SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, November 28, 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 10.24.18	*Hirsch*	Action
4. PRIME GRANT UPDATE	*Lovejoy*	Inform
5. INFECTION PREVENTION REPORT	*Matthews*	Inform
6. GOOD CATCH REVIEW	*Jones*	Inform
7. BOARD QUALITY CHARTER	*Jones*	Inform/Action
8. POLICIES AND PROCEDURES	*Jones*	Inform/Action
9. CLOSED SESSION: a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Hirsch*	Inform
10. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
11. 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		Danielle Jones, RN Mark Kobe, CNO Sabrina Kidd, MD CMO

**Italisized names indicate voting member*

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Meeting called to order at 5:02 pm	
2. PUBLIC COMMENT	*Hirsch*	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 09.26.18		**MOTION:** by Eisenstark to approve, 2nd by Mainardi. All in favor.
4. PATIENT CARE SERVICES DASHBOARD	*Kobe*	Inform
	Mr. Kobe reviewed the patient care services dashboard and the metrics by quarters.	
5. SKILLED NURSING UNIT ANNUAL REPORT	*Evans*	Inform
	Ms. Evans spoke about the scope of care within the SNF. She also spoke about the three month pilot project, brought about by the SNF Task Force, to increase revenue and decrease staffing expenses. SNF quality metrics were also reviewed.	
6. 2018 CONTRACT EVALUATION REPORT	*Jones*	Inform

AGENDA ITEM	DISCUSSION	ACTION
	Ms. Jones spoke about the review of patient care contracts and their metrics. She also reviewed the improvements for 2019.	
7. QUALITY AND RESOUCE MANAGEMENT REPORT	*Jones*	
	Ms. Jones reviewed the October priorties which were SVH scoring high at HSAG HIIN Regional Western Conference and patient experience.	
8. PARTNERSHIP HEALTHPLAN OF CALIFORNIA PRELIMINARY PERFORMANCE SUMMARY	*Jones*	
	Ms. Jones reviewed our preliminary performance summary. SVH has hit or exceeded all of the points. This resulted in an incentive payment from Partnership Health Plan.	
9. QUALITY COMMITTEE CHARTER	*Jones*	Inform/Action
	Reviewed previous edits and discussed further edits to be made. The following revisions will be made: • Page 2. Removal of "recommendation of the CEO", Removal of reference to Finance committee and last paragraph of Quantitative Quality Measures #2. remove the last two sentences. • Page 3. Remove "April" from the Required Annual Calendar Activities #1. • Page 4. Add #5 "The QC reviews and assesses the Annual Department Reports as annually assigned." QC Membership and Staff #1 bullet two change President to Chief. Bullet 3 change it to four members of the public. Membership will be 4 voting members and 3 non voting members. Last sentence of the page remove the semicolon.	**MOTION**: by Idell to approve with stated changes, 2nd by Eisenstark. All in favor
10. POLICIES AND PROCEDURES	*Jones*	
	<u>Revised:</u> Employment Conditions HR8610-12 Leaves-Bereavement HR8610-172F Leaves-Child-related School Acitivy & Child Care HR8610-172H	**MOTION:** by Eisenstark to approve, 2nd by Idell . All in favor.

AGENDA ITEM	DISCUSSION	ACTION
	Leaves Medical & Family Care (FMLA & CFRA) HR8610-172A Leaves- Pregnancy- Related Disability Leave HR8610-172B Patient Grievance and Complaint Policy PR8610-158 <u>Reviewed No Changes:</u> Compounding Drug Products MM8610-137 Compounding Policies, Annual Review of MM8610-160 IV Compounding Outside of the Pharmacy MM8610-118 Sterile Compounding MM8610-117 **Pharmacy Department** Preparation of Methotrexate IM Doses Using ChemoClave System Procedure 8390-05 QAPI Procedures-IV Room 8390-02 Sterile Compounding Procedures 8390-03	
11. CLOSED SESSION	*Hirsch*	
	Called to order at 6:27 pm	
12. REPORT OF CLOSED SESSION	*Hirsch*	
	6:28 pm	**MOTION:** by Eisenstark to approve, 2nd by Mainardi. All in favor.
13. ADJOURN	*Hirsch*	
	6:29 pm	

