SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, August 28, 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@sonomavalleyhospital.org 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 07.24.19	*Hirsch*	Action
4. ANNUAL RISK MANGAMENT REPORT	*Jones*	Inform
5. BOARD QUALITY REVIEW	*Jones*	Inform
6. CEO 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*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
July 24, 2019 5:00 PM
MINUTES
Schantz Conference Room

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

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Called to order at 5:00 pm, adjourn 5:03 pm Closed session called to order at 5:03 pm, adjourn at 5:26 pm Open session called to order at 5:26 pm	
2. PUBLIC COMMENT	*Hirsch*	
	None	
3. CONSENT CALENDAR		Action
• QC Minutes, 06.26.19		**MOTION:** by Webber to approve, 2nd by Eisenstark . All in favor.
4. PATIENT CARE SERVICES ANNUAL REPORT	*M. Kobe*	
	Mr. Kobe reviewed the PCS annual report for 2018. In this report he reviewed the Quality dashboard, OASCAHPS & HCAHPS, rate my hospital results, and financial performance. He also reviewed ED and Outpatient Surgery volumes and overall PCS turnover rates.	
5. CNO QUARTERLY PCS DASHBOARD	*M. Kobe*	

AGENDA ITEM	DISCUSSION	ACTION
	Mr. Kobe reviewed the second quarter dashboard. Opportunites for improvement were around falls. He reported that medication scanning has improved to greater than 90%.	
6. GOOD CATCH REPORT	*D. Jones*	
	Ms. Jones reviewed the Good Catch report in the last quarter. Four were around medications, one was around a paper chart.	
7. QUALITY AND RESOURCE MANAGEMENT REPORT	*D. Jones*	
	Ms. Jones spoke about the community engagement program event on Stroke education at Vintage House. This will be repeated due to high intrest. She reviewed the Quality and Risk Management Oversight for 2019 on reporting out of QAPI.	
8. CEO DASHBOARD	*D. Jones*	
	Ms. Jones reviewed the CEO dashboard.	
9. POLICIES AND PROCEDURES	*Jones*	
NEW Patient Safety Program GL8610-202 **REVISIONS:** Adverse Event Reporting GL8610-184 Code Blue-Broselow Carts and Emergency Medications QS8610-104 Code Management for DP SNF **REVIEWED NO CHANGES:** Influenza Vaccination Program for Staff and LIPs IC8610-142 **DEPARTMENTAL** **REVISIONS:** Nutritional Services Diet Orders and Diet Changes 8340-153 Fluid Restriction Allowance 8340-155	Discussion and review of revisions. Ms. Jones reviewed the new Patient Safety Program Policy. This was created to comply with CMS requirements.	**MOTION**: by Eisenstark to approve 2nd by Idell . All in favor.

AGENDA ITEM	DISCUSSION	ACTION
Food Nutrition Disaster Plan 8340-109 Registered Dietitian Nourishment Modifications 8340-173 Responsibilities of the Dietitian 8340-171 Medical Staff Departmental Policies Table of Contents		
10. CLOSED SESSION	*Hirsch*	
	Called to order at 5:03 pm	
11. REPORT OF CLOSED SESSION	*Hirsch*	
	Medical Staff Credentialing reviewed. Root cause analysis reviewed.	**MOTION:** by Eisenstark to approve credentialing, 2nd by Idell. All in favor.
12. ADJOURN	*Hirsch*	
	6:37 pm	

Annual Risk Management & Patient Safety Report FY 2019

Introduction

The purpose of the Risk Management Program is to develop, implement, continuously improve, and maintain processes for making and carrying out decisions that will minimize the adverse effects of potential losses to the organization in three areas of risk: business, regulatory and clinical.

Risk Management functions to identify and evaluate risks as a means to reduce injury to patients, staff members, and visitors within an organization. Additionally, Risk Management works proactively and reactively to either prevent incident or to minimize the damages following an event.

The Board of Directors has overall accountability and responsibility for the establishment and support of the Risk Management Program. The Board of Directors delegates the authority and responsibility to the President and CEO, Senior Management, Leadership, and Medical Staff Leadership to design, implement, assess, and if appropriate, redesign and improve the Risk Management Program.

