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

SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, November 16, 2016
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 District Clerk, Gigi Betta at ebetta@svh.com or 707.935.5004 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 • QC Minutes, 9.28.16	*Hirsch*	Action
4. QUALITY DASHBOARD	*Newman*	Inform/ Discussion
5. PATIENT CARE SERVICES Q4	*Kobe*	Inform
6. STATEMENT OF LEADERSHIP COMMITMENT TO ANTIMICROBIAL STEWARDSHIP	*Lovejoy*	Inform/Action
7. QUALITY REPORT NOVEMBER 2016	*Lovejoy*	Inform/Action
8. CLOSING COMMENTS/ANNOUNCEMENTS	*Hirsch*	
9. ADJOURN	*Hirsch*	
10. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*	
11. CLOSED SESSION: • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Sebastian*	Action
12. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
13. ADJOURN	*Hirsch*	

3.

CONSENT

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
MINUTES
Wednesday, September 28, 2016
Schantz Conference Room

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

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Meeting called to order at 5:00pm	
2. PUBLIC COMMENT	*Hirsch*	
	No public comment.	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 8.24.16	Minor change made under agenda item 6.	**MOTION** by Eisenstark to approve *as amended* and 2nd by Rymer. All in favor.
4. SURGERY DEPARTMENT UPDATE	*Sendaydiego*	Inform
	Mr. Sendaydiego presented the Surgical Safety Checklist, Audit Tool and the RF Assure Detection System to the Committee and gave detailed examples of how they have been effective in the SVH Surgery Department.	
5. POLICY & PROCEDURES	*Lovejoy*	Action
• Infection Prevention Policies • Infection Prevention-Aerosol Disease Control Plan • Communicable Disease Reporting • Multiple Policies August 2016		**MOTION** by Eisenstark to approve and 2nd by Mainardi. All in favor.
6. QUALITY REPORT SEPTEMBER 2016	*Lovejoy*	Inform/Action

AGENDA ITEM	DISCUSSION	ACTION
	The September Quality Report covered PRIME grant activities, the laboratory CLIA survey action plan, credentialing verification and the leadership dashboard.	
7. CLOSING COMMENTS/ANNOUNCEMENTS	*Hirsch*	
8. ADJOURN	*Hirsch*	
9. UPON ADJOURNMENT OF REGULAR SESSION	*Hirsch*	
10. CLOSED SESSION • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report		Action
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
	Medical Staff Credentialing & Peer Review Report unanimously approved, there were no issues and four expeditions. Nancy Iredale, MSC will send a flyer to the Medical Staff inviting them to the Dr. Jaffe presentation in the Basement Conference room on October 26, 2016 at 5:00pm. There will be a short reception and refreshments prior to the presentation.	
12. ADJOURNMENT AND ANNOUNCEMENTS	*Hirsch*	
	The Board Quality Committee Scorecard was distributed for Committee review prior to the meeting on November 16, 2016. The last of the Active Aging series will be on November 3, 2016 at Vintage House from 1-3pm. QC plans to invite Dr. Pope, Pain Management and his partners Drs. Wu and Hau to present tin future. Meeting adjourned at 6:00pm	

6.

ANTIMICROBIAL STEWARDSHIP

SONOMA VALLEY HOSPITAL

Statement of Leadership Commitment to Antimicrobial Stewardship

The hospital leadership team and governing body of Sonoma Valley Hospital understand that leadership support is critical to the success of the Antimicrobial Stewardship Program (ASP).

The hospital leadership team formally states that it is committed to dedicating human, financial, and information technology resources to improve and monitor antimicrobial use. Support includes but is not limited to:

- Ensuring staff are allocated sufficient time to contribute to stewardship activities
- Supporting training and education
- Ensuring multidisciplinary group participation to support stewardship activities

ASP Commitment Statement presented to the following Committees/Departments:

Board of Directors Date: _____

Medical Executive Committee Date: 10/20/16

Pharmacy and Therapeutics Committee Date: 9/22/16 CB

Antimicrobial Stewardship Team Date: 9/21/16 CB

_____ Date: 10/20/16

Signature, Chief Executive Officer

7.

QUALITY REPORT
NOVEMBER 2016

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

To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 11/16/16
Subject: Quality and Resource Management Report

August Priorities:

1. PRIME Grant Activities
2. AHRQ Patient Safety Culture Survey
3. Interim Life Safety Survey Action Plan
4. Leapfrog Survey and Safety Score Results
5. Current Quality Reporting Commitments

1. *Prime Grant Activities*

I attended the PRIME Data Summit on 10/18 to network with other hospitals doing PRIME projects. It was a useful day in that we identified a number of resources that can help with metrics going forward. I completed the final report for FY11 and it was accepted. We have received the full 1,250,000. 00 for this year. We are currently building the community case management database and will pilot the medication reconciliation/transition record process this month and into December. I have a meeting with La Luz to discuss training the Promotores to be community health coaches. I will collect baseline data for 2016 in December and develop a metrics scorecard.

