SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, March 22, 2017
5:00 p.m. Regular Session
(Closed Session will be held upon adjournment of the Regular Session)

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

AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a District meeting, please contact the Interim District Clerk, Vivian Woodall, at vwoodall@svh.com or 707.935.5005 at least 48 hours prior to the meeting.		
MISSION STATEMENT The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.		
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
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.	*Hirsch*	
3. CONSENT CALENDAR • Minutes 02.22.17	*Hirsch*	Action
4. POLICY & PROCEDURES	*Lovejoy*	Action
5. QUALITY REPORT MARCH 2017	*Lovejoy*	Inform/Action
6. ANNUAL INFECTION CONTROL REPORT	*Mathews*	Inform
7. ANNUAL CONTRACT REPORT	*Lovejoy*	Inform
8. REVIEW AND DISCUSSION OF BOARD QUALITY SCORECARD	*Lovejoy*	Inform/ Discussion
9. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*	
10. CLOSED SESSION: • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Sebastian/Hirsch*	Action
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
12. ADJOURN	*Hirsch*	

3.

CONSENT

+

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
February 22, 2017, 5PM
MINUTES
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch Howard Eisenstark, MD Susan Idell Kelsey Woodward Carol Snyder Cathy Webber		Joshua Rymer Ingrid Sheets Michael Mainardi Brian Sebastian, MD	Leslie Lovejoy Mark Kobe

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Meeting called to order at 5:01 p.m.	
2. PUBLIC COMMENT	*Hirsch*	
	No public comment.	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 01.25.17		**MOTION** by Eisenstark to approve and 2nd by Idell. All in favor
4. POLICY & PROCEDURES	*Lovejoy*	Action
	Dr. Eisenstark suggested some language be added to the informed consent policy; Ms. Lovejoy said the standard CHA language is used. . Dr. Eisenstark also mentioned the job shadowing policy was rather vague. Ms. Lovejoy said it is vague on purpose to allow it to cover various types of students and MDs who bring in students. She would check to see if the Med Staff had comments. Ms. Lovejoy will clarify these issues and return the policies for review at the March meeting.	**MOTION** by Idell to approve and 2nd by Eisenstark. All in favor.
5. QUALITY REPORT FEBRUARY 2017	*Lovejoy*	Inform/Action
	A summary discharge plan was created as part of the Prime Grant Transition Record, which will be	

AGENDA ITEM	DISCUSSION	ACTION
	completed by various team members. Follow-up appointments are made for patients for the first 7 days. Advance directive information is recorded, as well as "what matters most" to the patient. The regular discharge instructions are included behind this cover sheet. The self-management plan at the end was adopted as a best practice. This is the transition record we send to the next provider. This material all goes into the patient chart and is scanned on discharge. A personal health care record and magnet is also provided to the patient for home use. Paramedics will look for this file either on the front, or just inside the door, of the refrigerator. The first community health coach was assigned a patient. Next month the quality report will cover infrastructure reporting for the grant. Ms. Lovejoy is currently managing the med staff office.	
6. PATIENT CARE SERVICES DASHBOARD	*Kobe*	
	Mr. Kobe reviewed the 4th quarter results for the patient care services dashboard. Final 4th quarter numbers will come out the first part of March.	
7. QUALITY & RESOURCE MANAGEMENT DEPARTMENT ANNUAL REPORT	*Lovejoy*	
	Ms. Lovejoy presented an annual review on her own Quality and Resource Management department using a format suggested by the QC chair. The department impacts the bottom line through reducing extended stays. She also announced that the hospital credentialing survey is due within the next couple of months.	
8. UPON ADJOURNMENT OF REGULAR SESSION	*Hirsch*	
	Regular session adjourned at 6:00 p.m.	
9. CLOSED SESSION • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Hirsch*	Action

AGENDA ITEM	DISCUSSION	ACTION
10. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
	The Medical Staff Credentialing was unanimously approved.	
11. ADJORN	*Hirsch*	
	Meeting adjourned at 6:04 p.m.	

4.

POLICY & PROCEDURES

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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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.

Brian Sebastian, MD
Chair, P.I./P.T. Committee

3/14/17
Date

Kelly Mather
Chief Executive Officer

Date

Jane Hirsch
Chair, Board of Directors

Date

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	2/21/2017	Y	
P.I. Committee	2/23/2017		
Quality Committee	3/22/2017		
Board of Directors	4/06/2017		

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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Policy Submission Summary Sheet

Kathy Mathews, Clinical Quality Coordinator		Leslie Lovejoy, Chief Quality Officer	
Signature: Kathy Mathews	DATE: 2-22-17	Signature: Leslie Lovejoy	DATE: 2-22-17

ORGANIZATIONAL

REVIEWED/NO CHANGES

IC8610-118 Creuzfeldt-Jakob Disease
IC8610-126 Employee Food Refrigerator Temperature Monitoring
IC8610-138 Infection Prevention and Control Training for Healthcare Workers
IC8610-156 Pet Therapy Visitation
IC8610-168 Reporting Infections and Communicable Diseases to Infection Control Procedure
IC8610-174 Scabies Infestation and Outbreak Management
IC8610-176 Toy Cleaning Policy

REVISED

IC8610-122 Droplet Precautions
Reference added

IC8610-134 Hand Hygiene
Artificial nails and nail enhancements are not allowed for anyone providing patient care (rather than just personnel in high risk areas e.g., Surgery)

IC8610-146 Management of Multi-Drug Resistant Organisms Policy
Gloves must be worn when entering the isolation room. A gown must be worn if contact with the patient or his/her environment is anticipated. If the patient needs to ambulate for treatment purposes, the patient needs to bathe/shower, don a clean gown, wash hands prior to leaving the room with a healthcare worker. The healthcare worker accompanies the patient to reduce the risk of contact with other patients or the environment. Incontinent patients cannot ambulate. Isolation is required for pts with current or a history of MDRO. Discontinuing isolation is reviewed on a case by case basis and remains until a physician writes an order to discontinue isolation. This order must follow consultation and approval by the Infection Preventionist and Infectious Disease physician.

IC8610-150 Norovirus Outbreak Management
Updated Contact/Enteric Precautions and use of eye protection

IC8610-152 Neutropenic Precautions, Guidelines for Care of the Immunocompromised Patient
Removed the requirement for no flowers in intensive care. Flowers and plants are restricted from the rooms of immunosuppressed patients

IC8610-154 Outbreak Management
Influenza outbreak has been changed to include two or more laboratory confirmed cases of hospital onset influenza i.e., occurring 48 hours or longer after admission. Also, DPH will be notified of an outbreak.

IC8610-158 Pregnant and Breastfeeding Healthcare Workers
An N95 mask is required for care of patients with novel influenza, Varicella and Measles even if immune. A surgical mask is required for Rubella in accordance with Droplet Precautions. HBV vaccine is recommended at time of hire if appropriate.

IC8610-162 Prevention of Central Line Associated Blood Stream Infections, Prevention
Revised to include CLIP information

IC8610-164 Prevention of Surgical Site Infections
Artificial nails and nail polish are prohibited. SSIs are reported up to 90 days post op. Patients undergoing total joint replacement will follow the S. aureus Decolonization procedure. Timing of pre op antibiotics are withing 60 minutes of cut time and 90 minutes for vancomycin. PPE worn during a surgical case is removed before leaving the Surgery Department.

IC8610-166 Rehabilitation Services with Patients in Contact Isolation, Management
Contact Isolation patients with active diarrhea can't ambulate outside of the room. Patients with MRSA in their sputum who are actively coughing cannot ambulate outside of their room. (Surgical masks cannot prevent aerosolization). Patients in Airborne Isolation should not be out of the room for ambulation e.g., chickenpox. Patients should not be in contact with environmental surfaces. If so, surfaces are disinfected immediately.

IC8610-170 Reporting Positive Culture Results After Transfer to Another Facility Procedure
Removed Joint Commission references

IC8610-177 Table, Transmission Based Precautions for Selected Infections and Conditions
Revised with several changes to anthrax, brochiolitis, diarrhea, norovirus, hepatitis A, polio, and rabies

DEPARTMENTAL – INFECTION CONTROL

REVIEWED/NO CHANGES
IC8750-138 Mandatory Reporting Policy
IC8750-125 Post Discharge SSI Surveillance

REVISED
IC8750-108 Infection Control Committee
Updated to reflect current titles of individuals that comprise the committee

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Policy and Procedure - Approvals Signature Page

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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.