Year in Review

Accreditation

Sonoma Valley Hospital participated in a Clinical Laboratory Improvement Amendments (CLIA) survey in the Laboratory and a Skilled Nursing Annual California Department of Public Health Survey and a Center for Improvement in Healthcare Quality (CIHQ) Mid Cycle Survey. No patient safety or clinical risk issues were identified.

Sonoma Valley Hospital earned the CIHQ Acute Stroke Ready Certification. Certification is given to hospitals that meet high standards of care for the initial treatment of stroke patients when quick action and proper medication can save lives and limit the long-term disabling effects of a stroke. Acute Stroke Ready Hospitals are certified to provide immediate care for strokes, including life-saving medications, and then transport the patient to a primary or comprehensive stroke center.

Peer Review

Risk Management, along with Medical Staff developed a new Peer Review and Focused Professional Practice Evaluation policy. The new Peer Review and Focused Profession Practice Evaluation Policy has combined three policies into one and has created a standardized peer review process for medicine and surgical committees.

This policy defines the framework as the six general competencies established by Accreditation Council for Graduate Medical Education. Furthermore, the policy establishes monthly performance data review/report for Medical Executive Committee and established a Peer Review Committee separate from current med staff committees dedicated solely to the peer review process.

This policy also establishes guidelines for external peer review process, routine and expedited review processes. It also establishes time frame for review process completion 120 days of referral from the quality department.

Patient Safety Survey

Sonoma Valley Hospital conducted the Agency for Healthcare Research and Quality (AHRQ) Surveys on Patient Safety (SOPS) Culture in January 2019. The AHRQ Surveys on Patient Safety Culture program enables health care organizations to assess how their staff perceive various aspects of patient safety culture.

A number of strengths emerged from the results:

- Teamwork within units
- Supervisor/manager expectations & actions promoting patient safety
- Manager support for Patient Safety

The areas for improvement emerged from the results were related to:

- Feedback & Communication About Error

- Frequency of Events Reported
- Communication Openness
- Teamwork Across Units
- Staffing
- Non-punitive Response to Error
- Handoff & Transitions

The results were shared with the Administrative Team who recommended next steps related to identification of patient safety culture areas we want to focus on for improvement, definition of our organizational goals related to patient safety culture and the development of culture of safety initiatives to implement.

California Hospital Patient Safety Organization (CHPSO)

Sonoma Valley Hospital has consistently reported to the California Hospital Patient Safety Organization. Review of the annual update of the safety event reports submitted show that the content is thorough with logic and clear event descriptions. The event submissions are unbiased, fact driven and with little mention of "blame" or "fault." This points to the organizations hardwired culture of safety.

We anticipate an increase in the number of events reported as the front line staff at SVH become more sophisticated in identifying risk/harm and understand the reporting expectations. Staff also respond to the reporting culture and become more comfortable reporting once they understand SVH leader's response to those submissions.

Education

We used the Education Resource Funds to purchase some Utilization Management education materials and to assist with leader education The Director of Quality and Risk Management attended the CIHQ Annual Accreditation Summit, the Hospital Quality Institute Conference, the Northern California Hospital Quality Symposium and the annual American Society for Healthcare and Risk Management Conference.

Midas Risk/Patient Relations Committee

Risk Management continues to provide monthly education in the e-notification process. And oversees the Midas Risk/Pt Relations Committee. The focus has been moving from a silo approach to a holistic view of our systems, processes and procedures. The goal of Midas Risk/Pt

Relations Committee is to recognize and mitigate unsafe conditions, patient harm and serious safety events. The committee meets every other week to collaborate and facilitate best outcomes for organizational risk management.

Claims Reports

Clinical Claims

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

Two clinical claims were filed with BETA in FY 2019:

- One case was found to have no evidence of a complaint on file in Sonoma County. Since the statute of limitations for filing a complaint has run, we are now closing our file.
- One case was finalized with a settlement agreement and mutual release of liability. The cost associated with this case is related to write off payments and adjustments totaling $19,839.21.

In addition, each year Beta sets aside $2,500 for risk related education and $2,500 for outside peer review activities. Program Beta also provides free registration for numerous educational seminars and annual conferences and offers free on-site consultations and educational programs. BETA proved an onsite education for Medical Staff, Case Management and HIM related to legal aspects of medical record documentation, texting, collaboration, interdisciplinary teams, and professionalism.