2. *AHRQ Patient Safety Culture Survey*

We will not be conducting the usual survey this year. AHRQ has contracted with Westat Corp to redesign the survey and build a more effective benchmarking process. They are adding additional questions to make it more relevant as well. The survey will be sent out in March or April next year and we may not see data until June or July 2017.

3. *Interim Life Safety Survey Action Plan*

An Interim Life Safety Survey always follows the licensing survey for Skilled Nursing. The state was here in mid October to conduct the survey and the following is their cited deficiencies and our actions taken. Of interest is that the Safety Codes have just been revised to the 2012 CMS standards with new regulations. CIHQ gave us a heads up and the Chief Engineer and Director of Facilities had training to the new regulations earlier this year.

Deficiency	***Actions Taken/Monitoring***	***Responsible Person***
Door obstructed by mobile linen cart	The mobile linen cart was moved to allow the door to close at the time of the event./ SNF Unit Secretary will check that there are no door obstructions during the daily rounds for a period of 6 months. SNF Unit Secretary	M. Evans

	will remove any door obstructions and in-service staff in person in the area. Unit Secretary will complete a daily check list of non-compliant doors and with names of staff in-serviced. SNF DON will report results quarterly on the SNF Quality Control Indicator report that is presented to the Medical Staff PI committee	
Door propped open by water bottle	The water bottle was moved to allow the door to close during the survey. Work order 166633 was created on 11/7/16 to remove propping tools and create a sign to indicate the door is to remain closed at all times./ The Engineering staff will monitor the corridor fire doors quarterly to validate proper operation and that there are no obstructions. This monitoring is ongoing as part of preventive maintenance and the monitoring data will be tracked on the Engineering Quality Control Indicator Report and submitted quarterly to the Medical Staff PI Committee and will end on June 30th 2017 if 100% compliant. If less than 100% compliant, monitoring will continue for an additional 6 mos.	K. Drummond
Door closer for Emergency Food Storage Room not working	Work order# 166593 was created on 11/7/16 to be completed by Engineering staff to install a door closer on room# 1145 – Emergency Food Storage Room./ The Director of Facilities will validate that the work order is complete and closer works properly. No further monitoring action will be done.	K. Drummond
Lack of documentation for fire drills for one quarter	The fire drills schedule has been created in the work order system with a specific due date for each drill. The Plant Operations Manager has validated the work orders satisfy the compliance code of 1 drill per shift per quarter. Engineering team will conduct each drill prior to the due date./ The Director of Facilities will review the Weekly Open Compliance work order reports to monitor that fire drills are completed within 6 mos. This monitoring data will be tracked on the Engineering Quality Control Indicator Report and submitted quarterly to the Medical Staff PI Committee and will end on June 30th 2017 if 100% compliant. If less than 100% compliant, monitoring will continue for an additional 6 mos.	K. Drummond
Dating of pre-alarm batteries	Work order# 166586 created on 11/2/16 to be completed by Engineering staff to install new batteries on the pre-action fire alarm control panel and label them with the installation date. Batteries were ordered	K. Drummond

	11/3/16 and will be installed upon receipt/The Director of Facilities will validate that the work order is complete and batteries are labeled. No further monitoring action will be done	
Sprinkler head replacement and lack of protection from painting.	Work order# 166587 created on 11/2/16 for vendor to replace sprinkler head in Room 111 in the Skilled Nursing Unit. The vendor is scheduled for 11/8/16 B. The Plant Operations Manager will add a painting safety checklist to the safety manual that is reviewed with all Hospital contractors. All painting contractors must read and initial that they have read and understand the sprinkler head protection clause./ A. The Director of Facilities will validate that the work order is complete. No further monitoring will be done. B. The Engineering Coordinator will track that all contractors have read and signed the SVH Safety Manual on an annual basis. This monitoring data will be tracked on the Engineering Quality Control Indicator Report and submitted quarterly to the Medical Staff PI Committee and will end on June 30th 2017 if 100% compliant. If less than 100% compliant, monitoring will continue for an additional 6 mos	K. Drummond
Lack of access doors to fire dampers.	Work order# 166588 and 166589 created on 11/2/16 for Engineering staff to install 8X8 access doors and test fire smoke dampers./ The Director of Facilities will validate that the access doors are installed and the fire smoke dampers are accessible and operational. No further monitoring will be done.	K. Drummond
20 H size cylinders were grouped chained instead of individually chained. **On appeal**	Work order 166646 was created on 11/8/2016 for the engineering staff to individually secure the 20 H cylinders to the mounting rack./ The director of Facilities will validate that the cylinders have been individually secured. No further monitoring will be done.	K. Drummond
Battery operated lighting in the generator enclosure	Work order# 166594 created on 11/7/16 for Engineering staff to install battery operated lighting in the generator enclosure per NFPA 110, 1999 edition section 5-3.1. The light will be connected to the life safety branch on the load side of the transfer switch./ The Director of Facilities will validate that the lighting has been installed and is operational. This lighting will be tested as part of the ongoing monthly preventative maintenance program for all emergency lighting The monitoring data will be tracked on the Engineering Quality Control Indicator Report	K. Drummond

	and submitted quarterly to the Medical Staff PI Committee and will end on June 30th 2017 if 100% compliant. If less than 100% compliant, monitoring will continue for an additional 6 mos.	
Coat rack obstruction, lack of filter plates and switch labels	#1 The coat rack was removed from the room during the survey. Work order# 166590 created on 11/2/16 for Engineering staff licensed electrician to install filler plates on breaker switches 7 and 13 and label breaker switches 16 and 18 in electrical panel ELLSIA in the SNF Staff Lounge room #1123. #2 The light bulb recycling collection box was removed on the day of the survey away from electrical panel H2 in the Light bulb room #1131. #3 Work order#166591 created on 11/2/16 for Engineering staff licensed electrician to trace and label breaker switches 1 through 33 and create a circuit directory on the inside of the panel for electrical panel LI in the SNF PT Room #1127 #4 Work order# 166592 created on 11/2/16 for Engineering staff licensed electrician to trace and label breaker switches 32 and 34 in electrical panel ELLS2 in AV room #1143. A. The Director of Facilities will validate that panels ELLSIA, LI, and ELLS2 are fully labeled, circuit directories are inside of panel door and all breakers that are on are label or have filler plates as necessary. B. Language has been added to the ongoing preventative maintenance work order to check for code violations, including missing or illegible labels for breakers in use, missing or illegible circuit directories, missing filler plates for breakers not in use. This monitoring data will be tracked on the Engineering Quality Control Indicator Report and submitted quarterly to the Medical Staff PI Committee and will end on June 30th 2017 if 100% compliant. If less than 100% compliant, monitoring will continue for an additional 6 mos.	K. Drummond

4. *Leapfrog Survey and Safety Score Results:*

Attached please find the recently published Hospital Safety Grade and scorecard for discussion in committee. We moved up from a score of D, which is what I thought would happen. We will not be participating in the Hospital Survey going forward.

5. *Current Quality Reporting Commitments:*

Agency	***Indicators***	***Performance Period***	***Implications***
Anthem Blue Cross Q-HIP	53 indicators in 4 sections: Patient Safety Health Outcomes Member Satisfaction Bonus indicators	Annual	Earn increase in reimbursement
Partnership HIP	Less than 50 acute beds: Readmissions E TARS	7/2016-6/2017	
CMS ECQM	IP Electronic Core Measures Stroke 2: Discharged on Antithrombotic Therapy Stroke 3: Anticoagulation Therapy for Atrial Fibrillation/Flutter Stroke 5: Antithrombotic Therapy By End of Hospital Day 2 Stroke 6: Discharged on Statin Medication Stroke 8: Stroke Education Stroke 10: Assessed for Rehabilitation: VTE 1: Venous Thromboembolism Prophylaxis VTE 2: Intensive Care Unit Venous Thromboembolism Prophylaxis	Pilot 2016, Recommended indicators identified for 2017	2% Medicare penalty for not reporting in 2018
CMS	OP Core Measures Patient Safety Score HACS/HAIS Patient Experience Medicare spending per beneficiary	Rolling 12 months; currently 2015	None for OP; VBP currently at 2% earn back

Leapfrog	Hospital Survey responses & CMS data with Patient Safety Data as well	2013-2015 CMS/Patient Safety Data; 2015 data for 2016 Hospital Survey	Challenges due to being a small hospital. Discontinue following "C" score.
California Maternal Quality Care Collaboration	33 performance measures 16 hospital data quality measures	Ongoing database	Benchmarking; required by QHIP and Partnership
CMS Readmission Prevention Program	All cause readmission rate	3rd Q 2015-2nd Q 2016	2% penalty in Medicare reimbursement if score in lowest 25% of hospitals
CALHIIN	Reducing harm by 20% 11 Hospital Quality outcomes 4 process measures • Reducing readmissions by 12% • Creating a safety culture • Developing a measure of harm • Advancing person and family engagement	Sept 2016-Sept 2018	Public reporting & benchmarking opportunity

Topic for Discussion: Board Quality Dashboard structure

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LEAPFROG HOSPITAL SAFETY GRADE

Sonoma Valley Hospital

347 Andrieux Street
Sonoma, CA 95476-6811

This Hospital's Grade C

FALL 2016

Outcomes measures include errors, accidents, and injuries that this hospital has publicly reported.

Measure	The Hospital's Score	Worst Performing Hospital	Avg. Performing Hospital	Best Performing Hospital	Data Source	Time Period Covered
Dangerous object left in patient's body	0.386	0.386	0.025	0.000	CMS	07/01/2013 - 06/30/2015
Air or gas bubble in the blood	0	0.094	0.002	0.000	CMS	07/01/2013 - 06/30/2015
Patient falls	0	1.977	0.389	0.000	CMS	07/01/2013 - 06/30/2015
Infection in the blood during ICU stay	Not Available	2.496	0.505	0.000	2016 Leapfrog Hospital Survey	01/01/2015 - 12/31/2015
Infection in the urinary tract during ICU stay	Not Available	2.417	0.605	0.000	2016 Leapfrog Hospital Survey	01/01/2015 - 12/31/2015
Surgical site infection after colon surgery	0.000	3.640	0.929	0.000	2016 Leapfrog Hospital Survey	01/01/2015 - 12/31/2015
MRSA Infection	0.000	3.900	0.876	0.000	2016 Leapfrog Hospital Survey	01/01/2015 - 12/31/2015
C. diff. Infection	1.693	2.409	0.901	0.000	2016 Leapfrog Hospital Survey	01/01/2015 - 12/31/2015
Dangerous bed sores	1.24	2.24	0.44	0.03	CMS	07/01/2013 - 06/30/2015
Death from treatable serious complications	Not Available	184.16	136.84	70.79	CMS	07/01/2013 - 06/30/2015
Collapsed lung	0.39	0.70	0.41	0.19	CMS	07/01/2013 - 06/30/2015
Serious breathing problem	11.19	29.48	13.94	2.13	CMS	

						07/01/2013 - 06/30/2015
Dangerous blood clot	4.64	12.11	5.11	1.39	CMS	07/01/2013 - 06/30/2015
Surgical wound splits open	2.27	3.65	2.31	1.18	CMS	07/01/2013 - 06/30/2015
Accidental cuts and tears	1.38	2.97	1.43	0.32	CMS	07/01/2013 - 06/30/2015

Process measures include the management structures and procedures a hospital has in place to protect patients from errors, accidents, and injuries.

Measure	The Hospital's Score	Worst Performing Hospital	Avg. Performing Hospital	Best Performing Hospital	Data Source	Time Period Covered
Doctors order medications through a computer	100	5	73.47	100	2016 Leapfrog Hospital Survey	2016
Specially trained doctors care for ICU patients	5	5	41.66	100	2016 Leapfrog Hospital Survey	2016
Effective leadership to prevent errors	120.00	18.46	114.81	120.00	2016 Leapfrog Hospital Survey	2016
Staff work together to prevent errors	20.00	0.00	18.23	20.00	2016 Leapfrog Hospital Survey	2016
Training to improve safety	40.00	0.00	36.98	40.00	2016 Leapfrog Hospital Survey	2016
Track and reduce risks to patients	120.00	10.00	113.98	120.00	2016 Leapfrog Hospital Survey	2016
Enough qualified nurses	100.00	17.65	95.97	100.00	2016 Leapfrog Hospital Survey	2016
Staff accurately record patient medications	35.00	0.00	32.82	35.00	2016 Leapfrog Hospital Survey	2016
Handwashing	30.00	3.00	28.34	30.00	2016 Leapfrog Hospital Survey	2016
Take steps to prevent ventilator problems	20.00	0.00	18.41	20.00	2016 Leapfrog Hospital Survey	2016
Communication with nurses	4	1	3.32	5	CMS	10/01/2014 - 09/30/2015
Communication with doctors	3	1	2.95	5	CMS	10/01/2014 - 09/30/2015
Responsiveness of hospital staff	3	1	2.91	5	CMS	10/01/2014 - 09/30/2015
	3	1	2.86	5	CMS	

Communication about medicines						10/01/2014 - 09/30/2015
Communication about discharge	4	1	3.27	5	CMS	10/01/2014 - 09/30/2015