SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, SEPTEMBER 28, 2022

5:00 p.m. Regular Session

TO BE HELD VIA ZOOM VIDEOCONFERENCE

To Participate Via Zoom Videoconferencing
use the link below:
https://sonomavalleyhospital-org.zoom.us/j/98050082142?pwd=bWExcnlLRnp0T1I5TnVOcCtYaFgyZz09&from=addon

and Enter the **Meeting ID: 980 5008 2142**
Passcode: 423596

To Participate via Telephone only, dial:
1-669-900-9128 or 1-669-219-2599
and Enter the **Meeting ID: 980 5008 2142**
Passcode: 423596

AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a District meeting, please contact the Interim District Clerk, Stacey Finn, at sfinn@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	*Kornblatt Idell*	
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.*	*Kornblatt Idell*	
3. CONSENT CALENDAR • Minutes 08.24.22	*Kornblatt Idell*	Action
4. REHAB SERVICES QI/PI	*Gallo*	Inform
5. QUALITY INDICATOR PERFORMANCE AND PLAN	*Cooper*	Inform
6. PATIENT SATISFACTION DISCUSSION	*Cooper*	Inform
8. POLICIES AND PROCEDURES	*Cooper*	Review/ Recommend
9. MEETING SCHEDULE FOR NOVEMBER & DECEMBER	*Kornblatt Idell*	Action
10. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report		Action
11. ADJOURN	*Kornblatt Idell*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
August 24, 2022, 5:00 PM
MINUTES
Via Zoom Teleconference

Members Present – Via Zoom	Members Present cont.	Excused	Public/Staff – Via Zoom
Susan Kornblatt Idell Ingrid Sheets Carol Snyder Howard Eisenstark Michael Mainardi, MD			John Hennelly, CEO Jessica Winkler, CNO Chris Kutza, Pharmacy Director Andrew Solomon, MD, Chief of Staff Kylie Cooper, Quality and Risk Mgmt. Judy Bjorndal, Board Member Jenny Fontes, Board Clerk and Executive Assistant Kathy Beebe, Public

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Kornblatt Idell*	
	Meeting called to order at 5:00 p.m.	
2. PUBLIC COMMENT	*Kornblatt Idell*	
	None	
3. CONSENT CALENDAR	*Kornblatt Idell*	**ACTION**
• QC Minutes 07.27.22		**MOTION:** by Mainardi to approve with revisions, 2nd by Eisenstark. All in favor.
4. PHARMACY QI/PI	*Kutza*	**INFORM**
	Mr. Kutza reviewed the Pharmacy QI/PI. He discussed adverse drug events, including administration errors, high risk med errors, near misses, smart pump – no drug selected, and smart pump hard alerts and soft alerts. Mr. Kutza reviewed the antimicrobial	

	stewardship which included cefepime DOT, ertapenem DOT, levofloxacin DOT, meropenem DOT, pip-tazo dot, and antimicrobial spend PAPD. He touched on controlled substances and said they monitor anesthesia narcotic use and waste and do random audits of in-patient documentation of narcotic usage and said they are looking for patterns of use that may be concerning. Mr. Kutza discussed the IV room slide and said the IV room is where they mix IVs for patient use. On an annual basis they have a board of Pharmacy inspection for relicensing, so the IV room needs to be monitored closely. Pharmacy services include after hours interventions, pharmacy ED Tat, after hours pharmacy errors and clinical interventions-dollars saved. Lastly, Mr. Kutza reviewed ER pyxis override, pyxis overrides, and pyxis stockouts.	
5. QUALITY INDICATOR PERFORMANCE AND PLAN	*Cooper*	**INFORM**
	Ms. Cooper reviewed the Quality Indicator Performance and Plan for July 2022, which included mortality, AHRQ patient safety indicators, patient falls, readmissions, blood culture contamination, CIHQ stroke certification measures, utilization management, core measures, core measures sepsis, and infection prevention, inpatient patient satisfaction and ambulatory surgery patient satisfaction.	
6. PATIENT SATISFACTION DISCUSSION	*Cooper*	**INFORM**
	Ms. Cooper discussed the patient satisfaction results. She said the ER had 114 patients reply, the majority of people picked 5 out of 5. In-patient care, the Imaging Department, Physical Therapy, and Out-Patient Therapy all had great responses. Ms. Cooper said HCAPS are tied to Medicare and Rate My Hospital is an internal process to understand patient feedback. She said communication with patients is working because there has been a positive increase in the past three months. Ms. Cooper said communication, education on medications, and discharge instructions can have the	

	most impact. Ms. Idell Kornblatt would like to continue this conversation at future Quality Committee meetings.	
7. COMMITTEE MEMBER OPENING	*Kornblatt Idell*	**INFORM**
	Ms. Kornblatt Idell reminded the committee that there are two openings for community members on the committee.	
8. POLICIES AND PROCEDURES	*Cooper*	**REVIEW/ RECOMMEND**
	Ms. Cooper reviewed the following policies: PPE 90-day Supply Policy (EP) Stroke Admission Transfer Guidelines	
10. CLOSED SESSION/REPORT ON CLOSED SESSION	*Kornblatt Idell*	**ACTION**
a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	Medical Staff Credentialing was reviewed and approved.	**MOTION:** by Eisenstark to approve, 2nd by Sheets. All in favor.
11. ADJOURN	*Kornblatt Idell*	
	5:59 pm	

Rehab Services Report

Current YTD Review

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Therapy Staff

- Chris Gallo – Rehab Services Manager
- Marek Grzybowski PT- Lead OP
- Julius Rivera PT
- Christina Cary DPT
- Tori Dwyer DPT
- Austin Nickerson PTA
- Janine Cohen PT
- Christine Phillips PT
- Elise Alexander-Stone MACC SLP
- Tracey Airth-Edblom OTD, OTR/L, CHT

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Scope of Services

Physical Therapy- Inpatient / Outpatient with specialties in Pelvic health, Pilates, Balance, Golf and Vestibular/Concussion coming soon!

Speech Therapy- Inpatient / Outpatient with specialties in MBSS, LOUD Certification

Occupational Therapy- Outpatient with specialty in hand therapy including post-op static and dynamic splinting

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Accomplishments

- Staffing **Addition of needed staff in face of healthcare worker shortage including:**
  - **1 inpatient physical therapist**
  - **1 outpatient physical therapist and 1 outpatient PTA**
  - **1 Occupational therapist.**
- **Additional therapist c 20+ yrs of experience will be starting in Oct- bringing Vestibular/Concussion expertise.**

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Challenges

Staffing – IP- dearth of candidates, FMLA, Covid- necessitated me being full time inpatient therapist/manager.