Business Claims

No new claims.

Regulatory Claims

Sonoma Valley Hospital received the California Department of Public Health statement of deficiency for the retained sponge event in 2015. A plan of correction has been developed, initiated and submitted. An administrative penalty has been assessed in the amount of $12,600.

Precautionary Claims

The hazards of not preparing for potential issues can have significant, long-term effects. Neglecting to have comprehensive risk management plans in place can compromise patient care, increase liability risks, and result in financial losses. Thus, eight cases recognized as potential risks have been evaluated and submitted to BETA as precautionary.

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

Sonoma Valley Hospital did not have any serious or unusual events that resulted in the death or serious disability of a patient, personnel or visitor during this fiscal year.

There were two adverse events or near misses requiring an official Root Cause Analysis.

Patient Experience

Patients are encouraged to provide feedback about their care experience through the complaint/grievance process and we respond to those concerns in accordance to CMS guidelines that require an acknowledgement of the concern within 7 days if it can't be remedied while in the hospital and a final resolution letter within 30 days of the concern.

A Patient Experience Manager position was implemented to help patients and families understand the hospital's policies and billing structure. The Patient Experience Manger is a liaison between the patient/patient's family and the hospital by facilitating patient requests, immediately resolving patient concerns, and coordinating with department managers to facilitate the resolution of significant and/or clinical patient complaints.

We have seen a decrease in complaints while in the hospital while grievances and compliments remain in line with fiscal year 2018. The decrease in patient complaints is related to daily patient rounding by the Director of Patient Care Services and the Patient Experience Manager where patients are provided real time resolution and service recovery.

The data does not include the complaints that Business Office resolves regarding billing. However, 26% of the grievances are formal billing grievances sent to the Patient Experience Committee for resolution.

Event Type	Fiscal Year 2017	Fiscal Year 2018	Fiscal Year 2019	Activity
Complaints*	16	23	7	
Grievances**	51	43	43	
Compliments***	20	17	18	
Total	87	83	68	

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

Good Catch and E- Notification

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

Risk Management identified an opportunity related to the reporting of risk events. Our feedback from the frontline staff uncovered that the event entry forms were intimidating and time consuming. The staff felt that there were too many data fields that required specific entry. Additionally, the frontline staff shared that they don't understand why it is important to report or how their reporting can impact change. As a consequence, the staff had no real sense of inclusion or empowerment in the risk event reporting practice or process improvement.

In response to this valuable feedback, Risk Management implemented free text SBAR formatting to the risk event reporting:

S = Situation: a brief statement of the problem, why are you reporting this event?

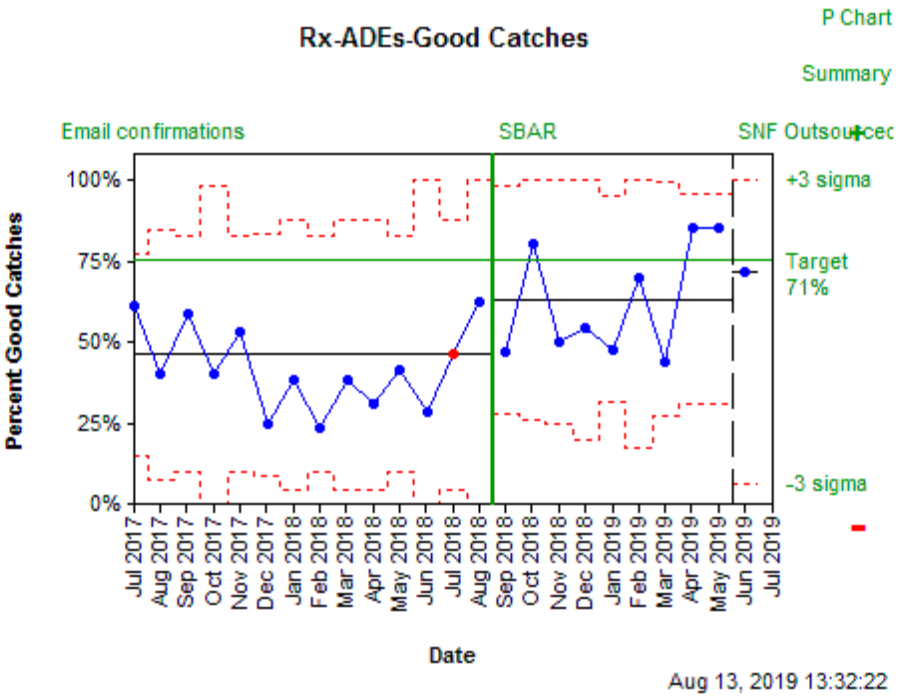
B = Background: Brief and important information related to the situation that is not further explained in the assessment section.

