SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, December 14, 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 • Minutes 11.16.16	*Hirsch*	Action
4. POLICY & PROCEDURES	*Lovejoy*	Action
5. QUALITY COMMITTEE WORK PLAN 2017	*Lovejoy*	Inform/Action
6. QUALITY REPORT DECEMBER 2016	*Lovejoy*	Inform/Action
7. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*	
8. CLOSED SESSION: • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Sebastian/Hirsch*	Action
9. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
10. ADJOURN	*Hirsch*	

3.

CONSENT

+

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
November 16, 2016, 5PM
MINUTES
Schantz Conference Room

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

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Meeting called to order 5:00 p.m.	
2. PUBLIC COMMENT	*Hirsch*	
	No public comment.	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 9.28.16		**MOTION** by Rymer to approve and 2nd by Mainardi. All in favor.
4. QUALITY DASHBOARD	*Newman*	Inform/Discuss
	The name has changed from Quality Dashboard to Board Quality Committee Scorecard. Committee members discussed format, suggested changes and asked for clarifications. Ms. Newman advised the Committee on the feasibility of proposed changes, explained the data collection process and answered other questions.	
5. PATIENT CARE SERVICES Q4	*Kobe*	Inform
	Mr. Kobe presented Patient Care Services Dashboard results for July-September 2016.	
6. STATEMENT OF LEADERSHIP COMMITMENT TO ANTIMICROBIAL STEWARDSHIP	*Lovejoy*	Inform/Action
	Ms. Lovejoy presented the executed Statement to Antimicrobial Stewardship which will be brought	**MOTION** to approve by Mainardi and 2nd by Idell. All in favor.

AGENDA ITEM	DISCUSSION	ACTION
	forward for Board approval on December 1, 2016.	
7. QUALITY REPORT NOVEMBER 2016	*Lovejoy*	Inform/Action
	Ms. Lovejoy's report included PRIME Grant activities, AHRQ survey, Interim Life Safety survey action plan and the current quality reporting commitments. The Hospital received a C score on the Leapfrog Safety report which is a full grade higher than the prior reporting period.	
8. CLOSING COMMENTS/ANNOUNCEMENTS	*Hirsch*	
9. ADJOURN	*Hirsch*	
	Regular meeting adjourned at 6:10pm	
10. UPON ADJOURNMENT OF REGULAR SESSION	*Hirsch*	
10. CLOSED SESSION • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	**Closed Session cancelled.**	Action
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
12. ADJOURNMENT AND ANNOUNCEMENTS	*Hirsch*	

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.

Organizational/Departmental:	
APPROVED BY: Chief Quality Officer	DATE: 10/09/16
Director's/Manager's Signature Leslie Lovejoy	Printed Name Leslie Lovejoy, RN, Ph.D.

Douglas Campbell, MD,
Chair, Medicine Committee — 10-13-16 Date

Mark Kobe RN, MSN
Chief Nursing Officer — 10-13-16 Date

Kelly Mather, MHA
Chief Executive Officer — 10/18/16 Date

Keith Chamberlin, MD, MBA
Chief of Medical Staff
Medical Executive Committee — 11-17-16 Date

Jane Hirsch, RN, MSN
Chair, Board of Directors — Date

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Policy Submission Summary Sheet

Title of Document: Care Transition Program policies
New document or revision written by: Leslie Lovejoy

Type: Organizational **X Revision X New Policy**	**Regulatory** **XCMS** **X CDPH** (formerly DHS) **XCIHQ** **❑Other: State Law**
Organizational: Clinical *(circle which type)*	**X Departmental** **❑ Interdepartmental** *(List departments effected)*

Please briefly state changes to existing document/form or overview of new document/form here:
(include reason for change(s) or new document/form)

REVISED

PC8750-113 Community Case Management in the Emergency Department: added Appendix A; At Risk Criteria and aligned priorities with the Care Transitions Program and PRIME Grant focus.

NEW POLICIES

DS 8750-123 Community Care Transitions Program: outlines the key components, workflow processes and core metrics of a post hospital and or skilled nursing discharge transitions program. Defines the Community Health Coach role and competencies.

DS 8750-124 Care Transitions Follow-up Phone Calls: identifies the structure, process and content for follow-up phone calls to patients discharge to home after an acute care or skilled nursing unit discharge.

