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SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, JUNE 24, 2020
5:00 p.m. Regular Session

(Closed Session will be held upon adjournment of the Regular Session)

TO BE HELD VIA ZOOM VIDEOCONFERENCE

To Participate Via Zoom Videoconferencing use the link below:

https://zoom.us/j/98792080549?pwd=VjIzS3lYM01rTGVwNm1EeVQ2MWhTUT09

and enter the Meeting ID: 987 9208 0549
Password: 932037

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1-669-900-9128 or 1-669-219-2599
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Password: 932037

AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a District meeting, please contact the District Clerk, Vivian Woodall, at vwoodall@sonomavalleyhospital.org or 707.935.5005 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 05.27.20	*Hirsch*	Action
4. SVH QUALITY INDICATOR PERFORMANCE AND PLAN	*Jones*	Inform
5. PROPOSED QUALITY COMMITTEE CHARTER		
6. POLICIES AND PROCEDURES	*Jones*	Action
7. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	*Hirsch*	Action
8. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
9. ADJOURN	*Hirsch*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
May 27, 2020 5:00 PM
MINUTES
Via Zoom Teleconference

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch via Zoom Susan Idell via Zoom Ingrid Sheets via Zoom Cathy Webber via Zoom	Howard Eisenstark, MD via Zoom Michael Mainardi, MD via Zoom	Carol Snyder	Sabrina Kidd, MD, CMO, via Zoom Danielle Jones, RN, Chief Quality Officer via Zoom Dr. Judith Bjorndahl via Zoom

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	5:03 pm. Ms. Hirsch introduced Dr. Judith Bjorndahl. Ms. Hirsch also asked Dr. Kidd for a brief update on the COVID-19 situation. Dr. Kidd indicated the Hospital is resuming all services as of next week. Although not in a surge, SVH will not be eliminating safety measures any time in the near future. All pre-op patients are being tested. The general community is now being tested through the SV Community Health Center.	
2. PUBLIC COMMENT	*Hirsch*	
	None	
3. CONSENT CALENDAR		Action
• QC Minutes, 02.26.20 (Revised) • QC Minutes, 04.22.20		**MOTION:** by Mainardi to approve, 2nd by Idell. All in favor.
4. SVH QUALITY INDICATOR PERFORMANCE AND PLAN	*Jones*	Inform
	Ms. Jones reviewed quality indicator performance for the month of April. A new hospice room has been created on the third floor (instead of the Skilled Nursing unit). She also reported on stroke readiness certification (three documentation opportunities) and a recent surprise CDPH visit on COVID preparedness (with no plan of correction).	

AGENDA ITEM	DISCUSSION	ACTION
5. POLICIES AND PROCEDURES	*Jones*	
	ORGANIZATIONAL **New:** None to report **Revisions:** Assessment and Disposition for Psychiatric Patients In the ED Clinical Nursing Procedures PC8610-124 **Reviewed/No Changes:** Informed Consent PR8610-134 Advanced Directives PR8610-100 **DEPARTMENTAL** **New:** **Rehab** Physical Therapy Medical Emergencies in SVH Hand and Physical Therapy Clinic 7770-141 Hazardous Material Handling in the Outpatient Rehabilitation Clinic 7770-143 **Laboratory** C. Difficile by PCR 7500-100 **Revisions:** **Wound Care** Conservative Sharp Debridement 7740-103 Pulse Lavage 7740-140 Silver Nitrate, Use of 7740-105 **Physical Therapy** Cold Pack Usage 7770-103 Department Staffing Plan 7770-109 Discharge Criteria of Rehabilitation Patients 7770-111 Gaits Belts, Use and Cleaning of 7770-117 Iontophoresis 7770-127 **Respiratory Therapy** PB 840 Ventilator 7721-57 Phillips V60 BiPap 7721-12 Scope of Service 7721-66 Vapotherm High Flow System 7721-71 **Laboratory** Quarantined Blood Products 7500-102 **Reviewed/No Changes:** **Physical Therapy**	**MOTION:** by Mainardi to approved all except for the two policies noted as being sent back for redraft; 2nd by Idell. All in favor.

AGENDA ITEM	DISCUSSION	ACTION
	Cancellation Policy 7710-100 Clinical Competency 7770-101 Contested Decision to Discontinue Skilled Rehab Services 7770-105 Collection of Co-Payment 7770-107 Downtime Scheduling Procedure 7770-112 Fluidotherapy Usage 7770-113 Frequently Used Terminology and Abbreviations 7770-115 Hot Pack/Heating Pad Usage 7770-119 Hoyer Lift 7770-121 Ice Massage 7770-123 Initial Evaluation 7770-125 MD Notification 7770-129 Paraffin Use 7770-131 Patient Education 7770-133 Phonophoresis 7770-135 Transcutaneous Electrical Nerve Stimulation 7770-137 Ultrasound 7770-139 **Retire:** **Respiratory Therapy** Aerosol Therapy T Piece or Tracheostomy Mist Alert Patient Protocol for Continuous CPAP Arterial Blood Gas Sampling Recommended Parameter Arterial Puncture for Blood Gas Analysis, Technique for Performing Auto Vent 3000 CPAP Treatment Procedure Alert Patient Protocol, CPAP Mask Procedure Cuff Leak Assessment Cuff Pressure Indicator Education Home Care Use of Compressor and Nebulizer Therapy Extubation Procedure Gas Cylinders Protocol Incentive Spirometry Indications Incentive Spirometry Infant Oxyhood Infection Control Metered Dose Inhaler Therapy Nasotracheal Suctioning-Recommended Parameters Oral Care for the Mechanically Ventilated Patient	