Brian Sebastian, MD
Chair, P.I./P.T. Committee

3/14/17
Date

Keith J. Chamberlin, MD MBA
President of Medical Staff

3/16/17
Date

Kelly Mather
Chief Executive Officer

Date

Jane Hirsch
Chair, Board of Directors

Date

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	1/17/2017	Y	
PI Committee	2/23/2017		
Medical Exec. Committee	3/16/2017		
Quality Committee	3/22/2017		
Board of Directors	4/06/2017		

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Policy Submission Summary Sheet

Kathy Mathews, Clinical Quality Coordinator		Leslie Lovejoy, Chief Quality Officer	
Signature: Kathy Mathews RN	DATE: 2.22.17	Signature: Leslie Lovejoy	DATE: 2/22/17

ORGANIZATIONAL

REVISED
IC8610-171 Staph aureus Decolonization Procedure for Patients Undergoing Total Joint Replacement Surgery
Rephrased for process clarity

Leslie Lovejoy, Chief Quality Officer	
Signature: Leslie Lovejoy	DATE: 2/22/17

ORGANIZATIONAL

REVIEWED / NO CHANGES
UR8610-102 Utilization Review

REVISED
IC8610-172 Standard Precautions
Updated reusable procedure trays and instruments processed according to Manufacturer's instructions and updated patient and visitor hygiene supplies

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Policy and Procedure - Approvals Signature Page

Review and Approval Requirements

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- 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.

Keith J. Chamberlin, MD MBA
President of Medical Staff

3/15/17
Date

Kelly Mather
Chief Executive Officer

Date

Jane Hirsch
Chair, Board of Directors

Date

Reviewed by:	Date	Approved (Y/N)	Comment
Medical Exec. Committee	3/16/2017		
Quality Committee	3/22/2017		
Board of Directors	4/06/2017		

SONOMA VALLEY HOSPITAL
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Policy Submission Summary Sheet

Mark Kobe, Chief Nursing Officer	
Signature:	DATE:

ORGANIZATIONAL

REVIEWED / NO CHANGES
MS8610-102 Autopsy Policy

SUBJECT: Informed Consent	POLICY # RI8610-107 PAGE 1 OF 4
DEPARTMENT: Organizational	EFFECTIVE: 10/07
APPROVED BY: CEO	REVIEW/REVISED: 02/10, 9/13, 9/16

PURPOSE
The purpose of the Informed Consent Policy is to define Sonoma Valley Hospital's policy regarding informed consent.

APPLICABILITY
This is an organization-wide policy. It applies to all services and care settings where procedures or treatments requiring informed consent are performed.

DEFINITION
Informed Consent: the provision of medical information in such a way that the patient has enough information to determine whether or not to submit to medical treatment.

POLICY
The patient or his or her representative (as allowed under State) has the right to make informed decisions regarding his or her care. This includes the right to consent to or refuse medical treatment. The right to make informed decisions means the patient or patient's representative is given adequate information in a manner they can understand, including the following:

- Being informed of his or her health status, diagnosis, and prognosis
- Being involved in care planning and treatment
- Being able to request or refuse treatment (Note: This right is not construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.)

Giving informed consent for a procedure or treatment is one type of informed decision that a patient or patient's representative may need to make. The primary purpose of the informed consent process is to ensure that the patient or patient's representative is given information necessary to enable him/her to evaluate a proposed procedure or treatment before agreeing to that procedure or treatment.

The Medical Staff defines the procedures and treatment requiring informed consent. This includes:

- Any procedure that is listed as a surgical procedure in any of the various billing coding systems used by the Centers for Medicare and Medicaid Services (CMS) or other surgical procedures performed by the organization regardless of payment source.
- Any other treatments or procedures for which California or Sonoma Valley Hospital requires informed consent.

SUBJECT: Informed Consent	POLICY # RI8610-107 PAGE 2 OF 4
DEPARTMENT: Organizational	EFFECTIVE: 10/07
APPROVED BY: CEO	REVIEW/REVISED: 02/10, 9/13, 9/16

The licensed independent practitioner (LIP) – or other individuals if permitted by law, regulation, and organization policy – is responsible for the procedure or treatment is responsible for obtaining informed consent from the patient.

For each procedure or treatment defined to require informed consent, a properly executed informed consent form must be in the patient's chart prior to the procedure or treatment except in emergencies. An "emergency" is defined as:

- Immediate threat to life or limb exists; and
- Immediate treatment is needed to prevent deterioration and aggravation of the patient's condition.

A patient's representative, rather than the patient may give informed consent in the following circumstances:

- An Advanced Directive is in effect that provides for a representative to give informed consent, i.e., surrogate decision maker, agent designated by Medical Power of Attorney or Attorney for Healthcare; and
- Parent or legal guardian of a minor
- A legally appointed Conservator

Telephone consents may only be accepted if the patient is unable to consent, the patient's condition will not allow for a delay in treatment, and the patient's representative can be reached by telephone. The consenter's name and relationship to the patient and "by telephone consent" should be documented on the consent form. The hospital staff member accepting the telephone consent will sign as the witness.

The process to obtain informed consent includes a discussion between the LIP responsible for the procedure or treatment and the patient covering the following elements:

1. Description of the proposed procedure or treatment, including anesthesia to be used;
2. Indications for the proposed procedure or treatment;
3. Material risks, benefits, and side effects for the patient related to the procedure or treatment and anesthesia, including the likelihood of each, based on the available clinical evidence, as informed by the responsible practitioner's judgment. Material risks could include risks with a high degree of likelihood but a low degree of severity, as well as those with a very low degree of likelihood but high degree of severity;
4. Potential problems that might occur during recuperation;
5. The likelihood of achieving goals;
6. Treatment alternatives, including the attendant material risks, benefits, and side effects;
7. The probable consequences of declining recommended or alternative therapies;

8. Who will conduct the procedure or treatment and administer the anesthesia;
9. Whether physicians other than the operating practitioner will be performing important tasks related to surgery, in accordance with the hospital's policy. Important surgical tasks include: opening and closing, dissecting tissue, removing tissue, harvesting grafts, transplanting tissue, administering anesthesia, implanting devices and placing invasive lines; and
10. When indicated, any limitations on the confidentiality of information learned from the patient.

A properly executed informed consent form will include at least the following:

1. Name of the hospital where the procedure or treatment is to take place;
2. Name of the specific procedure or treatment for which consent is to be given;
3. Name of the responsible practitioner who is performing the procedure or administering the medical treatment;
4. Statement that the procedure or treatment, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or patient's representative
   Note: Material risks could include risks with a high degree of likelihood but a low degree of severity, as well as those with a very low degree of likelihood but high degree of severity. The responsible practitioner, who uses available clinical evidence as informed by the practitioner's professional judgment, may determine which material risks, benefits and alternative will be discussed with the patient, unless a more prescriptive State regulation takes precedence;
5. Signature of the patient or the patient's legal representative;
6. Name of the practitioner who conducted the informed consent discussion with the patient or patient's representative;
7. Date, time, and signature of the person witnessing the patient or patient's legal representative signing the consent form;
8. Indication or listing of the material risks of the procedure or treatment that were discussed with the patient or patient's representative;
9. Statement, if applicable, that physicians other than the operating practitioner, will be performing important tasks related to the procedure or treatment, in accordance with the hospital's policies and based on their skill set and under the supervision of the responsible practitioner; and
10. Statement, if applicable, that qualified medical practitioners who are not physicians who will perform important parts of the procedures or treatment or administration of anesthesia will be performing only tasks that are within their scope of practice, as determined under State law and regulation, and for which they have been granted privileges by the hospital.

As part of the Informed Consent process, the LIP also assesses the capacity/ability of the patient to understand the nature and consequences of a decision and to make a decision and communicate a decision and to understand the significant risks, benefits and alternatives of the proposed procedure.