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SUBJECT: Community Care Transitions Program	POLICY # DS 8750- 123
	PAGE 1 OF 8
DEPARTMENT: Quality & Resource Management	EFFECTIVE: 11/16
APPROVED BY: Chief Quality Officer	REVISED/REVIEWED:

PURPOSE:
The purpose of this policy is to identify the key components, workflow processes and core metrics of a post hospital and/or skilled nursing discharge transitions of care program.

POLICY:
SVH has determined the need for post discharge transitional planning for patients being discharged from the emergency, acute and skilled nursing settings in order to improve the health of our community and reduce health disparities within this population.

MODEL:
SVH has adopted the Institute for Healthcare Improvement Innovation Series Care Coordination model, published in 2011 as an evidence-based model for providing better care at lower cost for people with multiple health and social needs.

KEY ELEMENTS:
SVH's Community Care Transitions Program considers the following elements in identifying members of our patient population that would benefit from participation in this program.

I. Assessment of the current Patient/Family Environment
A. Resources: presence of family or support persons and knowledge or history of using Resources.
B. Strengths: activity with church groups, social ties, connections with other service agencies.
C. Gifts: patient/family engagement, coping skills, life goals.

II. Patient Identification for Program Eligibility
A. Frequency of use of hospital based services e.g. ED or Acute admissions.
B. "At Risk" patients identified through the use of assessment tools; lack of a primary provider, no or low insurance, social or behavioral needs.
C. Health disparities such as the management of hypertension and diabetes mellitus in our Hispanic community.
D. DRG based frequencies for both admission and readmission e.g. sepsis.

III. Role of the Care Coordinator
A. Responsible for identifying health goals and what matters most to the patient to build engagement.
B. Coordinates services creating and supporting linkages between hospital and community health care provider.
C. Ensures the plan is carried out with the patient at the center of the plan.
D. Uses feedback loops to assess the effectiveness of service delivery.

IV. Value Proposition and Service Delivery

A. Care is coordinated within a multidisciplinary team with linkages to a list of services available to the patient.
B. Linkages work in tandem with the patient's own resources.
C. Care Coordinator defines components of the care services the patient has chosen and ensures that collaboration occurs among all involved.

PROGRAM GOALS:

A. Service coordination between direct care and support agency providers.
B. Appropriate and timely access to transitional services, pharmaceuticals, nutritional support, DME, and safe home placement.
C. Teaching, coaching and skill building related to acute and chronic health conditions.
D. Promoting and supporting an optimal primary care provider/patient relationship.

PROCEDURE:

I. Identifying the Care Coordinator and required skill set.

The core team consists of the community Case Manager, Social Worker and the Community Health Coach (see attachment A for role description and key competencies). In addition, the team may include a Behavioral Health Consultant, Palliative Care Consultant, Registered Dietician, Pharmacist, as well as provider/physician input.

Patient's most prominent need	Care Coordinator skill set
Mental Health	Social Worker Behavioral Health consultant
Medical Fragility • Linkages with primary care • Nutrition support • Linkages with provider agencies • Advance Care planning • Medication management	Community Case Manager Palliative Care/Social Work consult Community Health Coach Pharmacist consult Registered Dietician consult
Social Instability or lack of social support • Housing • Insurance • Navigation of delivery system • Support	Social Worker Community Health Coach

Note: some patients will have needs in all three areas. All patients have a care plan that the primary care provider co-creates with the patient and family.

II. Care Coordination Process:

This program begins with an inpatient visit during which the patient will be assessed for the potential to benefit from this program using evidence –based best practice risk assessment tools. Once identified, the Community Case Manager will explain the elements of the program and arrange, if needed, for a Community Health Coach to meet the patient prior to discharge. Patient and family consent to participate will be obtained.

A. All patients that are discharged to home will receive a post discharge follow-up telephone call within 48 hours of leaving the hospital or from leaving the Skilled Nursing Unit. See P/P 8750-124 for more details.

B. To reduce confusion and increase effective communication, care coordination will be conducted by the agency providing services and the primary care provider. See Attachments B, C & D which outline a standardized work flow process based on discharge disposition.

C. Multidisciplinary team meeting for hospital Community Care Transitions patients will occur weekly and be facilitated by the Community Case Manager. Home Health and Skilled Nursing will integrate their Care Transition patients into their current multidisciplinary team meeting process.

D. Care coordination concerns identified by the Community Health coach or Community Case Manager will be communicated to the primary care provider for resolution.

