 achievement points**
- Hospital rate equal to or greater than the achievement threshold and less than the benchmark: **1–9 achievement points**

Improvement Points: Awarded by comparing a hospital's rates during the performance period to that same hospital's rates from the baseline period:

- Hospital rate at or above benchmark: **9 improvement points**
- Hospital rate at or below baseline period rate: **0 improvement points**
- Hospital rate between the baseline period rate and the benchmark: **0–9 improvement points**

Consistency Points: The consistency points relate only to the Patient Experience of Care domain. The purpose of these points is to reward hospitals that have scores above the national 50th percentile in ALL 8 dimensions of the HCAHPS. If they do, they receive the full 20 points. If they don't, the LOWEST dimension is compared with the range between the national 0 percentile (floor) and the 50th percentile (threshold) and awarded points proportionately. This formula is to be used for each dimension to determine the lowest dimension from the performance period:

$$\frac{\text{Your hospital performance period score} - \text{floor}}{\text{National achievement threshold} - \text{floor}}$$

Domain Score

VBP measures roll up to a domain. FY 2013 has two domains, the Clinical Process of Care domain and the Patient Experience of Care domain. Measure scores are added and divided by the total possible points x 100 to determine the Clinical Process of Care domain score. Dimension scores are added together to arrive at the HCAHPS base points. Base points plus the consistency score are added together to determine the Patient Experience of Care domain score. Additional domains will be added in FY 2014 (Outcome domain) and FY 2015 (Efficiency domain).

Domain Weighting

The federal rule defines how much each domain will be weighted to calculate the Total Performance Score for each fiscal year. See pie charts in attached summaries for specific percentages for each domain.

Total Performance Score

A hospital's performance is assessed on the measures that comprise the domains. The domains are weighted and rolled up to the Total Performance Score. For instance, in FY 2013, the Total Performance Score is computed by multiplying the Clinical Process of Care domain score by 70% (domain weighting) and the Patient Experience of Care domain score by 30% (domain weighting), then adding those totals. The Total Performance Score is then translated into an incentive payment that makes a portion of the base DRG payment contingent on performance.

Incentive Payment

In FY 2014, 1.25% of DRG payments to eligible hospitals will be withheld to provide the estimated $963 million necessary for the program incentives. Following is the schedule for future withholding:

FY 2013:	1.00%	FY 2016:	1.75%
FY 2014:	1.25%	FY 2017:	2.00%
FY 2015:	1.50%	Succeeding years:	2.00%

Based on performance, hospitals will earn an incentive payment. The law requires the Centers for Medicare & Medicaid Services (CMS) to redistribute the estimated $963 million across all participating hospitals, based on their performance scores. CMS will use a linear exchange function to distribute the available amount of value-based incentive payments to hospitals, based on hospitals' total performance scores on the hospital VBP measures. To convert the total performance score to a value-based incentive payment factor that is applied to each discharge, there are six steps for each fiscal year:

Step 1: Estimate the hospital's total annual base-operating DRG amount.
Step 2: Calculate the estimated reduction amount across all eligible hospitals.
Step 3: Calculate the linear exchange function slope.
Step 4: For each hospital, calculate the value-based incentive payment percentage.
Step 5: Compute the net percentage change in the hospital's base operating DRG payment.
Step 6: Calculate the value-based incentive payment adjustment factor.

There is a review and correction period as well as an appeals process.

Eligibility Criteria

Eligible hospitals are paid through the inpatient prospective payment system, so critical access hospitals, children's hospitals, VA hospitals, long term care facilities, psychiatric hospitals, and rehabilitation hospitals are excluded. Eligible hospitals (PPS hospitals) need to meet additional criteria to be included.

- The Clinical Process of Care domain requires four or more measures, each with at least 10 cases.
- The Patient Experience of Care domain requires at least 100 HCAHPS surveys in the performance period.
- The Outcome domain in FY 2013 requires two or more mortality measures, each with at least 10 cases. In FY 2014, the minimum cases for the mortality measures changes to 25 cases. PSI-90 will require 3 cases as a minimum for any of the underlying indications. CLABSI will require the hospital to have at least one predicted infection during the applicable period.
- The Efficiency domain will require 25 cases for the Medicare Spending per Beneficiary measure.
- To be included in VBP, the hospital must meet these criteria for all domains.