Indicator	DY12Final	DY13MY	DY13Final	DY14MY	DY14Final	PRIMEOne Benchmarks 25th %tile	PRIMEOne Benchmarks 90th %tile
2.2.1 – DHCS All-Cause Readmissions (ACR) **Over 21**	**18.67%**	**11.39%**	**11.21%**			*17.45%*	*12.90%*
Num	14	9	12				
Den	75	79	107				
VISIT BASED: final PRIME Population 21 yo or older: minus L&D , cancer, exp, etc							
2.2.2 - NQF 0166: H-CAHPS – Care Transition Metrics: Understanding Your Care When You Left The Hospital	**52.38%**	**53.80%**	**52.64%**			*48%*	*61%*
Num	99	92	94				
Den	189	171	178				
USE HCAHPS VENDOR/Midas HCAHPS process focus results Note We do not currently use Mode adjustment since we utilize only 1 mode for the survey instrument-- cn							
2.2.4 - NQF 0646: Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) ALL AGES	**22.90%**	**53.05%**	**89.42%**			*5%*	*99%*
Num	60	148	245				
Den	262	279	274				
USE Report Track -PRIME Focus report							
2.2.5 - NQF 0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) ***18 Yrs and older***	**0.87%**	**15.29%**	**17.60%**			*5%*	*99%*
Num	2	37	44				
Den	229	242	250				
USE Report Track -PRIME Focus report							
2.2.3 - NQF 0097: Medication Reconciliation – 30 days	**1.40%**	**29.32%**	**23.96%**			*5%*	*99%*
Num	2	39	23				
Den	143	133	96				
USE Report Track -PRIME Focus report (SVCHC population only due to MOU)							

Infection Prevention Report: 3rd Quarter 2018

Indicator	Comparison Rates: 2013-2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Benchmarks/Actions/Comments
Quarterly reporting of National Healthcare Safety Network (NHSN) indicator data is required by CDPH. NHSN provides the predicated number of HAIs based on standardized infection rations (SIRS). ** Indicates public reporting on CDPH website. Green indicates no action indicated, yellow indicates above the predicted number of infections, red indicates action is recommended to reduce infections.						
****CLABSI (NHSN) (CMS Never Event)** *# Central Line Associated Bloodstream Infections (CLABSI)/1000 central line days*	**0 since 2011**	**0** 0/106	**0** 0/131	**0** 0/109		**NHSN predicts 0.51 CLABSIs per year.**
****CDI (NHSN)** *#Inpatient Hospital Acquired infections due to C. difficile per 10,000 patient days*	**2.1 /7.2 /12 15/21.7**	**10** 1/978	**9.9** 1/1006	0 **0/906**		**NHSN predicts 3.51 cases per year (4). Benchmark (MMWR) is 7.4/10,000 patient days.**
****MRSA Bloodstream Infections (NHSN)** *#bloodstream infections due to MRSA per 1000 pt. days*	**1.3 /0 /0 0/ 0**	**0** 0/1018	**0** 0/1069	**0** 0/989		**NHSN predicts 0.13 infections per year.**
****VRE Bloodstream Infections (NHSN)** *#Hospital Acquired bloodstream infections due to VRE per 1000 pt. days*	**0 x 5 yrs**	**0** 0/1018	**0** 0/1069	**0** 0/989		**SVH Benchmark: 1 per 1,000 patient days.**
****Hip: Deep or Organ Space Surgical Site Infections (NHSN)** *# infections/ # Total Hip Cases x 100*	**0 / 1.8% / 0** **1.6% / 0**	**0** 0/12	**0** **0/7**	**0** 0/8		**NHSN predicts 0.26 SSIs per year.**
****Knee: Deep or Organ/Space Surgical Site Infections (NHSN)** *# infections/ # Total Knee Cases x 100*	**0 / 1.7% / 2** **1.4% / 1.3%**	**0** 0/20	**0** **0/13**	**12.5%** 2/16		**NHSN predicts 0.28 SSIs per year. 4 total knee patients had "coded compiications" in < 30 days: 2 met NHSN criteria for Organ/Space Periprostetic SSI (12.5%). In addition, 2 had complications requiring post op IV abx but did not meet NHSN criteria for SSI and were not counted in the report. (25% SSI + complications). An investigation was conducted and findings reported to the Surgery Committee and Quality Management.**
****Overall Surgical Site Infections (SSI)** *Total # SSI/Total # surgeries x 100*	**0.2%/0.7% (12)/** **0.4% (6)/ 0.5% (8)/ 0.4% (8)**	0 0/431	**0.6%** **3/470**	**0.8%** 4/501		**NHSN predicts 1.6 SSIs per year for colon and hysterectomy surgery only, deep or organ space infections, within 30 days. 2 gastric sleeve patients developed Organ Space, Intraabdominal SSI. Note, 2 other GI patients with SSI were detected from 2nd quarter i.e.,Hernia Lap Hernia Repair (Class III) and Lap Choly (Class II. IP report from 2nd quarter was revised to reflect new data.**
Class I SSI rate	**<1% x 5 yrs**	0 0/341	**0.3%** **1/338**	0.5% 2/382		**No NHSN Class I (Clean Wound) rate benchmark**
Class II SSI rate	**< 1.3% x 5 yrs**	0 0/69	**0.8%** **1/120**	1.9% 2/104		**No NHSN Class II (Clean Contaminated) rate benchmark**
Total Joint SSI rate	**0 / 0.8%/1.9%/1.4%/1.4%**	**0 0/32**	**0 0/28**	10% 2/20		**No NHSN All Total Joint SSI rate Benchmark. 0.68%-1.6% expected SSI rate for total knee (CDC 2009)**
Post discharge surveillance surgeon compliance	**57% 2014/ 64% 2015/ 84% 2016/ 96.5% 2017**	99% Jan &Feb	**99%**	84.5%		**2014 Surgery Committee approved SSI reporting by surgeons monthly, to promote accurate SSI rates. Missing 2 surgeon's reports.**