III. Performance Improvement

This program will understandably go through many iterations and therefore will focus on the following indicators of program success as defined by the current grant. It is expected that the program will grow other goals and perhaps retire current metrics as the program matures.

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SUBJECT: Community Care Transitions Program	POLICY # DS 8750- 123
	PAGE 4 OF 8
DEPARTMENT: Quality & Resource Management	EFFECTIVE: 11/16
APPROVED BY: Chief Quality Officer	REVISED/REVIEWED:

A. Required Metrics: we will demonstrate a 10% improvement over baseline for the following indicators.

1. All Cause Readmission Rates;
2. ED utilization rate reduction
3. The provision of a transition record to the patient at the and the next Provider at the time of discharge;
4. A full Medication Reconciliation Discharge Instruction Document is provided to the patient and next provider at the time of discharge;
5. For Partnership patients only, medication reconciliation within 30 days post discharge documented in the primary care provider's office visit; and
6. Improved performance on three Care Transitions patient satisfaction questions in the HCAHPs Survey.

B. Patient Centered Indicators;

1. Satisfaction, using a paper survey, with the program and health coach.
2. Success in meeting personal health goals as determined by scoring methodology internally developed using the Midas Community Case Management module and based on the Coleman 4 Pillars model of change.
3. Others to be determined.

REFERENCES:

CIHQ Discharge Planning: DC-1
IHI Innovation Series Care Coordination Model
PRIME Grant focused on Partnership Patients

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SUBJECT: Community Care Transitions Program	POLICY # DS 8750- 123
	PAGE 5 OF 8
DEPARTMENT: Quality & Resource Management	EFFECTIVE: 11/16
APPROVED BY: Chief Quality Officer	REVISED/REVIEWED:

Appendix A.: Position Description: Volunteer Community Health Coach

Summary: The Health Coach acts as a client advocate and navigator of the healthcare delivery system in order to facilitate the client's self defined plan of care.

Education: In order to become a volunteer Community Health Coach, the individual must be enrolled in a course of education through an accredited school and be actively pursuing a health related specialty, be a healthcare professional in their own right, or be a member of the community who has attended a hospital-based educational program and Wellness University. The individual must successfully complete the educational programs that include topics such as: communication skills & relationship building, goal setting and motivational coaching, medical literacy, mental health and social issues, common symptoms, to name a few. Once completed the individual is eligible to volunteer as a Community Health Coach under the supervision of the Hospital's Care Transitions Program.

Responsibilities:

- Through the use of active listening skills, develops a supportive relationship with the client that encourages the client to express their health concerns;
- Works with the client, the primary care provider, and the Care Transitions Team to develop wellness goals and a behavioral plan to address healthy lifestyle choices;
- Identifies basic unmet needs and helps the client identify and develop strategies to break down barriers to adherence to established wellness goals;
- Works with the client to clarify transitions of care questions, follow-up appointments, discharge instructions and identifies access issues and the linkages to resolve problems.
- May accompany the client to doctor's appointments, attend community events, witness medication handling, and go shopping with the client. May not handle medications, provide transportation, do house cleaning or laundry, run errands, or handle the client's money;
- Visit with the client at least weekly or as needed for an hour per visit or visit via telephone outreach weekly or as needed;
- Documents all interactions and any care concerns and reports back to the Care Transitions Team; and
- Meets with the Care Transitions Team for client rounds weekly.