Public Reporting

Hospital performance information will be posted on Hospital Compare beginning in April 2013. This will include:

- Measure rates
- Condition-specific scores
- Domain-specific scores
- Total Performance Scores (TPS)

Incentive adjustment posting will be addressed in future rulemaking.

Improvement Resources:

- Why Not the Best? Quality improvement resources for health care professionals
- The CAHPS Improvement Guide
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

For more information:

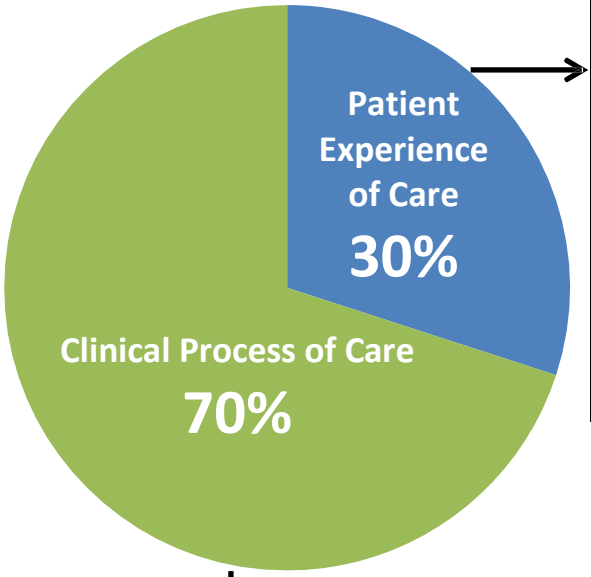
- Hospital Value-Based Purchasing Program
- Hospital Compare
- CMS Open Door Forum: Hospital Value-Based Purchasing, Fiscal Year 2013 Overview for Beneficiaries, Providers, and Stakeholders, a PowerPoint presentation.
- National Providers Call: Hospital Value-Based Purchasing, Fiscal Year 2014 Overview for Beneficiaries, Providers and Stakeholders, a PowerPoint presentation.
- For more information on how the Total Performance Score is converted to incentive payments: National Provider Call: Hospital Value-Based Purchasing, FY 2013 Actual Percentage Payment Summary Report, a PowerPoint presentation.

If you have questions regarding the Hospital Value-Based Purchasing Program, contact Hospital Quality Specialist Cassie Watson, RN, MSN, PhD, at (813) 865-3437 or cwatson@flqio.sdps.org.

This material was prepared by Stratis Health, the Medicare Quality Improvement Organization (QIO) for Minnesota and has been adapted for use by FMQAI, the Medicare QIO for Florida, and Health Services Advisory Group of California, the Medicare QIO for California, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.
Publication Nos. FL-10SOW-2013FLC706-2-648; CA-10SOW-7.4-030513-01

FY 2013 Value-Based Purchasing

(Discharges from October 1, 2012, to September 30, 2013)



PATIENT EXPERIENCE OF CARE DIMENSIONS	
Baseline Period	**Performance Period**
July 1, 2009 – March 31, 2010	July 1, 2011 – March 31, 2012