AGENDA ITEM	DISCUSSION	ACTION
	Oxygen Administration Per Nasal Cannula Oxygen Administration Per Venturi Mask Procedure Oxygen Delivered by Disposable Face Mask Oxygen Delivery by High Concentration Mask, Non-rebreather Mask Pulse Oximetry The Physical Therapy Medical Emergencies and the Laboratory C. Difficile policies are to be revised and brought back in June.	
6. CLOSED SESSION	*Hirsch*	
a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report **b.** Government Code §37624.3 and Calif. Health & Safety Code §§1461, 32155: Report of Medical Staff Bioethics Committee	Called to order at 5:56 pm.	
7. REPORT OF CLOSED SESSION	*Hirsch*	
	Medical Staff credentialing was reviewed. A report and protocol from the Bioethics Committee was reviewed.	**MOTION:** by Eisenstark to approve credentialing, 2nd by Idell, all in favor. **MOTION:** by Mainardi to approve, 2nd by Sheets. All in favor.
8. ADJOURN	*Hirsch*	
	6:06 pm	

Quality Indicator Performance & Plan

June 2020

Data for May 2020

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MORTALITY

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Scorecard Summary
Mortality

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Autopsies Mortalities					
▼	Acute Care Mortality Rate (M)	2.3%	15.3%		May 2020
–	Congestive Heart Failure Mortality Rate |M|	0.0%	11.5%		Apr 2020
–	COPD Mortality Rate |M|	0.0%	8.5%		May 2020
–	Ischemic Stroke Mortality Rate |M|	0.0%	13.8%		Apr 2020
▼	Pneumonia Mortality Rate |M|	0.0%	15.6%		May 2020
Quality > Process of Care > Sepsis Care					
–	Sepsis, Severe - Mortality Rate (M)	0.0%	25.0%		May 2020
▼	Septic Shock - Mortality Rate (M)	0.0%	25.0%		May 2020

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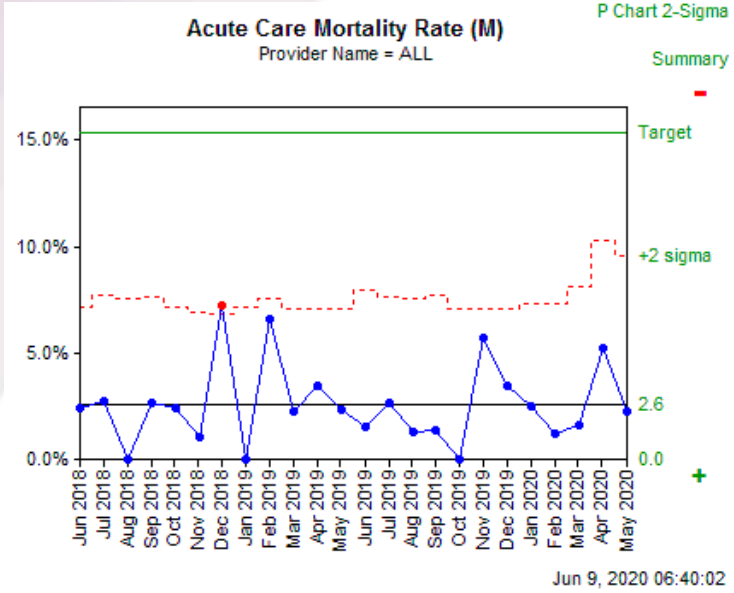
Acute Care Mortality Rate

Period	CDB009 - Acute Care - Mortality Rate (numerator)	CDB009 - Acute Care - Mortality Rate (denominator)	Percent
May 2020	1	44	2.3%
Apr 2020	2	38	5.3%
Mar 2020	1	61	1.6%
Feb 2020	1	81	1.2%
Jan 2020	2	80	2.5%
Dec 2019	3	86	3.5%
Nov 2019	5	88	5.7%
Oct 2019	0	89	0.0%
Sep 2019	1	72	1.4%
Aug 2019	1	76	1.3%
Jul 2019	2	74	2.7%
Jun 2019	1	66	1.5%



Mortality rate among acute care inpatient encounters

- Case Review
  - May 2020
  - One mortality
  - Hospice
    - Appropriate care provided
    - Hospice By The Bay evaluated the patient and accepted into care
      - No Face to face consultation with Hospitalist
    - Hospitalist not aware of Hospice evaluation and did not make the change to inpatient Hospice admission status
    - Follow up meeting with Hospice By The Bay

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PREVENTABLE HARM EVENTS

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Scorecard Summary
AHRQ Patient Safety Indicators