SUBJECT: Informed Consent	POLICY # RI8610-107 PAGE 4 OF 4
DEPARTMENT: Organizational	EFFECTIVE: 10/07
APPROVED BY: CEO	REVIEW/REVISED: 02/10, 9/13, 9/16

Informed consent will be documented in the patient's medical record and should include a summary of the discussion, and patient's or patient representative's understanding and agreement. If the LIP determines that the patient lacks capacity, the LIP must document their determination in the record, inform the patient of the determination and seek another person/representative who has been authorized to make healthcare decisions for the patient.

Appropriate hospital staff may witness the signature of the patient or patient's representative, but are not authorized to obtain informed consent. If a patient or patient representative voices concerns or lack of understanding about the proposed procedure or treatment, the consent form should not be signed, and the responsible LIP notified. The patient or patient's representative should not be asked to sign the consent form until he/she expresses understanding. Questions should be referred to the responsible LIP.

Appropriate translation of information provided during the informed consent process and of the consent forms will be provided when indicated.

Except in emergencies as describe in this policy, the properly executed informed consent will be in the medical record prior to the procedure or treatment.

The LIP responsible for the procedure or treatment is to use approved informed consent forms. If an informed consent form has been obtained outside the organization, and does not contain the elements as prescribed in this policy, an organization approved informed consent form must be obtained.

References:
CHA Consent Manual, 2015
CMS Medicare Conditions of Participation §482.13; §482.51; §482.24
CIHQ Patient Rights PR-5

SUBJECT: Job Shadow/Healthcare Observer Requirements	POLICY # HR8610-366
	PAGE 1 OF 7
DEPARTMENT: Organizational	EFFECTIVE:
APPROVED BY: Director of Human Resources	REVIEW/REVISED:

Purpose:
Healthcare Observations are intended as a time limited arrangement to allow persons to observe clinical or non-clinical staff for education purposes.

Policy:
The following must be complete before the observation event can be scheduled:

- ☐ Review/sign/return the fact sheet entitled HIPAA Training Observers/Vendors – see Attachment A.
- ☐ Review/sign/return the Confidentiality and Non-Disclosure Agreement, see Attachement B.
- ☐ Obtain a signature and return the Mentor Agreement, see Attachment C.
- ☐ Signed Parental Consent form if you are less than 18 years old, see attachment D.
- ☐ Produce evidence of the following Immunizations:
  - TB test within the last year prior to placement at SVH or a negative chest x-ray within the last year if TB skin test is positive
  - Documentation of 2 doses of MMR vaccine or documentation of positive antibody titers
  - Documentation of Tdap (tetanus, diphtheria and pertussis) vaccine, unless Td (tetanus and siphtheria toxiods) vaccine has been received within the past 2 years or less
  - Documentation of positive history of chickenpox, or positive antibody titer; if negative history and/or titer, 2 doses of varivax vaccine is required.
  - Documentation of seasonal flu vaccine
  - Hepatis B Vaccine or signed SVH declination.

Key Points
- Arrive on time to the designated location.
- Observers do not participate in patient care in any manner.
- Dress should be appropriate to the setting and/or as specified when scheduled.
- Observers should not carry cell phones or other electronic personal devices during the experience.
- Observers are not allowed to enter isolation rooms.
- Observation experiences are not allowed or will be suspended in the event of type of incident such as a disaster, or if the observer has evidence of any illness such as cough, fever, etc.
- Once all requirements are met the observation experience will be scheduled.
- Observers are expected to be respectful of patients, staff, and others they encounter and follow appropriate Standards of Behavior.

- Patients have the right to refuse having an observer in their room; respect this right and remain flexible if a patient is uncomfortable having you observe.

Reference:
CIHQ Standard of Care HR-4: Management of Contract / Volunteer Staff; CMS 482.23
CIHQ Standard of Care PR-7: Personal Privacy; CMS 482.13
Sonoma County Public Health Order October 2014
CDC, NHSN Healthcare Personnel Vaccination Module

SUBJECT: Job Shadow/Healthcare Observer Requirements	POLICY # HR8610-366
	PAGE 3 OF 7
DEPARTMENT: Organizational	EFFECTIVE:
APPROVED BY: Director of Human Resources	REVIEW/REVISED:

Attachment A

HIPAA Training Observers/Vendors

HIPAA is a Federal law 3 Key Areas:

- Privacy of Protected Health Information (PHI)
- Security of electronically stored health care data
- Electronic transaction standards (financial billing standards)

PHI – Protected Health Information

- PHI includes demographic information such as: Name, address, phone, date of birth, Social Security Number and any other information that could identify the individual.
- PHI can be used for treatment, payment and operations only without authorization from the patient.

Mum's The Word

- Keep conversations out of elevators, cafeteria, and individuals not involved in the treatment of the patient.
- Do not view, share, discuss PHI without a need to know, or unless it is for the following: treatment, payment and operations.

Key Patient Rights:

- Notice of Privacy Practice – document outlining ways patient information can be used, shared and disclosed by law.
- Request Restriction – Patient may request a restriction such as "confidential status" no information given out to visitors.
- Access to PHI – Patient may request a copy of their medical record, refer patient to Health Information Management (HIM).
- Amendment to PHI – A patient requests a change in their medical record due to incorrect/inaccurate data. Refer to Privacy Officer.
- Accounting of the uses/disclosures of PHI – A patient may request a listing of disclosures of PHI made by the organization. Exceptions: treatment, payment and operations and applicable laws.
- Right to file a complaint - Privacy complaints are investigated by the Privacy Officer.

SUBJECT: Job Shadow/Healthcare Observer Requirements	POLICY # HR8610-366
	PAGE 4 OF 7
DEPARTMENT: Organizational	EFFECTIVE:
APPROVED BY: Director of Human Resources	REVIEW/REVISED:

All Patient Rights have corresponding policies; you may request a copy of any policy, or contact the Privacy Officer, Rosemary Pryzmant, x5254 for any questions/concerns.

SVH Expectations:

- We take privacy seriously and our patients expect our Hospital to demonstrate this commitment.
- As a Vendor/Observer we expect compliance with our Confidentiality Agreement. Any inappropriate sharing, copying, and disclosing of PHI will result in the termination of your experience at SVH.

I have reviewed the above information and agree to coply with its contents.

Signed_____Date_____

SUBJECT: Job Shadow/Healthcare Observer Requirements	POLICY # HR8610-366
	PAGE 5 OF 7
DEPARTMENT: Organizational	EFFECTIVE:
APPROVED BY: Director of Human Resources	REVIEW/REVISED:

Attachment B

Sonoma Valley Hospital
Confidentiality and Non-Disclosure Agreement
Non-Computer Access Version

Organizational information that may include, but is not liited to, financial, patient identifiable and, employee identifiable, from any source or in any form may be considered confidential. Information's confidentiality and integrity are to be preserved and its availability maintained. The value and sensitivity of information is protected by law and by the strict policies of SVH.

The intent of these laws and policies is to assure that confidential information will remain confidential through its use, only as a necessity to accomplish SVH's organizational mission.

1. I will not access or request any information I have no responsibilities for. In addition, I will not access any other confidential information, including personnel, billing, financial, health or other private information I do not need to perform the duties assigned me by SVH.
2. I will not disclose or communicate any Confidential Information to any person whatsoever, except in connection with the performance of my assigned duties.
3. I will not copy or reproduce, in whole or in part, or permit any other person to copy or reproduce, in whole or in part, any Confidential Information other than in the regular course of SVH business.
4. I will comply with all policies and procedures about the confidentiality of information.
5. I will not disclose protected health information or other information that is considered proprietary, sensitive, or confidential unless there is a need to know basis or unless I am otherwise required by law to do so.
6. I agree that disclosure of confidential information is prohibited indefinitely, even after termination of business relationship, unless specifically waived in writing by the authorized party.

I further understand and agree that my failure to fulfill any of the obligations set forth in this Confidentiality Agreement or my violation of any terms of this Agreement may result in my being subjected to: 1) Volunteer opportunities would be terminated for the individual, in accordance with SVH policies and procedures, 2) termination of the individual and/or contract, 3) appropriate legal action and/or 4) other action as deemed appropriate by Hospital Administration.