A = Assessment: Describe what occurred. Include only factual information that is critical to the incident.

R = Recommendation: Identify potential actions to take that would avoid a problem in the future or that will improve the current process.

This new technique in risk event formatting has facilitated prompt and appropriate communication in our event reporting and created a safe environment where staff can provide objective facts, and recommendations to prevent potential risk events. We have seen an increase in reporting since SBAR implementation.

Additionally, the Quality Data Analyst attended the annual Midas conference bringing back refinements to our use of this database that have improved data gathering and reporting. The Quality Data Analyst's presentation at Midas Plus Western Regional Group was well received.



The table below demonstrates a continued improvement in the staff's willingness to report. Themes identified by both types of reporting are addressed by Leadership, Medical Staff and the Safety Committee to reduce the potential for harm for patients, employees and visitors.

The ideal level of reporting proposed by national patient safety and quality forums is two notification forms per employee per year. Total employees at SVH in fiscal year 2019 were 443. Clearly we are meeting that reporting benchmark.

		Good Catch	Non-Medication eNotifications	Medication eNotifications	Total
FY2019	*24*	13 non-med 11 med	1013	178	**1191**
FY2018	*13*	4 non-med 9 med	969	177	**1146**
FY2017	*29*	16 non-med 13 med	1014	167	**1181**
FY2016	***14***	**10 non-med** **4 med**	**919**	**203**	**1122**

Work place Violence Reporting

Workplace Violence pertains to any situation involving use of physical force against an employee by a patient or a person accompanying a patient that results in, or has the high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury and regardless of the offender's intentions.

Sonoma Valley Hospital is committed to preventing workplace violence and to maintaining a safe work environment. Risk Management has partnered with the Work Place Violence Committee to adopt guidelines to deal with intimidation, harassment or other threats of or actual violence that may occur during work related activities.

Fiscal Year 2019 Goals

The Table below addresses the goals set for fiscal year 2019 and our progress towards meeting them.

FISCAL YEAR 2019 GOALS AND RISK REDUCTION STRATEGIES
• Investigate IHI Framework for Improving Joy in Work, building toward organizational High Reliability. **Goal Met. Introduced IHI Framework to Quality, Risk, and Leadership. Shared with the Rewards and Recognition Committee.**

• Communicate department specific data related to patient safety and patient relations event reporting to invite feedback on the system from frontline staff. **Goal Met. Created SBAR for event reporting based on staff feedback.**
• Refocus on management of patient relations including the complaint and grievance process. **Goal Met. Established monthly multidisciplinary committee**
• Process improvement related to Good Catch investigation and review. **Goal Met. Updated the internal process for review and created a quarterly report for staff and leadership communication.**
• Align event types with national patient safety reporting best practice and standard formats to increase relevance in California Hospital Patient Safety Organization (CHPSO) collaborative. **Goal Met.**
• Provide at least one training in risk mitigation for leaders. **Goal Met. BETA provided onsite education for legal aspects of medical record documentation, texting, collaboration and interdisciplinary teams. And interdisciplinary professionalism and communication to the Medical Staff.**

Fiscal Year 2020 Goals

Goals and Risk Reduction Strategies for 2020

Proposed Goals for the next fiscal year include:

- Train new leadership members to accurate and timely response to e-notifications and the complaint/grievance process
- Provide at least one training in risk mitigation for leaders
- Create Risk Management STATIT indicators for real time process control
- Develop “Make the Call for Safety” a voicemail system that allows staff, visitors and family to report unexpected events or Good Catches