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Patient Safety > AHRQ Patient Safety Indicators_PSI					
	PSI 02 (v2019) Death in Low-mortality DRGs - Per 1000 ACA (M)	0.00	0.21		Mar 2020
	PSI 03 (v2019) Pressure Ulcer - Per 1000 ACA (M)	0.00	0.51		May 2020
	PSI 04 (v2019) Death in Surgical IP w/Ser Comp, Overall - Per 1000 ACA (M)	0.00	146.36		Mar 2020
	PSI 05 (v2019) Retained Surgical Item/Device Fragment - Per 1000 ACA (M)	0.00	0.00		May 2020
	PSI 06 (v2019) Iatrogenic Pneumothorax - Per 1000 ACA (M)	0.00	0.21		May 2020
	PSI 07 (v2019) Central Venous Catheter-related BSI - Per 1000 ACA (M)	0.00	0.12		May 2020
	PSI 08 (v2019) In Hospital Fall with Hip Fracture - Per 1000 ACA (M)	0.00	0.08		May 2020
	PSI 09 (v2019) Perioperative Hemorrhage or Hematoma - Per 1000 ACA (M)	0.00	2.29		May 2020
	PSI 10 (v2019) Postop Acute Kidney Injury Requiring Dialysis - Per 1000 ACA (M)	0.00	0.73		May 2020
	PSI 11 (v2019) Postoperative Respiratory Failure - Per 1000 ACA (M)	0.00	5.53		May 2020
	PSI 12 (v2019) Perioperative Pulmonary Embolism or DVT - Per 1000 ACA (M)	0.00	3.45		May 2020
	PSI 13 (v2019) Postoperative Sepsis - Per 1000 ACA (M)	0.00	4.05		May 2020
	PSI 14 (v2019) Postoperative Wound Dehiscence - Per 1000 ACA (M)	0.00	0.69		May 2020
	PSI 15 (v2019) Accidental Puncture or Laceration - Per 1000 ACA (M)	0.00	1.06		May 2020
	PSI 90 (v2019) Midas Patient Safety Indicators Composite, ACA (M)	0.00	1.00		May 2020

The Patient Safety Indicators (PSIs) provide information on potentially avoidable safety events that represent opportunities for improvement in the delivery of care.

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Scorecard Summary

Patient Falls

Preventable Harm

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Patient Safety > Falls					
▲	RM ACUTE FALL- NO INJURY (M) per 1000 patient days	5.59	3.75		May 2020
—	RM ACUTE FALL- WITH INJURY (M) per 1000 patient days	0.00	3.75		May 2020
—	Falls with injury % of all Acute falls |M|	0.0%	0.0%		May 2020

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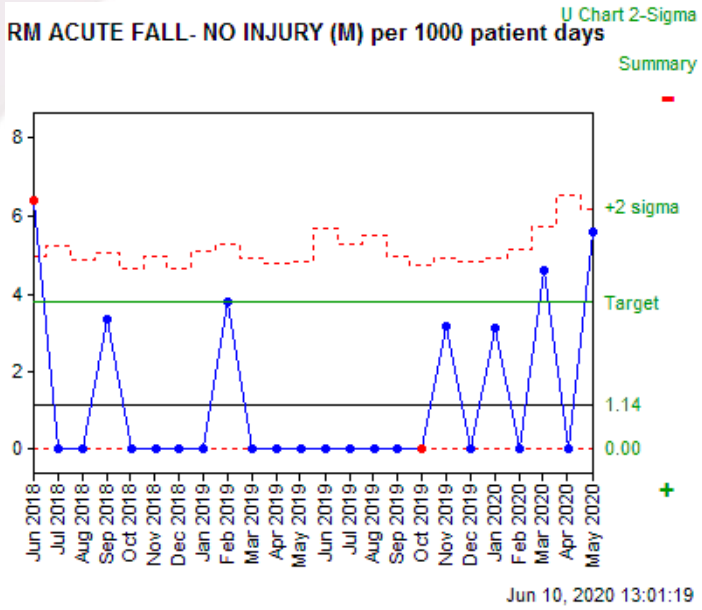
Acute Fall Rate

Period	C-RM Event: Fall-NO Injury: Acute only (numerator)	S-FS-SVH ADJUSTED PATIENT DAYS: Acute	Rate
May 2020	1	179	5.59
Apr 2020	0	156	0.00
Mar 2020	1	218	4.59
Feb 2020	0	286	0.00
Jan 2020	1	321	3.12
Dec 2019	0	336	0.00
Nov 2019	1	319	3.13
Oct 2019	0	351	0.00
Sep 2019	0	312	0.00
Aug 2019	0	240	0.00
Jul 2019	0	269	0.00
Jun 2019	0	220	0.00



- Case Review
  - May 2020
  - One fall
    - History of falls, confusion, encephalopathy, intermittently cooperative
    - Fall precautions were not implemented
  - Next Steps
    - Director of Patient Care Services is implementing a post-fall huddle

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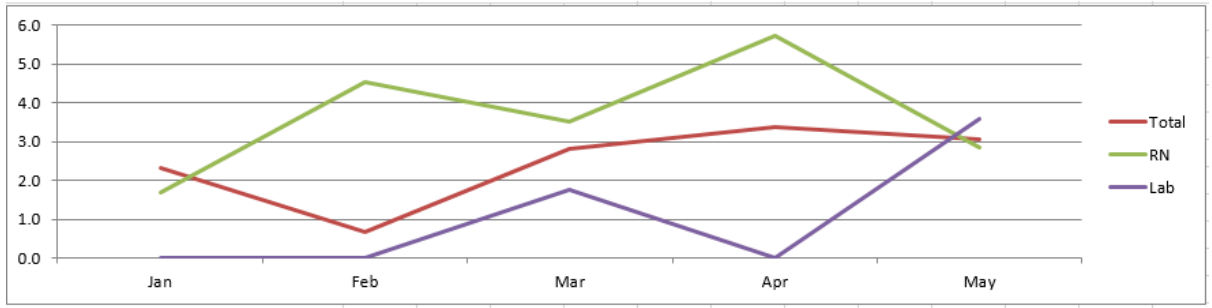
Scorecard Summary
Contaminated Blood Cultures