Name_____ Date:_____
(*Please Print)*

Signature_____
Department_____

SUBJECT: Job Shadow/Healthcare Observer Requirements	POLICY # HR8610-366 PAGE 6 OF 7
DEPARTMENT: Organizational	EFFECTIVE:
APPROVED BY: Director of Human Resources	REVIEW/REVISED:

Attachment C

SONOMA VALLEY HOSPITAL MENTOR AGREEMENT

Participant Name:_____
(Please Print)

Name of Mentor:_____
(Please Print)

I have been in communication with the above person who would like to do an observation experience with me on this date:_____

I agree to act as their mentor while they are in SVH. As such, I assume responsibility for directing this individual in their interactions with patients and staff.

I will be responsible for:

- Obtaining observation consent from patients for this person
- Facilitating this individual's learning objectives
- Encouraging his/her adherence to SVH behavior standards
- Helping him/her maintain patient confidentiality

I understand that if I have questions about SVH's HIPAA Compliance Program or other Privacy/Security concerns I should call the Health Information Manager at x5254.

not be granted until these requirements have been satisfied by the individual to be mentored.

Signature of Mentor:_____

Signature of Participant:_____

SUBJECT: Job Shadow/Healthcare Observer Requirements	POLICY # HR8610-366
	PAGE 7 OF 7
DEPARTMENT: Organizational	EFFECTIVE:
APPROVED BY: Director of Human Resources	REVIEW/REVISED:

Date:_____

Attachment D

SONOMA VALLEY HOSPITAL PARENTAL CONSENT FORM

<u>If observer is under 18 years of age, parent/guardian must complete</u>

Permission is granted for my son/daughter:

- To participate in a job shadowing experience with Sonoma Valley Hospital
- To be provided emergency medical care if injured while participating in the Job Shadow/Observer experience.

Observer's Name:_____

Parent/Guardian Name (please print):_____

Parent/Guardian Signature:_____

Date: _____

5.

QUALITY REPORT
MARCH 2017

To: Sonoma Valley Health Care District Board Quality Committee
From: Leslie Lovejoy
Date: 03/22/17
Subject: Quality and Resource Management Report

March Priorities:

1. PRIME Grant Activities
2. Board Quality Scorecard Format
3. Managing Changes in Department
4. Survey Prep

1. *Prime Grant Activities*

I completed the mid cycle reporting on infrastructure metrics last week. The State will provide comments and ask for more information as needed. We will see some funds release in June. WE have interviewed a number of community members for the Community Health Coach role and accepted four more in addition to Ingrid. One of the volunteers will help me create the orientation binder for the coaches. I have created a core competency checklist and identified the training sessions that we will offer to build those competencies (see attached).

2. Board Quality Scorecard Format:

For discussion this session. I passed it out last session for you to review.

3. Managing Changes in Department:

Until I can find a replacement, Cindi Newman and I will be managing the functions of the Medical Staff Office. In addition our Informatics Nurse has decided to make a change and will be leaving on March 17th. Both positions are posted. We have an intermediate plan to use contract help for the upgrade to our electronic health record that is starting next week. I have two highly qualified candidates to the Director of Quality and Risk Management position and will start interviews next week.

4. CIHQ Triennial Survey Prep:

We have been notified by CIHQ that our survey has been scheduled. Document binders have been updated with the required documents for the survey. I initiated training of the new Quality coordinator on her duties as Survey Coordinator and she has sent out the updated survey response plans to leadership. I am sure CIHQ will be walking through our doors in the next 4-6 weeks. We are prepared!

Topic: 1. Annual Contract Review (Lovejoy)
2. Annual Infection Control Report (Mathews)

Community Health Coach			
Core Training and Competencies			
Dates	Topic	Reading Assignments	Activity/Competency
Session 1	***A Global Perspective:*** Understanding the healthcare system, the role and purpose of the community health worker within the Care Transitions Program; and understanding the risks inherent in transitions of care.	None	Care Transitions Café Discussion.
Session 2	***Forming Relationships/Communication Techniques:*** Establishing trust, building rapport, learning to listen, reflect back and clarify. Healthy boundaries and confidentiality.	Chapter 9	Role Play demonstration of concepts.
Session 3	***What Matters Most I:*** Intro to goal setting from a patient/family centered perspective	Chapters 1-3	Interview and document a discussion using session two concepts.
Session 4	***What Matters Most II:*** Action planning and problem solving. Motivating behavioral change.	Handouts	Submit a goal statement and action steps based on what matters most.
Session 5	***Personal Challenges:*** Understanding the common barriers that arise in supporting self management: social issues, cultural, behavioral, nutritional, end of life, & financial.	Chapters 4 & 5	Test of concepts.
Session 6	***Medical Literacy:*** Medication lists, advance directives & POLST forms, disease specific compliance, and frequent medical terminology. Provider agencies and their roles.	Chapter 19	Test of terminology and medical literacy.
Session 7	***Preparing for a Home Visit and documentation:*** Review of paperwork, phone call scripting, who to contact and for what concerns. Team meetings.	Orientation binder	Role play phone calls. Self evaluation of skill level and further needs for education

*__Prerequisite__: Wellness University and/or a college course in coaching or health related field e.g. nursing, medical student, nutritional service, pharmacy or Lay person who completes all training and has a successful supervised visit.

6.

ANNUAL INFECTION CONTROL REPORT

Infection Prevention

Annual Board Quality Committee Report

March 16, 2017

Kathy Mathews RN
Clinical Quality Coordinator, Infection Prevention

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2016 Healthcare Associated Infections

- Serious bloodstream infections have decreased in recent years due to infection prevention measures
- Central Line Associated Bloodstream Infections (CLABSI): The hospital and SNF have not had a CLABSI since 2011. Practitioners follow infection prevention “best practices” (aka CLIP). Audits reveal excellent practice
- Methicillin Resistant *Staph aureus (MRSA)* bacteremia: Zero since 2014.
- *Vancomycin Resistant Enterococcus (VRE) bacteremia: Zero since 2013*

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Antimicrobial Stewardship

- In 2007 the Antimicrobial Stewardship Program (ASP) identified Fluoroquinolone and Piperacillin/tazobactam were overused in the hospital

- Fluoroquinolones were overused for cystitis and community acquired pneumonia

- Piperacillin/tazobactam was being overused in a variety of patients

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Effect of ASP on $$$

- Flouroquinolone pharmacy charges
  - 2008: $10,169
  - 2011: $2,359
  - 77% reduction
- Piperacillin/tazobactam
  - 2008: $51,363
  - 2011: $14,624
  - 72% reduction