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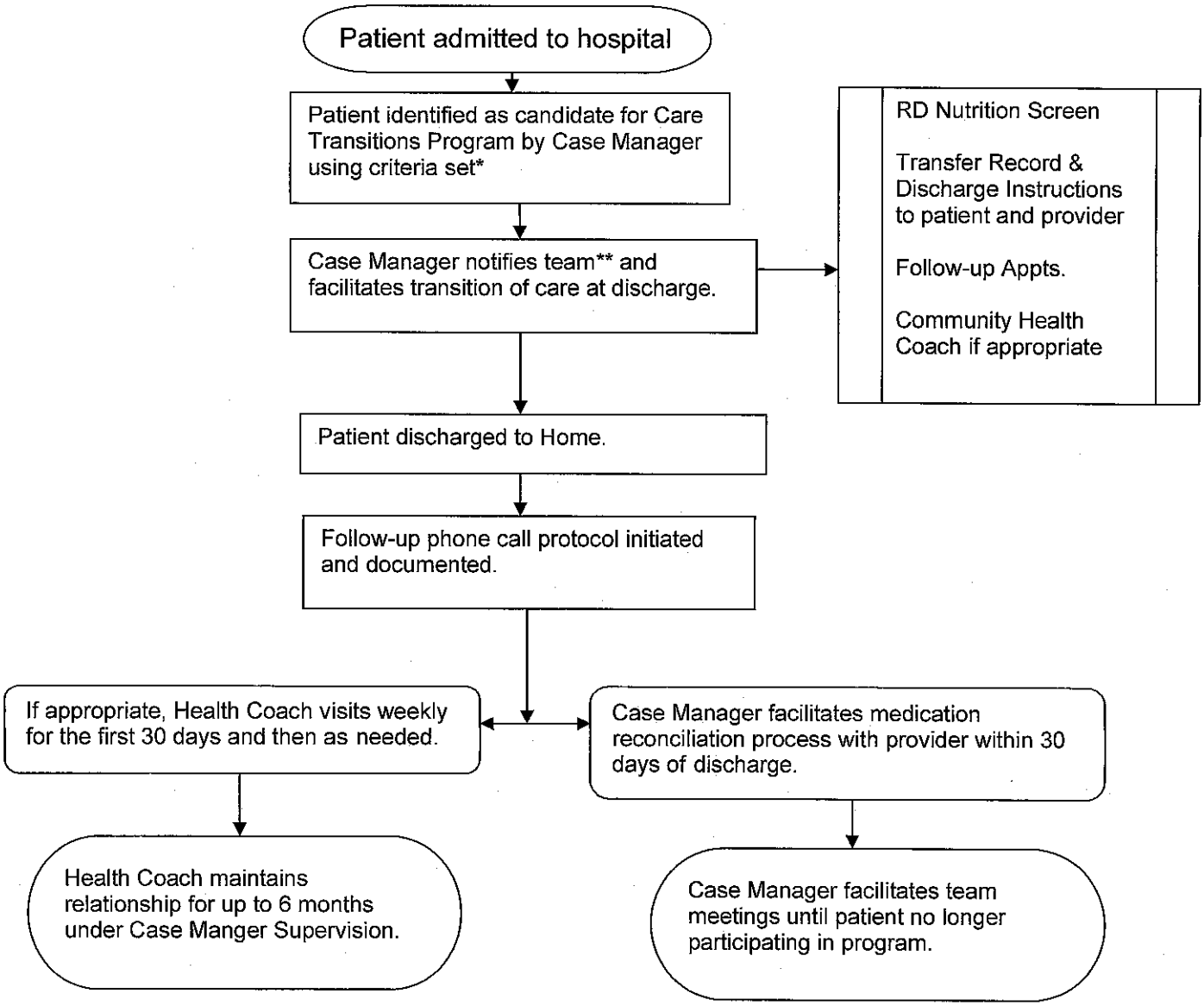
SUBJECT: Community Care Transitions Program	POLICY # DS 8750- 123
	PAGE 6 OF 8
DEPARTMENT: Quality & Resource Management	EFFECTIVE: 11/16
APPROVED BY: Chief Quality Officer	REVISED/REVIEWED:

Attachment B

Community Care Transitions: Acute to Home



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SUBJECT: Community Care Transitions Program	POLICY # DS 8750- 123
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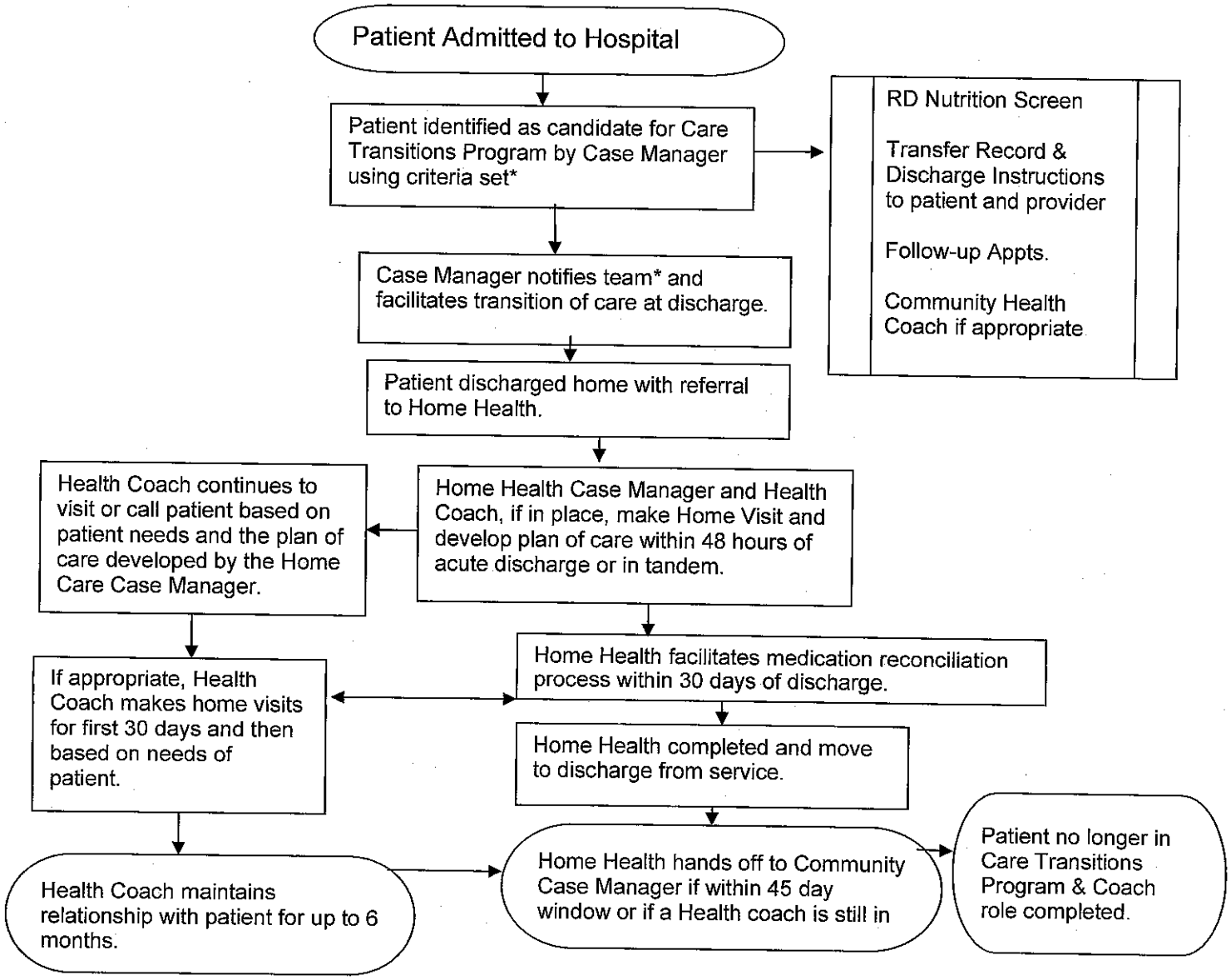
DEPARTMENT: Quality & Resource Management	EFFECTIVE: 11/16
APPROVED BY: Chief Quality Officer	REVISED/REVIEWED:

Attachment C

Community Care Transitions: Acute to Home with Home Health



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SUBJECT: Community Care Transitions Program	POLICY # DS 8750- 123
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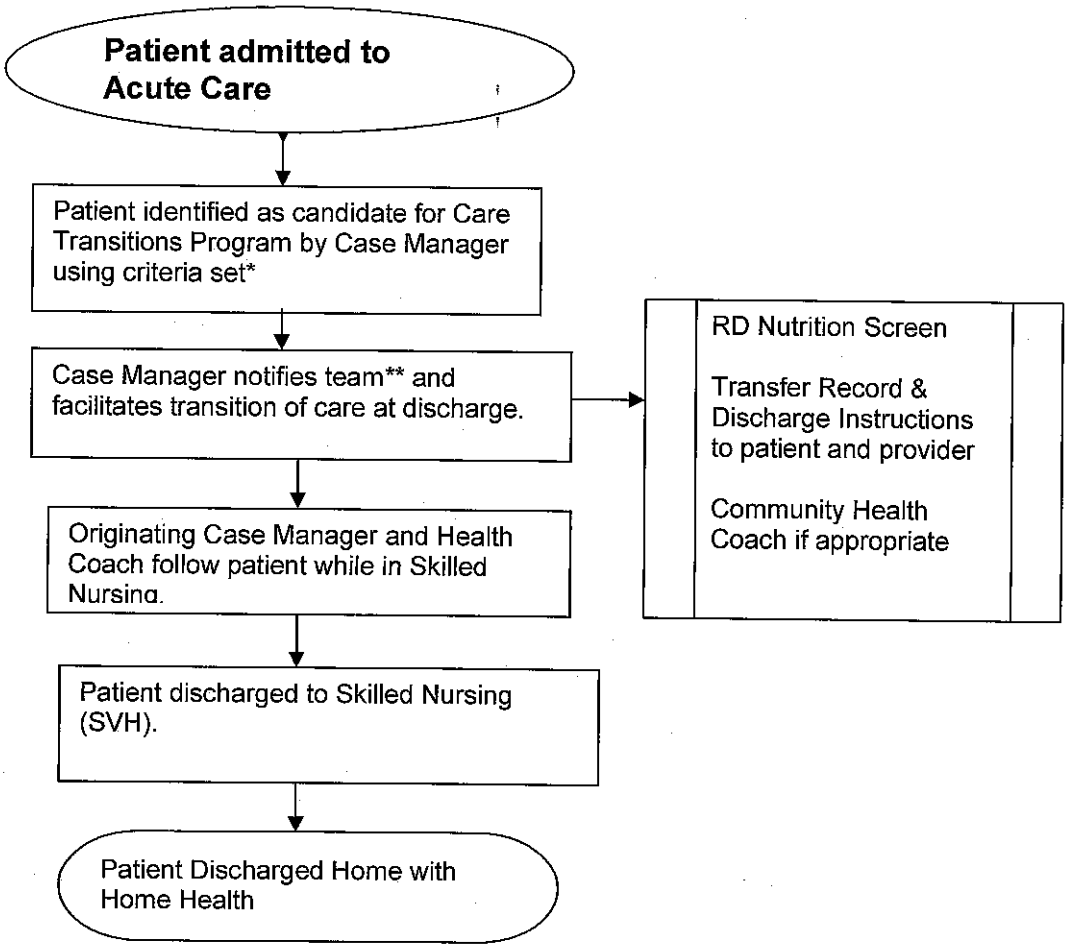
DEPARTMENT: Quality & Resource Management	EFFECTIVE: 11/16
APPROVED BY: Chief Quality Officer	REVISED/REVIEWED:

Attachment D

Community Care Transitions: Acute to Skilled Nursing and then Home with Home Health



* Lace Tool Score greater than 9; Social Needs Tool; meets ED at risk criteria; meets insurance criteria
** Team: Medical Social Worker, Community Health Coach, Sound Transitions Nurse, Registered Dietician, Primary Care Provider, and/or Sonoma Valley Community Health Clinic if applicable.

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SUBJECT: Community Care Transitions Follow –Up Calls	POLICY #DS 8750- 124
	PAGE 1 OF 2
DEPARTMENT: Quality & Resource Management	EFFECTIVE: 11/16
APPROVED BY: Chief Quality Officer	REVISED/REVIEWED:

PURPOSE:
To identify the structure, process and content for follow-up phone calls to patients discharged to home after an acute care or skilled nursing unit discharge.

POLICY:
Coordination of care entails the provision of assistance to ensure the effectiveness and efficient organization of, and access to, services and resources that are appropriate to the patient's needs. Follow-up phone calls, for a period of 45 days or as needed following an acute or skilled nursing discharge, provide an avenue to identifying care & compliance concerns, education needs, and medication issues that if left unresolved could lead to re-admission to the hospital.

PROCEDURE:

I. Follow- Up Phone Calls

A. All patients receive a follow up phone call within 48 hours of discharge.

B. Patients are then scheduled for phone calls every seven days, unless discharged with a referral to Healing at Home. Healing at Home Case Managers will maintain contact with the patient on a weekly basis. Follow-up phone calls will be initiated post discharge from Home Care.

C. Patient discharged to SVH Skilled Nursing Unit will be followed by Case Management and initiate follow-up phone calls after discharge from the Skilled Nursing Unit.

II. Content of Phone Calls

A. The first 48 hour call will address the following:

- Address what matters most, e.g. do they have any worries or concerns about recovery;
- Review the discharge instructions;
- Confirm support, medication pick up, nutrition and other plan of care items;
- Confirm follow-up appointment, will they be able to make appointment and do they have transportation. What questions do they have for their physician when they meet with their physician; and

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SUBJECT: Community Care Transitions Follow –Up Calls	POLICY #DS 8750- 124
	PAGE 2 OF 2
DEPARTMENT: Quality & Resource Management	EFFECTIVE: 11/16
APPROVED BY: Chief Quality Officer	REVISED/REVIEWED:

- Document the phone call and report any issues to hospital case management for follow up.

