SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, October 24, 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 09.26.18	*Hirsch*	Action
4. PATIENT CARE SERVICES DASHBOARD QUARTER 3	*Kobe*	Inform
5. SKILLED NURSING REPORT	*M. Evans*	Inform
6. 2018 CONTRACT EVALUATION REPORT	*Jones*	Inform
7. QUALITY AND RESOURCE MANAGEMENT REPORT	*Jones*	Inform
8. PARTNERSHIP HEALTHPLAN OF CALIFORNIA PREMLIMINARY PERFORMANCE SUMMARY	*Jones*	Inform
9. QC CHARTER	*Jones*	Inform/Action
10. POLICIES AND PROCEDURES	*Jones*	Inform/Action
11. CLOSED SESSION: a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Hirsch*	Inform
12. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
13. ADJOURN	*Hirsch*	

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
September 26, 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*	Cathy Webber *Susan Idell*	Michael Brown, MD Ingrid Sheets	Leslie Lovejoy Sabrina Kidd, MD

**Italisized names indicate voting member*

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Meeting called to order at 5:00 pm	
2. PUBLIC COMMENT	*Hirsch*	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 08.22.18		**MOTION:** by Eisenstark to approve, 2nd by Mainardi. All in favor.
4. POLICIES AND PROCEDURES	*Lovejoy*	Inform/Action
	Policies: A. Ventilator Associated Pneumonia (VAP) and Nonventilator Pneumonia Prevention IC8610-179- *needs to come back with clarification on mortality data and addition of references.* B. Hiring Process Recruitment and Selection HR8610-325 C. References HR8610-196 D. *Retired*: Requisition for Employee HR8610-101 E. Scribes in the Emergency Department 7010-21 F. Scheduling Per Diem Policy 8560-01 G. Medical Imaging Dept Policies per TOC	**MOTION:** by Eisenstark to approve policies B – H 2nd by Idell. All in favor

AGENDA ITEM	DISCUSSION	ACTION
	H. *Retired* – Ventilator Associated Pneumonia (VAP) Prevention 6010-17	
5. QUALITY COMMITTEE CHARTER	*Hirsch*	Inform/Action
	Discussion regarding proposed revisions. These revisions included alignment with Medical Staff ByLaws, membership, voting members and attendance, how often the charter should be reviewed and the alignment with the language from the 2014 revision that was never approved. The 2014 version will be emailed out for committee review. Stated revisions will come back for review at the next meeting.	
8. REPORT OF CLOSED SESSION	Adjourn to closed session at 5:52 pm	Action
	Medical Staff credentialing report reviewed and approved.	**MOTION:** by Hohorst to approve, 2nd by Eisenstark. All in favor.
9. ADJOURN	*Hirsch*	
	Meeting adjourned at 6:00 pm	

Patient Care Services Dashboard 2018

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

Medication Scanning Rate	2017-18				
	Q4	Q1	Q2	Q3	Goal
SNF	89.0%	89.0%	87.0%	85.0%	≥80%
Acute	87.0%	87.0%	83.0%	85.0%	≥90%
ED	82.0%	87.0%	84.0%	78.0%	≥90%

Falls (Per 1000 days)	2017-18 Rolling Quarterly Average				
	Q1-Q4	Q2-Q1	Q3-Q2	Q4-Q3	50th %tile
SNF	1.0	1.40	1.20	1.90	6.22
Acute	2.1	2.30	2.80	2.90	3.75

Hospital Acquired Pressure Ulcer Incidents (Per 1000 admissions)	2017-18				
	Q4	Q1	Q2	Q3	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				
	Q4	Q1	Q2	Q3	Goal
SNF (n=18)	1	1	2	3	≤1
Acute (n=65)	6	3	5	2	≤6
Healing at Home (n=11)	2	2	1	8	≤1
Total Nursing Turnover	9	6	8	13	≤8

Patient Experience (CAHPS)	2017-18				
	Q3	Q4	Q1	Q2	Goal
HCAHPS					
RN Communication	87.5	87.8	78.9	75.2	80.0
Responsiveness of Staff	72.9	77.5	71.4	50.8	67.7
OASCAHPS					
Care of Patients (MD/RN respect)			97	94.6	97.1
Would Recommend			85.4	77.6	88.6
RATE MY HOSPITAL - ED					
Overall score	4.5	4.6	4.7	4.7	≥4.5

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

2017-2018 Skilled Nursing Facility Annual Quality Review

Introduction: The Skilled Nursing Facility, (SNF) is a 27 – bed, Distinct Part, (DP) SNF located within the hospital grounds. The goal of the SNF is to provide post-acute care so that our patients may be restored to their prior level of function. Our Key Health care services are; Physical Therapy, Occupational Therapy, Speech Therapy, post – operative care, post stroke and cardiac surgery care, frequent antibiotic infusions, and wound care.

As of October 1, 2018, the SNF Task Force in conjunction with the Board of Directors has recommended a 3-month pilot project to increase revenue and decrease staffing expenses. Specifically, the unit will 1.) Decrease its capacity to 15 patients. 2.) Monitor RUGS (Resource Utilization Group) scores and associated reimbursement. 3.) Redefine admission criteria. 4.) Monitor the effect of the decreased SNF capacity on the acute units and DRGs. 5). Monitor the impact of the reduced nurse to patient staffing ratios on quality metrics.

The Skilled Nursing Facility assists the hospital to meet its financial goals by providing post-acute care in the SNF when the DRG, (Diagnosis-related group) is met in the acute hospital but, the patient is not yet able to return to their prior living situation. In addition to providing rehabilitation and skilled nursing care, the SNF Case Management and Nursing Team(s) arrange for care after discharge. Physician's appointments are made, medication teaching is given, and Homecare and all other appropriate referrals are made in an attempt to prevent readmissions back to the acute hospital.

Stakeholders: Primary stakeholders are patients, physicians, our workforce and the community.

Regulatory Requirements: Sonoma Valley Hospital's D/P SNF is regulated by the California Department of Public Health Licensing Division, Life Safety Code Division, Office of Statewide Hospital Planning and Development (OSHPD), Title 22 California Code of Regulations, and the Centers for Medicare and Medicaid Services, (CMS).

Key Sources of Competitive and Comparative Data: Key sources of competitive and comparative data from within the post-acute care profession come from; the CA Department of Public Health annual Licensing recertification surveys, CMS certification surveys every two years, CASPER reports, (Certification and Survey Provider Enhanced Reports), Medicare's 5- Star rating system, Medicare.gov website, and the American Health Care Association's (AHCA) Long Term Care Trend Tracker. Data from outside the long-term care profession would include our own Quality/ Performance Improvement initiatives, Post Discharge Patient Satisfaction surveys, daily patient rounding, and employee satisfaction and retention data.

Department Mission: To restore, maintain or improve the health and *function* of our patients so that they may return to the community.
Leadership Team: Medical Director, SNF Administrator, Director of Nursing
Workforce Profile: 15 Registered Nurses, 15 Certified Nursing Assistants, 1 Activities Director, 1.5 Unit Secretaries, 1 Intake Coordinator. The SNF also is supported by the Medical staff, Rehabilitation Services, Nutritional Services, Laboratory, Medical Imaging Department(s) and Environmental Services.
Quality Metrics: Key Elements of our Performance Improvement system include Quality Monitoring for high risk – high volume, high risk – low volume, and problem – prone patients. Our plans are based on regulatory guidelines, industry standards and Best Practices and revised quarterly based on results.

Performance Goal	Objective	Metric	Actual Results	CA & National Results
Service Excellence	Highly Satisfied Patients 90% or > satisfied	Per Discharge Call Back Questionnaire, "Did you get help as soon as you needed it"	2017 = 94% of our patients were satisfied with prompt response to call lights when asked about their experience.	Goal Met
People	High Employee Satisfaction/ Engagement 80th % or >	Per Press Ganey Staff Satisfaction / Engagement survey	2016 = 4.44/5.0 2017 = 4.32/5.0 2018 = 4.41/5.0	Action Planning Readiness 96% ile 96% ile 98% ile
Finance	Volume > Expenses 0% variance from budget Revenue 0 % variance From budget	Per Monthly Financials	Volume (Pt Days) FY 18 = 6,361 FY 17 = 6,553 FY 16 =7312 FY 15= 7350 FY 14 =7565 FY 13 = 7624 FY 12 =7470	FY 18 Gross = Revenue = $13,408,434 on a budget of $13,076,397 (+$332,037 over budget). (FY 17 Gross Revenue = $12,733,584) FY 18 Expenses = $2, 879,607 on a budget of $2,590,415 (-$289, 192) over budget (FY 17 Expenses = $2,642,634) FY 18 Contribution Margin = +$42,845
Quality	Reduce Falls	Midas Risk Report and CASPER Reports, (Certification and Survey Provider Enhanced Reports)	2018 = 0.151/1000 patient days. 2017= 0.181/1000 patient days, (3rd Quarter Data)	CA Average = 1.7% Nation. Average =3.3% (goal met)
	Remain a Restraint – free unit	CASPER Reports	0 % Restraint rate x6 years	CA Average = 0.5% Nation. Average = 0.3% (goal met)
	Excellent survey results	Per CMS/ CDPH Federal and Recertification Surveys	2017= 8 deficiencies 5 out of 8 involved environmental services and the dietary dept. 1) apparent rodent nest under sink, 2) microwave in activity room w/ dried food particles, no recent Orkin inspection.3) No nutritional analysis for disaster menu and disaster menu was not approved by a dietitian. 4)	CA Average = 10.9 Nation. Average = 6.9

			Open food in kitchen not dated, expired food in disaster closet, 5) No air gap in kitchen. The other three deficiencies involved inconsistent documentation of the pain scale before and after medication administration for pain, lack of date on suction equipment and lack of nutritional documentation for a Hospice patient who experienced weight loss.	
IMPACT ACT Goals (Improving Medicare Post – Acute Care Transformation Act) (2015-2018)	Reduce newly received psychotropic medications	CASPER Reports	2017 = 2.2% 2018 = 3.3% (Through 7/31/18)	CA av. = 1.5% Nat. av. = 2.0% Goal unmet)
	% patients given flu vaccine	CASPER Reports	2017 = 91.5%	CA av = 85.1% Nation. av. 81.0%
	% patients given pneumococcal vaccine	CASPER Reports	2017 = 90.4%	CA = 83.8% Nat. av. = 81.7%
	Increase Staff Stability	SVH Human Resource Dept.	2017 SNF Staff Turnover =18.2% (and 21.9% hospital wide in Nursing Services).2016 SNF Staff Turnover = 11.8%.	Goal < 10%
FY 19 VBP score:	The Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) is used in the SNF VBP Program. The SNFRM estimates the risk-standardized rate of unplanned readmissions within 30 days.	CASPER Reports	=100%, Rank 1 = 1% increase in Medicare Part A payments effective Oct. 1, 2018. (Based on readmission rates from January 1, 2017, through December 31, 2017, and the baseline period, January 1, 2015, through December 31, 2015).	National Average is 19%
Summary of Quality Metrics Met	To provide high quality of quality care with excellent clinical outcomes for our patients	. CASPER Reports	Pressure ulcers, falls, restraints, UTI's, use of catheters, use of anti-anxiety meds, reduced symptoms of depression, incontinence, readmission rates, complaints/citations, staffing ratios, flu and pneumovac administration.	
Summary of Quality Metrics Unmet		CASPER Reports	Antipsychotic medication use, # of patients reporting moderate to severe pain, ability to move independently worsened, excessive weight loss > 5%.	

Strategic Challenges and Advantages: The SNF at Sonoma Valley Hospital has all of the services of the acute care hospital available to its patients. There is 24/7 physician coverage and on-site and medical imaging, laboratory and ER services. The unit's small size, frequent physician visits, and skilled nurses are attractive to our patients. However, due to challenges with recruiting and retaining therapy staff, and the high cost of nursing staff, the unit has been threatened with closure. The unit is currently involved in a pilot program recommended by the SNF Task Force to increase the unit's profitability.

Conclusion: In summary, The Sonoma Valley Hospital DP/ SNF continues to receive excellent survey results and high ratings for post-acute care. The community supports the SNF, and our patients enjoy frequent physician visits and an all RN staff. The patients in our SNF are typically "sicker" than in a community based SNF due to our proximity to the acute care hospital and shorter lengths of stay. Due to the increased cost of staffing, decreased RUGS reimbursement, and high turnover of therapy staff, it has become necessary to implement strategic measures to increase profitability to remain viable. The SNF Task Force will monitor the effect of the decreased nurse to patient ratios and increased therapy minutes on the unit's revenue and expenses. We will closely monitor the impact of these tactics on quality outcomes.

October 16, 2018

To: Board Quality Committee & MEC
RE: Annual Report of Patient Care Contract Administration and Evaluation
FROM: Laura Gallmeyer, Quality Coordinator & Danielle Jones Director of Quality and Risk Management

Background:

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

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

The purpose of having quarterly reviews is to ensure that contract entities are providing the same level of high-quality care, treatment and service as that provided directly by the organization and that such care, treatment and service is provided in a safe and effective manner.

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

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

Annual Report:

The Quality Coordinator manages a contract database of 133 patient care contracts. Management of patient care contracts ensures consistency regarding the organization's oversight of the care, treatment, and services provided through contractual arrangements as well as ensure that contracts are authorized at the appropriate administrative level and executed in a consistent fashion throughout the organization.

Results of Patient Care Contract Evaluation:

- Most (97%) patient care contracts met their individual performance metrics and the required regulatory standards. Those that did not meet all performance indicators required action plans and closer monitoring during the course of the year.

The following patient care contracts were added in 2018:

1. ADVANCED MEDICAL PERSONNEL, Staffing for Healthcare Professionals
2. ALEXANDRIDIS, ALEXIS, MD, Wound Care Medical Director and Staffing
3. ANESTHESIOLOGY CONSULTANTS OF MARIN, Coverage Services and Medical Director
4. BROADWAY VILLA – TRANSFER, TRANSFER AGREEMENT
5. CALIFORNIA ADVANCED IMAGING MEDICAL ASSOCIATES, INC., DIAGNOSTIC RADIOLOGY SERVICES
6. CALIFORNIA PACIFIC MEDICAL CENTER - STROKE TELEMEDICINE STROKE TELEMEDICINE
7. GERSTMAN, PHYLLIS, RHIA, CCS MEDICAL RECORDS CODER
8. GRAND CANYON UNIVERSITY, NURSING AND HEALTH CARE PROFRESSIONS PRECEPTORSHIP
9. MANUEL-ARGUELLES, DAISY MD- 1206B CLINIC PROFESSIONAL SERVICES - 1206B CLINIC
10. MEDEFIS, STAFFING AGENCY
11. MISHRA, SABHASH MD- 1206B CLINIC, PROFESSIONAL SERVICES - 1206B CLINIC
12. PACIFIC UNION COLLEGE, NURSING STUDENT AGREEMENT
13. PERRYMAN, SCOTT CORP - GEN SURG CALL, GENERAL SURGERY CALL
14. SANTA BARBARA CITY COLLEGE MEDICAL RECORDS CODING PRECEPTORSHIP
15. SCHAFER, JOHN MD - 1206B CLINIC, PROFESSIONAL SERVICES - 1206B CLINIC
16. SONOMA VALLEY EMERGENCY PHYSICIANS MEDICAL GROUP, INC., AGREEMENT TO PROVIDE PHYSICIAN SERVICES TO THE EMERGENCY DEPARTMENT
17. SPECIALISTS ON CALL (SOC), TELEMED FOR EMERGENCY NEUROLOGY AND PSYCHIATRY
18. STEADY, STEPHEN, MD COVERAGE SERVICE FOR GASTROENTEROLOGY
19. UC DAVIS – TELEMEDICINE, PROVIDE IN-PATIENT AND OUT-PATIENT INFECTIOUS DISEASE CONSULTATION THROUGH THE USE OF TELEMEDICINE
20. VERDUCCI, DENNIS MD - SNF MED DIR AND COVERED SERVICES MEDICAL DIRECTOR & COVERAGE
21. WESTWAYS STAFFING NURSING STAFFING AGENCY
22. WHOLE HEALTH WEIGHT LOSS INST. - GEN SURG CALL - PERRYMAN & LEE, GENERAL SUGERY CALL - PERRYMAN & LEE

Beginning this year, we will keep data of closed and/or terminated contracts and for what reason as part of our continuous performance improvement activities.

The following patient care contracts have been terminated in 2018:

Agreement	Reason
CALIFORNIA STATE UNIVERSITY, CHICO	No students, elected not to renew at end date
PRIMA MEDICAL FOUNDATION - CALL PERRYMAN - GEN SURG	Agreement directly with Physician replaced this one
SAWYER, RUSSELL, MD / WOUND CARE STAFFING	Dr. Alexandridis took over as Wound Care Director
PRIMA MEDICAL FOUNDATION - CALL LEE - GEN SURG	Agreement directly with Physician replaced this one
GOLDEN GATE DIETETIC INTERNSHIP	No students, terminated due to no students
MARYWOOD UNIVERSITY	No students, terminated due to no students
DENIGRIS, STEPHEN, MD - GASTRO CALL	Physician retired at time of contract expiration
UNIVERSITY OF OREGON	No students, elected not to renew at end date
OPTIMINSIGHT / EXECUTIVE HEALTH RESOURCES	No longer effective in helping us with Denials. We weren't having medical necessity documentation issues since it was made a quality indicator for the Hospitalists and so we were really paying them for very little value.
SUMMIT PAIN ALLIANCE	Study completed
CDAPP SWEET SUCCESS	Closure of OB unit
LIBERTY UNIVERSITY INC	No students, terminated due to no students
SANTA ROSA FAMILY MEDICINE RESIDENCY	No students, terminated due to no students
SONOMA STATE UNIVERSITY - HEALTH NAVIGATOR	No students, terminated due to no students
SONOMA DEVELOPMENTAL CENTER - TRANSFER	Facility is closing
UCSF, PERINATAL/NEONATAL TRAINING	Closure of OB unit

Improvements for 2019:

1. Create standardize performance metrics to be based on outcomes, safety, efficacy and process
2. Provide contract evaluation education to SVH leadership
3. Collect quarterly reviews in accordance with the quarterly QAPI data collection to incorporate contract data directly into the QAPI program
4. Notify the contract service of the defined expectations in writing

Name of Contract Service Provider: _____

Date of Review: _____ Name/Title of Reviewer: _____

Nature of Service(s) Provided (Description): _____ _____

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.		
2. Abides by applicable standards of accrediting or certifying agencies to which the organization itself must adhere.		
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.		
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.		
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, and timely manner emphasizing the need – as applicable to the scope and nature of the contract service – to improve health outcomes and the prevent and reduce medical		

Performance Metrics

METRIC	____ QTR	____ QTR	___ QTR	___ QTR	Cumulative Total

Evaluation and Data will be submitted to the _____ committee on a _____basis (timeframe):_____

Analysis:

Actions Taken:

Follow-up:

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To: Sonoma Valley Healthcare District Board Quality Committee
From: Danielle Jones
Date: 10/18/18
Subject: Quality and Resource Management Report

October Priorities:

1. SVH Scores High at HSAG HIIN Regional Western Conference
2. Patient Experience

SVH Scores High at HSAG HIIN Regional Western Conference

Health Services Advisory Group (HGAS) is an independent consultant under contract with CMS. Their focus is to improve quality of healthcare services for best possible patient outcomes. They collaborate with the Health Improvement Innovation Network (HIIN) which is a nationwide network of close to 1600 hospitals in 16 districts. Sonoma Valley Hospital was recognized as one of only 14 HIIN hospitals who are performing in the best quartile of performance on three or more HIIN topic areas. Recently, Kathy Mathews, RN, Infection Control and Chris Kutza, Director of SVH Pharmacy, presented at the western regional HIIN Conference. They each shared our reduction strategies for improvement in the areas of Hospital Acquired Infection (HAI) and Adverse Drug Event (ADE). SVH ranks in the top quartile of all hospitals nationwide. We attribute this recognition and strong results to our strong culture of safety. SVH received high marks at the regional gathering and was recognized alongside Kaiser Walnut Creek and Kaiser Redwood City.

Patient Experience

Kathy Mathews has taken on the role of Patient Experience Manger and will be responsible for oversight of the patient relations program which includes management of patient/customer grievance, concerns and complaint process. We have recently partnered with Press Ganey to conduct our HCAHPS survey process and provide support in understanding and improving the entire patient experience. We are currently researching best practices for improving response rates and plan to move from the phone survey methodology to the CMS gold standard of mail methodology beginning January 1, 2019. For HCAHPS results to be publicly reported on Hospital

Compare, hospitals only need 25 completed surveys in the 12-month reporting period**.** In order to get HCAHPS Star Ratings on Hospital Compare, they have to have at least 100 completed surveys. Any hospital that does not receive 300 returns over a 12-month period, as this is CMS's target, will see a footnote applied to their top box scores on Hospital Compare. In terms of reimbursement, CMS requires a minimum of 100 completed surveys to be included in the Value Based Purchasing calculation. Next steps are to present Press Ganey and Patient Experience to Leadership at the next leadership meeting in November and then roll out to front line staff through orientation and partnering with department directors for improved patient and staff education about the importance of the survey prior to discharge.

Partnership HealthPlan of California

FY 2017/18 Hospital Quality Improvement Program: PRELIMINARY Performance Summary

Hospital PHCID #	Hospital Name:
3283	**Sonoma Valley Hospital**

Measure	Target	Actual Result	Points Earned	Points Possible
Readmissions				
All Cause 30 Day Readmission Rate	Full pts: (≤ 13.0 %) Half pts: (13.1 % - 16.0 %)	7.3%	40	40
Palliative Care Capacity				
Option 1: Dedicated Inpatient Palliative Care Team *or* Option 2: Inpatient Palliative Care Capacity	Met? Yes or No	Yes	20	20
Clinical Quality: OB/Newborn				
Rate of Early Elective Delivery	Full pts: (≤ 1.5 %) Half pts: (1.5 % - 3.0 %)	N/A	0	0
NTSV C Section Rate	Full pts: (< 23.9 %) Half pts: (3.0 % - 5.0 %)	N/A	0	0
Exclusive Breast Milk Feeding	Full pts: (≥ 70.0 %) Half pts: (65.0 % - < 70.0 %)	N/A	0	0
CMQCC Participation	Existing Hospitals: 12 months for full points, 6 months for partial New Hospitals: 6 months for full points	N/A	0	0
CPQCC Participation	Joined? Yes or No	N/A	0	0
Patient Safety				
VTE-6: Hospital Acquired Potentially-Preventable Venous Thromboembolism	Full points: ≤ 5.0 %	N/A	0	0
CHPSO Patient Safety Organization Participation	Met? Yes or No	Yes	20	20
Operations and Efficiency				
QI Capacity	Met? Yes or No	Yes	20	20
Total Points			**100**	**100**
QIP Score				100%

SUBJECT: Quality Committee Charter	
	PAGE 1 of 5
	EFFECTIVE: 12/1/11
APPROVED BY: Board of Directors (12/1/11)	REVISED: 8/27/14

Purpose:
Consistent with the Mission of the District the Board, with the assistance of its Quality Committee (QC), serves as the steward for overall quality improvement for the District. The QC shall constitute a committee of the District Board of Directors. The Board shall refer all matters brought to it by any party regarding the quality of patient care, patient safety, and patient satisfaction to the QC for review, assessment, and recommended Board action. The QC makes recommendations and reports to the Board. It has no authority to make decisions or take actions on behalf of the District unless the Board specifically delegates such authority.
The QC shall assist the Board in its responsibility to ensure that the Hospital provides high-quality patient care, patient safety, and patient satisfaction. To this end the QC shall:

1. Formulate policy to convey Board expectations and directives for Board action;
2. Make recommendations to the Board among alternative courses of action, including but not limited to physician credentialing, and oversight activities;
3. Provide oversight, monitoring and assessment of key organizational processes, outcomes, and external reports.

Policy:
SCOPE AND APPLICABILITY
This is a SVHCD Board Policy and it specifically applies to the Board, the Quality Committee, the Finance, Committee, the Medical Staff, and the CEO of SVH.

RESPONSIBILITY

Physician Credentialing

1. The QC shall ensure that recommendations from the Medical Executive Committee and Medical Staff are in accordance with the standards and requirements of the Medical Staff Bylaws, Rules, and Regulations with regard to: completed applications for initial medical staff and allied health staff appointment; initial staff category assignment, initial department/divisional affiliation; membership prerogatives and initial clinical privileges; completed applications for reappointment of medical staff, staff category; clinical privileges; establishment of categories of allied health professionals permitted to practice at the hospital; the appointment and reappointment of allied health professionals; and privileges granted to allied health professionals.

2. The QC shall, in closed session, on a case by case basis, fully, rigorously, and carefully review the recommendations of the Medical Staff regarding the appointment, reappointment, and privilege delineation of physicians and submit recommendations to the Board for review and action.

Develop Policies

1. The QC shall submit recommendations for action to the Board on draft policies developed by the QC and those developed by the Hospital regarding quality patient care, patient safety, and patient satisfaction.

SUBJECT: Quality Committee Charter	
	PAGE 2 of 5
	EFFECTIVE: 12/1/11
APPROVED BY: Board of Directors (12/1/11)	REVISED: 8/27/14

Oversight

Annual Quality Improvement Plan

1. The QC shall review and analyze findings and recommendations from the CEO resulting from the Hospital's prior year Annual Quality Improvement Plan, including but not limited to a comparison of the plan to actual accomplishments, administrative review, and evaluation activities conducted, findings and actions taken, system or process failures and actions taken to improve safety, both proactively and in response to actual occurrences.

2. The QC shall review the Hospital's Annual Quality Improvement Plan for continuously improving quality, patient safety, and patient satisfaction and submit the analysis with recommendations establishing priorities to the Board for discussion and action. The Hospital's plans should include, but not be limited to, assessing the effectiveness and results of the quality review using metrics and benchmarks, utilization review, performance improvement, implementing and improving electronic medical/health records, professional education, risk management programs, and patient care related activities and policies of the Hospital and/or Medical Staff, as applicable.

Medical Staff Bylaws

1. The QC shall review the Medical Staff's fulfillment of its responsibilities in accordance with the Medical Staff Bylaws, applicable law and regulation, and accreditation standards and make recommendations to the Board.

Quantitative Quality Measures

1. The QC shall assess and recommend quantitative measures to be used by our Board in assessing the quality of the Medical Staff's and Hospital's services and submit them to the Board for deliberation and action. The recommendations shall include descriptions that show how the organization measures and reports the improvement of patient care, as well as management accountability.

2. The QC shall review all reports by and Hospital responses to accreditation organizations, e.g., Fire Marshals, Environmental Health, State Department of Health Services (DHS), and other external organizations conducting management, programmatic, physical plant audits/assessments/reviews that are directly or indirectly related to the quality of health care delivery in the Hospital (quality patient care, patient safety, and patient satisfaction). Track all uncompleted/open items until remedied/closed by the Hospital, and make recommendations and report to the Board for its action as appropriate. This includes the final OSHPD report on a construction project prior to licensing by DHS, but it does not include on-going OSHPD reviews/inspections/reports while a project is in design or construction. This does not include routine financial audits, unless the audit identifies quality patient care, patient safety, and/or patient satisfaction issues, in which case the

Audit Committee shall refer the audit to the QC for its review and recommendations to the Board.

Commented [DJ1]: This is not currently happening and we discussed removing it in our last review.

3. The QC shall ensure there is an effective, supportive, and confidential process for anyone (the Medical Staff, other health care professionals; Hospital administration; leaders and staff; patients, and their families and friends; and the public) to bring issues to the QC directly or via the Hospital—as a group, personally or anonymously--in order to promote the reporting of quality and patient safety problems and medical errors, and to protect those who ask questions and report problems.

4. The QC shall review and assess the process for identifying, reporting, and analyzing "adverse patient events" and medical errors. The QC shall develop a process for the QC to address these quality deficiencies, in the most transparent manner possible, without unnecessarily increasing the District's liability exposure.

5. The QC shall review the assessment of patient needs/satisfaction, and submit this assessment with recommendations to the Board for review and possible action. This may include, but is not limited to CMS Value Based Purchasing information; patient satisfaction surveys; reports and comparisons to other hospitals, state and national standards; and patient and/or family compliments and complaints.

6. The QC in collaboration with and after consultation with the Director of Human Resources, reviews systems that could adversely affect quality of care.

Hospital Policies

1. The QC shall assure that the Hospital's administrative policies and procedures, including the policies and procedures relative to quality, patient safety and patient satisfaction, are reviewed and approved by the appropriate Hospital leaders, submitted to the Board for action, and are consistent with the District and Hospital Mission, Vision and Values, Board policy, accreditation standards, and prevailing standards of care and evidence-based practices.

Other

1. Perform other duties related to high-quality patient care, patient safety, and patient satisfaction as assigned by the Board.

Annual QC Work Plan

The QC shall develop an Annual QC Work Plan comprised of the required annual activities and additional activities selected by the QC. The Annual QC Work Plan shall be reviewed and acted on by the Board after considering the Hospital's work plan to support the QC.

Required Annual Calendar Activities:

1. The QC shall review the adequacy of financial and human resources currently allocated for maintaining high-quality care, patient safety, and patient satisfaction in April, in advance of the annual budget process and provide an assessment to the Board and CEO with

recommendations for action.

2. The QC Work Plan shall be submitted to the Board for its review and action no later than December.

3. The QC shall report on the status of its prior year's work plan accomplishments by December.

4. The QC reviews and assesses all Board policies regarding quality specifically including the QC Charter, and makes recommendations to the Board for action in December.

QC Membership and Staff

The QC shall have seven voting members (including three members of the public) and up to four non-voting public member alternates. All public members are appointed pursuant to Board policy and pursuant to Health and Safety Code Section 32155.

1. The seven voting members of the QC are as follows:

   - Two Board members, one of whom shall be the QC chair, the other the vice-chair. Substitutions for one or both Board members may be made by the Board chair for any QC meeting.

   - One designated position from the Medical Staff leadership, i.e., the Chief or the Vice Chief. Substitutions may be made by the President for one Medical Staff member for any QC meeting.

   - Three members of the public. Substitutions may be made by the QC Chair from the prioritized non-voting public member alternates for any QC meeting. These substitutes shall attend closed session QC meetings and vote as QC members.

2. The non-voting public member alternates may attend QC meetings and fully participate in the open meeting discussions. They may also attend closed sessions; when substituting for a voting public member, they shall vote as QC members.

3. Members of the public must be stakeholders of the District. Stakeholders have been defined by the District Board for the purposes of committee membership as:

- Living some or all of the time in the District, OR
- Maintaining a place of Business in the District, OR
- Being an accredited member of the Hospital's staff

4. Staff to the QC include the Hospital's Chief Medical Officer (CMO), Chief Nursing Officer (CNO), and the Director of Quality and Resource Management who shall be the lead staff in support of the QC Chair for meetings, documents, and activities. These individuals who staff the QC are not voting members. Staff is expected to attend the QC meetings. The CEO may attend all QC and subcommittee meetings and shall be a resource at the QC meetings upon request of the QC Chair.

Frequency of QC Meetings
The QC shall meet monthly, unless there is a need for additional meetings.

Public Participation
All QC meetings shall be announced and conducted pursuant to the Brown Act. Physician Credentialing and Privileges are discussed and action is taken in QC Closed Session without the general public.

The general public, patients and their families and friends, Medical Staff, and Hospital staff are always welcome to attend and provide input. Other Board members may attend but may not comment as it may be a Brown Act violation.

Narrowly focused and short term ad hoc subcommittees may meet to address specific issues that will be brought to the QC for review and referral to the Board for its deliberation and action. Subcommittee meetings are not subject to the Brown Act.

Reference:

POLICY HISTORY
December 1, 2011--Board Policy regarding the QC was first adopted.

FREQUENCY OF REVIEW/REVISION
This shall occur every two years or more often if required. If revisions are needed they will be taken to the Board for action.

Policy and Procedures – Summary of Changes
Board Quality Committee, October 24nd, 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:

Employment Conditions HR8610-102

Added an EEO statement, detailed the new conditions for bridging of service for seniority and benefits purposes, revised section on employment of relatives (replacing separate policy), clarified key dates, and removed language regarding Hiring Process as that has been combined into newly revised policy #HR8610-325. Hospital's decision is to expand the period of separation for consideration of reinstatement, while re-defining reinstatement to refer only to bridging of years of service and benefits eligibility. Needed clearer language in regards to hiring of relatives and updated definitions of key dates to reflect reinstatement conditions.

Leaves - Bereavement HR8610-172F

Updated language and organization of topics for clearer understanding. Expanded on the definition of "immediate family member."

Leaves - Child-related School Activity & Child Care HR8610-172H

Updated language for clarity; removed reference to time off specifically for suspension from school (falls within the parameters of the need for time off and does not need special consideration); added language to define "parent" as well as "child-related school activity."

Leaves - Medical & Family Care (FMLA & CFRA) HR8610-172A

Significant update to provide better organization and clarity to the rules and required process, while ensuring the policy is compliant with current law. Additionally, changed the amount of leave provided under this policy to match the amount of leave required under FMLA and CFRA law (changed from 16 weeks to 12 weeks of leave time). Also, removed reference to leaves granted for military-related purposes and will instead add to separate policy. As a small hospital, having employee's off work for a prolonged period of time causes a direct amount of hardship to other employees as well as finances associated with providing necessary coverage. Therefore, it is unreasonable that SVH should provide more leave time than required by law.

Leaves - Pregnancy-Related Disability Leave HR8610-172B
Revised to provide language clarity related to the provisions of this type of leave and clearer process requirements/conditions. Changes were made to ensure consistency with revisions made to HR8610-172A and ensure compliance with current law.

Patient Grievance and Complaint Policy PR8610-158
Minor spelling correction and clarification surrounding responders to clarify the roles for the patient experience in regards to grievances. Organizational oversight has changed.

REVIEWED/NO CHANGES:

Compounding Drug Products MM8610-137
Compounding Policies, Annual Review of MM8610-160
IV Compounding Outside of the Pharmacy MM8610-118
Sterile Compounding MM8610-117

DEPARTMENTAL

REVIEWED/NO CHANGES:

Pharmacy Department

Preparation of Methotrexate IM Doses Using ChemoClave System Procedure 8390-05
QAPI Procedures-IV Room 8390-02
Sterile Compounding Procedures 8390-03