JUNE 2019

Patient Experience	Current Performance	FY 2019 Goal	National Benchmark
Would Recommend Hospital	67th	> 60th percentile	50th percentile
Inpatient Overall Rating	62.5%	>60th percentile	50th percentile
Outpatient Services	4.74	Rate My Hospital	4.5
Emergency	4.54	Rate My Hospital	4.5
Quality & Safety	**YTD Performance**	**FY 2019 Goal**	**Benchmark**
CLABSI	0	<1	<.51
CAUTI	0	<1	<1.04
SSI – Colon Surgery	0	<1	N/A
SSI – Total Joint	0	<1.5%	N/A
MRSA Bacteremia	0	<.13	<.13
C. Diff	0	3.5	7.4/10,000 pt days
PSI – 90 Composite	2	<1	<1
Heart Failure Mortality Rate	12.5%	TBD	17.3%
Pneumonia Mortality Rate	18.1%	TBD	23.6%
Stroke Mortality Rate	14.7%	TBD	19.7%
Sepsis Mortality Rate	10.2%	<18%	25%
30 Day All- Cause Readmissions	9.50%	< 10 %	< 18.5%
Serious Safety Events	0	0	0
Falls	2	< 2.3	2.3
Pressure Ulcers	0	<3.7	3.7
Injuries to Staff	16	< 10	17
Adverse Drug Events with Harm	0	0	0
Reportable HIPAA Privacy Events	0	0	0
SNF Star Rating	4	4	3
Hospital Star Rating	4	4	3
Our People	**Performance**	**FY 2019 Goal**	**Benchmark**
Staff Satisfaction Survey	61st percentile	75th percentile	50th percentile
Turnover	17.7%	< 10%	< 15%
Financial Stability	**YTD Performance**	**FY 2019 Goal**	**Benchmark**
EBDA	6.1%	1%	3%
FTE's/AOB	3.88	4.3	5.3
Days Cash on Hand	35	20	30
Days in Accounts Receivable	43	49	50
Length of Stay	3.8	3.85	4.03
Funds raised by SVHF	$17.5 million	$20 million	$1 million
Strategic Growth	**YTD Performance**	**FY 2019 Goal**	**Benchmark**
Inpatient Discharges	1023	1000	1000
Outpatient Visits	54,596	53,000	51,924
Emergency Visits	10,181	10,000	11,040
Surgeries + Special Procedures	2950	2500	2,568
Community Benefit Hours	1222	1200	1200

Note: Colors demonstrate comparison to National Benchmark

Policy and Procedures – Summary of Changes
Board Quality Committee, August 28th, 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

NEW:

CAIR Utilization PC8610-188
This is a required policy for Partnership reimbursement.

Continuity of Operations Plan (COOP) EP8610-107
Continuity of Operations is a plan that supplements the Emergency Operations Plan. The COOP focuses on maintaining business operations so that healthcare can continue to be delivered to the community. Hospitals are also a business and focus must be maintained on the business operations so that the organization remains viable financially to assure healthcare delivery to our community.

REVISIONS:

Aggressive Behavior Management-Code Grey CE8610-102
Construct of team was ill-defined. Reporting of event has changed in Midas system to Workplace Violence Reporting. Team constructed of members available on a 24-7 basis.

Prevention of Surgical Site Infections IC8610-132
All inpatients will have total body wipe with CHG clothes. All outpatients will be informed to do the same by Surgery Department. All total joint recipients will follow this policy and will use mupiricin intranasally in accordance with the S. aureus decolonization policy.

DEPARTMENTAL

RETIRE:

A Woman's Place Policies – See Table of Contents

SUBJECT: CAIR Utilization	POLICY: PC8610-188
	PAGE 1
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

POLICY:

To submit statewide immunization records by using the California Immunization Registry (CAIR) Data Exchange.

PROCEDURE:

1. All immunization data will be uploaded to CAIR via the following process at the time of vaccine administration:
    a. At the time of vaccine administration the nurse manually enters required vaccine information In Paragon Patient Profile
    b. The entered information is immediately and automatically transmitted to CAIR through the Sonoma Valley Hospital Mirth interface connection with CAIR.
    c. CAIR to provide Sonoma Valley Hospital Pharmacy with report of fall-out cases as encountered.
    d. Employee Health Vaccines are manually entered.
2. CAIR is an 'opt out' registry. CAIR data will be managed according to the CAIR Sharing Policy (http://cairweb.org/cair-disclosure-policy/#sharing)