Blood Culture Report - Monthly for 2020					
	Jan	Feb	Mar	Apr	May
Total Blood Cultures Processed	130	147	142	118	98
True Postive Cultures	6	11	7	11	8
True Postive Culture Rate (percent)	4.6	7.5	4.9	9.3	8.2
Total Contamination Cultures	3	1	4	4	3
Total Contamination Rate (percent)	**2.3**	**0.7**	**2.8**	**3.4**	**3.1**
Acceptable Contamination Rate ≤3.0%	Yes	Yes	Yes	No	No
Blood Cultures Drawn by RN Staff	59	66	85	70	70
Contaminated Culture Reported	1	3	3	4	2
RN Contamination Rate (percent)	*1.7*	*4.5*	*3.5*	*5.7*	*2.9*
Acceptable Contamination Rate ≤3.0%*	Yes	Yes	Yes	No	Yes
Blood Culture Drawn by Lab Staff	88	64	57	48	28
Contaminated Culture Reported	0	0	1	0	1
Lab Contamination Rate (percent)	*0*	*0*	*1.8*	*0.0*	*3.6*
Acceptable Contamination Rate ≤3.0%	Yes	Yes	Yes	Yes	No
	* RN Contaminate Rate changed May 2020				



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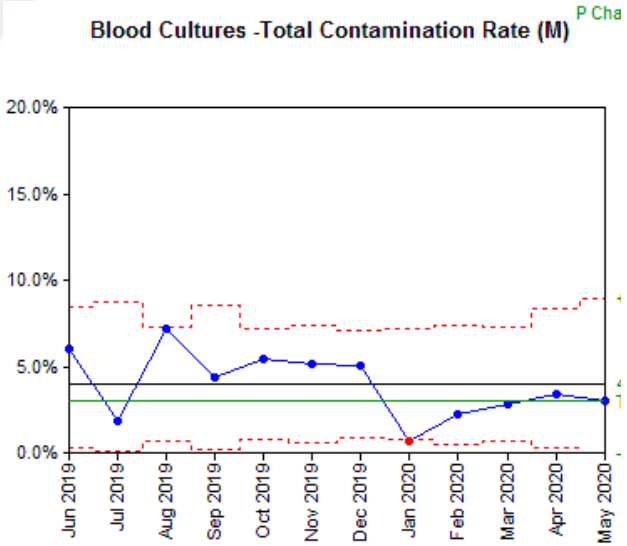
Contaminated Blood Cultures Rate

Month	Total Contaminated Cultures (num)	Total Blood Cultures Processed (den)	Percent
May 2020	3	98	3.1%
Apr 2020	4	118	3.4%
Mar 2020	4	142	2.8%
Feb 2020	3	130	2.3%
Jan 2020	1	147	0.7%
Dec 2019	8	159	5.0%
Nov 2019	7	135	5.2%
Oct 2019	8	147	5.4%
Sep 2019	5	114	4.4%
Aug 2019	10	139	7.2%
Jul 2019	2	105	1.9%
Jun 2019	7	116	6.0%



- Case Review
  - May 2020
  - Three contaminated blood cultures
    - One lab
    - Two RN
      - RN documented blood culture draw through EMT IV

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MEDICATION EVENTS

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Scorecard Summary
Adverse Drug Events

Quality > Pharmacy > Adverse Drug Events					
▲	Rx-ADEs-Administration Errors Per 10,000 Doses	1.19	1.00		May 2020
▼	Rx-ADEs-High Risk Med Errors Per 10,000 Doses	0.24	1.13		May 2020
—	Rx-Adverse Drug Reactions	4	n/a		Q1-2020
—	Rx-Adverse Drug Reactions-Antibiotics	25%	n/a		Q1-2020
▲	Rx-Adverse Drug Reactions-Anticoagulants	25%	n/a		Q1-2020
—	Rx-Adverse Drug Reactions-Cardiovascular	25%	n/a		Jan 2020

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CORE MEASURES

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Scorecard Summary
Core Measures

Quality > Core Measures					
▲	Core OP-18b - Median Time ED Arrival to ED Departure - Reporting Measure (M)	156.00	140.00		May 2020
–	Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)	100.0%	72.0%		May 2020
Quality > Core Measures > HOP Measures > HOP Colonoscpy					
▲	Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M)	75.0%	89.0%		Mar 2020
Quality > Core Measures > Sepsis					
–	SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock (M)	66.7%	81.0%		May 2020
▲	SEPa - Severe Sepsis 3 Hour Bundle (M)	100.0%	94.0%		May 2020
▼	SEPb - Severe Sepsis 6 Hour Bundle (M)	66.7%	100.0%		May 2020
▼	SEPc - Septic Shock 3 Hour Bundle (M)	80.0%	100.0%		May 2020
–	SEPd - Septic Shock 6 Hour Bundle (M)	100.0%	100.0%		May 2020
–	SEP1aa - severe sepsis - initial lactate management (as of 1/20) (M)	100.0%	94.0%		May 2020
–	SEP1ab - severe sepsis - broad spectrum antibiotic (as of 1/20) (M)	100.0%	94.0%		May 2020
▲	SEP1ac - severe sepsis - blood culture collection (as of 1/20) (M)	100.0%	100.0%		May 2020
▼	SEP1b - severe sepsis - repeat lactate level measurement (as of 1/20) (M)	66.7%	100.0%		May 2020
▼	SEP1c - septic shock - resuscitation w/ crystalloid fluids (as of 1/20) (M)	80.0%	100.0%		May 2020
–	SEP1da - septic shock - vasopressors (as of 1/20) (M)	100.0%	100.0%		May 2020
–	SEP1db - septic shock - repeat volume status/tissue perfusion assess (as of 1/20) (M)	100.0%	100.0%		May 2020