OP-Volume of patients in context of other Valley provider closing –staffing shortage-nationwide, loss of staff- -prolonged waiting times, greater patient/provider variation

Utilization of travelers- cost- learning curves- impact on quality measures

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Volumes

- OP Rehab Visits

	2020	2021
PT	8,614	11,606
OT	1,049	1,247
ST	470	527
Totals	10,133	13,380

- IP Units of service

PT	5439	5513
ST	1104	1000

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2022 Rehab Services Quality Data

Rehab Services

Indicator	Performance	Most Recent	Trend	Period				
Rehab Services| Distance Ambulated Per plan of care |M|								
67% / 33% — History	Breaches Alarm	50% (4/8)	Deteriorated	Aug 2022	90%	80%	n/a	54%
Rehab Services| Inpatient Knee Extensor Range of Motion |M|								
75% / 25% — History	Target Met	100% (8/8)	No Change	Aug 2022	80%	75%	n/a	93%
Rehab Services| Inpatient Knee Flexion Range of Motion |M|								
25% / 25% / 50% — History	Breaches Alarm	38% (3/8)	Deteriorated	Aug 2022	90%	80%	n/a	75%
Rehab Services| Outpatient Chart Audits |M|								
8% / 92% — History	Breaches Alarm	79% (15/19)	Improved	Aug 2022	90%	80%	n/a	63%
Rehab Services| Outpatient Functional Ability Monitored - OT |M|								
16% / 59% / 25% — History	Target Undefined	n/a (0/0)		Aug 2022	90%	80%	n/a	69%
Rehab Services| Outpatient Functional Ability Monitored - PT |M|								
83% / 8% / 9% — History	Target Met	100% (2/2)	No Change	Aug 2022	90%	80%	n/a	97%
Rehab Services| Outpatient Timed Get Up & Go Score (TUG) recorded for Total Knee patients |M|								
16% / 67% / 17% — History	Breaches Alarm	50% (1/2)	Deteriorated	Aug 2022	90%	80%	n/a	62%

Goals for 2023

- Develop Aquatic Program in conjunction with Sonoma Splash
- Develop Vestibular/Concussion program
- EPIC Integration

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Quality Indicator Performance & Plan

September Board Quality

Data for August 2022

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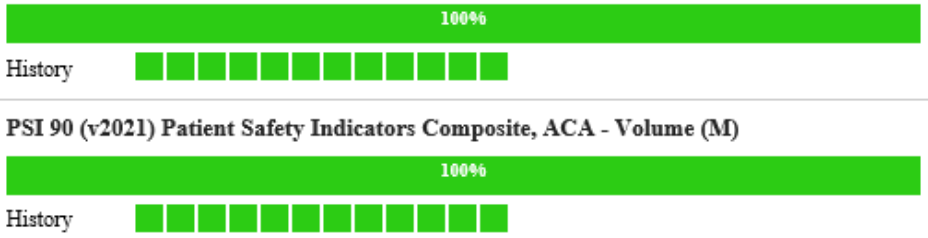
Mortality

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Acute Care Mortality Rate (M)								
	Target Met	1.6% 1/62	Deteriorated	Aug 2022	15.3%	n/a	n/a	3.2%
COPD Mortality Rate |M|								
	Target Met	0.0% 0/1	No Change	Aug 2022	8.5%	n/a	n/a	6.7%
Congestive Heart Failure Mortality Rate |M|								
	Target Met	0.0% 0/4	No Change	Aug 2022	11.5%	n/a	n/a	10.3%
Pneumonia Mortality Rate |M|								
	Target Met	0.0% 0/2	No Change	Aug 2022	15.6%	n/a	n/a	8.6%
Ischemic Stroke Mortality Rate |M|								
	Target Met	0.0% 0/2	No Change	Aug 2022	13.8%	n/a	n/a	0.0%
Hemorrhagic Stroke - Mortality Rate (M)								
	Target Met	0.0% 0/1	Improved	Aug 2022	0.0%	1.0%	n/a	20.0%

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Sepsis, Severe - Mortality Rate (M)								
	Target Met	0.0% 0/5	No Change	Aug 2022	25.0%	n/a	n/a	3.8%
Septic Shock - Mortality Rate (Q)								
	Target Met	0.0% 0/11	No Change	Q2-2022	0.0%	n/a	n/a	12.8%

AHRQ Patient Safety Indicators

Indicator	Performance	Most Recent	Trend	Period				
PSI 90 (v2021) Midas Patient Safety Indicators Composite, ACA (M)	Target Met	0.00 0/0.012	No Change	Aug 2022	0.00	n/a	n/a	0.00
PSI 90 (v2021) Patient Safety Indicators Composite, ACA - Volume (M)	Target Met	0	No Change	Aug 2022	0	n/a	n/a	0



The Patient Safety Indicators 90 (PSIs)

- PSI 03 Pressure Ulcer
- PSI 06 Iatrogenic Pneumothorax Rate
- PSI 08 In Hospital Fall with Hip Fracture
- PSI 09 Perioperative Hemorrhage or Hematoma
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis
- PSI 11 Postoperative Respiratory Failure
- PSI 12 Perioperative Pulmonary Embolism or DVT
- PSI 13 Postoperative Sepsis
- PSI 14a Postoperative Wound Dehiscence, Open
- PSI 14b Postoperative Wound Dehiscence, Non-Open
- PSI 15 Accidental Puncture or Laceration

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Patient Falls

Preventable Harm

Quality > Patient Safety > Falls

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
RM ACUTE FALL- All (M) per 1000 patient days								
75% / 25%	Target Met	0.00 0/238	Improved	Aug 2022	3.75	4.00	n/a	1.84
History								
RM ACUTE FALL- WITH INJURY (M) per 1000 patient days								
100%	Target Met	0.00 0/238	No Change	Aug 2022	3.75	4.00	n/a	0.31
History								

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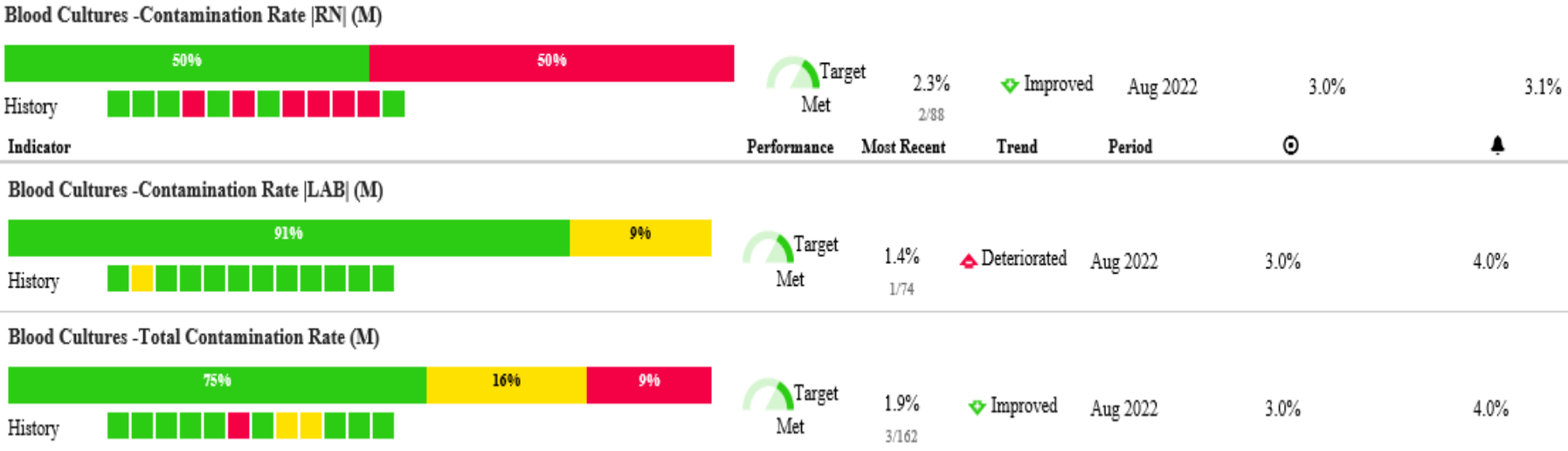
Readmissions