B. Weekly Phone Calls will address the following:

- Address what matters most currently, e.g. concerns/worries about their health;
- Identify any goals they have set as a result of their visit with their physician and where they are in meeting those goals;
- Assess medication compliance, nutrition, support and any disease related activities e.g. daily weights, BP monitoring, blood glucose etc.
- Document call and refer concerns to hospital case management for follow up.

C. Case Management may initiate a home visit and/or Community Health Coach based on concerns that arise and are communicated to the Primary Care Provider.

D. The Primary Care Provider may also contact Case Management and request a visit.

REFERENCES:
CIHQ Discharge Planning: DC-1

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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

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

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

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

Organizational: Medication Management Policies and Procedures	
APPROVED BY:	DATE: 09/21/2016
Director's/Manager's Signature	Printed Name Chris Kutza, Director of Pharmacy

Brian Sebastian, MD
Chair, PI & P&T Committee — Date: 9/22/16

Kelly Mather,
Chief Executive Officer — Date: 10/20/16

Keith J. Chamberlin, MD MBA
President of the Medical Staff — Date: 10-17-16

Jane Hirsch
Chair, Board of Directors — Date

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Policy Submission Summary Sheet

Title of Document: **Organizational Policy**
New Document or Revision written by: **Chris Kutza**
Date of Document: **7-28-16**

Type:	**Regulatory:**
X **Revisions** X **New Policy**	X **CIHQ** X **CDPH** X **CMS** ☐ **Other:**
Organizational:	☐ **Departmental**
X **Clinical** ☐ **Non-Clinical**	☐ **Interdepartmental** (list departments effected)

Please briefly state changes to existing document/form or overview of new document/form here:
(include reason for change(s) or new document/form)

MM8610-105 Malignant Hyperthermia, Management of Patient with: Updated to include the "To-Do" checklist for clinical staff in the event of an MH Crisis

MM8610-149 Antimicrobial Stewardship: Updated to reflect newer requirements by CMS and CDPH

MM8610-154 Patient Controlled Analgesia (PCA): Updated to reflect new concentration of hydromorphone PCA (0.2mg/ml).

MM8610-116 Use of Medication Not Procured by the Facility: Reviewed-no changes

MM8610-122 Formulary Management: Reviewed-no changes

MM8610-123 Storage of Medications: Reviewed-added reference to new policy MM8610-158 Hazardous Drug Handling

MM8610-124 Inspection of Nursing Units and Medication Storage Areas: Reviewed-no changes

MM8610-125 Temperature Monitoring of Medication Storage: Reviewed-removed references to The Joint Commission

MM8610-126 Adverse Drug Events-Quality Assurance: Reviewed-removed references to The Joint Commission

MM8610-127 Multi-Dose and Single-Dose Vials: Reviewed-removed references to The Joint Commission

Reviewed; no changes by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team			
Surgery Committee	N/A		
Medicine Committee	N/A		
P.I. or P. T. Committee	**9/22/2016**	Yes	
Medical Executive Committee	**10/20/2016**	Yes	
Board Quality ~~[illegible]~~	**12/[illegible]/2016**	12/14/16	
Board of Directors	**01/05/2017**		

5.

2016 WORK PLAN

2016 Quality Committee Work Plan

January 1/27	February 2/24	March 3/23	April 4/27
▪ 2015 Plan evaluation and development of 2016 Plan	▪ AHRQ Culture of Safety Results ▪ 3rd Quarter Quality Dashboard and Harm Score discussion	▪ Annual Infection Control Report* (Kathy) ▪ 2015 Contract Evaluation Report*	▪ Annual Home Care Report *(Barbara) ▪ Skilled Nursing Report (Melissa)*
May 5/25	**June 6/22**	**July 7/27**	**August 8/24**
▪ Annual review of QA/PI Program	▪ Patient Care Services Report (Mark) ▪ Hospitalist Services Report (Drs Cohen & Verducci)	▪ Annual Risk Management Report (Kathy)	• Medication Safety Report *(Chris) • Information Services Update (Fe)
September 9/28	**October 10/26**	**November 11/16**	**December 12/14**
▪ Performance Improvement Reports – PI Fair ▪ Community Care Network (Leslie & Dr. Cohen)	Patient Safety Education Session with Board Dr. Rory Jaffe MD Medical Director, CHPSO 5p-7:30p **Confirmed**	▪ Satellite Dialysis (Rep & Michelle) ▪ Employee Direct (Michelle)	▪ Evaluation of the Quality Committee Work Plan

*Required

6.

QUALITY REPORT
DECEMBER 2016

To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 12/14/16
Subject: Quality and Resource Management Report

December Priorities:

1. PRIME Grant Activities
2. Annual PI Fair results
3. Board Quality Scorecard format
4. Evaluation of the 2016 Work Plan for this committee

1. *Prime Grant Activities*

Cindy and I are currently building the Community Case Management database and have scheduled case manager training in the system in early January. The department will assume all inpatient follow-up calls on January 2nd and we will have our Transition Record with Discharge Medication reconciliation in place for roll out January 2nd. I will bring the initial scorecard to this committee in February with the six month data for reporting to the state at the end of March. Our target population has expanded from just Partnership to Medi-Cal and Medicare/Medi-Cal so we will definitely be able to meet our target denominator of 30 cases. I have scheduled an orientation to Community Health Coaching for the 18th of January to recruit willing participants in this part of the project. The PRIME grant Steering Committee met last month to review the policies/ procedures and patient flow algorhythms. We are also consulting with the Patient Advisor member of the patient Experience Team to review the Self Management plans and discharge instructions to ensure they are understandable and patient centered.

2. Annual PI Fair Results

The annual performance improvement fair went well. There were 18 projects: 10 clinical and 8 support services/non clinical:

CLINICAL PROJECTS

Project
1. Early Management of Severe Sepsis
2. Management of C. Difficile Infections
3. Urinary Incontinence: an Equal Opportunity Disorder
4. Sweet Success
5. Improving Medication Histories
6. Op Physical Therapy documentation and Reimbursement Project
7. Early Progressive Mobilization in the ICU
8. Laboratory Frequencies and Priorities
9. How Do I know? **(Informational Only)**

10. Reducing Harm with Good Catch Program

SUPPORT SERVICES PROJECTS

Project
11. Infusion Documentation in the Emergency Department
12. Health Heros
13. Why SVH needs a Vendor Credentialing Program
14. Cost-Per-Hire
15. Implementation of a Paperless Accounts Payable System
16. Clinical Engineering Program - More bang for our buck
17. Medicare Rights
18. Healing At Home Financial Improvement Project

Ingrid and Cathy did a terrific job in the judging and provided me with some great feedback for the teams. We invited the public and had three community members attend. All three were impressed and asked great questions. This year, I rotated the posters throughout the hospital for three weeks so that the staff, physicians and community members who did not attend the fair could see the projects. I received quite a bit of positive feedback on this new process so I will keep doing it from now on. Peter Hohorst also suggested that the winners present their projects to the full board.

The Winners were: Good Catch, Management of C. difficile, and Infusion documentation in the ED. The People's choice winner was: Urinary Incontinence: An Equal Opportunity disorder.

This year I will meet with each of the teams to give them feedback on their projects and to ensure follow-up steps for projects that were just getting off the ground. I will do a follow-up board for the 2017 fair so that we know what happened with these projects.

3. Board Quality Scorecard Format:

Cindi is working on the suggestions that were made and will have a template for the January meeting.

4. Evaluation of the 2016 Quality Committee Work Plan

Attached please find the Work Plan. The Committee heard from most of the presentations. The Community Care Network presentation ended up being the PRIME Grant presentation and Michelle Donaldson did not present on Satellite Dialysis. This program was going to be housed in the old Emergency Department but the State and OSHPD denied the project. The Employee direct Program started off well and then was purchased by another company. Processes were changed that made the case management process difficult. Michelle has worked with the new company and we are now cautiously optimistic that things will work better. If this continues to be something we do, I will ask her to come and present.

Jane and Joshua have given me a template outline for department presentations so that they are consistent in what they present. I will go over the structure with each leader presenting next year.

This Committee sponsored Dr. Rory Jaffe's presentation on Patient Safety which went very well.

One suggestion not implemented was to have frontline staff members attend to give their perspective on their work life experiences. I would like to make that a priority this next year.

Another suggestion was that committee members attend and observe Safety Committee, Multidisciplinary Huddles etc. to gain an understanding of our culture. I would like to open that up for possibility in 2017.

Jane and I participated in an interview for a magazine on how Board Quality Committees function. I have not seen the published article but when it does come out I will share it with you.