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

SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, March 27, 2019
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 02.27.2019	*Hirsch*	Action
4. STRATEGIC PLAN AND FINANCIAL STABILITY	*Mather*	Inform
5. QUALITY AND RESOURCE MANAGEMENT REPORT	*Jones*	Inform
6. HQI DASHBOARD	*Jones*	Inform
7. POLICIES AND PROCEDURES	*Jones*	Inform/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
February 27, 2019 5:00 PM
MINUTES
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch Carol Snyder Michael Mainardi, MD Ingrid Sheets Susan Idell Howard Eisenstark, MD		Cathy Webber Michael Brown, MD Mark Kobe	Danielle Jones, RN Sabrina Kidd, MD

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS		
	Called to order at 5:00 pm	
2. PUBLIC COMMENT		
3. CONSENT CALENDAR		Action
• QC Minutes, 01.30.19		**MOTION:** by Idell to approve, 2nd by Eisenstark . All in favor.
4. ANNUAL INFECTION PREVENTION REPORT	*Mathews*	
	Ms. Mathews reviewed the annual infection prevention report. This included the 2018 goals, infection rates, as well as the plan for 2019.	
5. PERFORMANCE IMPROVEMENT PROJECTS/FAIR	*Jones*	
	Ms. Jones reviewed the performance improvement projects, also known as 100 day workouts. The goal is to have three 10 project sessions a year. These projects will be presented at the PI Fair to be scheduled in the fall.	

AGENDA ITEM	DISCUSSION	ACTION
6. QUALITY AND RESOURCE MANAGEMENT REPORT	*Jones*	
	Ms. Jones reviewed the quality and resource management report for February. The report included mortality, readmissions, patient experience and effectiveness of care core measures related to sepsis, stroke and colonoscopy surveillance.	
7. 2018 MEDICATION ERROR REPORT	*Jones*	
	Ms. Jones reviewed the 2018 medication error report. She reported that there was 158 total errors with 37 administrative related and 16 potentially preventable. She also spoke to the corrective actions taken in response to the errors. She also reviewed the department specific break down of administration errors.	
9. POLICIES AND PROCEDURES	*Jones*	
	New Contract Administration – Patient Care GL8610-139 Stroke Adminssion Transfer Guidelines PC8610-184 – recommendations by Dr. Eisenstark reviewed and discussed. Third paragraph, keep purpose as is. **Revisions** Abbreviations and Symbols used MR8610-102 Administration of Medications MM8610-106 Formulary Management MM8610-122 Malignant Hyperthermia Management of Patient with MM8610-105 Central Venous Catheter and Port Access and Management PC8610-120 Surgical Invasive Procedure and Site Confirmation Verification OI8610-104 Annual Medical Surveillance HR8610-164.7 Dress Code HR8610-230 Employee Assistance HR8610-355 Employee Health Services HR8610-164 Grievance Policy (Employee) HR8610-186 Harassment HR8610-188 Infectious Disease Work Restrictions Exposures HR8610-164.9	**Motion**: by Idell to approve with stated changes, 2nd by Mainardi with stated changes. All in favor

AGENDA ITEM	DISCUSSION	ACTION
	Overtime HR8610-135 Pay Periods and Pay Checks HR8610-124 Post Offer Pre-Employment Screening HR8610-164.1 Respiratory Protection Program HR8610-164.14 Time and Attendance Records HR8610-122 **Retire** Holiday Premium Pay HR8610-154 **Departmental** Nutrition Dry Storage 8310-173 Refrigerator Freezer Storage 8340-174 Occupational Health Department Manual	
10. CLOSED SESSION	*Hirsch*	
	Called to order at 6:00pm	
11. REPORT OF CLOSED SESSION	*Hirsch*	
	Medical Staff Credentialing reviewed.	**MOTION:** by Mainardi to approve credentialing, 2nd by idell All in favor.
12. ADJOURN	*Hirsch*	

To: Sonoma Valley Healthcare District Board Quality Committee
From: Danielle Jones
Date: 3/27/19
Subject: Quality and Resource Management Report

March Priorities: CIHQ Stroke Ready Certification, CMS 5 Star, 100 Day Workouts

CIHQ Stroke Ready Certification

- Scheduled for April
- Recognizes hospitals that meet standards to support better outcomes for stroke care. To be eligible, SVH has created a variety of practice standards, including:
    - Dedicated stroke-focused program
    - Staffing by qualified medical professionals trained in stroke care
    - A qualified practitioner assesses a suspected stroke patient within 15 minutes of arrival
    - Diagnostic imaging and laboratory testing is done quickly to facilitate the administration of IV thrombolytics in eligible patients
    - Telemedicine is available within 20 minutes of it being deemed necessary
    - Transfer protocols are in place with a Primary Stroke Center or Comprehensive Stroke Center for the continuation of stroke care