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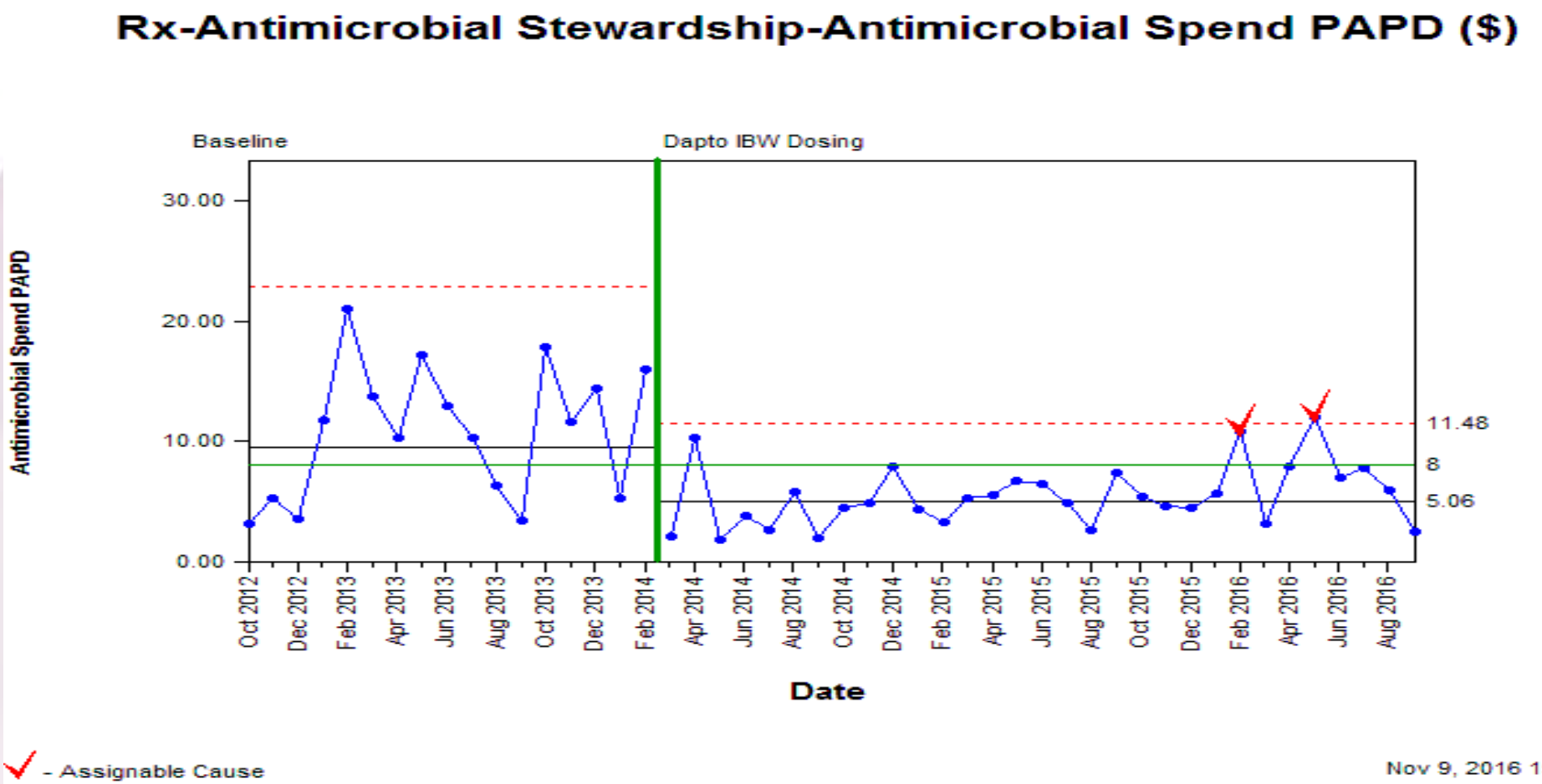
Spending on Antibiotics Decreased



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What can be done to reduce C. difficile?

- Reduce the number of patients that get hospital onset *C. diff* infections by 50%
- Reduce the Sonoma Valley Hospital *C. diff* rate below benchmark
- Reduce the cost associated with *C. diff* by 50%

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Cochrane Review-Probiotics

- 23 studies, 4,213 participants
- When probiotics are given with antibiotics they **reduce** the risk of developing *C. diff* by 64%
- Probiotics reduce the risk of side effects of antibiotics
  - Cramping – Nausea
  - Fever – Soft stools
  - Flatulence – Taste disturbances

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Improvements

- Physician education and computerized physician order entry (CPOE)
- Emergency department's role
- Patient education re: antibiotics and proton pump inhibitors (PPIs)
- Ensure 90% of patients on antibiotics get probiotics
- Revise environmental services (EVS) practices

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DATE OF AUDIT	# OF PATIENTS PRESCRIBED ANTIBIOTICS	# OF PATIENTS TAKING LCY AND/OR PROBIOTICS	COMPLIANCE RATE
June 2014	22	2	4.7%
August 2014	58	39	62.2%
February 2016	78	74	95.0%

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High Five for Hand Hygiene

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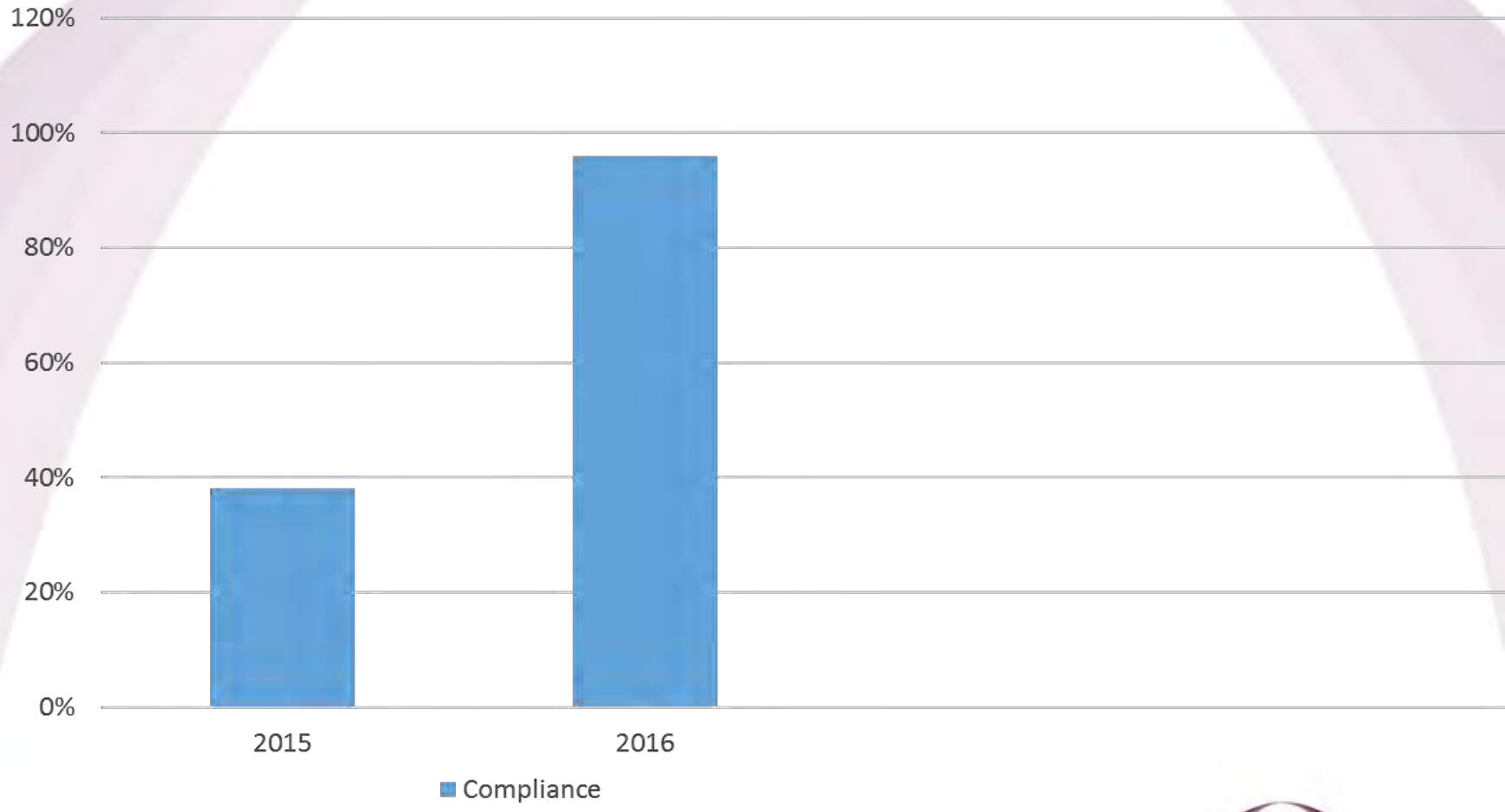
Hand Hygiene Compliance Pre- and Post-High Five Campaign