Readmissions

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
30-DV Inpatients - % Readmit to Acute Care within 30 Days (M)								
100%	Target Met	3.57% 2/56	Improved	Aug 2022	15.30%	15.50%	n/a	7.76%
History								
COPD, CMS Readm - % Readmit within 30 Days, ACA (M)								
50% 9% 41%	Target Met	0.0% 0/1	No Change	Aug 2022	19.5%	20.0%	n/a	8.3%
History								
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
75% 25%	Target Met	0.0% 0/3	No Change	Aug 2022	21.6%	22.0%	n/a	10.3%
History								
Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
83% 17%	Target Met	0.0% 0/2	No Change	Aug 2022	4.0%	5.0%	n/a	12.5%
History								
PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
75% 25%	Target Met	0.0% 0/2	No Change	Aug 2022	16.6%	17.0%	n/a	10.7%
History								
Sepsis, Severe - % Readmit within 30 Days (M)								
100%	Target Met	0.0% 0/5	No Change	Aug 2022	12.0%	13.0%	n/a	0.1%
History								
Septic Shock - % Readmit within 30 Days (M)								
100%	Target Met	1.0% 1/1	Deteriorated	Jul 2022	13.3%	14.0%	n/a	0.2%
History								

Blood Culture Contamination



Month	RN-Contaminated Culture Reports (num)	Blood Cultures Drawn by RN (den)	Percent
Aug 2022	2	88	2.3%
Jul 2022	4	89	4.5%
Jun 2022	3	82	3.7%
May 2022	5	107	4.7%
Apr 2022	5	81	6.2%
Mar 2022	2	71	2.8%
Feb 2022	8	92	8.7%
Jan 2022	2	88	2.3%
Dec 2021	3	92	3.3%
Nov 2021	2	91	2.2%
Oct 2021	2	92	2.2%
Sep 2021	1	71	1.4%

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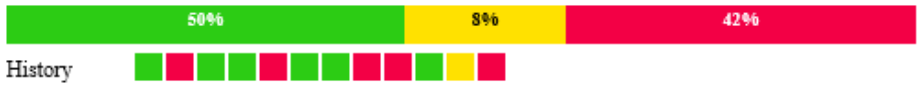
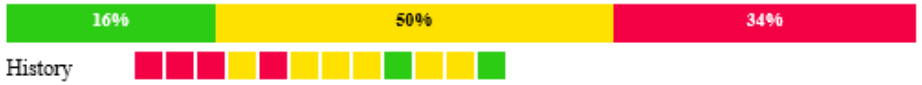
CIHQ Stroke Certification Measures

CDSTK-03|Median- Code Stroke Called |M| elapsed time (mins)	Target Met	0	Improved	Aug 2022	10	11	n/a	2
CDSTK-04|Median- Door to Phys Eval |M| minutes	Target Met	0.00	No Change	Aug 2022	10.00	11.00	n/a	0.75
CDSTK-05|Median- Door to CT Scanner |M|elapsed time (minutes)	Target Met	10.50	Deteriorated	Aug 2022	25.00	26.00	n/a	5.00
CDSTK-06|Median- Neuro Consult Contacted |M| minutes	Target Met	16.00	Improved	Aug 2022	30.00	31.00	n/a	18.75
CDSTK-07|Median- CT Read by Radiology |M| minutes	Target Met	30.00	Improved	Aug 2022	45.00	46.00	n/a	27.50
CDSTK-08|Median- Lab Results Posted |M| minutes	Target Met	27.00	Improved	Aug 2022	45.00	46.00	n/a	30.25
CDSTK-10|Median- Door to EKG Complete |M| minutes	Target Met	37.00	Improved	Aug 2022	60.00	61.00	n/a	40.00
CDSTK-11|Median-Door to tPA Decision |M| minutes	Target Met	54.00	Deteriorated	Aug 2022	60.00	61.00	n/a	35.00
CDSTK-12|Median-Door to tPA |M| minutes	Target Undefined	n/a		Aug 2022	60.00	61.00	n/a	71.00

Utilization Management

Utilization Management

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
1 Day Stay Rate Medi-Cal |M|								
	Breaches Alarm	11.11% 2/18	Deteriorated	Aug 2022	2.61%	5.00%	n/a	6.62%
1 Day Stay Rate-Medicare |M|								
	Breaches Alarm	13.33% 4/30	Deteriorated	Aug 2022	8.10%	10.00%	n/a	9.34%
Acute Care - Geometric Mean Length of Stay |M|								
	Target Met	2.75 30.1988/11	Improved	Aug 2022	2.75	3.23	n/a	3.21
Acute Care Age over 64 - MS-DRG Case Mix Index |M|								
	Bet. Target & Alarm	1.44 54.8406/38	Deteriorated	Aug 2022	1.56	1.40	n/a	1.50
Acute Care- MS-DRG Case Mix Index |M|								
	Bet. Target & Alarm	1.46 86.3859/59	Deteriorated	Aug 2022	1.55	1.40	n/a	1.50

Geometric mean is a statistical/mathematical term that is applied in many other areas outside of health care. This is calculated by multiplying all of the lengths of stay and then taking the nth root of that number (where n=number of patients). (Minimizes the impact of outliers)

The Case Mix Index (CMI) is the average relative DRG weight of a hospital's inpatient discharges, calculated by summing the Medicare Severity-Diagnosis Related Group (MS-DRG) weight for each discharge and dividing the total by the number of discharges.

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Core Measures

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M)								
	Target Met	100.0% 5/5	— No Change	Aug 2022	88.0%	50.0%	n/a	97.6%
Indicator	**Performance**	**Most Recent**	**Trend**	**Period**	⊙	🔔		✕
Core OP 18b Median Time ED Arrival to ED Departure - Reporting Measure (M)								
	Breaches Alarm	154.00	Improved	Aug 2022	132.00	140.00	n/a	147.00
Indicator	**Performance**	**Most Recent**	**Trend**	**Period**	⊙	🔔		✕
Core OP 22 ED LWBS Emergency Dept Left Without Being Seen (M)								
	Target Met	1.9% 15/792	Improved	Aug 2022	2.0%	2.5%	n/a	2.0%
Indicator	**Performance**	**Most Recent**	**Trend**	**Period**	⊙	🔔		✕
Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)								
	Target Undefined	n/a		Aug 2022	72.0%	70.0%	n/a	95.2%

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Core Measures Sepsis

Core Measures > Sepsis -SEP-1-

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock (M)								
	Target Met	85.7% 6/7	Improved	Aug 2022	81.0%	80.0%	n/a	82.4%
SEPa - Severe Sepsis 3 Hour Bundle (M)								
	Target Met	100.0% 7/7	Improved	Aug 2022	94.0%	90.0%	n/a	89.5%
SEPb - Severe Sepsis 6 Hour Bundle (M)								
	Target Met	100.0% 5/5	No Change	Aug 2022	100.0%	90.0%	n/a	98.1%

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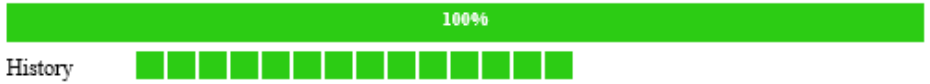
Infection Prevention

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
IC-Surveillance| HAI-C.DIFF Inpatient infections per 10k pt days |M|								
	Target Met	0	No Change	Aug 2022	1	1	n/a	0
IC-Surveillance| HAI-CAUTI Inpatient infections per 10k patient days |M|								
	Breaches Alarm	1	Deteriorated	Aug 2022	1	1	n/a	0
IC-Surveillance| HAI-CLABSI Inpatient infections per 10k patient days |M|								
	Target Met	0	No Change	Aug 2022	1	1	n/a	0
IC-Surveillance| HAI-MRSA Inpatient infections per 10k patient days |M|								
	Target Met	0	No Change	Aug 2022	1	1	n/a	0
IC-Surveillance| HAI-SSI infections per 10k pt days |M|								
	Target Met	0	No Change	Aug 2022	1	1	n/a	0

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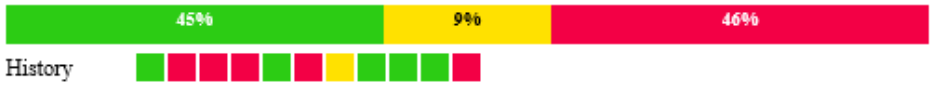
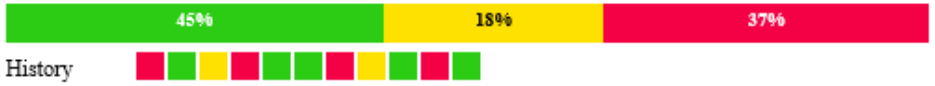
Inpatient Patient Satisfaction
N= 14

Patients' Perspectives of Care Surveys > Hospital -HCAHPS-

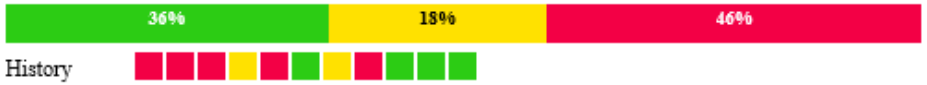
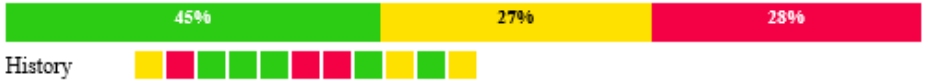
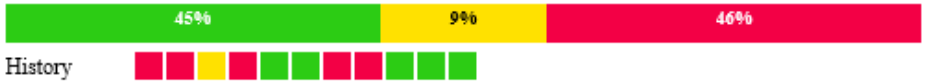
Indicator	Performance	Most Recent	Trend	Period				
01-Rate hospital 0-10 |M| Rank	Breaches Alarm	17	Deteriorated	Jul 2022	50	30	n/a	59
02-Recommend the hospital |M| Rank	Target Met	58	Deteriorated	Jul 2022	50	30	n/a	78
03-Communication w/ Nurses |M| Rank	Breaches Alarm	22	Deteriorated	Jul 2022	50	30	n/a	48
04-Response of Hosp Staff |M| Rank	Target Met	93	Improved	Jul 2022	50	30	n/a	74
05-Communication w/ Doctors |M| Rank	Breaches Alarm	3	Deteriorated	Jul 2022	50	30	n/a	49
06-Cleanliness of hospital environment|M| Rank	Target Met	81	Improved	Jul 2022	50	30	n/a	46





HCAHPS

Inpatient Patient Satisfaction

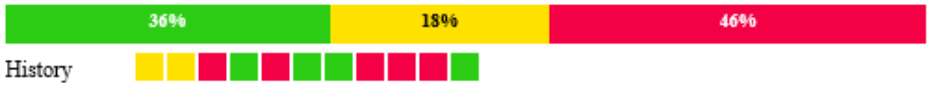
08-Communication About Medicines |M| Rank 	Target Met	84	Deteriorated	Jul 2022	60	30	n/a	45
09-Discharge Information |M| Rank 	Bet. Target & Alarm	35	Deteriorated	Jul 2022	50	30	n/a	47
10-Care Transitions |M| Rank 	Target Met	93	No Change	Jul 2022	50	30	n/a	48

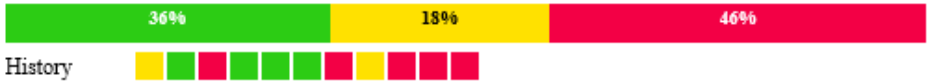
SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

Ambulatory Surgery Patient Satisfaction
N= 19

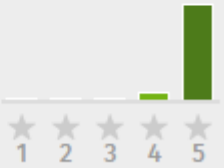
Patients' Perspectives of Care Surveys

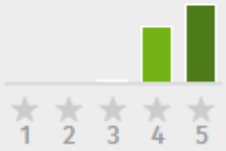
Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
01-OAS Recommend the Facility |M| Rank	Target Met	97	Improved	Jul 2022	50	30	n/a	55
02-OAS Communication |M| Rank	Target Met	73	Improved	Jul 2022	60	30	n/a	42
03-OAS Facility/Personal Treatment |M| Rank	Target Met	82	Deteriorated	Jul 2022	80	30	n/a	75
04-OAS Discharge |M| Rank	Breaches Alarm	1	Deteriorated	Jul 2022	70	30	n/a	43
05-OAS Staff treat w/courtesy and respect |M| Rank	Target Met	99	No Change	Jul 2022	60	30	n/a	76
07-OAS Facility Clean |M| Rank	Target Met	99	Improved	Jul 2022	60	30	n/a	91
ED-Time Physician Spent With Me Score (M)	Target Met	4.63	Deteriorated	Aug 2022	4.50	4.30	n/a	4.49





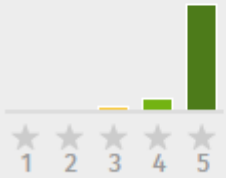
Rate My Hospital
Scale 1-5
July Data

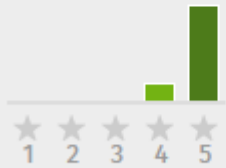
Rank	Department	Responses	Average Score	Score breakdown
1	Sonoma Valley Hospital / Emergency Department	101	4.65 95% CI: 4.49—4.81	

Rank	Department	Responses	Average Score	Score breakdown
1	Sonoma Valley Hospital / Inpatient Care	6	4.54 95% CI: 4.12—4.95	

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

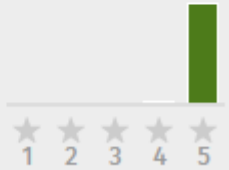
Rate My Hospital Scale 1-5

Rank	Department	Responses	Average Score	Score breakdown
1	Sonoma Valley Hospital / Medical Imaging	161	4.77 95% CI: 4.69—4.85	

Rank	Department	Responses	Average Score	Score breakdown
1	Sonoma Valley Hospital / Hand and Physical Therapy	18	4.81 95% CI: 4.64—4.99	

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

Rate My Hospital
Scale 1-5

Rank	Department	Responses	Average Score	Score breakdown
1	Sonoma Valley Hospital / Outpatient Surgery	32	4.95 95% CI: 4.88—5.00	

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

Document Tasks By Committee

Listing of currently pending and/or upcoming document tasks grouped by committee.