Infection Prevention Report: 3rd Quarter 2018

Indicator	Comparison Rates: 2013-2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Benchmarks/Actions/Comments
Quarterly reporting of National Healthcare Safety Network (NHSN) indicator data is required by CDPH. NHSN provides the predicated number of HAIs based on standardized infection rations (SIRS). ** Indicates public reporting on CDPH website. Green indicates no action indicated, yellow indicates above the predicted number of infections, red indicates action is recommended to reduce infections.						
Hand Hygiene Compliance *Stealth hand hygiene observations: # opportunities/# observed*	**2017 98.7%**	**100%** 6/6	**71%** **5/7**	**100%** 21/21		**>90%**
****Ventilator Associated Event (VAE): Pneumonia** *# Ventilator Associated Pneumonias or events/ # vent days x 1000*	**0 x 4 yrs.**	**0** 0/20	**0** 0/41	**0** 0/25		**NHSN Benchmark: 1.1 per 1,000 ventilator days.**
****Hospital Acquired Pneumonia (HAP)** *# hospital acquired pneumonia/# pt days x 1000 pt days*		**acute 1/1018 .9** **SNF 1.2 2/1706**	**acute 0.9 1/1069** SNF 0 0/1493	**0** 0/989		**Benchmark 1.2 cases per 1,000 pt days. In 2018, rates calculated for acute and SNF separately. HAPPI project implemented with prevention triggers in EMR.**
****Inpatient Hospital Acquired Catheter Associated Urinary Tract Infections (CA-UTI) (CMS Never Event)** *# inpatient CAUTI/# catheter days x 1000*	**0.7 /0 / 1.7 1.4/1.6**	**0** 0/283	**0** 0/28	**0** **0/307**		**NHSN predicts 1.04 CAUTIs per year.**
SNF Hospital Acquired Catheter Associated Urinary Tract Infections (CA-UTI) *# SNF CAUTI/# catheter days x 1000*	**2.6 / 3.3/ 5.7/ 7.6/2.6**	**9.5** 1/105	**0** 0/133	16.9 **3/177**		**No NHSN SIR for SNF. Previous NHSN benchmark was 1.5 per 1000 pt days. In addition to CAUTIs, 6 pts didn't meet NHSN criteria for CAUTI but were treated for UTI.**
SNF Hospital Acquired *C. Difficile* Infections (CDI) *# SNF CDI/# patient days x 10,000*	**20 /11.7 /2/2/ 3.6**	**11.7** 2/1706	**6.7** 1/1493	**11.4** 2/1749		**Benchmark: 7.4 per 10,000 patient days. 2 patients developed CDI post abx therapy 6 days apart in August. The CDI rate 1/18-9/18 is 10.1 per 10,000 pt days.**
SNF Central line associated bloodstream infections (CLABSI) *# Central Line Associated Bloodstream Infections (CLABSI)/central line days x 1000*	**1 / 0/ 0 /0 /2.7**	0 0/93	0 0/101	o 142		**Previous NHSN benchmark: 0.8 per 1,000 central line days.**
Healing at Home Associated Infections *# of infections/Total visits x 1000*	**0.3 / 0.6 / 0/0 0.1**	**0.9 UTI** 0.4 CDI	0.9 UTI not CAUTI	N/A		**SVH Benchmark: 1.5 per 1,000 home care visits**
MRSA Active Surveillance Cultures (nares cultures only) *# positives/total screened x 100*	**14%** **20%/26%/9.2%**	**10%**	3.4%	**7.9%**		**Nares surveillance perofrmed in accordance with California law.**
% ESBL(E. coli;K. pneumoniae, K. oxytoca, P. [illegible)	**2%**	4%	2.9%	3.9%		**ASP monitors antibiogram and updates annually.**
# CRE cases	**0/0/0/1**	0	0	0		**Track and trend**
Legionella Monitoring: water samples and patients with HA pneumonia		0 pts./ 3 cfu/ml water	0 pts/ water cx neg.	NA		**Water management company now in contract with SVH to assist with the water management program. Initial assessment performed.**
Environmental Cleanliness Monitoring		95%	91%	no report		
Total Influenza Vaccination All HCP	80%			no report		CDPH benchmark 90%
Physicians, LIP, Pas	88%					
Employees	78%					
volunteers	86%					
Students	100%					

GOOD CATCH AWARDS

The following employees were recognized for identifying and reporting potential safety issues affecting patient care or employee/visitor safety.

Employee	*Safety Issue Identified*	*Actions Taken to Prevent Harm*
Myra Garcia (Med Surg) RM 18-206	RN found that pt is VRE (vancomycin-resistant enterococci) positive in UA done and now pt placed in isolation room to limit exposure	***Pt moved to Isolation for Infection Control***
Michelle Masciorini (Med-Surg) RM 18-780	*RN noticed that patient had increased confusion. RN took patient's VS, which all were table. RN moved patient's purse and heard something which sounded like pill's. RN looked in patient's purse and discovered that the patient had valium in her purse, which was not there the night prior as same RN did the admission.*	***Pills were sent to the pharmacy (appropriately),*** ***MD aware of incident and patient suffered no adverse effects.***
Savanna Long (SCU) RM 18-909	*Pt admitted to SCU preop for scheduled total hip surgery. Savannah Long, RN, noticed in lab work that patient had low platelet count. She ordered a stat repeat of the test. She also alerted the operating room to not open sterile supplies as low platelets put a patient at high risk for bleeding..*	***RN alerted anesthesia and surgeon that repeat platelet count was still very low. Surgery was cancelled*** ***Savanna advocated for patient safety in alerting MDs early on as well as repeating the lab work for accuracy.***
Dorcas Muhia (Med Surg) RM 18-923	*She discovered a medication safety issue and reported it to Pharmacy. Thank you Dorcas for discovering this error and reporting it promptly. Upon Rph investigation of medication on the patient's e-MAR not showing correctly in the Pyxis, it was confirmed that there was a significant problem with Pyxis. The ordered medication rx 740959 was visible on the eMAR but not on the Pyxis machine.*	**This order apparently got entered right as the server went down for maintenance and did not cross over when it came back up. No harm to patient, no other orders impacted. Pharmacy to educate nursing/physicians**
Cynthia McAleer (Med Surg) RM 18-936	*Cynthia Mcaleer RN notified Rph of clindamycin IV on post-partum eMAR that should have been DC'd after delivery. Rph investigated the Order Set and discovered that the MD view read "until delivery", but the eMAR did not have a stop date or a similar note. Cynthia phoned MD for an order to DC the med via telephone order and she completed this.*	***Outcomes: Pharmacy informatics added a note to "Discontinue after delivery" on the antibiotic orders.***

GOOD CATCH AWARDS

The following employees were recognized for identifying and reporting potential safety issues affecting patient care or employee/visitor safety.

Employee	*Safety Issue Identified*	*Actions Taken to Prevent Harm*
Manjeet Kaur (SNF) RM 18-949	*The pyxis cube opened for Cipro, and Manjeet recognized that Cephalexin was loaded instead* *Incorrect medication was removed from the pocket. Pharmacy was notified to please come remove incorrect med and restock correct med*	**Med Checks complete*, no harm to patient***
Julia Okuba (Med Surg) RM 18-1044	*Pt is on Heparin 7,000iu SQ Q hrs. Pharmacy dispensed 10,000/10mls instead of 10,000iu/1ml. and recommended to give 0.7mls. That is an underdose as that would be 700units only. Wrong strength of heparin supplied to floor by Pharmacy*	***This was discovered by this RN and the Nursing Supervisor was notified and the right strength was obtained and given to the patient***
SCU Team Dr Solomon RM 18-1000	*This patient arrived to pacu for a peg tube placement. Pt coded briefly during this procedure in surgery, has long standing list of comorbitites. Pt's clinical status deteriorated brieftly and noted by Dr Solomon. She became arrhythmic and had poor perfusion, no pulse identified.*	***CPR was performed for almost 1.5min. No defibrillation was necessary. Airway was managed via mask and bag method. She was stabilized and returned to her baseline prior to transfer to ICU for further care.***

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

SUBJECT: Quality Committee Charter

EFFECTIVE: 12/1/11

APPROVED BY: Board of Directors (12/1/11)

REVISED: 10/15/18

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.

Oversight

Annual Quality Improvement Plan

1. The QC shall review and analyze findings and recommendations 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 Finance Committee shall refer the audit to the QC for its review and recommendations to the Board.

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 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.

5. The QC reviews and assesses the Annual Department Reports for: Infection Prevention, Contract Evaluations, Skilled Nursing, QAPI, Risk Management and Pharmacy.

QC Membership and Staff

The QC shall have up to eight voting members. All public members are appointed pursuant to Board policy.

1. The 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 Medical Staff President for one Medical Staff member for any QC meeting.

    - Up to five members of the public.

    - In the event of a tie, the Director of Quality shall cast the deciding vote.

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, November 28th, 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

NEW:

Surge Policy to Manage Patient Influx EP8610-102
The former surge policy was imbedded in the Emergency Operations Plan and new CMS regulation requires it to be a separate policy.

CMS 1135 Waiver for Disaster Conditions EP8610-103
This policy is required to be in compliance with CIHQ Disaster Management regulations.

Delegation of Authority EP8610-104
This policy is required to be in compliance with CIHQ Disaster Management regulations.

REVISIONS:

DVT-PE Prophylaxis and Treatment Protocol MM8610-152
Removed fondaparinux from the protocol and used only heparin and enoxaparin. Fondaparinux will be used after discussing with the physician only for patients who cannot receive alternatives. Clarified frequency of platelet check to be day 2, 7, and 14. Changes were made to simplify the protocol and reduce expenses.

Medication Reconciliation MM8610-144
Changed language from physician to provider. Updated purpose to reflect all departments involved in the medication reconciliation process. Added an inclusive list of role responsibility. Included expectation that a complete home medication list must be obtained by RN for all patients. Defined goal for timeframe re: obtain list of medications to 30 minutes with in decision to admit. Changes were made to define the formal process in which healthcare providers partner with patients and their families to ensure accurate and complete medication information transfer at interfaces of care. This includes admission and discharge from a hospital or changes in care setting, service, or level of care.

SUBJECT: Surge Policy to Manage Patient Influx	POLICY #EP8610-102
	PAGE 1 OF 2
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:

To provide guidelines and identify a process to manage a disaster involving an influx of patients that cannot be managed effectively with routine procedures or resources within the hospital environment.

POLICY:

Sonoma Valley Hospital will provide a guide for prompt mobilization and coordination of personnel and facilities in time of disaster involving an influx of patients that cannot be managed effectively with routine procedures or resources within the hospital. Hospital systems are assumed to be overwhelmed and efforts to coordinate with community agencies will be enacted (EMS, SVFA, MOHAC, local police).

PROCEDURE:

1. Plan initiation:

   Notification- Call received by hospital of anticipated influx of patients via EMS radio and/or notification from Sonoma County Department of Public Health Medical Health Operational Area Coordinator (MHOAC). ED MD on duty will assess anticipated number of patients and severity of illness/injury and determine departments' ability to function or determine if volume is beyond departments' normal capacity to safely care for patients.

2. Activation:

   Disaster Code will be initiated and Incident Command Center established.

3. Stages of Surge :

   a. Stage One: can be handled by ED and appropriate ancillary departments. If majority of patients are urgent or emergent, may elevate to stage two.
   b. Stage Two: additional staffing is anticipated to handle the influx of patients. Department call lists are activated
   c. Stage Three: Influx of patients is greater than expected and overwhelming available resources can safely handle.

4. Alternate Care Sites:

    A. Initiate plan to erect auxiliary tent structure in suitable location (Old ED parking lot, Main entrance parking lot).
    B. Contact Hospitalist and SNFist to discharge or transfer any appropriate patients.
    C. Contact Redcomm and update hospital status and need for potential transportation
    D. Begin contact with facilities SVH has transfer agreements (St. Joes Transfer Center, Sutter transfer Center).
    E. See Emergency Operations Plan for listing of Alternate Care Sites (Attachment A of EOP)

5. Rapidly reduce routine hospital patient activity

    A. Cancel elective procedures and surgeries
    B. Discharge all appropriate patients
    C. Transfer appropriate SNF patients to local Alternate Care Sites
    D. Consider utilization of Home Health agencies
    E. Follow further instruction and guidance from Incident Command Center

REFERENCE:
CIHQ 42 CFR 482.15 Emergency Preparedness Policies and Procedures

OWNER:
Emergency Management Committee

AUTHORS/REVIEWERS:
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Dawn Kuwahara, Chief Ancillary Services Officer
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APPROVALS:
Policy & Procedure Team: 11/20/18
Board Quality Committee:
The Board of Directors:

SUBJECT: 1135 Waivers	POLICY #EP8610-103
	PAGE 1 OF 4
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:

To provide guidelines and identify a process to access and acquire Federal waiver for CMS Conditions of Participation in times of disaster response.

POLICY:

Under Section 319 of the PHS Act, the HHS Secretary may declare a public health emergency if — after consulting with public health officials as necessary — he or she determines that a disease or disorder presents an emergency or an emergency otherwise exists, such in cases of significant infectious disease outbreaks or bioterrorist attacks.

Declaring a public health emergency allows the Secretary to take certain actions in response, and can be necessary to authorize a variety of discretionary response actions under the statutes HHS administers.

When the President declares a major disaster or emergency under the Stafford Act and the HHS Secretary declares a public health emergency under Section 319 of the Public Health Service Act, Section 1135 of the Social Security Act authorizes the Secretary to waive or modify certain federal laws, including:

- Conditions of participation or other certification requirements under Medicare, Medicaid and the Children's Health Program (CHIP)
- Preapproval requirements under Medicare, Medicaid and CHIP
- State licenses for physicians and other health care professionals, for purposes of Medicare, Medicaid and CHIP reimbursement only. The state determines whether a non-federal provider is authorized to provide services in the state without state licensure.
- Emergency Medical Treatment and Labor Act (EMTALA) requirements for redirecting individuals to another location, if the transfer arises out of emergency circumstances. This waiver is effective only if actions under the waiver do not discriminate based on a patient's source of payment or ability to pay.
- Stark self-referral sanctions
- Performance deadlines and timetables
- Limitations on payment for health care items and services furnished to Medicare Advantage enrollees by non-network providers

SUBJECT: 1135 Waivers	POLICY #EP8610-103
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REVISED:	

In addition to this authority, referred to as the 1135 waiver authority, Section 1812(f) of the Social Security Act authorizes the Secretary to provide for skilled-nursing facility coverage in the absence of a qualifying hospital stay, as long as this action does not increase overall program payments and does not alter the facility's "acute care nature" (that is, its orientation toward relatively short-term and intensive care).

Duration of a Section 1135 Waiver

Waivers under Section 1135 of the Social Security Act typically end with the termination of the emergency period or 60 days from the date the waiver or modification is first published, unless the Secretary extends the waiver by notice for additional periods of up to 60 days.

For public health emergencies that do not involve a pandemic disease, EMTALA and Health Insurance Portability and Accountability Act of 1996 requirements are limited to a 72-hour period beginning upon implementation of a hospital disaster protocol. Waiver of EMTALA requirements for emergencies that involve a pandemic disease last until the pandemic-related public health emergency is terminated. The 1135 waiver authority applies only to federal requirements for licensure or conditions of participation, not state.

Implementation of 1135 Waiver Authority

Once an 1135 waiver has been authorized, health care providers can submit requests to operate under that authority to the state survey agency or Centers for Medicare & Medicaid Services (CMS) regional office. These requests generally include a justification for the waiver and expected duration of the modification requested. Providers and suppliers have been asked to keep careful records of beneficiaries to whom they provide services to ensure that proper payment is made. The state survey agency and regional office review the provider's request and make appropriate decisions, usually on a case-by-case basis. Providers are expected to return to compliance with any waived requirements prior to the end of the emergency period.

Federally certified or approved providers must operate under normal rules and regulations, unless they have sought and have been granted modifications for specific requirements under the 1135 waiver authority.

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1135 Waiver Request Format

Though there is no specific form or format required to request a waiver, impacted providers should provide the California Department of Public Health (CDPH) with certain information, including:

- Provider name/type
- Full address (including county/city/town/state)

- CMS Certification Number (Medicare provider number)
- Contact information for follow-up questions, should the regional office need additional clarification
- A brief summary of why the waiver is needed that clearly states the issue's scope and impact. For example: Critical access hospital is sole community provider without reasonable transfer options at this point during the specified emergent event (e.g. flooding, tornado, fires, or flu outbreak). Facility needs a waiver to exceed its bed limit by X number of beds for Y days/weeks (be specific).
- The type of relief or regulatory requirement waiver sought

Providers should send this information to the San Francisco Regional Office at rosfoso@ cms.hhs.gov and copy CDPH. This will ensure the waiver request does not conflict with any state requirements and that all concerns are addressed in a timely fashion.

For more information on the 1135 waiver process, visit the CMS website.

REFERENCE:
CIHQ 42 CFR 482.15 Emergency Preparedness Policies and Procedures

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Policy & Procedure Team: 11/20/18
Board Quality Committee:
The Board of Directors:

SUBJECT: Delegation of Authority	POLICY #EP8610-104
	PAGE 1 OF 4
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:

To provide guidelines to the organization to identify which staff would assume specific roles in another's absence through succession planning, delegations of authority and who is authorized to act in the absence of the administrator or person legally responsible for the operations of the organization.

POLICY:

The emergency preparedness plan addresses the continuity of operations, including delegations of authority and succession plan when indicated.

1. In the event that the Administrator of SVH (Chief Executive Officer, CEO) is unavailable in an emergency situation, authority is delegated to the Chief Nursing Officer (CNO).

2. In the event that the CEO becomes deceased, the Chief Financial Officer (CFO) is delegated authority for the organization. Clinical operations would be delegated to the CNO.

3. In the event the CNO is unavailable or deceased, the Director of Patient Care Services is delegated authority for clinical operations.

REFERENCES:
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