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Bleach + UV Disinfection

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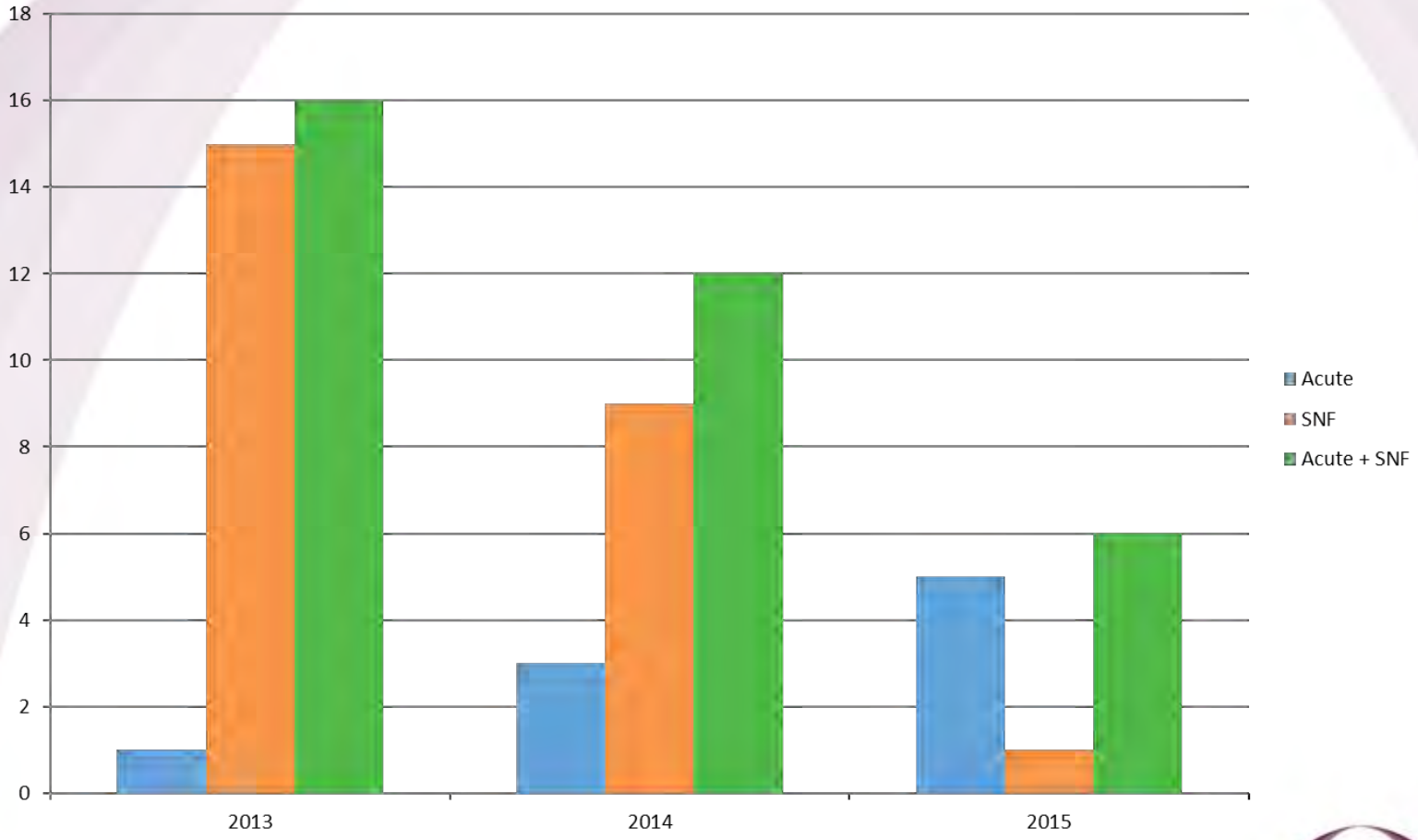
CDI Infections Reduced



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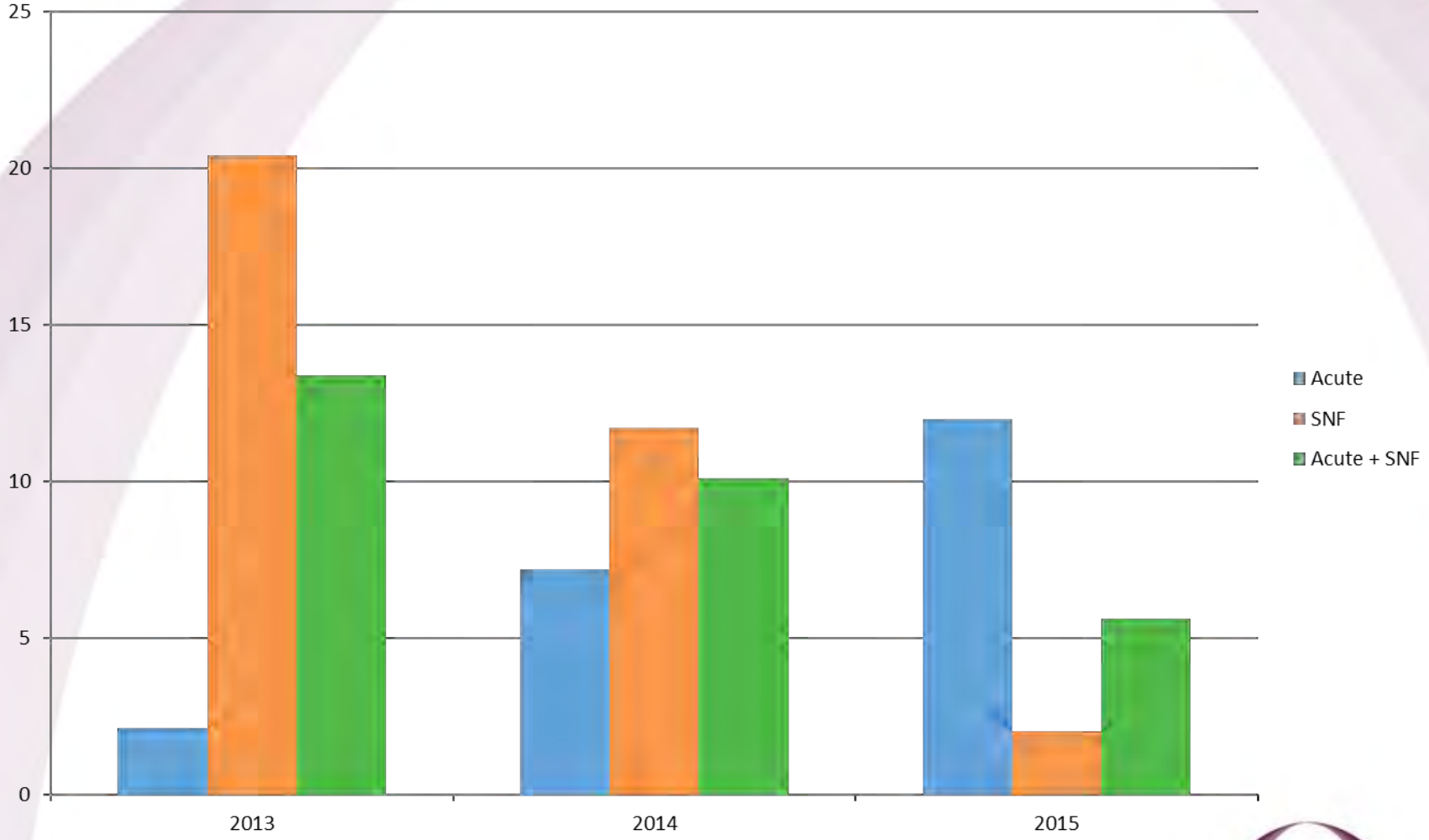
C. diff Rates 2013–2015



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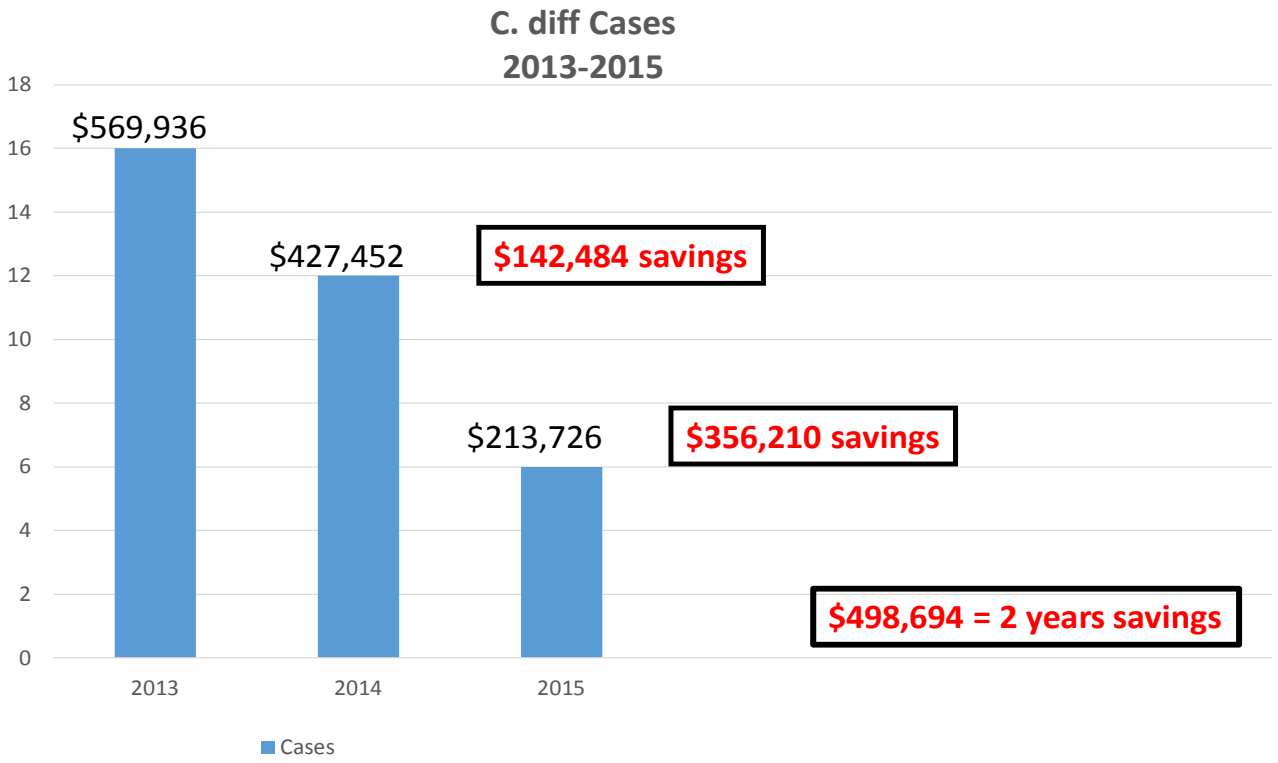
C. diff Prevention Saves $$$$



$35,621 = average cost for a single in-patient C. diff (6)

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Surgical Site Infections

- Total Hip Replacement Benchmark Rate 0.67% (0 risk index) to 2.40% (higher risk index) Annual rate 1.6 (1 SSI)
- Improved procedure for pre op process using CHG wipes vs Hibiclens shower.
- Total Knee Replacement Benchmark Rate 0.58% (0 risk index) to 1.60 (higher risk index). Annual rate 1.4%. Decreased from 2% in 2015.
- Total Joint rate 1.4% (1.9 2015)
- Overall SSI rate 0.5% (8 SSIs)

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Catheter Associated Urinary Tract Infections

- NHSN Benchmark: 1.3 per 1,000 catheter days. Annual rate 1.4. Implemented reporting of pts with foley at huddle daily to facilitate foley removal asap.

- NHSN Benchmark: 1.5 per 1,000 catheter days. Annual rate 7.6. Improvement noted since cluster in 1st quarter i.e., fewer foley days and CAUTIs.

- Plan Performance Improvement project in 2017

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Questions?

For more information

935-5180

kmathews@svh.com

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Infection Prevention HAI Report for 4th Quarter 2016

Indicator	Comparison 2013 /2014/2015 rates	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Benchmarks/Actions/Comments
National Healthcare Safety Network (NHSN) indicator data are a requirement of California Department of Public Health (CDPH) and Senate Bill 1058 mandated reporting. Data are entered into the National Healthcare Safety Network (NHSN) system for public reporting by CDPH. Overall SSI rate includes all SSIs identified regardless of wound class. There is no NHSN benchmark. Green indicates no action, yellow indicates above benchmark, red indicates greater than the NHSN 90th percentile or internal benchmark. Action is recommended when rates exceed the 90th percentile.						
CLABSI (NHSN) (CMS Never Event) *# Central Line Associated Bloodstream Infections (CLABSI)/1000 central line days*	**0 x 3 yrs**	**0** 0/132	**0** 0/106	**0** 0/168	**0** 0/158	**NHSN Benchmark: 0.8 per 1,000 central line days(ICU). SVH (acute units) have not had a CLABSI since 2011! Practitioner CLIP practices remain excellent and reported to NHSN.**
CDI (NHSN) *#Inpatient Hospital Acquired infections due to C. difficile per 10,000 patient days*	**2.1 /7.2 /12**	**32** 4/1247	**0** 0/1036	16.2 **2/1230**	**8.71** 1/1147	**Benchmark (2 MMWR) is 7.4/10,000 patient days. 2016 rate is 15 per 10,000 days in acute (7 cases), an increase since 2015, rate 12 (5 cases). There was a cluster of cases in Dec '15-Jan '16. However the combined rate for acute and SNF is 7.3.**
MRSA Bloodstream Infections (NHSN) *#bloodstream infections due to MRSA per 1000 pt. days*	**1.3 /0 /0**	**0** 0/1247	**0** 0/1036	**0** 0/1131	**0** 0/1196	**SVH Benchmark: 1 per 1,000 patient days. ED and acute care unit infections are reported to NHSN.**
VRE Bloodstream Infections (NHSN) *#Hospital Acquired bloodstream infections due to VRE per 1000 pt. days*	**0 x 3 yrs**	**0** 0/1247	**0** 0/1036	**0** 0/1131	**0** 0/	**SVH Benchmark: 1 per 1,000 patient days. ED and acute care unit infections are reported to NHSN.**
Hip: Deep or Organ/Space Surgical Site Infections (NHSN) *# infections/ # Total Hip Cases x 100*	**0 / 1.8% / 0**	**0** 0/13	**8.3%** 1/12	**0** 0/17	**0** 0/17	**NHSN Benchmark: Risk stratified. Rate range 0.67% (0 risk index) to 2.40% (higher risk index) Annual rate 1.6. Improved procedure for pre op process using CHG.**
Knee: Deep or Organ/Space Surgical Site Infections (NHSN) *# infections/ # Total Knee Cases x 100*	**0 / 1.7% / 2**	**0** 0/15	**0** 0/13	**0** 0/21	**4.7** 1/21	**NHSN Benchmark: Risk stratefied. Rate range 0.58% (0 risk index) to 1.60 (higher risk index). Annual rate 1.4%**
Overall Surgical Site Infections (SSI) *Total # SSI/Total # surgeries x 100*	**0.2%** (3 SSIs) **0.7%**(12 SSIs) **0.4%** (6 SSIs)	0.5% 2/392	**0.6%** 2/361	**0.3%** 1/358	**0.7%** 3/413	**<1% (SVH trended data). No NHSN benchmark for all surgeries. 3rd quarter rate revised due to late entry of new SSI. Annual rate 0.5%**
Class I SSI rate	**<1% x 3 yrs**	0.3% 1/326	0.62% 2/318	1/	0.3% 1/326	**Benchmark 1.2-2.9 . Annual 0.4%**
Class II SSI rate	**< 1% x 3 yrs**	1.7% 1/56	0 0/58	0	2.9%2 /67	**Benchmark 2.4 2 lap chole SSIs , investigation of disinfection of laparoscopes. No sterilization breaches reported in November. Annual rate 1.2%**
Total Joint SSI rate	**0 / 0.8% / 1.9%**	**0 0/34**	3.4% 1/29	0 0/41	2.5%1 /39	**No NHSN benchmark for combined total joint cases. 2016 annual rate is 1.4% (1.9% in 2015).**
Post discharge surveillance surgeon compliance	**57% 2014 64% 2015**	87%	96%	72%	81%	**2014 Surgery Committee approved SSI reporting by surgeons monthly, to promote accurate SSI rates. 81% Oct. Nov & Dec follow up still underway due to reduced reporting.**

Indicator	Comparison 2013 /2014/2015 rates	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Benchmarks/Actions/Comments
National Healthcare Safety Network (NHSN) indicator data are a requirement of California Department of Public Health (CDPH) and Senate Bill 1058 mandated reporting. Data are entered into the National Healthcare Safety Network (NHSN) system for public reporting by CDPH. Overall SSI rate includes all SSIs identified regardless of wound class. There is no NHSN benchmark. Green indicates no action, yellow indicates above benchmark, red indicates greater than the NHSN 90th percentile or internal benchmark. Action is recommended when rates exceed the 90th percentile.						
Immediate Use Steam Sterilization *# of IUSS/total number of procedures*	**12% / 9.3%/ 14**	**0**	**0** 0/361	**0**	**0**	**Internal Benchmark 12%. CIHQ Mid-cycle survey recommendation: do not use IUSS as routine method for sterilization. 4th quarter 2015 new product intervention ended IUSS.**
Ventilator Associated Event (VAE): Pneumonia *# Ventilator Associated Pneumonias or events/ # vent days x 1000*	**0 x 3 yrs.**	**0** 0/38	**0** 0/40	**0** 0/68	**0 0/48**	**NHSN Benchmark: 1.1 per 1,000 ventilator days.**
Hospital Acquired Pneumonia (HAP) *# hospital acquired pneumonia/# patient days*	**0.2 /0.5 / 0.9**	**0.8** 1/1247	**0.9** 1/1036	**0.9** 1/1131	**0.8** 1/1196	**5-15 cases per 1,000 admissions (3)**
Inpatient Hospital Acquired Catheter Associated Urinary Tract Infections (CA-UTI) (CMS Never Event) *# inpatient CAUTI/# catheter days x 1000*	**0.7 /0 / 1.7**	0 0/322	**3.11** 1/321	**0** **0/385**	**2.8** **1/347**	**NHSN Benchmark: 1.3 per 1,000 catheter days. Annual rate 1.4. Implemented reporting of pts with foley at huddle daily to facilitate foley removal asap. Plan IP education in 2017.**
SNF Hospital Acquired Catheter Associated Urinary Tract Infections (CA-UTI) *# SNF CAUTI/# catheter days x 1000*	**2.6 / 3.3/ 5.7**	**11.4** 4/349	**6** **1/166**	6.9 **1/144**	**0** **0/124**	**NHSN Benchmark: 1.5 per 1,000 catheter days. 4 UTIs but none meet criteria for CAUTI. Annual rate 7.6. Improvement noted since cluster in 1st quarter i.e, fewer foley days and CAUTIs. Plan IP education in 2017.**
SNF Hospital Acquired *C. Difficile* Infections (CDI) *# SNF CDI/# patient days x 10,000*	**20 /11.7 /2**	**0** 0/1961	**6.12** 1/1633	**0** 0/1795	**0** 1458	**NHSN Benchmark: 7.4 per 10,000 patient days. Annual rate 2. Sustained improvement for two years.**
SNF Central line associated bloodstream infections (CLABSI) *# Central Line Associated Bloodstream Infections (CLABSI)/central line days x 1000*	**1 / 0/ 0**	0 0/121	0 0/109	0 0/150	0 0/92	**NHSN Benchmark: 0.8 per 1,000 central line days (SNF).**
Healing at Home Associated Infections *# of infections/Total visits x 1000*	**0.3 / 0.6 / 0**	**0.36** 1/2777	**0** 0/2745	**0** 0/2814	**0.4** 1/2735	**SVH Benchmark: 1.5 per 1,000 home care visits (SVH Trended Data). 1 UTI in patient with hx of recurrent UTI. Not catheter related. Annual rate 0.2.**
MRSA Active Surveillance Cultures (nares cultures only) *# positives/total screened x 100*	**14%** **20%/26%**	**12.5**	**7%**	**8%**	**4.7%** 6/127	**Patients have a nasal screen for MRSA in accordance with California law. They are notified and provided with patient education.**
% ESBL(E. coli;K. pneumoniae, K. oxytoca, P. mirabilis)	**2% /3%**	3%	3.20%	4.5%	4.3%	**ASP monitors antibiogram and updates annually.**
# CRE	**0 / 0**	0	0	0	0	**Track and trend**
References: 1.) Device-associated Module, AJIC2015; 43:206-221 2.) MMWR, Vital Signs: Preventing Clostridium difficile Infections, March 9, 2012/61 (09); 157-162 3.) 2.Klevens RM, Edwards JR, Richards CL Jr, et al. Estimating health care-associated infections and deaths in U.S. hospitals, 2002. Public Health Rep 2007; 122:160–166						

7.

ANNUAL CONTRACT REPORT

March 13th, 2017

To: Board Quality Committee & MEC
RE: Annual Report of Contract Administration and Evaluation
FROM: Laura Gallmeyer, Contract Administration & Leslie Lovejoy, Chief Quality Officer

Background: Per CIHQ and CMS, a report outlining current contract administration and the completion of an evaluation of each contract is required on an annual basis. Discussion within Leadership, Administration and Medical Staff Committees are included in the annual review such that members of the organization can voice comments, concerns, and advice regarding the quality, safety and efficacy of contracted services that impact patient care.

A standardized evaluation tool (see attached) is used for evaluation purposes that include not only regulatory requirements but also at least three (3) performance indicators based on the identified scope of work. These indicators are developed by the contractor and the Leader assigned to administer the contract.

Performance is monitored quarterly and reported annually during the first quarter. Leaders are expected to ensure that contracted services that do not meet performance thresholds are placed on action plans to improve performance or may be terminated for cause.

The Chief Medical Officer is responsible for the development and monitoring of additional performance metrics as part of contracted independent physician groups e.g. Valley Emergency Medical Group, Sound Hospitalist Group, etc. Scorecards or dashboards have been developed and may be reported within Medical Staff Committees. The Chief Medical Officer seeks out physician input into these contracts and the effectiveness of the group members in providing patient care to our community.

Annual Report:

The Hospital manages a database of 139 patient care contracts and 196 non-patient care contracts. Centralization of contracts ensures consistency regarding the organization's oversight of the care, treatment, and services provided through contractual arrangements as well as ensures that contracts are authorized at the appropriate administrative level and executed in a consistent fashion throughout the organization.

Results of Evaluation:

- Most (97%) contracts met their individual performance metrics and the required regulatory standards. Those that did not meet all performance indicators required action plans and closer monitoring during the course of the year. (Maxim Staffing is the only service reported as having increased monitoring and oversight)

- In March 2016, the hospital participated in a CIHQ survey in which the organizations contract development, monitoring and review process was found in compliance with all Performance Standards.

- The following patient care contracts were added in 2016:
    1. Aya Healthcare – Nurse Staffing Agency
    2. Azari, Parinaz MD – Pain Management
    3. Hospice By the Bay – Palliative Care Consulting
    4. Idaho State University – Speech Pathology Student Preceptorship
    5. Kidd, Sabrina MD – General and Colorectal Surgery Call Coverage
    6. Laserent – Medical Technician Staffing
    7. Mariano, Elpidio MD – General Surgery Call Coverage
    8. Marywood University – Dietary Student Internship
    9. Prima Medical Foundation – Lee / General Surgery Call Coverage
    10. Prima Medical Foundation – Perryman / General Surgery Call Coverage
    11. Sacramento State University – Physical Therapy Student Preceptorship
    12. Santa Rosa Family Medicine Residency – Family Medicine Student Preceptorship
    13. Sawyer, Russell MD – Medical Director, Wound Care
    14. Sequoia Mind Health – Goodwin / Adult Psychiatry Telemedicine
    15. Still, A.T. University – Physical Training Student Preceptorship
    16. Summit Pain Alliance – Participation in Research Project
    17. Trustaff – Nurse Staffing Agency
    18. University of Florida – Pharmacy Student Preceptorship
    19. Veluz, Cesar MD – General Surgery Call Coverage
    20. Vic the Picc – Nurse Staffing / Special Catheter Insertion

- Beginning this year, we began keeping data of closed and/or terminated contracts and for what reason as part of our continuous performance improvement activities.
    - Eastern Michigan University – Dietary Internship Program not a good fit for Sonoma Valley Hospital
    - Redwood Regional Medical Group – No longer utilizing
    - Titan Medical Group – No longer utilizing