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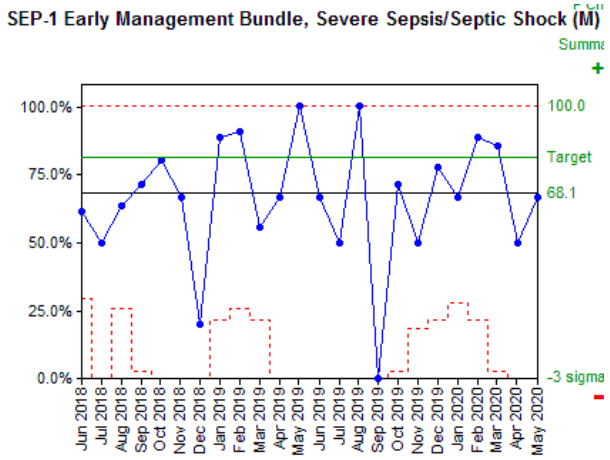
Sepsis Core Measure

Period	Numerator	Denominator	Percent
May 2020	4	6	66.7%
Apr 2020	1	2	50.0%
Mar 2020	6	7	85.7%
Feb 2020	8	9	88.9%
Jan 2020	8	12	66.7%
Dec 2019	7	9	77.8%
Nov 2019	4	8	50.0%
Oct 2019	5	7	71.4%
Sep 2019	0	3	0.0%
Aug 2019	1	1	100.0%
Jul 2019	2	4	50.0%
Jun 2019	2	3	66.7%



- Case Review
  - May 2020
  - Two fallouts
    - Physician Opportunity for Improvement
      - Repeat lactate was not ordered within the 6 hour time frame
        - Lactate reflex high for SVH lab protocol (2.1 vs. 2.0)
      - RN Opportunity for Improvement
        - The target volume of crystalloid fluids was NOT initiated within the specified time frame

This measure focuses on patients with a diagnosis of severe sepsis or septic shock. Consistent with Surviving Sepsis campaign guidelines, it assesses measurement of lactate, obtaining blood cultures, administering broad spectrum antibiotics, fluid resuscitation, vasopressor administration, reassessment of volume status and tissue perfusion, and repeat lactate measurement. As reflected in the data elements and their definitions, the first three interventions should occur within 3 hours of presentation of severe sepsis, while the remaining interventions are expected to occur within 6 hours of presentation of septic shock.

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READMISSION

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Scorecard Summary
Readmissions

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Process of Care > Sepsis Care					
● ▲	Sepsis, Severe - % Readmit within 30 Days (M)	0.2%	12.0%		May 2020
● ▲	Septic Shock - % Readmit within 30 Days (M)	0.5%	13.3%		May 2020
Quality > Readmissions					
● ▲	30-DV Inpatients - % Readmit to Acute Care within 30 Days (M)	7.0%	15.3%		May 2020
● –	COPD, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0.0%	19.5%		May 2020
● –	HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0.0%	21.6%		Apr 2020
● –	Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0.0%	4.0%		May 2020
● –	PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0%	17%		May 2020

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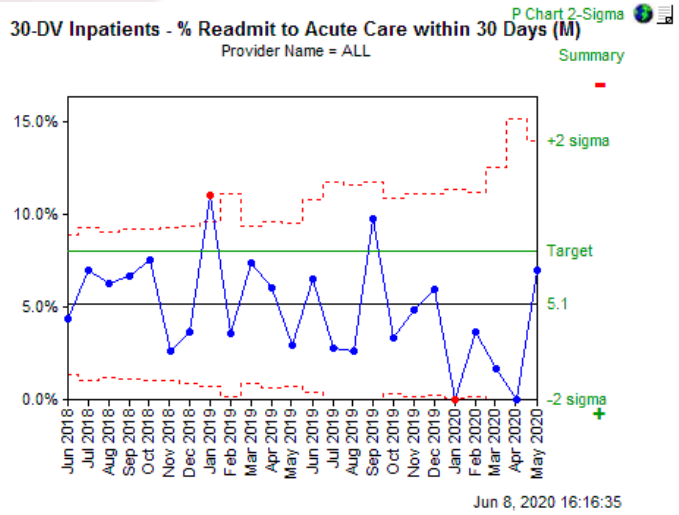
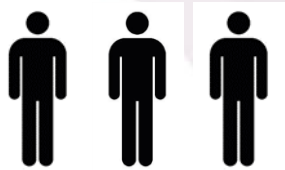
Readmission Rate

Period	CDB919 - Inpatients - % Readmit to Acute Care within 30 Days (numerator)	CDB919 - Inpatients - % Readmit to Acute Care within 30 Days (denominator)	Percent
May 2020	3	43	7.0%
Apr 2020	0	37	0.0%
Mar 2020	1	60	1.7%
Feb 2020	3	82	3.7%
Jan 2020	0	78	0.0%
Dec 2019	5	84	6.0%
Nov 2019	4	83	4.8%
Oct 2019	3	90	3.3%
Sep 2019	7	72	9.7%
Aug 2019	2	75	2.7%
Jul 2019	2	72	2.8%
Jun 2019	6	92	6.5%



- Case Review
  - May 2020
  - Three readmissions
    - Changes to home medication
    - Pain management/medication education, physician communication, lack of knowledge of disease management
    - Palliative care consult needed
  - Next Steps
    - Medication Reconciliation PI project



Percentage of encounters for which the patient was readmitted to the same facility within 30 days among all inpatient encounters

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HUMAN EXPERIENCE

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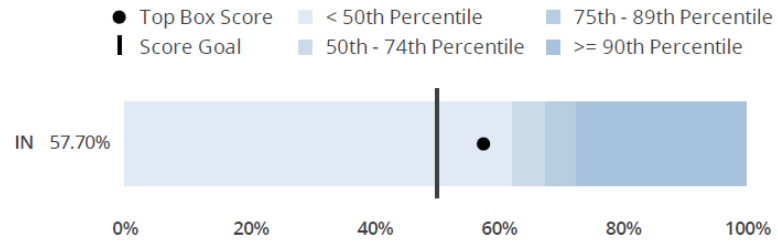
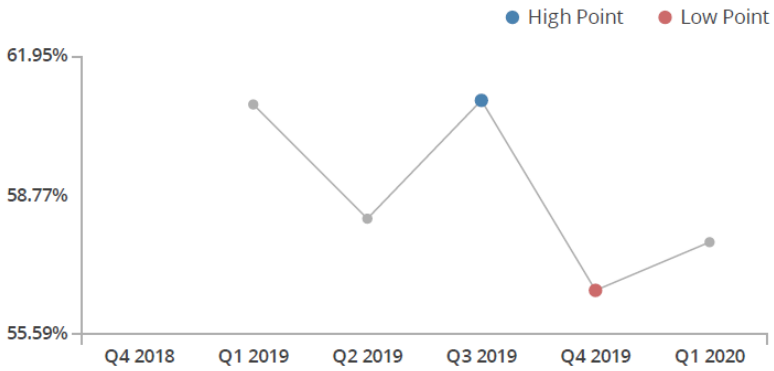
Inpatient Patient Satisfaction

Service Line Performance

PG Overall





n	56
Top Box Score	57.70%
Score Goal	50.00%
Percentile Rank	26

Time Period	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020
n		29	46	42	41	56
Top Box Score	N/A	60.86%	58.24%	60.95%	56.59%	57.70%
Percentile Rank	N/A	35	21	33	17	26

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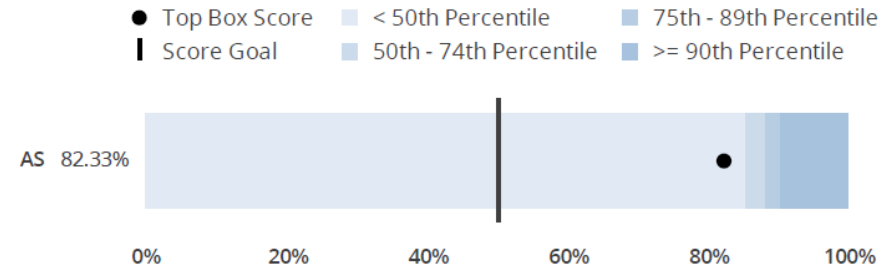
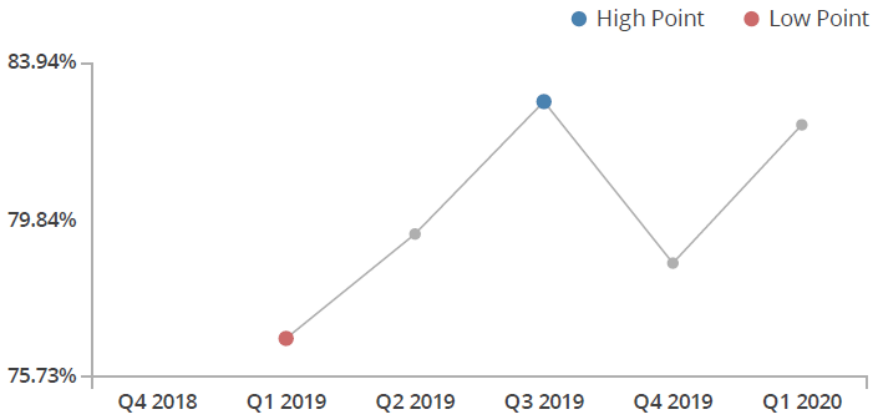
Surgery Patient Satisfaction

Service Line Performance

PG Overall





n	127
Top Box Score	82.33%
Score Goal	50.00%
Percentile Rank	25

Time Period	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020
n		89	198	162	112	127
Top Box Score	N/A	76.73%	79.47%	82.94%	78.71%	82.33%
Percentile Rank	N/A	7	14	34	11	25

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

Rate My Hospital

WEEKLY RATE MY HOSPITAL SCORES AND COMMENTS

Week ending June 12, 2020

Overall score: **4.73**

970 surveys sent since May 11, 2020.

249 responded (25.7%)

1134 total service recoveries since inception

Average department scores:

ED	4.56
OP Surg	4.72
OP PT	4.80
INPT Care	4.75
Imaging	4.78
Cardiopulm	4.84

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

Positive Feedback

Our ER is amazing!

I was well looked after

I pre-admissioned, so it was super easy

Fantastic staff all around!! Thank you.

The kitchen staff was very sweet, they went out of their way to bring me something that was forgotten on my meal tray

SVH is a real community asset

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

SUBJECT: Charter	POLICY: QA8610-108
	PAGE 0
DEPARTMENT: ORGANIZATIONAL	EFFECTIVE:
REVISED:	

NEW POLICY
Briefly state the reasons for creating a new policy.

WHY:

OWNER:
Chief Quality Officer

AUTHORS/REVIEWERS:
Danielle Jones, MSN, BSN, RN, HACP, Chief Quality Officer

APPROVALS:
Policy & Procedure Team:
Board Quality Committee:
The Board of Directors:

SUBJECT: Charter	POLICY: QA8610-108
	PAGE 1
DEPARTMENT: ORGANIZATIONAL	EFFECTIVE:
REVISED:	

PURPOSE:

The ~~Quality and Patient Safety Committee~~ [LG1]~~(Committee)~~ Board Quality Committee is responsible for guiding and assisting the Executive Leaders, Medical ~~Board~~[LG2]Staff, and the Governing Board in fulfilling their responsibility to oversee safety, quality, and effectiveness of care at Sonoma Valley Hospital; and to meet or exceed standards and regulations that govern health care organizations.

RESPONSIBILITIES:

The Committee has three broad sets of responsibilities.

1. ~~The first is~~ To directly oversee that quality assurance and improvement processes are in place and operating in the hospital ~~and clinics~~.
2. T~~The second is t~~o enhance quality across and throughout the patient care, technical, ~~patient care~~, and operations of the Sonoma Valley Hospital. ~~The latter~~This encompasses all aspects of the interface and experience between patients, families, and the community. This also includes coordination and alignment within the organization.
3. T~~The third is t~~o assure continual learning and skills development for risk surveillance, prevention, and continual improvement.

The committee ~~tests~~ examines all activities against the Institute of Medicine's Six Aims for Improvement: safe, effective, patient/family-centered, efficient, timely, and equitable. These aims are the drivers to the ~~Triple Quadruple~~[LG3] Triple Healthcare Aim: Better Care for patients ~~and~~and positive staff engagement ~~providers~~[LG4], Better Population Health, Lower Per Capita Cost.

~~In fulfilling these responsibilities, the committee expressly relies on the confidential protections afforded by law to review activities conducted for the purpose of reducing mortality, morbidity and improving the care provided to patients.~~

POLICY:

Oversight

As the governing body, the Governance Board is charged by law and by accrediting and regulatory organizations (e.g., Center for Improvement in Healthcare Quality CIHQ) with insuring the quality of care rendered by hospital ~~and clinics~~ through its various divisions and departments. The Committee has the delegated authority to establish accountability in medical

staff and management to assure improvement is occurring and targeted outcomes are achieved. To help meet this responsibility, the Board Quality Committee exists to:

- Develop the quality goals and blueprint (priorities and strategies) for Sonoma Valley Hospital, using an inclusive and data driven-process.
- Review and monitor patient safety, risk mitigation, quality assurance, and improvement plans and progress.
- Have the authority to initiate inquiries, studies, and investigations within the purview of duties assigned to the Committee.
- Perform, on behalf of the Governance Board and Medical Staff Leadership, such other activities as are required by the ~~TJC~~CIHQ, Centers for Medicaid and Medicare Services (CMS), ~~National Committee for Quality Assurance (NCQA)~~ and other external accrediting and regulatory bodies.
- ~~Perform such other activities as requested by the Executive Leadership of Sonoma Valley Hospital.~~
- Render reports and recommendations to the Executive Leadership Committee of Sonoma Valley Hospital, and Medical Board on its activities.
- ~~Perform such other activities as requested by the Executive Leadership of Sonoma Valley Hospital.~~
- Review all new and updated hospital organizational and [LG5]department policies for adherence to quality and safety priorities.
- Review all medical credentialing. ~~staff requiests to start or change staff clinical privileges for regulatory completeness, and quality and safety priorities, prior to sending requests to the Governing Body.~~
- ~~Review medical staff bylaws [DJ6]for completeness and adherence to legal requirements.~~
- Perform such other activities as requested by the Executive Leadership of Sonoma Valley Hospital.
-
-

- ~~The Committee has the delegated authority to establish accountability in medical staff and management to assure improvement is occurring and targeted outcomes are achieved.~~

Quality Integration

1. The Committee monitors the quality assurance and improvement activities of Sonoma Valley Hospital's entities to enhance the quality of care provided throughout the hospital or medical center system and encourage a consistent standard of care. Monitored activities include but are not limited to:
   a. Quality Performance Indicator Set
      i. Mortality
      ii. Preventable Harm Events
      iii. Healthcare Acquired Infection
      iv. Medication Events
      v. Never Events
      vi. Core Measures
      vii. Readmissions
      viii. Utilization Review
   b. Patient Experience
   c. Accreditation & Regulatory Standards
   d. Quality Assurance Performance Improvement
   e. Culture of Safety
   f. Risk Event Reports
   g. Policies & Procedures
   ~~1.~~h. Patient Care Contracts
   ~~*(List as relevant to the organization)*~~

~~2.~~• The Committee assures the coordination and alignment of quality initiatives throughout Sonoma Valley Hospital ~~.~~

~~3.~~• The Committee may initiate inquiries and make suggestions for improvement.

~~4.~~• The Committee conducts annual reviews of the following key areas:
- ~~a.~~ Improvement goal achievement
- ~~b.~~ Clinical outcomes (priorities and improvement)
- ~~c.~~ Patient Safety/Event Analysis/Risk Trending
- ~~d.~~ Culture of Patient Safety
- ~~e.~~ Accreditation and Regulatory Reviews
- ~~f.~~ Environment of Care and Disaster Management plans

~~5.~~ The Committee monitors the progress of quality assurance and improvement processes and serves as champion of issues concerning quality to other committees.

~~6.~~ The Committee identifies barriers to improvement for resolution and systematically addresses and eliminates barriers and excuses.

PROCEDURE:

Guidelines

Guidelines are designed to govern the operations of the Committee. ~~They will be developed over time~~[LG7] ~~as the Committee functions and performs its responsibilities.~~

~~1. Handling of Confidential Documents Absent a specific request, confidential documents will not be forwarded to Committee members who have indicated they will not be attending a meeting. Confidential documents will be distributed ahead of meetings with the standard agenda package. They will be separately identified, numbered and logged. They will be collected following review at meetings. A return envelope will be forwarded to Committee members unexpectedly unable to attend a meeting so they will have a convenient method of returning these materials. If sent electronically, appropriate security will be used.~~

~~2.~~1. Standard Agenda

The standard Agenda for the council will include:

- Quality Performance Indicator Set
- Clinical Priorities (clinical outcomes/process improvement), including:
  - Quality Assurance Performance Improvement
  - ~~*(List relevant services)*~~
  - Patient harm
  - Patient safety (adverse event reduction, healthcare acquired infection reduction, risk mitigation)
  - Performance to accreditation and regulatory standards and requirements
  - Patient Experience
  - Culture of Safety
  - Policies and Procedures
  - Environmental safety and disaster management
  - Medical Staff Credentialing

Rules

Authority to Act	~~Yes, within charter and~~ In compliance with the Charter and as directed by Executive Leadership and the District Board

SUBJECT: Charter	POLICY: QA8610-108
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DEPARTMENT: ORGANIZATIONAL	EFFECTIVE:
REVISED:	

~~Composition~~	~~Medical and Clinical Staff Leadership appointments; Operations, Executive~~ ~~Staff, and Board Members~~ ~~Patient/ Families membership should be considered~~
Meeting Schedule	At least ~~T~~ten meetings per year
Recommend Size:	~~Based on organization~~The Board Quality Committee shall have at least seven and no more than nine voting members. Two Board members, one of whom shall be the QC chair, the other the vice-chair. One designated position from the Medical Staff leadership, i.e., the Chief or the Vice Chief. At least four and no more than six members of the public.
Quorum Requirement:	~~Based on organization~~Half plus one member present.
Chair	Two appointed Board Members ~~Board Chair or Chief Executive Officer (CEO)~~
~~Major Staff Support~~	~~Chief Quality Officer and Patient Safety Officer, Quality Staff~~
~~Notices Forwarded To~~Composition	Committee Members, Presenters, CEO, Chief Medical Officer (CMO) and Chief Nursing Officer (CNO), Chief Quality Officer (CQO)
~~Non-member attendees~~	~~Staff resources as requested~~ ~~Subject matter experts as requested~~

~~**Summary of Quality and Patient Safety Committee Roles and Responsibility**~~

~~Provides the operational oversight to assess that quality and its measurement are anchored Sonoma Valley Hospital's Vision and Mission; and to assess the ability of Sonoma Valley Hospital to execute against identified Quality and Safety strategies. The Board is ultimately responsible for the work of Sonoma Valley Hospital and quality of that work and is assisted by the work of the Quality and Patient Safety Committee.~~

~~The Quality and Patient Safety Committee has the following specific responsibilities:~~

1. ~~Inspiring top-tier outcome performance in all clinical programs.~~
2. ~~Requiring consistency of purpose in achieving best practice in clinical outcome and safety.~~
3. ~~Keeping improvement as the focus against the theoretical limits of what is possible: aiming for zero defect care.~~
4. ~~Evaluating whether or not processes are in place and operating to demonstrate improvement is occurring.~~
5. ~~Reviewing key initiatives.~~
6. ~~Requiring measures.~~
7. ~~Focusing on performance results.~~
8. ~~Escalating barriers to progress to appropriate forums for resolution.~~
9. ~~Evaluating if community needs are met, which includes public accountability and regulatory~~
10. ~~C~~compliance.
11. ~~Leading celebration of gains made.~~
- ~~Improving its own methods.~~
- ~~Review all new and updated hospital organization and~~ [LG8]~~department policies for adherence to quality and safety priorities.~~
- ~~Review all medical staff requests to start or change staff clinical privileges for regulatory completeness, and quality and safety priorities, prior to sending requests to the Governing Body.~~

~~12.~~1. ~~Review medical staff bylaws for completeness and adherence to legal~~ requirements.

REFERENCES:
www.hginstitute.org

SUBJECT: Compliance Program Plan	POLICY:
	PAGE 1
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

CHANGE SUMMARY

WHAT: The Compliance Committee reviewed and updated the entire Compliance Program Plan to ensure a complete and up-to-date program based on best practices. Updates included identification of the current members of the Compliance Committee, roles and responsibilities, establishing the Compliance Hotline, communication to employees, required training for both employees and our Governing Board, identifying conflicts of interest and reporting responsibilities.

WHY: Past due for a regular review and update, in accordance to the plan itself. Last update was completed in 2014.

OWNER:
Lynn McKissock, Chief Compliance Officer

AUTHORS/REVIEWERS:
Danielle Jones, Chief Quality Officer
Dawn Kuwahara, Chief Ancillary Officer
Fe Sendaydiego, Chief Information Officer
Mark Kobe, Chief Nursing Officer
Rosemary Pryszmant, HIM Manager & Privacy Officer
Sarah Dungan, Controller
Stacey Finn, Medical Staff Coordinator