SVHCD QUALITY COMMITTEE MEETING
AGENDA
WEDNESDAY, MAY 25, 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, 4.27.16	*Hirsch*	Action
4. POLICY & PROCEDURES ✓ Materials Management Multiple, April 2016	*Lovejoy*	Action
5. QUALITY REPORT ✓ Quality & Resource Management Report, May 2016 ✓ Annual Review QA/PI Program	*Lovejoy*	Inform/Action
6. CLOSING COMMENTS/ANNOUNCEMENTS	*Hirsch*	
7. ADJOURN	*Hirsch*	
8. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*	
9. CLOSED SESSION: • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Sebastian*	Action
10. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
11. ADJOURN	*Hirsch*	

3.

CONSENT

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
MINUTES
Wednesday, April 27, 2016
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch Carol Snyder Michael Mainardi Ingrid Sheets	Kelsey Woodward Susan Idell Joshua Rymer	Brian Sebastian, M.D. Howard Eisenstark Cathy Webber	Joyce Miller Leslie Lovejoy Robbie Cohen, M.D. Mark Kobe Gigi Betta Melissa Evans Barbara Lee

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	The meeting was called to order at 5:00p.	
2. PUBLIC COMMENT	*Hirsch*	
	No public comment.	
3. CONSENT CALENDAR	*Hirsch*	Action
✓ QC Minutes, 03.23.16		**MOTION** by Idell to approve Consent and 2nd by Mainardi. All in favor.
4. ANNUAL SKILLED NURSING REPORT	*Evans*	Inform
	Ms. Evans shared the SNF annual report including regulatory requirements, surveys, rating and measuring systems, trends, challenges, future strategies and goals.	
5. ANNUAL HOME CARE REPORT	*Lee*	Inform
	Ms. Lee presented the Home Care annual report including 4th quarter summary of accomplishments, infection results, patient satisfaction, trends and goals	
6. Q1 PATIENT CARE SERVICES DASBOARD	*Kobe*	Inform
	Mr. Kobe shared the patient care services dashboard results through the 1st quarter 2015-2016.	

AGENDA ITEM	DISCUSSION	ACTION
7. POLICY & PROCEDURES	*Lovejoy*	Action
✓ Pharmacy Policies: MM 8610-155-6 ✓ Multiple Policies, April 2016: 7010-01 & 6171-154		**MOTION** by Mainardi to approve Policy & Procedures and 2nd by Idell. All in favor.
8. QUALITY REPORT	*Lovejoy*	Inform/Action
✓ Quality & Resource Management Report April2016	Ms. Lovejoy presented April 2016 priorities including Good Catch awards, POC QM documentation for Skilled Nursing, unscheduled licensing surveys, and performance improvement projects.	**MOTION** by Mainardi to approve Quality Report and 2nd by Sheets. All in favor.
9. CLOSING COMMENTS	*Hirsch*	
10. ADJOURN	*Hirsch*	
11. UPON ADJOURNMENT OF REGULAR SESSION	*Hirsch*	
12. CLOSED SESSION		Action
✓ Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report		
13. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
14. ADJOURN	*Hirsch*	
	Meeting adjourned at 6:50pm.	

4.

POLICY & PROCEDURES

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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

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

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

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

Organizational: Materials Management Department Policies	
APPROVED BY: **Director of Materials Management**	DATE: **4-22-16**
Director's/Manager's Signature Ellen Shannahan	Printed Name **Ellen Shannahan**

Ken Jensen
Chief Financial Officer — 5/17/16 Date

Leslie Lovejoy, RN
Chief Quality & Nursing Officer — Date

Kelly Mather
Chief Executive Officer — Date

Jane Hirsch
Chair, Board of Directors — Date

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Policy Submission Summary Sheet

Title of Document: **Materials Management Department**

New Document or Revision written by: **Ellen Shannahan**

Date of Document: **4-19-16**

Type:	**Regulatory:**
X Revision **❑ New Policy**	**❑ CIHQ** **❑ CDPH** **❑ CMS** **❑ Other:**
Organizational:	**X Departmental**
❑ Clinical **X Non-Clinical**	**❑ Interdepartmental**

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

On all policies below, deleted reference to TJC. Added revision date.

EC8400-106	Cleaning in Materials Management – No Change
EC8400-109	Equipment Inspection – No Change
EC8400-103	Handling of Sharps – No Change
EC8400-104	Hazardous Substances – No Change
EC8400-101	Phone Tree – No Change
EC8400-114	Product Failure – No Change
EC8400-113	Product Recalls – No Change
EC8400-112	Purchase Order Returns – No Change
EC8400-105	Quality Improvement Plan – No Change
EC8400-110	Receiving Procedures – No Change
EC8400-111	Rotation of Stock – No Change
EC8400-107	Safety in Materials Management – No Change
EC8400-108	Security in Materials Management – No Change
EC8400-100	Statement of Service – Added SCU under Distribution, deleted Special Procedures Deleted Line 3 referencing stickering of supplies
EC8400-102	System Downtime Procedures – Procedure No. 1, changed "three part form" to sequential form

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	**4/19/2016**	Yes	
Surgery Committee	n/a		
Medicine Committee	n/a		
P.I. or P.T. Committee	n/a		
Medical Executive Committee	n/a		
Quality Board	**5/24/2016**		
Board of Directors	**6/02/2016**		

5.

Quality Report
May 2016

To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 05/25/16
Subject: Quality and Resource Management Report

May Priorities:

1. Plan of correction for the CDPH survey
2. Hospital Quality Survey Participation
3. CALHEN oversight meeting

1. *Plan of Correction for the CDPH survey*

We received the request for a plan of correction related to our unannounced state licening survey. There were no real surprises and I will provide action plans in the June meeting as the team is busy writing them at this time.

2. *Hospital Quality Survey Participation*

We are in the process of completing the Leapfrog Hospital survey by the end of June. Leapfrog will use the responses to the survey and the new Medicare data that was recently posted on Hospital compare. I am hopeful that we will see a change in our score. We will not be participating in the survey going forward. Anthem Blue Cross has been asking the hospital to participate in their Q-HIP quality survey for a number of years. The department decided that we would participate this year and the survey was completed. We will be hearing back about our score and have 15 days to respond with changes. Yet again, different questions but they do use Hospital compare as well as there data from our care of their patients. They do not publish this data so we will not be asked for public comment. Participation in this survey does provide a reimbursement incentive to the hospital.

3. *CALHEN oversight meeting*

Project leaders provided Quality with an update on their performance improvement projects and identified their outcome measures. All teams are on track to complete their projects by the end of this year.

Topic for discussion this meeting:

- Annual QA/PI Program Evaluation

6.

Annual Review
QA/PI Program

Quality Assurance/Performance Improvement
Program Review 2015

Purpose

The Quality Department, in cooperation with the Medical Staff Performance Improvement Committee and Administrative Leadership, has completed an appraisal of the Performance Improvement Program.

The purpose of this appraisal is to:

- Evaluate the comprehensiveness and scope of the program.
- Assess the effectiveness of the FOCUS / PDSA model.
- Measure the extent of interdisciplinary collaboration.
- Assure that all key functions and dimensions of performance have been addressed.
- Provide the Governance, Administration and Medical Staff leaders with the results of prior year activities to assist in development of priorities for improvement.
- Determine the extent to which the Performance Improvement Program supported the mission and vision.

Scope and Applicability

This is an organization-wide program. It applies to all settings of care and services provided by Sonoma Valley Hospital.

Findings

Home Care successfully completed their state survey as did the Skilled Nursing Facility. Any and all deficiencies identified through these surveys have been resolved and added to departmental quality control monitoring. We successfully completed plans of correction for a cited EMTALA violation and effectively implemented strategies to reduce risk to patient safety concerns in the Surgery Department. We partnered with Program Beta, our insurance carrier, to provide nursing staff education on documentation in the medical record as a result of a finding from an intense analysis completed that addressed a retained sponge. We completed the Leapfrog hospital survey and identified some opportunities for improvement. An Action Plan was developed and is in the process of completion.

Over the past year there was a great deal of improvement in the development of a performance improvement infrastructure and department specific performance improvement such that each department identified the complexity of work flow processes and opportunities to improve based on some form of prioritization process, including considerations of risk, volume and problem proneness. The Quality Department developed a monitoring system to ensure full compliance with quarterly reporting. In addition a formal policy and procedure process was refined, with monthly reports to Leadership of policy updates and talking points for frontline staff that need to know about changes.

The senior team performed a formal organization-wide Performance Improvement Project prioritization process that identified four projects: Population Health/Community Care Network; Paragon 12.1 and 13 upgrade; Home Care Transformation Project; and Email Encryption. The Population Health/Community care Network project resulted in the submission of a 5-year PRIME grant currently pending approval. We implemented Paragon 12.1 but decided to delay implementation of Paragon 13 until 2016. The Home Care Transformation Project resulted in a re-thinking of the scope of community services and implemented efficiencies in operations. The Email Encryption project began late 2015 and is expected to be completed in 2016. Each of the prioritized projects aligned with both our strategic plan and with the hospital's overarching mission, vision and values.

This year, there was an increased use of the PDSA as Leaders have become more confident in the process and the expectations have been set that all projects will be reported using this process. A Project Review Team now functions as the central repository of all performance improvement projects and monthly reports of progress are requested and noted during team meetings. We fully implemented a project request tool and all projects are reviewed by the team and then reviewed in senior leadership before the project is begun.

The organization held its Second Annual Performance Improvement Fair to continue to improve the organization's use of performance improvement tools and to move towards data driven decision making. There was great improvement in the quality of the projects and in the presentations. The Quality and Information Systems Departments added a software tool (STATIT) that provides statistical process control analysis of data to enhance decision making. The STATIT Team is currently working to build a core group of super users and building scorecards that will be more visible in the fall of 2016.

The Quality Department provided education to leadership on the topics of statistical process control, CIHQ standards interpretation and compliance; use of outlook tools to manage emails and held drop-in Quality Clinics on a monthly basis to provide coaching and provided weekly drop in sessions for leaders to become proficient in e-notification reporting and management. The CQO attended the annual CIHQ and the Hospital Quality Institute conferences and brought back best practices that are in the process of being adopted. The Quality Data Analyst attended the annual Midas conference bringing back refinements to our use of this database that have improved data gathering and reporting. An annual review of the budget for Quality, Risk Management and Patient Safety indicates adequate staffing and resources have been allocated to these functions.

This was also the year of refining and building more effective databases for reporting. Midas Seeker, a medical staff credentialing and documentation database has been updated and is now able to provide more meaningful reporting and medical staff documentation management. Midas Care Management data base which is used for Case Management and Utilization Review has been updated and we have started to standardize how information is entered and reported out. In 2016 we will be building the Midas Community Case Management module to prepare for our expansion of case management into the community.

Interdisciplinary collaboration was demonstrated through the Sorry Works process, Culture of Safety Program; Project Review Team, IT Steering Committee, Utilization Review Program; Pharmacy and Therapeutics Committee; Grievance Committee; departmental and cross departmental performance improvement projects and organization-wide performance improvement. Increasing the meetings of the Medical Staff Performance

Improvement Committee and the further development of the Board Quality Committee Quality Scorecard allowed for more consistent and coordinated reporting of projects and mandated activities.

The Performance Improvement Program supports the hospital's mission and is well on the way to supporting an organizational Culture of Quality and Safety.

Assessment of Performance

The effectiveness of the PI program is measured by its accomplishments. Data was collected and aggregated on performance measures and thoroughly analyzed. Intensive assessments were completed when SVH detected or suspected a significant undesirable performance or variation. Progress was made on the following program goals:

I. *Performance Improvement Infrastructure Goals*

Performance Goal	Outcome
Provide an organized schedule of education for leaders to improve understanding and the quality of our program.	Completed for 2015; ongoing
Implement STATIT.	Installed, STATIT team in place, demonstration to leadership in June, new leadership dashboards will use this beginning July 2016
Refine medical staff and board quality dashboards/scorecards to make them clinically relevant with meaningful data.	Ongoing but making good headway
Refine Project Management process and infrastructure to better manage and communicate projects throughout the organization.	Completed
Implement a QC monitoring oversight process to ensure compliant quality control reporting by department	Completed
Implement a Policy and Procedure feedback system for leaders to communicate revisions to frontline staff.	Completed

II. *Performance Improvement, Reportable Outcome Measures*

Hospital Compare Quality Performance Report : Overall Star Rating: 4 (22.21% of hospitals receive this rating= better	Data Range:4thQ 2014-3rd Q 2015

than average)	
Outpatient Measures: • Flu Vaccination of staff & MD's • Median time to transfer to another facility for acute coronary intervention (rate) 36 mins • Aspirin on arrival (100%) • Median time to ECG (3 mins) • Median time from ED arrival to departure for ED discharged patients (133 mins) • Median time from ED arrival to provider contact for ED patients (16 mins) • Left without being seen (2%) • Median time to pain mgmt for long bone FX (77 mins) • Received Head CT/MRI scan interpretation w/45 minutes of ED arrival (73%) • Appropriate F/U interval for normal colonoscopy in average risk patient (31%) • Colonoscopy interval for patients with HX of Adenomatous Polyps – avoidance of inappropriate use (50%)	• Better than state/national (82/84) • Better than state/national rate (69/57) • Better than state/national (97/97%) • Better than state/national (9/7) (Note: 10% of all hospitals submitting data performed equal to or better than SVH.) • Better than state (134) above national(115) top 10% = 94 mins • Better than state/national (24/20) top 10% = 10 mins • Same as state/national (2/2) top 10% = 0 • Above both state and national (60/53), top 10% = 32 mins • Better than state/national (69/68), top 10% =100% • Above both state/national (69/74), top 10% = 100% • Below state/national (68/80), top 10% = 100%
Inpatient Measures: • Evaluation of LVS function in Heart Failure (100%) • Stoke Measures (97%) • VTE Measures (97%) • Pneumonia ABX selection (78%) • SCIP (Surgical Care) (98%) • Median time from ED arrival to ED departure for admission (287 mins) • Admit decision time to ED departure time (115 mins) • Influenza Immunization of patients (95%) • Elective delivery before 37 weeks (0%)	• Better than state/national (99/98), top 10%=100% • Equal to state/better than national (97/96), top 10% = 100% • Better than state/national (80/80), top 10% = 100% • Above the state/national (97/95), top 10% 100% • Better than state/below national (98/99), top 10% =100% • Better than state/national, top 10% = 178 mins • Below both state/national (90/60), top 10% = 40 mins • Better than state/national (94/94, top 10% = 100% • Better than state/nations (2/3), top 10% = 0%

Thirty Day Mortality Rates for AMI, Heart Failure, Pneumonia & Stoke	No different than the national rate
Thirty Day Readmission Rate Condition Specific for AMI, Heart Failure, COPD, Pneumonia	No different than the national rate No penalties accrued to SVH
Thirty Day Readmission Rate, Procedure Based for Total Joint Replacement	No different than the national rate No penalties accrued to SVH
Patient Safety Indicators Aggregate (.90)	Same as national benchmark No penalties accrued to SVH
Values Based Purchasing Score/CMS October 1, 2013-June 30, 2015 = 0.44	Better than national benchmark (.54) Earn back plus bonus
Leapfrog Hospital Survey and Score (A to C))	Action Plan in place; complete survey by end of June. Score moved to D in spring 2016.
HCAHPS (3 Stars: average performance; 51.58% of hospitals score here)	CNO reporting to Leadership, Medical Staff & Board

Assessment of Effectiveness

The Performance Improvement Program, in 2015, met the needs of the Performance Improvement Committee, Medical Executive Committee and Sonoma Valley Hospital.

Objectives for Next Evaluation Period

With input from the medical staff and leadership, the Administrative Team performed an assessment of potential organizational performance improvement activities for 2016 that align with the strategic plan and core strategic initiatives and reflects the scope and complexity of patient care services. In addition to departmental and interdepartmental continuous performance improvement activities, the organization will focus on the following priorities.

A. Prioritized Organizational Performance Improvement Projects for 2016 include the following:

- CALHEN Sepsis Management
- CALHEN Iatrogenic Delirium Management
- CALHEN C. difficile Prevention
- Paragon 13

B. Performance Improvement Infrastructure Goals:

- Provide an organized schedule of education for Leaders, Physicians and Board members to enhance skills in performance improvement with a focus on best practices to improve patient safety.
- Increase frontline staff and physician involvement in performance improvement and patient safety activities.

- Improve quality monitoring and case identification for medical staff quality of care reviews.
- Work with Information systems to develop ability to meet E Quality Measures reporting
- Develop a process for leadership to share the results of e-notification reporting for their department.
- Participate in CALHEN and CHPSO improvement projects and reporting for external benchmarking.
- Develop relationship with National Registries for Orthopedics and Bariatric data sharing.
- Implement PRIME Grant to improve the patient experience, reduce readmissions and decrease ED utilization.
- Complete Leapfrog Action Plan and Hospital Survey
- Complete Q-HIP Blue Cross Annual Quality Survey

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