OWNER:
Chief Quality Officer

AUTHORS/REVIEWERS:
Danielle Jones, Chief Quality Officer
Mark Kobe, Chief Nursing Officer
Fe Sendaydiego, Chief Information Officer
Andrea O'Donnell, Senior Nurse Informatics Analyst
Michael Kovacs, Information Systems Project Manager

APPROVALS:
Policy & Procedure Team: 8/20/19
Board Quality Committee:
The Board of Directors:

SUBJECT: Continuity of Operations Plan (COOP)	POLICY # EP8610-107
	PAGE 1 OF 5
DEPARTMENT: ORGANIZATIONAL	EFFECTIVE:
REVIEW/REVISED:	

POLICY:

The purpose of the Continuity of Operations Plan (COOP) is to provide guidance for ensuring that the essential business functions of Sonoma Valley Hospital (SVH) are able to continue in the event that a manmade, natural, or technological emergency disrupts, or threatens to disrupt, normal operations. This COOP describes how Sonoma Valley Hospital could operate with a significantly reduced workforce and diminished availability of resources and be able to conduct clinical and essential business operations from an alternate work site should the primary site become unusable.

This COOP recognizes SVH's dependence on computer technology for daily operation. To address these issues, additional information is provided in the Emergency Operations Plan. It is the policy of SVH that a viable continuity of Operations Plan is established, maintained, and implemented when necessary to ensure continuing high levels of patient care, service quality and availability in the event of a disaster, emergency, or other sudden business interruption.

The CEO is responsible for implementing the COOP when necessary to continue SVH operations. Senior management is responsible for planning and using the COOP guidelines in order to continue the mission of the Hospital during an emergency that disrupts normal business operations. The provisions of this document apply to Sonoma Valley Hospital, its business offices and all related clinics and facilities that are part of the SVH system.

PROCEDURE:

Senior management, along with other SVH employees identified as the managers and supervisors for essential services, plan and periodically review this Continuity of Operations Plan to maintain its viability. A copy of this plan is maintained by the Emergency Preparedness Coordinator's and it is backed-up electronically on the Intranet.

The COOP for Sonoma Valley Hospital is designed to meet the objectives listed below:

1. Ensure continuous performance of SVH's essential functions and operations during an emergency or other sudden business interruption. This includes:
    - Using the Incident Command System (ICS) to manage emergency recovery operations. The Incident Commander assigns roles to SVH personnel to assess the situation. See the Emergency Operations Plan for details.
    - Issuing "Situation Reports" to the Senior Management Team. Senior management makes the final decision to implement the COOP after analyzing the reports.

2. Based on the current organizational chart, Senior Management designates principal managers and support staff to carry out essential functions prior to an emergency or disaster event.

3. If necessary, relocate SVH operations based on the Situation Reports from the Incident Commander.

Advance planning as necessary to achieve timely and orderly recovery from an emergency:

1. Have Memorandums of Understanding (MOU) in place with suppliers to continue to receive essential supplies during a disaster.

2. Have agreements in place with community organizations for cooperative support and patient exchange, such as Sonoma County Department of Public Health, California CAHAN network alerts and other community organizations such as local hospitals and healthcare clinics and/or physician offices.

3. Have a plan for off-site business operations at other SVH satellite sites

4. Senior leadership recognizes that as a result of an IT outage or other technology interruption such as a power failure, hardware failure, or data center incident, SVH may lose productivity and the ability to deliver patient care as efficiently as before the interruption.

5. Having a method of record keeping through the use of portable devices to record working hours for staff, access to financial records for vendors, staff rosters, and a means to send billing in order to continue SVH's financial viability.

6. Develop a strategy for continuous review and planning to improve the ability to recover from a business interruption.

7. Have a plan for maintaining inventory and rotation of emergency supplies:
   - Supplies are inventoried and rotated in and out of SVH stock to prevent retention of expired supplies and these supplies are tracked and periodically replaced.

8. All SVH data and patient records are backed-up offsite in a remote location to ensure access to patient records and to maintain financial continuity. The Chief

Information Officer oversees the security operations for protected health information, financial and other data security.

9. Designated Human Resources staff maintain employee lists sorted by zip code and phone number to identify staff who are available for call-backs in an emergency.
   - Procedures are in place for entering employee hours on a manual time-recording form if the electronic payroll application is not accessible

10. SVH maintains contact information for the Sonoma County medical volunteer corps to supplement SVH clinical staffing if necessary. Procedures for credentialing clinical volunteers in an emergency are in the "Emergency Credentialing" section of the Emergency Operations Plan.