CMS 5 Star Hospital

Mortality 22% of CMS 5 Star Rating

- Goal: Reduction of preventable deaths in acute care setting and identification of Palliative Care opportunities
    - Palliative Care-Discussed use of the Surprise Question with Medicine Committee as indicator for Palliative Care consult

Readmission 22% of CMS 5 Star Rating

- Goal: Identify patients who are at high risk of being readmitted be so that further readmissions can be avoided
    - Completed build of Readmission review focus study in Midas to be completed by Case management used concurrently for readmitted patients. Next steps to train case management and create reports that will be used to communicate opportunities at Med Staff meetings.
    - February 2019 All Cause, All Payer Readmission Review-100% of readmissions were related in initial visit, 43% of patients had a known readmission risk, 14% were identified as lack of patient compliance, palliative care issues and substance use disorder.

Patient Experience 22% of CMS 5 Star Rating

- Goal: Continue to focus on Patient Experience to increase satisfaction for inpatients and outpatient surgery through CAHPS measurements
    - Partnering with Case Management to make sure we properly address all grievances as well as compliments, we use the Midas system for documentation and follow up.
    - Established twice a month standing appointments with the Director of Patient Care Services to implement action items for optimization of HCAHPS scores to achieve CMS 5 star status.
    - Identified tactics that high performing hospitals use to improve HCAHPS scores and overall patient experience related to connecting unit-level and organizational HCAHPS results to performance goals

Safety of Care (Hospital Acquired Infections & Harms) of 22% CMS 5 Star Rating

- Goal: Continue to provide safe, timely, and efficient patient centered care while eliminating hospital acquired harm
    - Enhance nurse driven patient care protocols
    - Maintain low overall SSI rate (0.4%)
    - Continue surgeon reported post discharge SSI >90%
    - Maintain zero ventilator associated pneumonias
    - Implement a hospital-associated pneumonia prevention program
    - Maintain zero CLABSI, HA MRSA or HA VRE

100 Day Workouts

- Administrative team presented 25 day progress on Q1 projects that include:
    - Bar Code Mediation Administration in the Emergency Department
    - Marketing and Community Outreach to provide greater clarity in patient directed documents in the Laboratory
    - Emergency Department point of sales collection improvement
    - Medical Imaging pricing structure
    - Employee engagement survey development and implementation
    - Respiratory Therapy supply chain standardization
    - Biomedical contract review
    - Ancillary utilization and reimbursement focus in Emergency Department
    - Access to Medical Imaging improvement
    - Readmission & Mortality reduction
    - Pre-operative EKG

Quality Transparency Dashboard

Hospital Quality Institute

Outcome Measures:	CLABSI (Lower is Better)	Colon SSI (Lower is Better)	NTSV (Lower is Better)	Sepsis Mortality (Lower is Better)	VTE (Lower is Better)
Sonoma Valley Hospital	**Not Available**	**Not Available**	**Not Available**	**10.16**	**Not Available**
California Level	*0.82*	*0.94*	*24.60*	*14.90*	*3.00*
National Level	*1.00*	*1.00*	*26.00*	*25.00*	*3.00*
Measure Period	04/01/2017-03/31/2018	04/01/2017-03/31/2018	01/01/2017-12/31/2017	01/01/2017-12/31/2017	04/01/2017-03/31/2018

Program Status Measures:

☐ Yes ☐ No ☑ Not a maternity hospital	**This hospital has a Maternity Safety Program in place.** A maternity safety program provides a coordinated approach and emergency response to risks associated with pregnancy and childbirth.
☑ Yes ☐ No	**This hospital has a Sepsis Protocol in place.** A sepsis protocol provides guidance for a coordinated approach to identification and treatment of an infection and inflammatory response which is present throughout the body.
☑ Yes ☐ No	**This hospital has a Respiratory Monitoring program in place.** Respiratory monitoring provides guidance for assessment of risk of respiratory depression, and includes continuous monitoring of breathing and functioning of the lungs and circulatory system when indicated.

Outcome Measure Definitions:

CLABSI - Central line-Associated Blood Stream Infection: A serious infection that occurs when germs enter the bloodstream through a central line. A central line is a special intravenous catheter (IV) that allows access to a major vein close to the heart and can stay in place for weeks or months. The value shown above is a Standardized Infection Ratio (SIR), which is the ratio of observed-to-expected infections during the measure period. SIRs below 1.00 indicate that the observed number of infections during the measure period was lower than would be expected under normal conditions, whereas values above 1.00 indicate that the observed number of infections was higher than expected. **Limitations:** In the calculation of the Standardized Infection Ratio (SIR), the CDC adjusts for differences between hospitals. However, patient risk factors are not taken into account. These patient-specific variables (e.g., poor skin integrity, immunosuppression) can increase the risk of developing a central line infection. Hence, the SIR for hospitals that care for more medically complex or immunosuppressed patients may not be adequately adjusted to account for those patient-specific risk factors.

Colon SSI - Colon Surgical Site Infection: An infection (usually bacteria) that occurs after a person has colorectal surgery that occurs at the body site where the surgery took place. While some involve only the skin, others are more serious and can involve tissues under the skin, organs, or implanted material. The value shown above is a Standardized Infection Ratio (SIR), which is the ratio of observed-to-expected infections during the measure period. SIRs below 1.00 indicate that the observed number of infections during the measure period was lower than would be expected under normal conditions, whereas values above 1.00 indicate that the observed number of infections was higher than expected. **Limitations:** Some, but not all patient-specific risk factors are included in the adjustment of the SIR for these types of infections. However, not all relevant risk factors are included (e.g., trauma, emergency procedures). Hence, the SIRs for hospitals performing more complex procedures or with larger volumes of trauma or emergency procedures may not be adequately adjusted to account for those patient-specific risk factors

NTSV - Nulliparous, Term, Singleton, Vertex Cesarean Birth Rate: The percentage of cesarean (surgical) births among first-time mothers who are at least 37 weeks pregnant with one baby in a head down position (not breech or transverse). Lower values indicate that fewer cesareans were performed in the hospital among primarily low risk, first-time mothers. **Limitations:** NTSV rates do not take into account certain obstetric conditions, such as placenta previa, that may make Cesarean delivery the safer route for both mother and infant.

Sepsis Mortality: Percent of patients, with a severe infection, who die in the hospital. Most sepsis cases (over 90%) start outside the hospital. Lower percentage of death indicates better survival. **Limitations:** Use of discharge/administrative data is limiting since such data has lower specificity for diagnoses than clinical data. In addition, without risk adjustment for differences in patient-specific factors, comparing rates among hospitals is difficult.

VTE - Venous thromboembolism: The measure of patients who develop deep vein clots who had not received potentially preventive treatment. **Limitations:** Although not adjusted to account for patient-specific risk factors, this rate is helpful in distinguishing a hospital's adherence to the best practice of administration of appropriate VTE prophylaxis to all appropriate patients.

Hospital Comments:

Release Date: 03/21/2019

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Policy and Procedures – Summary of Changes
Board Quality Committee, March 27th, 2019

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:

Attendance HR8610-211

Significant re-write of this policy adding language to ensure employees would not be subject to discipline/corrective action for the first three days (or 24 hours) of unscheduled absences in a calendar year (per state law); added definition of a scheduled absence, for clarity; added consequences for tardiness and early departures; created a cumulative "point" system correlating to appropriate corrective action; general reorganization to topics to provide improved reference. These revisions provide guidance on how to handle and counsel employees in situations of repetitive tardiness or early departures in addition to unscheduled absences; to ensure compliance with new and/or current federal and state laws.

Hazardous Material Spill Response CE8610-144
Hostage Active Shooter, Code Silver CE8610-147
Infant Pediatric Security Code Pink & Purple CE8610-148

All three of these policies were updated with a consistent overhead emergency paging protocol to provide a universal approach to overhead emergency paging.

REVIEWED/NO CHANGES:

Safety Rounds CE8610-174
Patient Controlled Analgesia (PCA) MM8610-154

DEPARTMENTAL

Medical Records

Release of Information-Patient Requests 8700-161

Revision made to process for request of deceased patient records. Added clarification that an advance care directive or durable healthcare power of attorney is no longer valid after a patient expires and cannot be used as proof of personal representative status. In addition, revision made to policy that clarifies that the next of kin on the death certificate can be used to determine personal representative status only when there is no probate administrator. Also clarifies that if a personal representative has been identified, family members requesting records will need to contact the personal representative to request authorization for record copies.