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)
Run date: 09/22/2022 10:12 AM

Report Parameters

Filtered by: Document Set: - All Available Document Sets -
Committee: 07 BOD-Quality (P&P Review)
Include Current Tasks: Yes
Include Upcoming Tasks: No

Grouped by: Committee

Sorted by: Document Title

Report Statistics

Total Documents: 20

Committee: 07 BOD-Quality (P&P Review)

Committee Members: **Finn, Stacey (sfinn), Newman, Cindi (cnewman)**

Current Approval Tasks (due now)

Document	Task/Status	Pending Since	Days Pending
Change from Natural Gas to Propane *Engineering Dept*	**Pending Approval**	9/6/2022	16

Summary Of Changes: **Reviewed, no changes.**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Gatenian, Grigory (ggatenian)**

Approvers: **Drummond, Kimberly (kdrummond) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Document	Task/Status	Pending Since	Days Pending
COVID-19 Surge Planning-Pharmacy *Emergency Preparedness Policies (EP)*	**Pending Approval**	9/22/2022	0

Summary Of Changes: **Deleted COVID-19 from title. Policy is generic to all pharmacy surge planning.**
no other changes

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Kutza, Chris (ckutza), Kobe, Mark (mkobe)**

Approvers: **00 Clinical P&P multidisciplinary review -> 01 P&P Committee - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Document	Task/Status	Pending Since	Days Pending
Critical Tests Results-Medical Imaging *Targeted Quality & Safety Initiatives Policies (QS)*	**Pending Approval**	9/22/2022	0

Summary Of Changes: **Reviewed Policy, Title Changes, Grammatical Changes, Change in Vendor for Remote Radiology Service, change is stat turn around time for Teleradiology services**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Young, Dave (dyoung)**

ExpertReviewers: **Medical Director-Diagnostic Radiology**

Approvers: **Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Electrical Lock Out Procedure	**Pending Approval**	9/6/2022	16
Engineering Dept			

Summary Of Changes: **Reviewed, no changes other than Approval personnel workflow**
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Gatenian, Grigory (ggatenian)**
Approvers: **Drummond, Kimberly (kdrummond) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Electrical Safety	**Pending Approval**	9/6/2022	16
Engineering Dept			

Summary Of Changes: **Reviewed, no changes other than approval personnel**
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Gatenian, Grigory (ggatenian)**
Approvers: **Drummond, Kimberly (kdrummond) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Emergency Battery Powered Lghts	**Pending Approval**	9/6/2022	16
Engineering Dept			

Summary Of Changes: **The policy was reviewed and no changes were made.**
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Gatenian, Grigory (ggatenian)**
Approvers: **Drummond, Kimberly (kdrummond) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Emergency Operations Plan	**Pending Approval**	9/22/2022	0
Emergency Preparedness Policies (EP)			

Summary Of Changes: **Substantive revisions including updating essential and emergent resource contacts, citation of SVH reference policy, Multiple grammatical changes. Addition Attachment I Temporary Emergent Staffing Agreement, Attachment J SVH Specialty Services & Transfer Guide. Attachment K, The First 10 Minutes of an Emergency, Update Long Term Care facilities list. Updated current reference links. Include link to Incident Response Guides including updated information on response to Active Shooter**
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Kobe, Mark (mkobe)**
ExpertReviewers: **Cooper, Kylie (kcooper), Finn, Stacey (sfinn), Hennelly, John (jhennelly), Kutza, Chris (ckutza), Kuwahara, Dawn (dkuwahara), McKissock, Lynn (lmckissock)**
Approvers: **00 Clinical P&P multidisciplinary review -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Hospital Evacuation During Disaster	**Pending Approval**	9/22/2022	0
Emergency Preparedness Policies (EP)			

Summary Of Changes: **Minor grammatical changes, updated Author/Reviewers list and updated hospital department locations**
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Kobe, Mark (mkobe)**
ExpertReviewers: **Finn, Stacey (sfinn)**
Approvers: **Kobe, Mark (mkobe) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

NEW VERSION::Annual Performance Evaluations	**Pending Approval**	9/6/2022	16
Human Resources Policies (HR)			

Summary Of Changes: **NEW Policy**

Replacing previous, outdated version that has now been retired.
Changed the schedule for the annual reviews to occur on the annual anniversary of the employee's employment or effective date of new position.
Updated procedures to correspond to current, electronic system and process.

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **McKissock, Lynn (lmckissock)**
Approvers: **Cooper, Kylie (kcooper) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

NEW:: FNS Department Employee Meals	**Pending Approval**	9/6/2022	16
Food & Nutrition Services Dept Policies			

Summary Of Changes: **New policy providing guidelines for FNS department employee meals**

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Finn, Bridget (bfinn)**
Approvers: **Drummond, Kimberly (kdrummond) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

NEW:::Delegation of Responsibilities, Clinical Lab	**Pending Approval**	9/22/2022	0
Laboratory Services Policies (LB)			

Summary Of Changes: **NEW POLICY**
This policy is being written as a result of our recent CLIA Survey. It is in response to a cited deficiency.

WHY: It identifies what responsibilities can be delegated by the Lab Medical Director to the Lab General Supervisor and Lab Technical Supervisor.

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Kuwahara, Dawn (dkuwahara), Ramos, Karen (kramos)**
ExpertReviewers: **Medical Director-Lab**
Approvers: **01 P&P Committee -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

NEW::Medicinal Cannabis Use in the Terminally Ill	**Pending Approval**	8/29/2022	24
Patient Rights Policies (PR)			

Summary Of Changes: **NEW POLICY**
To formulate a policy that allows permission for terminally ill patients to use medicinal cannabis while in the care of Sonoma Valley Hospital as required by SB 311, known as the Compassionate Access to Medical Cannabis Act.
WHY:
Effective January 1, 2022, SB 311, known as the Compassionate Access to Medical Cannabis Act (the Act), requires general acute care hospitals to permit terminally ill patients to use medicinal cannabis while in the health care facility.

Updated to include documentation in the medical record and monitoring by RN's

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Kutza, Chris (ckutza), Cooper, Kylie (kcooper)**
ExpertReviewers: **Kutza, Chris (ckutza)**

SUBJECT: Annual Performance Evaluations	POLICY # HR8610-372
	Page 1 of 3
DEPARTMENT: Organizational	EFFECTIVE: 10/22
REVIEW/REVISED:	

NEW POLICY

To replace the previous policy due to total re-write.

OWNER:
Chief Human Resource Officer

AUTHORS/REVIEWERS:
Chief Human Resource Officer
Director of Quality
Board Quality Committee

SUBJECT: Annual Performance Evaluations	POLICY # HR8610-372
	Page 2 of 3
DEPARTMENT: Organizational	EFFECTIVE: 10/22
REVIEW/REVISED:	

Purpose:
The employee performance evaluation process is designed to provide a means for discussing, planning and reviewing the performance of each employee; to promote meaningful, two-way communication about job performance successes, provide useful feedback about current job performance needs, identify future development opportunities, and to facilitate better working relationships.

Policy:
Hospital supervisors, managers, directors (Leaders) shall coach and counsel on an ongoing basis, as needed or requested, to discuss immediate needs, support, training, and/or professional development objectives and opportunities.

At least annually (as measured by the employee's latest date of hire or effective date of transfer or promotion into a new position), all hospital staff will receive a written performance evaluation completed by means of an individual performance evaluation meeting. The performance evaluation meeting and corresponding forms, are designed to facilitate an open conversation to discuss expectations regarding performance, provide feedback, assist in the development of strategies to achieve job requirements, identify strengths, and establish goals and objectives for continuous growth.

For newly hired, transferred or promoted employees, also see Orientation Period policy, #HR8610-112.

Procedure:

1. Each Leader shall review/audit the job description for the position under their purview to ensure current accuracy and relevancy of the position's requirements. If changes are identified, results shall be reviewed with the employee, and then obtain concurrence of the Administrative Representative. New or updated job descriptions are forwarded to Human Resources for processing. (See Job Descriptions policy, #HR8610-108, for further information)
2. Each employee shall receive a current job description as part of the initiation of the annual performance evaluation process. Employees shall complete their Self Evaluation form and submit to their direct Leader. The Self Evaluation form is provided electronically and is stored and maintained in the HRIS Employee Portal (Human Resources Information System), accessible from the hospital's intranet homepage.
3. The Leader will receive electronic notification when the employee has submitted their Self Evaluation form. Leader shall review the employee's form and reference, as needed, in the completion of the Manager's Review form prior to the performance evaluation meeting. The Manager's Review form is also stored and maintained in the HRIS Employee Portal.

4. An open and direct discussion between Leader and employee should occur during the performance evaluation meeting while reviewing the Manager's Review report.
5. Upon completion of the performance evaluation meeting, the Leader should revise any content in the Manager's Review report if adjustments were identified/discussed, and then submit to the employee for final review.
6. Once the Manager's Review report has been finalized, both the employee and the supervisor will electronically sign the evaluation report and an electronic copy will be retained in the HRIS Employee Portal platform for retention and future reference.

Reference:
Society for Human Resources Management (SHRM)

OWNER:
Chief Human Resource Officer

AUTHORS/REVIEWERS:
Chief Human Resource Officer
Director of Quality
Board Quality Committee

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

SUBJECT: FNS Department Employee Meals	POLICY: 8340-181
	Page 1 of 3
DEPARTMENT: Food and Nutrition Services	EFFECTIVE:
REVISED:	

Why/Objective:

To provide guidelines for Food and Nutrition Service staff meals whilst on duty.

OWNER:
Chief of Support Services

AUTHORS/REVIEWERS:
Director of Culinary Services

SUBJECT: FNS Department Employee Meals	POLICY: 8340-181
	Page 2 of 3
DEPARTMENT: Food and Nutrition Services	EFFECTIVE:
REVISED:	

PURPOSE:

To provide guidelines for Food and Nutrition Service staff meals whilst on duty.

POLICY:

All Food and Nutrition Services employees are entitled to one staff meal from the Vitality Café per shift worked. Staff meals will have an approximate value of $6.00 wholesale cost per day. Meals can be purchased in one transaction or split into two transactions, each represented by a "half meal." Items are classified based on approximate wholesale cost.

PROCEDURE:

Options for employee meals are as follows:

- Hot meal and drink (breakfast or lunch) = meal
- Grab and go sandwich/wrap/salad and drink = meal
- Grab and go sandwich/wrap/salad and snack = meal
- Drink and one snack item = half meal
- 2 snack items = half meal
- 2 drinks = half meal

All salad bar items need to be weighed and paid for separately

Snack = 2 cookies, 1 bag chips, 2 string or snack cheese, 1 slice cake or dessert, oatmeal, 2 pieces bacon or sausage, packaged fresh fruit, pickles, hard boiled eggs, cottage cheese, ½ wrap, bagel, scrambled eggs, hash browns, hot lunch side dish only

Employee meals will be rung into POS system utilizing the "employee meal" or "employee meal – half" key for tracking purposes.

Questions on items not specifically classified will be addressed by Director of Food and Nutrition Services or designated representative based on item cost

OWNER:
Chief of Support Services

SUBJECT: FNS Department Employee Meals	POLICY: 8340-181
	Page 3 of 3
DEPARTMENT: Food and Nutrition Services	EFFECTIVE:
REVISED:	

AUTHORS/REVIEWERS:
Director of Culinary Services
Board Quality Committee

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

SUBJECT: Delegation of Responsibilities, Clinical Lab	POLICY: LB8610-137
	Page 1 of 4
DEPARTMENT: Organization	EFFECTIVE:
REVISED:	

NEW POLICY
This policy is being written as a result of our recent CLIA Survey. It is in response to a cited deficiency.

WHY:

It identifies what responsibilities can be delegated by the Lab Medical Director to the Lab General Supervisor and Lab Technical Supervisor.

OWNER:
Chief Ancillary Officer

AUTHORS/REVIEWERS:
Laboratory Manager
Laboratory Medical Director

SUBJECT: Delegation of Responsibilities, Clinical Lab	POLICY: LB8610-137
	Page 2 of 4
DEPARTMENT: Organization	EFFECTIVE:
REVISED:	

PURPOSE:
To identify what responsibilities can be delegated by the Lab Medical Director to the Lab General Supervisor and Lab Technical Supervisor.

POLICY:
The Lab Medical Director (LMD) can delegate some responsibilities but remains "ultimately responsible and must ensure that all duties are properly performed and applicable CLIA regulations are met." CLIA delegated responsibilities must be in writing.

PROCEDURE:
The LMD must:

1. Ensure testing systems provide quality services during the preanalytic, analytic, and postanalytic phases and are appropriate for the patient population.
2. Ensure the laboratory's physical and environmental conditions are adequate and appropriate for the testing performed.
3. Provide an environment safe from physical, chemical, and biological hazards, and ensure safety and biohazard requirements are followed.
4. Ensure a general supervisor (high complexity testing) is available to provide day to day supervision of all testing personnel and reporting of test results and provide on-site supervision for specific minimally qualified testing personnel when they are performing high complexity testing.
5. Retain sufficient numbers of appropriated educated, experience, and/or trained personnel to provide consultation, properly supervise, and accurately perform tests and report test results in accordance with the written duties and responsibilities specified.
6. Assure new test procedures are reviewed, included in the procedure manual and followed by personnel.
7. Ensure each employee's responsibilities and duties are specified in writing.

The LMD may:

1. Delegate, in writing to a clinical consultant the responsibilities for ensuring:
   - Test reports include pertinent information for test interpretation, and
   - Availability for consultation concerning test results and the interpretation, of those results as they relate to specific patient conditions.

2. Delegate in writing to a technical consultant (moderate complexity) or technical supervisor (high complexity) the responsibilities for ensuring:
    - Appropriate test method selection.
    - Adequate method verification to determine the accuracy and precision of the test.
    - Enrollment of the laboratory in a CMS-approved proficiency testing (PT) program for the test performed.
    - PT samples are tested in accordance with the CLIA requirements.
    - PT results are returned within the time frames establish the by PT program.
    - PT reports are reviewed by the appropriate staff.
    - Corrective action plans are followed when PT results are found to be unacceptable or unsatisfactory.
    - Quality assessment and quality control programs are established and maintained.
    - Acceptable analytical test performance are established and maintained for each test system.
    - Remedial actions are taken and documented when significant deviations from the laboratory's established performance characteristics are identified, and patient test results are reported only when the system is functioning properly.
    - Personnel have been appropriately trained and demonstrate competency prior to testing patient specimens.
    - Policies and procedures are established for monitoring personnel competency in all phases (preanalytic, analytic, and postanalytic) of testing to assure the ongoing competency of all individuals who perform testing.
    - Remedial training or continuing education needs are identified and training provided; and
    - An approved procedure manual is available to all personnel.

As the LMD, you must monitor the conditions in the laboratory and ensure a quality management plan:

1. Ensure effective communication among management.
2. Review quality control and quality assessment methods.
3. If no problems are identified through quality control or quality assessment programs, investigate the need for more stringent or sensitive programs.
4. Ensure quality assessment activities include a mechanism for resolution for complaints received.
5. Ensure quality assessment activities include a mechanism to address breakdown in communication between the laboratory and those authorized to order tests and receive test results.
6. Review sample of PT results; ensure PT samples are test in same manner as patient specimens and the cause of PT failures is identified, corrected and documented.

7. Ensure lab staff and management are aware of CLIA requirements that preclude them from referring PT specimens to another lab or communicating about the results until after the date when the lab must report PT results.
8. Review a sampling of results obtained from procedures and their outcomes to verify accuracy of tests for which PT is not required.
9. Review policies and procedures for personnel evaluation and sampling of personnel evaluation.
10. Review a sampling of analytic performances of test systems for acceptability.

REFERENCES:
Clinical Laboratory Improvement Amendments (CLIA), Dept. of Health and Human Services, Centers for Medicare and Medicaid Services. Laboratory director responsibilities. Published August 2006.

OWNER:
Chief Ancillary Officer

AUTHORS/REVIEWERS:
Laboratory Manager
Laboratory Medical Director
Board Quality Committee

APPROVALS:
Policy & Procedure Team:
Medicine Committee:
Surgery Committee:
Performance Improvement/
Pharmacy & Therapeutics Committee
Medical Executive Committee:
The Board of Directors:

SUBJECT: Medicinal Cannabis Use in the Terminally Ill	POLICY: PR 8610-2201 Page 1 of 8
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

NEW POLICY

To formulate a policy that allows permission for terminally ill patients to use medicinal cannabis while in the care of Sonoma Valley Hospital as required by SB 311, known as the Compassionate Access to Medical Cannabis Act.

WHY:

Effective January 1, 2022, SB 311, known as the Compassionate Access to Medical Cannabis Act (the Act), requires general acute care hospitals to permit terminally ill patients to use medicinal cannabis while in the health care facility**.**

OWNER:

Director of Quality and Risk Management

AUTHORS/REVIEWERS:

Chief Medical Officer
Director of Pharmacy

SUBJECT: Medicinal Cannabis Use in the Terminally Ill	POLICY: PR 8610-2201 Page 2 of 8
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:

To formulize a policy that allows permission for terminally ill patients to use medicinal cannabis while in the care of Sonoma Valley Hospital (SVH).

POLICY:

In accordance with SB 311 all terminally ill patients will have the right to use medicinal marijuana while hospitalized at Sonoma Valley Hospital (SVH). This policy only applies to inpatients. The permission to use medicinal cannabis does not apply to a patient receiving emergency services and care and does not apply to the SVH Emergency Department. The law requires healthcare facilities to allow the use of medical cannabis on their premises for terminally ill qualified patients who have a valid Medical Marijuana Identification Card (MMIC) and/or recommendation from an attending physician.

DEFINITIONS:

Terminally ill means a patient with a medical condition resulting in a prognosis of life of one year or less if the disease follows its natural course.

Medical Marijuana Identification Card (MMIC) is a photo identification issued by the California Department of Public Health (CDPH) per HSC 11362.71 that verifies the validity and expiration date of the Qualified Patient's letter of recommendation for the medicinal use of cannabis.

Qualified Patient means an individual who possesses or cultivates cannabis for personal medicinal purposes upon the written or oral recommendation or approval of a physician licensed to practice medicine in California (HSC 11362.5(d))

Attending Physician means an individual who possesses a license in good standing to practice medicine, podiatry, or osteopathy issued by the Medical Board of California, the California Board of Podiatric Medicine, or the Osteopathic Medical Board of California and who has taken responsibility for an aspect of the medical care, treatment, diagnosis, counseling, or referral of a patient and who has conducted a medical examination of that patient before recording in the patient's medical record the physician's assessment of whether the patient has a serious medical condition and whether the medical use of cannabis is appropriate (HSC 11362.7(a)).

PROCEDURE:

A. Verifying Government-Issued Photo Identification (ID)

1. If the identity of the Qualified Patient or a designated Primary Caregiver presenting a MMIC or letter of recommendation has not already been established in the course of treatment, staff will request and inspect a government-issued photo ID from the Qualified Patient. The Primary Caregiver designated by the Qualified Patient may present ID in lieu of the patient if:
a. The Qualified Patient is under the age of eighteen (18), or
b. The Qualified Patient is incapable of presenting identification due to a physical or mental disability.

2. All government issued photo IDs presented by a Qualified Patient or a designated Primary Caregiver must be valid and unexpired. Acceptable forms of ID include:
a. The person's United States passport; other country's passport; or proper government-issued documentation for international travel provided it is lawful to use as identification in the United States.
b. The person's motor vehicle driver's license, whether issued by California or by any other state, territory, or possession of the United States, or the District of Columbia, provided the license displays a picture of the person.
c. A California identification card issued by the Department of Motor Vehicles; or
d. Any other identification card issued by a state, territory, or possession of the United States, the District of Columbia, or the United States that bears a picture of the person, the name of the person, the person's date of birth, and a physical description of the person.

3. Make a visual comparison of the picture and the individual presenting the ID to determine if the picture is similar in gender, race, and overall appearance. Remember that hairstyles, hair color, facial hair, and body weight can change over time.

4. Return the ID to the individual who presented it.

B. Verifying of MMIC

1. If the verification of a MMIC cannot be completed immediately, make a copy of the MMIC and return the original card to the Qualified Patient or Primary Caregiver that presented the card.
2. Inspect the MMIC card by comparing it to the sample card (see Exhibit A). All valid MMIC cards will conform to the sample.
a. Except as described below, the MMIC should be unexpired.

i. Special Note: On January 21, 2021, Governor Newsom issued another executive order Executive Order N-01-21 (PDF), affecting the expiration date of MMIC, which concerns current MMIC cardholders and their designated Primary Caregivers. Pursuant to this executive order, MMICs that would otherwise have expired on or after March 4, 2020, shall be valid until this Order is modified or rescinded, or until the State of Emergency is terminated, whichever occurs sooner.

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b. The picture on the MMIC should match the government-issued photo identification (ID) presented by the Qualified Patient or Primary Caregiver. Remember that hairstyles, hair color, facial hair, and body weight can change over time.

3. Visit http://mmic.cdph.ca.gov/MMIC_Search.aspx to verify the MMIC.

4. Enter the nine-digit Unique User Identification Number printed on the MMIC into the field indicated on the website. The website will return a result of verified or unverified.

5. Return the MMIC to the Qualified Patient or Primary Caregiver.

6. Record the results of the verification per the document retention and destruction procedure.

7. Transmit the results of the verification process to the designated personnel (e.g., attending physician).

C. Verifying a Letter of Recommendation

1. Make a copy of the original letter of recommendation for medical cannabis use presented by the Qualified Patient or the Primary Caregiver designated by the Qualified Patient and return the original copy to the presenting individual.

2. Complete a Consent for Verification Form (CVF) for the patient (see Exhibit B). Be sure to collect and record the recommending physician's contact information on the form.

3. Have the Qualified Patient sign the CVF. The Primary Caregiver designated by the Qualified Patient must sign the form if:
a. The Qualified Patient is under the age of eighteen (18), or
b. The Qualified Patient is incapable of signing the form due to a physical or mental disability.

4. Make a copy of the government-issued photo ID presented by the individual who signed the CVF.

5. Verify that the attending physician who signed the letter of recommendation was licensed by the Medical Board of California, the California Board of Podiatric Medicine, or the Osteopathic Medical Board of California on the date on which the attending physician signed the letter of recommendation.
a. Visit the California Medical Board's license verification page at https://www.mbc.ca.gov/License-Verification/default.aspx
b. Enter the information for the attending physician requested on the website.
c. The web site will result results indicating the status of the attending physician's license or date of revocation.

6. Transmit the CVF and a copy of the letter of recommendation to the recommending physician using the contact method and information recorded on the form. A recommending physician may request or require that recommendations be submitted for verification in a specific manner, including:
a. A telephone call with the physician or the physician's authorized agent,
b. A fax or scanned copy of the Consent for Verification Form and letter of recommendation, or
c. A web-based verification system designated by the recommending physician.

7. If the letter of recommendation cannot be verified immediately, attach the CVF the copy of the letter of recommendation and file both documents in the place designated for
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a. recommendation, or
b. A web-based verification system designated by the recommending physician.

8~~7~~. If the letter of recommendation cannot be verified immediately, attach the CVF the copy of the letter of recommendation and file both documents in the place designated for pending verifications.

9~~8~~. Record the results of the verification per the document retention and destruction procedure.

10~~9~~. Transmit the results of the verification process to the designated personnel (e.g., attending physician).

D. Patient or designee signs Sonoma Valley Hospital SB 311 Waiver

1. Patient or designee must sign Sonoma Valley Hospital SB 311 Waiver- See attachment B

2. Smoking or vaporizing is prohibited on the premises of SVH, therefore smoking or vaporizing cannabis or cannabis goods would be an immediate violation of this policy and the patient's right to use cannabis will be revoked.

E. STORAGE

1. Medicinal cannabis is considered the personal property of the patient and is not treated as a medication by SVH.
2. The manner in which a patient stores and uses medicinal cannabis will be reasonably restricted, including requiring that the medicinal cannabis is stored in a locked container to ensure the safety of other patients, guests, and employees of the health care facility, compliance with other state laws, and the safe operations of the health care facility.
    a. The patient's medicinal cannabis must be stored in a locked container.
    b. SVH will provide the locked container for the patient

F. DOCUMENTATION IN MEDICAL RECORD

1. The hospital must include the use of medicinal cannabis within the patient's medical record. The attending Physician will document in the medical record that the patient is self-administering medicinal marijuana including the amount and frequency. On the home medication list the pharmacist will document that the patient is taking medicinal marijuana.

2. SB 311 Chapter 4.9 does not require a health care facility to provide a patient with a recommendation to use medicinal cannabis in compliance with the Compassionate Use Act of 1996 and Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10 or include medicinal cannabis in a patient's discharge plan.

3. Nursing staff will monitor patient for any side effects and response to the self-administered doses, in a daily progress note.

G. COMPLIANCE WITH FEDERAL LAW

1. Health & Safety Code 1649.3 states notwithstanding the classification of medicinal cannabis as a Schedule I drug and any other law, health facilities permitting patient use of medicinal cannabis shall comply with drug and medication requirements applicable to Schedule II, III, and IV drugs and shall be subject to enforcement actions by the State Department of Public Health.

2. Health & Safety Code 1649.5 states that

(a) Compliance with this chapter shall not be a condition for obtaining, retaining, or renewing a license as a health care facility.

(b) This chapter does not reduce, expand, or otherwise modify the laws restricting the cultivation, possession, distribution, or use of cannabis that may be otherwise applicable, including, but not limited to, the Control, Regulate and Tax Adult Use of Marijuana Act, an initiative measure enacted by the approval of Proposition 64 at the November 8, 2016, statewide general election, and any amendments to that act.

3. Health & Safety Code1649.6 states that

(a) If a federal regulatory agency, the United States Department of Justice (US DOJ), or the federal Centers for Medicare and Medicaid Services (CMS) takes one of the following actions, a health care facility may suspend compliance with Section 1649.2 until the regulatory agency, the US DOJ, or CMS notifies the health care facility that it may resume permitting the use of medicinal cannabis within the facility:

(1) A federal regulatory agency or the US DOJ initiates enforcement action against a health care facility related to the facility's compliance with a state-regulated medical marijuana program.

(2) A federal regulatory agency, the US DOJ, or CMS issues a rule or otherwise provides notification to the health care facility that expressly prohibits the use of medical marijuana in health care facilities or otherwise prohibits compliance with a state-regulated medical marijuana program.

(b) This section does not permit a health care facility to prohibit patient use of medicinal cannabis due solely to the fact that cannabis is a Schedule I drug pursuant to the federal Uniform Controlled Substances Act, or other federal constraints on the use of medicinal cannabis that were in existence prior to the enactment of this chapter.

REFERENCES:

SB 311, Chapter4.9 (commencing with section 1649 of the Health & Safety Code), 2021 Compassionate Access to Medical Cannabis Act
California Healthcare Facility Implementation Guide for Ryan's Law, SB 311, Americans for Safe Access

OWNER:
Director of Quality and Risk Management

AUTHORS/REVIEWERS:

SUBJECT: Medicinal Cannabis Use in the Terminally Ill	POLICY: PR 8610-2201
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DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

Director of Pharmacy
Chief Medical Officer
Board Quality Committee

APPROVALS:
Policy & Procedure Team:
Medicine Committee:
Performance Improvement/
Pharmacy & Therapeutics Committee
Medical Executive Committee:
The Board of Directors: