SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, July 25, 2018
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 Quality Committee meeting, please contact the District Clerk, Stacey Finn, at sfinn@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 06.27.18	*Hirsch*	Action
4. PATIENT CARE SERVICES DASHBOARD	*Kobe*	Inform
5. HOME HEALTH HCAHPS UPDATE	*Jones*	Inform
6. RISK MANGANGMENT & PATIENT SAFETY REPORT FY18	*Jones*	Inform
7. POLICIES & PROCEDURES	*Jones*	Action
8. CLOSED SESSION: a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Hirsch*	Inform
9. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
10. ADJOURN	*Hirsch*	

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
June 26, 2018, 5:00 PM
MINUTES
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch Peter Hohorst Carol Snyder Howard Eisenstark, MD Michael Mainardi, MD Ingrid Sheets	Kelsey Woodward Cathy Webber	Susan Idell Michael Brown, MD	Janine Clark Danielle Jones Leslie Lovejoy Dr. Adrienne Green Dr. Russell Sawyer

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Meeting called to order at 4:59 pm Introduction of Dr. Green, CMO at UCSF.	
2. PUBLIC COMMENT	*Hirsch*	
	None	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 05.23.18		**MOTION:** by Mainardi to approve, 2nd by Sheets. All in favor.
4. PRIME GRANT UPDATE	*Lovejoy*	Inform
	Ms. Lovejoy reviewed the Prime Grant data from demonstration years 12 and 13. All areas showed improvement. There is the greatest opportunity for improvement in medication reconciliation 30 days post discharge.	
5. SURGERY DEPARTMENT ANNUAL REVIEW 2017	*Clark/Sawyer*	Inform
	In Ms. Clark's overview of Surgical services she reviewed the pain program and the PI project that was done last year to streamline procedures. There will be an upcoming launch	

AGENDA ITEM	DISCUSSION	ACTION
	of the new electronic health record which will streamline charting. She said today is the start of the 23hr total joint program, which starts with total knee replacements. The goal in this program is to have these patients discharged in 23 hours. Dr. Sawyer spoke about the addition of Dr. Alexandritis to the medical staff and her services. He said that with her expertise the hospital can offer a level of service that no other facility in the area can. Ms. Hirsch asked about what kind of quality programs are in place. Ms. Jones spoke about the QAPI program which identifies specific issues that are addressed accordingly. Mr. Hohorst asked about how often all three OR suites are full during the week. Ms. Clark explained that the rooms and cases are dictated by how many anesthesiologists are working.	
6. Q1 2018 QC DASHBOARD	*Jones*	Inform
	Ms. Jones reviewed the six core measures data. In the Emergency Department the area of opportunity for improvement continued to be time in the ER. In a discussion about the low result for time frame of CT results, Ms. Jones said that the poor result is due to lack of documentation of physician to physician reports, not the actual fall out of the 45 minutes. Dr. Mainardi requested the average time for results to be presented. Ms. Sheets asked about the pain management of the long bones. Ms. Jones said that is no longer being tracked by CMS. In response to question regarding the Home Health scores, Ms. Jones will investigate their accuracy.	
7. GOOD CATCHES 2017	*Jones*	Inform
	Ms. Jones reviewed the Good Catch awards. These awards recognize those who identify and report potential safety issues affecting patient care or employee/visitor safety.	
8. Quality Report	Jones	
	Ms. Jones reported that high level disinfection rounding and medication reconciliation were the May priorities. The high level disinfection rounding was focused per CIHQ suggestions on Cardiopulmonary, Central Sterile	

AGENDA ITEM	DISCUSSION	ACTION
	Processing, Surgery and Pharmacy centered on OR cleanliness. Medication reconciliation had a goal of the home medication list completed within 30 minutes of decision to admit, and document what the patient is actually taking. Work flows were identified and a pilot is planned for the ED in July.	
8. POLICIES & PROCEDURES	*Jones*	Action
	The following policy updates were reviewed: Autopsy Classification of Employees Disability Hours Paid Time Off Parking Guidelines Required Certifications Shift Differential New policies reviewed were: Job Shadow Healthcare Observer Requirements Oral Care - Requested edit to add where Lippincott is found on the intranet.	**MOTION:** by Eisenstark to approve with stated edits, 2nd by Mainardi All in favor.
9. UPON ADJOURNMENT OF REGULAR SESSION	*Hirsch*	
	Regular session adjourned at 6:22 p.m.	
10. CLOSED SESSION a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Lovejoy*	Action
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
		MOTION: by Mainardi to approve credentialing, 2nd by Eisenstark. All in favor.
12. ADJOURN	*Hirsch*	
	Meeting adjourned at 6:26 p.m.	

Patient Care Services Dashboard 2018

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

Medication Scanning Rate	2017-18				
	Q3	Q4	Q1	Q2	Goal
SNF	88.4%	89.0%	89.0%	87.0%	≥80%
Acute	91.3%	87.0%	87.0%	83.0%	≥90%
ED	86.0%	82.0%	87.0%	84.0%	≥90%

Falls (Per 1000 days)	2017-18 Rolling Quarterly Average				
	Q4-Q3	Q1-Q4	Q2-Q1	Q3-Q2	50th %tile
SNF	0.9	1.0	1.40	1.20	6.22
Acute	1.7	2.1	2.30	2.80	3.75

Hospital Acquired Pressure Ulcer Incidents (Per 1000 admissions)	2017-18				
	Q3	Q4	Q1	Q2	National
SNF	0.0	0.0	0.0	0.0	3.17
Acute	0.0	0.0	0.0	0.0	3.68

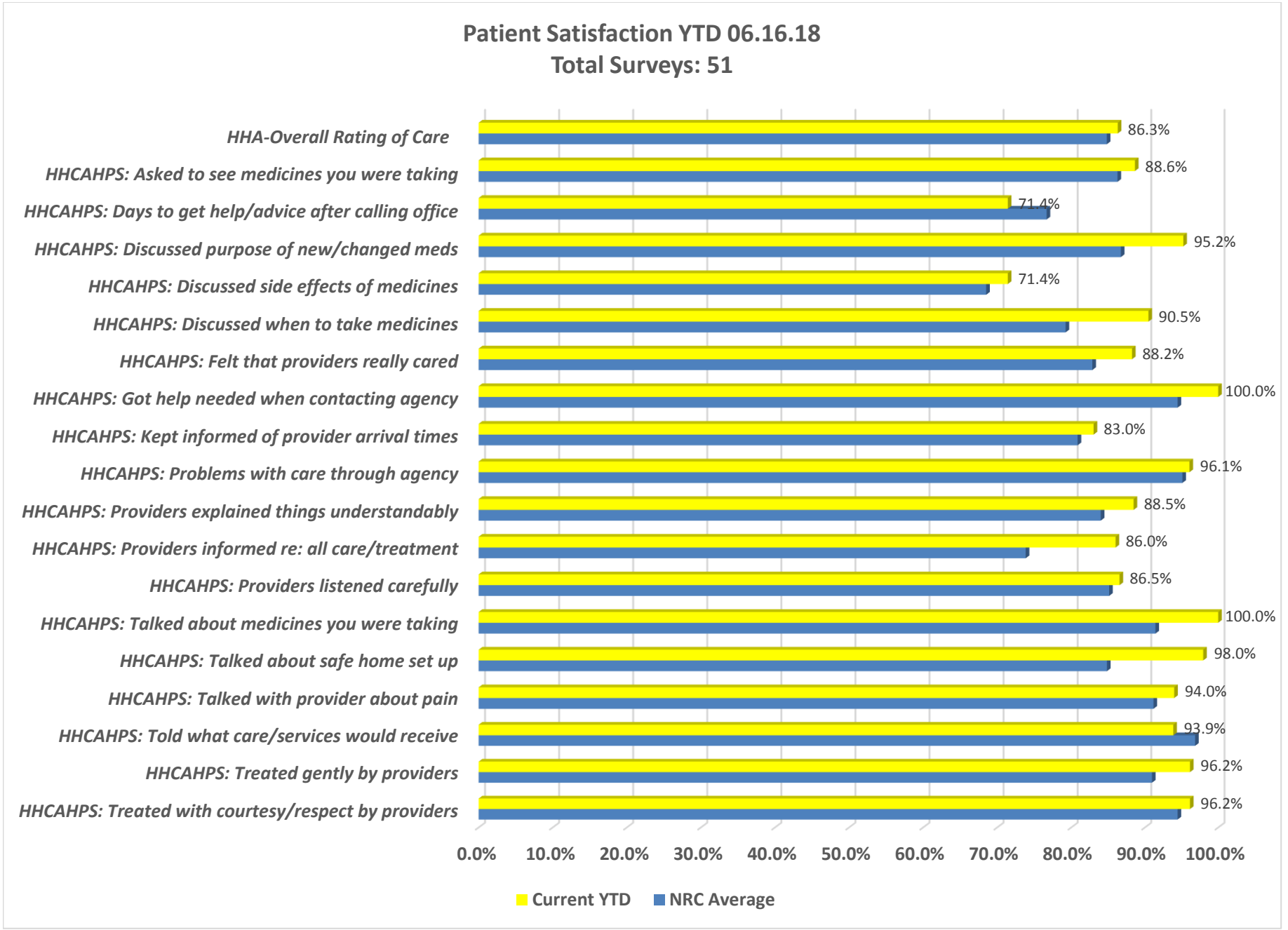
Nursing Turnover	2017-18 RNs/Quarter				
	Q3	Q4	Q1	Q2	Goal
SNF (n=18)	0	1	1	2	≤1
Acute (n=65)	5	6	3	5	≤6
Healing at Home (n=11)	0	2	2	1	≤1
Total Nursing Turnover	5	9	6	8	≤8

Patient Experience (CAHPS)	2017-18				
	Q3	Q4	Q1	Q2	Goal
HCAHPS					
RN Communication	84.0	87.5	78.9	N/A	80.0
Responsiveness of Staff	N/A	N/A	71.4	N/A	67.7
OASCAHPS					
Care of Patients (MD/RN respect)	N/A		97	N/A	97.1
Would Recommend			85.4	N/A	88.6
RATE MY HOSPITAL - ED					
Overall score	N/A	4.5	4.6	4.7	≥4.5

Nurse Staffing Effectiveness: Transfers r/t staffing/beds	2017-18				
	Q3	Q4	Q1	Q2	Goal
	1	0	0	0	≤0

Green = Goal Met Yellow = Below goal Red = Continues below goal or significantly below goal

2013 Hospital falls std from J Amer Med, AHRQ & PubMed


Patient Satisfaction YTD 06.16.18
Total Surveys: 51
HHA-Overall Rating of Care
HHCAHPS: Asked to see medicines you were taking
HHCAHPS: Days to get help/advice after calling office
HHCAHPS: Discussed purpose of new/changed meds
HHCAHPS: Discussed side effects of medicines
HHCAHPS: Discussed when to take medicines
HHCAHPS: Felt that providers really cared
HHCAHPS: Got help needed when contacting agency
HHCAHPS: Kept informed of provider arrival times
HHCAHPS: Problems with care through agency
HHCAHPS: Providers explained things understandably
HHCAHPS: Providers informed re: all care/treatment
HHCAHPS: Providers listened carefully
HHCAHPS: Talked about medicines you were taking
HHCAHPS: Talked about safe home set up
HHCAHPS: Talked with provider about pain
HHCAHPS: Told what care/services would receive
HHCAHPS: Treated gently by providers
HHCAHPS: Treated with courtesy/respect by providers
86.3%
88.6%
71.4%
95.2%
71.4%
90.5%
88.2%
100.0%
83.0%
96.1%
88.5%
86.0%
86.5%
100.0%
98.0%
94.0%
93.9%
96.2%
96.2%
0.0%
10.0%
20.0%
30.0%
40.0%
50.0%
60.0%
70.0%
80.0%
90.0%
100.0%
Current YTD
NRC Average

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

Periodic Risk Management & Patient Safety Report (FY18)

I. ***Introduction***

The purpose of the Risk Management Program is to develop, implement, continuously improve, and maintain processes for making and carrying out decisions that will minimize the adverse effects of potential losses to the organization in three areas of risk: business, regulatory and clinical. The governing body delegates responsibility to the CEO and the Senior Leadership and to the Medical Executive Committee.

II. Year in Review:

- Sonoma Valley Hospital had an inactive year related to claims.
- A new Director of Quality and Risk Management was hired.
- We participated in a Skilled Nursing Facility Annual Relicensing Survey. No patient safety or clinical risk issues were identified.
- We completed and reported our first year of data to the California Hospital Patient Safety Organization (CHPSO). Review of the annual update of the safety event reports submitted show that the content is thorough with logic and clear event descriptions. The event submissions are unbiased, fact driven and with little mention of "blame" or "fault." This points to the organizations hardwired culture of safety. We anticipate an increase in the number of events reported as the front line staff at SVH become more sophisticated in identifying risk/harm and understand the reporting expectations. Staff will also respond to the reporting culture and become more comfortable reporting once they understand SVH leader's response to those submissions.
- We used the Education Resource Funds to purchase some Utilization Management and Risk Management education materials and to assist with leader education at the CIHQ Annual Accreditation Summit. Our Risk Manager attended the annual California Association for Risk Management Conference in Napa.

- We provided **Reducing Risk in Nursing Documentation** education to Home Health, Skilled Nursing Facility, and acute nursing departments.

- We completed a **Risk Management Program assessment** by Beta where it was determined that Sonoma Valley Hospital has the necessary key elements in place to provide day to day operations and leadership for an organizational risk management program.

- We continued to refine our policy and procedure activity and have moved from paper to electronic processes and approvals without the extra expense of software implementation.

- We continue to provide twice monthly leadership education in the e-notification investigation process. With a focus on event type, risk framing (accurate significance level) and leader expectations. We began to address the need for closing the feedback loop to the event reporter. We implemented an auto response email that is sent to the event reporter (if identity is known) and the lead event investigator providing event number and acknowledgment of receipt. Identified area for continued improvement is related to leadership follow through to the event reporter at conclusion of investigation.

The Table below addresses the goals set for fiscal year 2018 and our progress towards meeting them.

FISCAL YEAR 2018 GOALS AND RISK REDUCTION STRATEGIES
• Train new leadership members to accurate and timely investigate e-notifications and respond to the complaint/grievance process. **Provided twice monthly workgroups to leadership with a focus on risk management and technical support of patient safety events.**
• Provide at least one training in risk mitigation for leaders. **Goal not met. We will add to fiscal year 2018 goals.**
• Attend departmental staff meetings and go over department specific data and get feedback on the system from frontline staff. **Not met due to leadership turnover rate. We will add to fiscal year 2018 goals.**
• Determine feasibility to track leadership follow-through with departmental specific data. **Ability to track leadership follow through is limited to information provided by the leader in the event report. Investigation/validation of that information is beyond the scope of current resources.**

III. Claims Reports

A. Clinical Claims:

SVH has had an association with BETA Healthcare Group since 1997. BETA HCG Risk Management Authority administers risk-sharing pools under a joint powers agreement pursuant to California Government Code Claim Section 6500, et seq. and Section 990, et seq. Coverage limits for Hospital Professional and General liability is $15 million with a $5,000 deductible. Emergency Department Professional coverage limits are $1 million/$3 million with a $5,000 deductible.

In addition, each year Beta sets aside $3,600 for risk related education and $2,500 for outside peer review activities. Program Beta also provides free registration for numerous educational seminars and annual conferences and offers free on-site consultations and educational programs.

Sonoma Valley Hospital has a very low claims history. The table below outlines our claims from calendar years 2012 through June 2017. Like the rest of the nation, the Emergency Department is at the most risk for having a claim reported.

Calendar Year	***Origin of claim***	***Total Claims***	***Beta Paid***	***SVH Paid***
2012	Emergency Dept (5)* Medical Imaging (1) Birth Center (1)	ED Closed 1 Closed (NP) 1 Closed (NP)	$1,070,245 (MD)	$5,000
2013	Emergency Dept (2) Grounds (1)	3 Closed	0	0
2014	Emergency Dept (2) Medical Imaging/SNF (1)	ED cases Closed MI case Dismissed	$350,000 (District) $59,998 (MDs)	11,000
2015	Emergency Dept (1)	Closed	0	0
2016	Emergency Department (1) Home Care (1)	Closed	0	Pending
2017	Emergency Department (1) Home Care (1)	Open Dismissed	0	0
Total		13		$16,000

* One case

B. **Business Claims**: No new claims.

C. **Regulatory Claims**: Payments to CDPH for HIPAA breach penalties from 2014 totaling $1400.

III. "Never Events/Hospital Acquired Conditions (HACS)/Adverse Events

The hospital did not have any serious or unusual events that resulted in the death or serious disability of a patient, personnel or visitor during this fiscal year. The hospital did have three adverse events that required an official Root Cause Analysis.

IV. Patient Relations Summary Data

Patients are encouraged to provide feedback about their care experience through the complaint/grievance process and we respond to those concerns in accordance to CMS guidelines that require an acknowledgement of the concern within 7 days if it can't be remedied while in the hospital and a final resolution letter within 30 days of the concern. We have improved in sending out the 7 day letter but have some opportunity to improve in meeting the 30 day " final letter" window. Responsibility for this function of the Patient Experience belongs to the Chief Nursing Officer.

We have seen an increase in complaints while in the hospital and a decrease in grievance and compliment reporting after discharge over the past year. Complaints stem from minor issues that can typically be resolved by staff present at the time the concern is voiced, while grievances are more serious and generally require investigation into allegations regarding the quality of patient care. The data includes complaints that Business Office receives regarding billing that also touches on possible quality of care issues. Billing only grievances/complaints are not represented in this data.

There is very little that can be intuited from the changes from one year to the next. Leaders are expected monitor issues and make process improvements as identified.

Event Type	Fiscal Year 2015	Fiscal Year 2016	Fiscal Year 2017	Fiscal Year 2018	Activity
Complaints*	24	7	16	22	
Grievances**	59	70	51	43	
Compliments***	27	60	20	18	
Total	***110***	***137***	***87***	***83***	

*Complaints = Concerns resolved while still in the hospital or upon discharge
**Grievances = Concerns formally addressed through a phone call or letter by the patient
*** Compliments: not all compliments are captured and placed in the Midas database; the source is usually an email and sometimes a letter

V. Good Catch and E- Notification Summary Data:

One indicator of the effectiveness of any risk management program is the willingness of frontline staff to report unusual occurrences and concerns through the notification system. A Good Catch is the recognition of an event that could have been harmful to a patient, employee or visitor, but was prevented. Near misses occur at a much higher rate than actual errors in healthcare. Proactive reporting of near misses car prevent more serious errors.

Results from the AHRQ Hospital Survey on Patient Safety 2.0 Pilot

The goal of this survey is to assess the patient safety culture at Sonoma Valley Hospital with an emphasis on patient safety and error and event reporting.

Sonoma Valley Hospital consistently outperformed the national pilot hospitals in all 12 categories which include; Communication Openness, Feedback and Communication About Error, Frequency of Events Reported, Handoffs and Transitions, Management Supports for Patient Safety, Overall Perception of Patient Safety, Non-punitive Response to Error, Organizational Learning-Continuous Improvement, Staffing, Supervisor/Manager Expectations and Actions, Promoting Patient Safety, Teamwork Across Units and Teamwork Within Units.

Strengths

- 85% of employees surveyed reported **Overall Perceptions of Patient Safety** to be excellent or very good
- 97% reported that their supervisor, manager, or clinical leader seriously **considers staff suggestions for improving patient safety**

Opportunities

- Number of employees surveyed who report a safety event
- Reporting mistakes that are caught and corrected before reaching the patient (near miss/good catch)

The table below demonstrates a continued improvement in the staff's willingness to report:

	Good Catch		Non-Medication eNotifications	Medication eNotifications	Total Col D & Col E
FY2018	*13*	4 non-med 9 med	969	177	1146
FY2017	*29*	16 non-med 13 med	1014	167	1181
FY2016	*14*	10 non-med 4 med	919	203	1122
FY2015	*21*	9 non-med 12 med	757	23	780

Themes identified by Good Catch and event/incident reporting are addressed by Leadership, Medical Staff and the Safety Committee to reduce the potential for harm for patients, employees and visitors.

VI. Goals and Risk Reduction Strategies for Fiscal Year 2019

Proposed Goals for the next fiscal year include:

- Investigate IHI Framework for **Improving Joy in Work**, building toward organizational High Reliability
- Communicate department specific data related to patient safety and patient relations event reporting to invite feedback on the system from frontline staff
- Refocus on management of patient relations including the complaint and grievance process
- Process improvement related to Good Catch investigation and review
- Align event types with national patient safety reporting best practice and standard formats to increase relevance in California Hospital Patient Safety Organization (CHPSO) collaborative
- Provide at least one training in risk mitigation for leaders

Policy and Procedures – Summary of Changes
Board Quality Committee, July 25th, 2018

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

REVISIONS:

Standby Time HR8610-136

This is a Hospital policy identifying certain positions that need to be on standby, ready to report to work within 30 minutes of call when services are needed, and how that time is compensated. Updated language and definitions for clearer explanations of how standby, call-back, call-in, and call-off pay works. Added standby pay rate schedule to the policy as an attachment and updated job titles to current titles, where appropriate. Removed specific exceptions to general policy and added reference to individual department policy, where appropriate. Changes Ensure clear understanding and expectations of employees when placed on standby, when called back, when called in on an unscheduled work day, and when called off due to lack of work.

Call In Pay HR8610-139

To be retired. Information is covered in the updated “standby Time HR8610-136” policy.

Call Off Pay HR8610-138

To be retired. Information is covered in the updated “standby Time HR8610-136” policy.

DEPARTMENTAL

REVISIONS:

Pediatric Patient in Surgery, Care of the PC7420-111

Due to the specialty nature of pediatric surgery, we will no longer do surgical cases in children under the age of 6. In addition, we will only do urgent/emergent surgeries on children between the ages of 6-10 if it is required before transferring them to a specialty pediatric hospital/care center. Parents are not allowed in the O.R. unless special circumstances agreed upon by both surgeon and anesthesiologist. Why: Because of the infrequency and specialty nature of pediatric surgery and anesthesia, these patients will be better served by clinicians trained and prepared to care for pediatric patients.