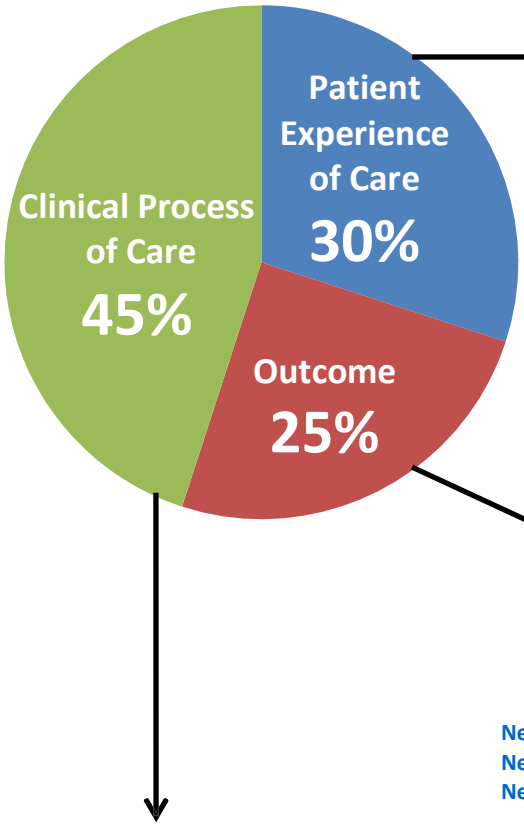
HCAHPS Survey Dimensions	HCAHPS Performance Standard		
	Floor (%)	Threshold (%)	Benchmark (%)
Communication with nurses	38.98	75.18	84.70
Communication with doctors	51.51	79.42	88.95
Responsiveness of hospital staff	30.25	61.82	77.69
Pain management	34.76	68.75	77.90
Communication about medications	29.27	59.28	70.42
Cleanliness and quietness	36.88	62.80	77.64
Discharge information	50.47	81.93	89.09
Overall rating of hospital	29.32	66.02	82.52

CLINICAL PROCESS OF CARE	
Baseline Period	**Performance Period**
July 1, 2009 – March 31, 2010	July 1, 2011 – March 31, 2012

MEASURES	Threshold (%)	Benchmark (%)
AMI 7a Fibrinolytic agent received w/in 30' of hospital arrival	65.48	91.91
AMI 8a PCI received w/in 90' of hospital arrival	91.86	100.00
HF 1 Discharge instructions	90.77	100.00
PN 3b Blood culture before 1st antibiotic received in hospital	96.43	100.00
PN 6 Initial antibiotic selection for CAP immunocompetent pt	92.77	99.58
SCIP 1 Abx w/in 1 hr before incision or w/in2 hrs if Vancomycin/ Quinolone is used	97.35	99.98
SCIP 2 Received prophylactic Abx consistent with recommendations	97.66	100.00
SCIP 3 Prophylactic Abx discontinued w/in 24 hrs of surgery end time or 48 hrs for cardiac surgery	95.07	99.68
SCIP 4 Controlled 6 AM postoperative serum glucose – cardiac surgery	94.28	99.63
SCIP-VTE 1 Recommended VTE prophylaxis ordered during admission	95.00	100.00
SCIP VTE2 Received VTE prophylaxis w/in 24 hrs prior to or after surgery	93.07	99.85
SCIP-Card 2 Pre-admission beta-blocker and perioperative period beta blocker	93.99	100.00

FY 2014 Value-Based Purchasing Domain Weighting

(Discharges from October 1, 2013 to September 30, 2014)



PATIENT EXPERIENCE OF CARE		
Baseline Period		**Performance Period**
April 1, 2010 – December 31, 2010		April 1, 2012 – December 31, 2012
HCAHPS Survey Dimensions	**HCAHPS Performance Standard**	
	Floor (%)	**Threshold (%)**	**Benchmark (%)**
Communication with nurses	42.84	75.79	84.99
Communication with doctors	55.49	79.57	88.45
Responsiveness of hospital staff	32.15	62.21	78.08
Pain management	40.79	68.99	77.92
Communication about medications	36.01	59.85	71.54
Cleanliness and quietness	38.52	63.54	78.10
Discharge information	54.73	82.72	89.24
Overall rating of hospital	30.91	67.33	82.55

OUTCOME		
Baseline Period		**Performance Period**
July 1, 2009 – June 30, 2010		July 1, 2011 – June 30, 2012
Measure (Displayed as survival rate)	**Threshold (%)**	**Benchmark (%)**
New! 30-day mortality, AMI	84.77	86.73
New! 30-day mortality, heart failure	88.61	90.42
New! 30-day mortality, pneumonia	88.18	90.21

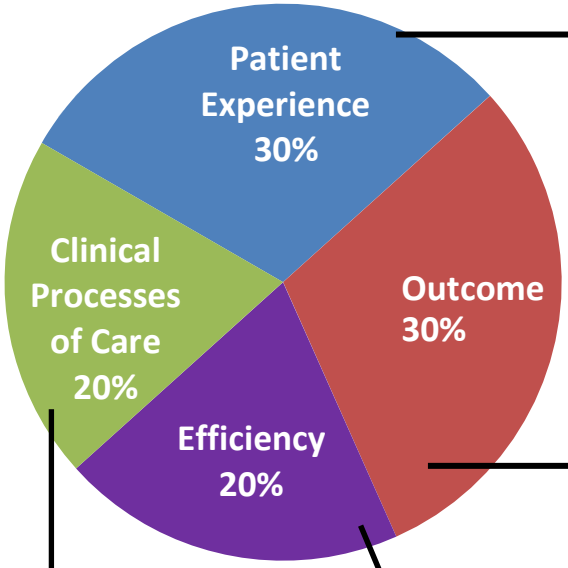
CLINICAL PROCESS OF CARE		
Baseline Period	**Performance Period**	
April 1, 2010 – December 31, 2010	April 1, 2012 – December 31, 2012	
Measures	**Threshold (%)**	**Benchmark (%)**
AMI 7a Fibrinolytic agent received w/in 30' of hospital arrival	80.66	96.30
AMI 8a PCI received w/in 90' of hospital arrival	93.44	100.00
HF 1 Discharge instructions	92.66	100.00
PN 3b Blood culture before 1st antibiotic received in hospital	97.30	100.00
PN 6 Initial antibiotic selection for CAP immunocompetent pt	94.46	100.00
SCIP 1 Abx w/in 1 hr before incision or w/in2 hrs if Vancomycin/Quinolone is used	98.07	100.00
SCIP 2 Received prophylactic Abx consistent with recommendations	98.13	100.00
SCIP 3 Prophylactic Abx discontinued w/in 24 hrs of surgery end time or 48 hrs for cardiac surgery	96.63	99.96
SCIP 4 Controlled 6 AM postoperative serum glucose – cardiac surgery	96.34	100.00
SCIP 9 Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2	92.86	99.89
SCIP-Card 2 Pre-admission beta-blocker and perioperative period beta blocker	95.65	100.00
SCIP-VTE 1 Recommended VTE prophylaxis ordered during admission	94.62	100.00
SCIP VTE2 Received VTE prophylaxis w/in 24 hrs prior to or after surgery	94.92	99.83

New!

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES
FMQAI
HSAG HEALTH SERVICES ADVISORY GROUP

FY 2015 Value-Based Purchasing Domain Weighting

(Discharges from October 1, 2014 to September 30, 2015)



PATIENT EXPERIENCE OF CARE

Baseline Period	Performance Period
January 1, 2011 – December 31, 2011	January 1, 2013 – December 31, 2013

HCAHPS Survey Dimensions	HCAHPS Performance Standard		
	Floor (%)	Threshold (%)	Benchmark (%)
Communication with nurses	47.77	76.56	85.70
Communication with doctors	55.62	79.88	88.79
Responsiveness of hospital staff	35.10	63.17	79.06
Pain management	43.58	69.46	78.17
Communication about medications	35.48	60.89	71.85
Cleanliness and quietness	41.94	64.07	78.90
Discharge information	57.67	83.54	89.72
Overall rating of hospital	32.82	67.96	83.44

OUTCOME

Mortality

Baseline Period	Performance Period
October 1, 2010 – June 30, 2011	October 1, 2012 – June 30, 2013

Measure (Displayed as survival rate)	Threshold (%)	*Benchmark (%)*
30-day mortality, AMI	84.74	86.23
30-day mortality, heart failure	88.15	90.03
30-day mortality, pneumonia	88.26	90.41

Complication/Patient Safety for Selected Indicators

Baseline Period	Performance Period
October 15, 2010 – June 30, 2011	October 15, 2012 – June 30, 2013

Measure	Threshold (%)	Benchmark (%)
AHRQ PSI composite **New!**	62.28	45.17

Central Line-associated Blood Stream Infection

Baseline Period	Performance Period
January 1, 2011 – December 31, 2011	February 1, 2013 – December 31, 2013

Measure	Threshold (*)	Benchmark (%)
CLABSI **New!**	.437	00.00

*Standardized infection ratio

CLINICAL PROCESS OF CARE

Baseline Period	Performance Period
January 1, 2011 – December 31, 2011	January 1, 2013 – December 31, 2013

Measures	Threshold (%)	Benchmark (%)
AMI 7a Fibrinolytic agent received w/in 30' of hospital arrival	80.00	100
AMI 8a PCI received w/in 90' of hospital arrival	95.34	100
HF 1 Discharge instructions	92.09*	100.00
PN 3b Blood culture before 1st antibiotic received in hospital	94.11	100
PN 6 Initial antibiotic selection for CAP immunocompetent pt	97.78	100
SCIP 1 Abx w/in 1 hr before incision or w/in2 hrs if Vancomycin/Quinolone is used	97.17	100
SCIP 2 Received prophylactic Abx consistent with recommendations	98.63	100
SCIP 3 Prophylactic Abx discontinued w/in 24 hrs of surgery end time or 48 hrs for cardiac surgery	98.63	100
SCIP 4 Controlled 6 AM postoperative serum glucose – cardiac surgery	97.49	100
SCIP 9 Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2	95.79	99.76
SCIP-Card 2 Pre-admission beta-blocker and perioperative period beta blocker	95.91	100
New! SCIP VTE-1 was removed from FY2015 measures	-------	-------
SCIP VTE2 Received VTE prophylaxis within 24 hrs prior to or after surgery	94.89	99.99

*This is the proposed achievement threshold in the August 31, 2012, IPPS rule. The final performance standard was not listed for this measure.

EFFICIENCY

Baseline Period	Performance Period
May 1, 2011 – December 31, 2011	May 1, 2013 – December 31, 2013

Measure	Threshold (%)	Benchmark (%)
MSPB-1 Medicare spending per beneficiary **New!**	Median Medicare spending per beneficiary ratio across all hospitals during the performance period.	Mean of lowest decile of Medicare spending per beneficiary ratios across all hospitals during the performance period.

This material was prepared by Stratis Health, the Medicare Quality Improvement Organization (QIO) for Minnesota and has been adapted for use by FMQAI, the Medicare QIO for Florida, and Health Services Advisory Group of California, the Medicare QIO for California, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication Nos. FL-10SOW-2013FLC706-2-648; CA-10SOW-7.4-030513-01

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6.

BOARD QUALITY DASHBOARD REPORT FOR 2nd QUARTER

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

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 organization has an effective quality assurance and performance improvement program (QAPI).

1. Surgical Services Volumes by Service Fiscal Year 2013

	Jul-Sept		Oct-Dec		Jan-Mar		Apr-Jun		Totals
SERVICE	**IP**	**OP**	**IP**	**OP**	**IP**	**OP**	**IP**	**OP**	
General	34	35	35	31	32	29	30	48	274
OBGYN	16	17	14	22	17	16	11	22	135
Ophthalmology	0	50	0	45	0	45	0	48	188
Orthopedic	62	107	51	118	55	106	57	101	657
Pain Management	0	39	0	36	0	37	0	39	151
Podiatry	1	12	1	16	0	15	3	4	52
Urology	3	9	3	5	3	3	1	5	32
Vascular Surgery	0	5	0	3	1	4	0	7	20
Endoscopy	24	80	13	84	24	66	14	82	387
Totals	**140**	**354**	**117**	**360**	**132**	**321**	**116**	**356**	**1896**

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	11.94				N/A	30	

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	64.28				N/A	96	

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 weeks post discharge. There are many questions on the survey and the hospital has shown a significant improvement over the past two years. We chose 3 questions upon which to focus our attention.

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%	70.7%	71.9%				N/A	90.00%	

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%	85.7%	86.1%				N/A	90.00%	

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%	91.4%	88.7%				N/A	90.00%	

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%	4.2%				N/A	16.0%	

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%**	**4.2%**				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%**				**N/A**	**18.0%**	

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%**				N/A	**23.0%**	

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%	**11.11%**	**0.00%**				N/A	**17.6%**	

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%**				**N/A**	**TBD**	**TBD**

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

5. Hospital Acquired Infections: Quality Patient Outcomes and Safety

Infections are tracked for 16 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	