11. The CEO and Senior Management Team ensure that mission-essential functions can continue, or resume as quickly as possible, by making sure any task not deemed an essential function is deferred until additional personnel and resources become available and conditions permit.

12. The CEO, Incident Commander and ICC General Staff members determine the need for full or partial COOP implementation. This determination is based on the severity of the event and the level of threat. The severity of the events is defined by whether this is a local event or more widespread, whether the incident poses a danger to life and health for those effected by the disaster, the level of threat is defined by the proximity of the center to the incident and the estimated effect on the hospital's ability to continue essential operations.

13. The Federal Torts Claims Act extends coverage for healthcare facilities providing care at alternate sites. Prior approval is not necessary but the hospital must notify HRSA (Health Resources and Services Administration) within 15 days of the change in site location.

Integrity of Health Information

In the event of an unplanned electronic medical record outage for greater than 6 hours, the Chief Information Officer and Senior Management is informed. The Incident Command System is activated by the senior manager on site at the time of the incident. Decision making authority is delegated according the SVH's succession plan. See Downtime policy for implementation procedures.

Consult the Emergency Operations Plan for further in depth information.

Financial Recovery
Depending on the conditions and the scale of the incident, SVH senior management will assess and seek financial recovery resources in accordance with the following:

- The eligibility of acute care hospitals for federal reimbursement for response costs and losses remains ambiguous. SVH will gain reimbursement through county channels under certain circumstances by filing a Resource Request.

- After a disaster occurs and the President has issued a Federal Disaster Declaration, SVH may apply for assistance through FEMA and the OES (Office of Emergency Services) after a full assessment by senior management.

- Following a presidential disaster declaration, the Hazard Mitigation Grant Program (HMGP) is activated.

- Sonoma Valley Hospital may be eligible for emergency protective measures (i.e., emergency access such as provision of shelters or emergency care or provision of food, water, medicine, and other essential needs), and may be eligible for permanent repair work (i.e., repair or replacement of damaged elements restoring the damaged facility's): pre-disaster design, pre-disaster function, pre-disaster capacity through the Hazard Mitigation Grant Program from the Federal government.

REFERENCES:
Federal Emergency Management Agency
http://www.fema.gov/pdf/about/org/ncp/coop/continuity_plan_federal_d_a.pdf
SETRAC
http://www.setrac.org/go/doc/4207/1671227/
California Public Health and Medical Emergency Operations Manual
http://www.emsa.ca.gov/Media/Default/PDF/EOM712011_DMS.pdf

SUBJECT: Continuity of Operations Plan (COOP)	POLICY # EP8610-107
	PAGE 5 OF 5
DEPARTMENT: ORGANIZATIONAL	EFFECTIVE:
REVIEW/REVISED:	

OWNER:
Chief Executive Officer

AUTHORS/REVIEWERS:
Mark Kobe, RN MPA Chief Nursing Officer

COMMITTEE APPROVALS:
Policy & Procedure Team: 8/20/19
Board Quality Committee:
The Board:

To Retire

A Woman's Place Policies
Amniocentesi
Amnioinfusion with IUPC
Amniotomy policy
Attire and Traffic in the OB-OR
Bakri Balloon
Birth Certification
Bonding Between Parent and Newborn
Care of Labor Patient
Care of the Postpartum Patient after Recovery
Cesarean Birth, Admission of Support Person
Cesarean Birth, Duties of Birthplace Nurse
Criteria for Admission to 3-South
Determining High Risk Obstetric Patients
Discharging the Newborn
Discharging the Post Partum Patient
Electronic Fetal-Uterine Monitoring
Emergency Cesarean Section
Epidural Anesthesia
External Version
Fetal Spiral Electrode Monitoring
Group B Streptoccocal Management in Labor
Infant Feeding
Infection Control- Perinatal Unit
Intrathecal Injection, Assisting with
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APPROVALS:
Policy & Procedure Team: 6/18/19
Surgery Committee: 8/8/19
Medical Executive Committee: 8/15/19
Board Quality Committee:
The Board of Directors: