SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, AUGUST 27, 2025

5:00 pm Regular Session

Held in Person:

SVH Administrative Conference Room

To Participate Via Zoom Videoconferencing, use the link below:
https://sonomavalleyhospital-org.zoom.us/j/99901004530?from=addon

Meeting ID: 999 0100 4530

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AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a District meeting, please contact the Board Clerk, Whitney Reese, at wreese@sonomavalleyhospital.org, 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	*Daniel Kittleson, DDS*	
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.*	*Daniel Kittleson, DDS*	
3. CONSENT CALENDAR • Minutes 06.25.25	*Daniel Kittleson, DDS*	Action
4. INPATIENT SERVICES QA/PI	*Jane Taylor RN, MSN, CENP*	Inform
5. PATIENT CARE SERVICES DASHBOARD 2ND QTR (2025)	*Jessica Winkler, DNP, RN, NEA-BC, CCRN-K*	Inform
6. QUALITY INDICATOR PERFORMANCE & PLAN	*Louise Wyatt, RN JD*	Inform
7. POLICIES AND PROCEDURES	*Louise Wyatt, RN JD*	Inform
8. ADJOURN	*Daniel Kittleson, DDS*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
Wednesday, June 25, 2025, 5:00 PM
MINUTES

Members Present	Excused/Not Present	Public/Staff – Via Zoom
Daniel Kittleson, DDS Wendy Lee Myatt Howard Eisenstark, MD Michael Mainardi, MD Kathy Beebe, RN PhD Carol Snyder Carl Speizer, MD Susan Kornblatt Idell Paul Amara, MD, FACOG, via zoom		Louise Wyatt, RN JD, SVH Director of Quality Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, SVH CNO Whitney Reese, SVH Board Clerk Leslie Petersen, SVH Foundation ED

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Daniel Kittleson, DDS*	
Kittleson called meeting to order at 5:00 p.m. Kittleson reminded that there is no July Quality Committee meeting and announced new SVH staff elections: Dr. Amara is new Chief of Staff, Dr. Rainow is new Vice Chief of Staff, Dr. Walther is Chair of Medicine, Dr. Fenton is Vice Chair of Medicine, Dr. Alexandridis is Chair of Surgery, and Dr. Weiss is Vice Chair of Surgery.		
2. PUBLIC COMMENT SECTION	*Daniel Kittleson, DDS*	
No public comments		
3. CONSENT CALENDAR	*Daniel Kittleson, DDS*	ACTION
Minutes 05.28.25	*Motion to approve by Eisenstark 2nd by Lee Myatt. All in favor.*	
4. EMERGENCY DEPARTMENT QA/PI	*Jessica Winkler, DNP, RN, NEA-BC, CCRN*	INFORM
Winkler presented for ED. Volumes have been trending upward, with a 9% increase compared to last year, and patient satisfaction remains strong despite higher demand. The "left without being seen" rate has dropped significantly, averaging about 1.2%, thanks in part to nurse-		

initiated order sets that keep patients engaged. Transfers remain steady at 8-10%, though admissions are trending slightly higher due to improved collaboration with hospitalists. Staff engagement is up, with employee survey results showing improvement and patient experience scores remain high overall. Operational improvements, including the addition of a clinical coordinator, better coordination with EMS, and adjustments to the ER's physical layout and equipment placement, are further strengthening efficiency and patient experience. The department continues to rely on some travelers but is actively recruiting permanent staff. Looking ahead, priorities include follow-up call protocols, emergency fire drills, survey readiness, and advancing age-friendly care initiatives.		
5. QUALITY INDICATOR PERFORMANCE & PLAN	*Louise Wyatt, RN JD*	INFORM
Wyatt presented a quality department overview and update, recognizing the expertise of its team members and highlighting significant progress with Age-Friendly Health System implementation, including "What Matters" conversations, medication review, mentation assessments, and mobility tracking for patients 65+. Risk management data showed most reported events in 2024 were medication related but resulted in no or minor harm, and staff explained how incidents are reviewed through monthly committees with physician champions. The team also reviewed patient satisfaction trends, where nursing care was praised though food services remained a common concern despite the new room-service model. Discussion was had around restraints, orthopedic length of stay, suicide precaution documentation requirements, and the need for more intuitive Epic workflows, with leadership affirming action plans and policy updates already underway. Looking forward, initiatives for 2025 include reducing CHF and COPD readmissions through early identification and Epic chat communication, strengthening skilled nursing facility collaboration, preparing for geriatric ED and surgical accreditation, and continuing multidisciplinary rounds that engage nutrition, PT, pharmacy, and respiratory therapy to reduce length of stay. Wyatt expressed confidence in the quality department's readiness for survey and commitment to advancing patient safety, quality outcomes, and continuous improvement.		
5. POLICIES & PROCEDURES	*Louise Wyatt, RN JD*	INFORM
Wyatt presented small changes in existing policies and procedures. No new policies were introduced.		
6. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	*Daniel Kittleson, DDS*	ACTION
Motion to recommend (with one revision requested) to Board of Directors for approval by Eisenstark, 2nd by Speizer. All in favor.		
7. ADJOURN	*Daniel Kittleson, DDS*	INFORM
	Meeting adjourned at 6:10 p.m.	

Quality Assurance Process Improvement

Inpatient Team

Jane Taylor RN, MSN, CENP
August 2025

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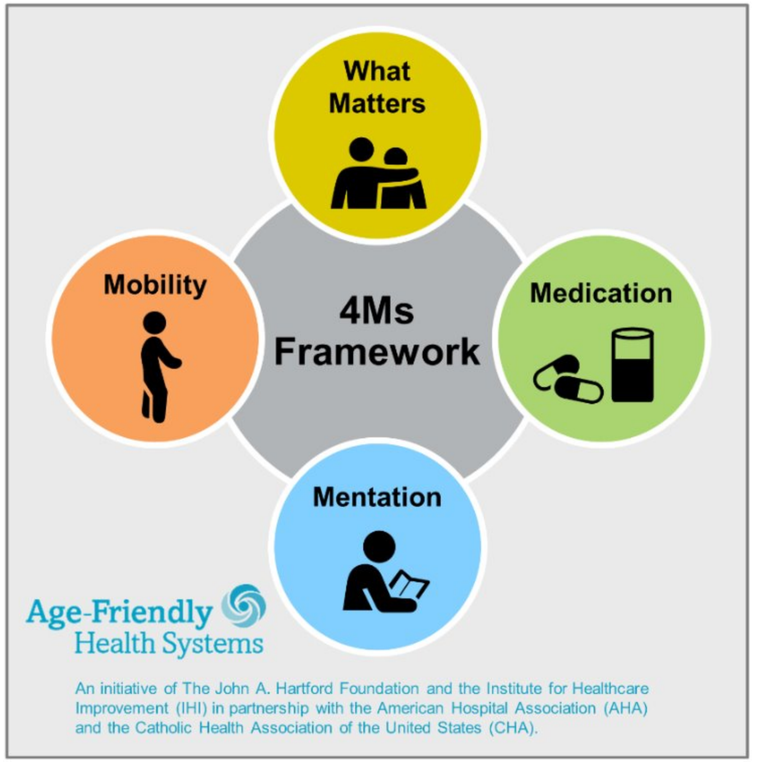
Quality Assurance 2025

3rd Floor Inpatient Team

1. Individualized Care Plans
2. Nursing Education on Discharge
3. Hand Hygiene
4. Patient Mobility, part of AFHS

Age Friendly Health System

- Designated as IHI Age Friendly Health System – Committed to Care Excellence
- Delirium Prevention strategies: sleep promotion using masks, lights on during day, CAM assessment for MedSurg and ICU, medication adjustments
- Collaboration with Pharmacy to prevent medication related issues
- Recliners in use for improving mobility, encouraging OOB for AM meals



What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

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Individualized Care Plans

All Patients should have a Care Plan that is individualized to their specific disease and needs

1st and 2nd Quarter 2025 Performance:

85 – 95 % -

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Nursing Education at Discharge

- Utilizing EPIC condition and medicationEducation tools to include in each After Visit Summary
- Pharmacy and RN Review with patient and family upon discharge to any disposition
- Press Ganey HCAPHS 2025 Quarter 1 Top Box Scores for Discharge Information:

SVH – 86.84%

CA State – 87.17%

All PG Database – 86.23%

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Hand Hygiene

All Staff and Providers for ICU and MedSurg

- Remain at 80-90% Compliance
- Continue to coach and educate on Hand Hygiene IN/OUT of patient rooms

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Patient Mobility

Percentage of Patients that have mobility measured Q Shift: 2025

January - 90

February - 90

March - 90

April - 80

May - 60

June - 75

July - 80

Initiative to increase OOB for AM Meals in Med Surg and ICU

- Discussion during huddles
- Engage the team - UA, CNA, RNs
- Engage the patient

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Other Quality Areas of Focus for 2025

Wound Care - Skin Assessment within 4 hours of Admission – 4E4H
Wound documentation and consult to WCRN

Inpatient Stroke Care - Achieved the 2025 Silver Plus Recognition for Quality Measures

Readmission Reduction – COPD and CHF: discharge checklists using MY PLAN, meds to beds, schedule follow up before DC,

Restraint use – education and review of all restraint use

ICU Remodel – ensuring safe quality care while in construction phase; optimize the unit to improve efficiency and performance

Onboarding/Education and Competency Improvements

Patient Care Services Dashboard 2025

Emergency Departmen	Quality Assurance				
	Q1	Q2	Q3	Q4	Target
Barcode Scanning Rate	82%	87%			>85%
1:1 Obs of High Risk Patients	75%	80%			100%
RN Bld Cx Contamination Rate	2.95%	1.95%			<3%

Inpatient	Quality Assurance				
Patient Discharge Education (AVS) related to diagnosis	Q1	Q2	Q3	Q4	Target
	72%	87%			90%
Mobility: OOB for Breakfast	67%	48%			90%

Surgical Services	Quality Assurance				
	Q1	Q2	Q3	Q4	Target
Day of Surgery Cx' Cases	2.86%	4.85%			<4%
First Case On-Time Start	58%	60%			80%

All	Medication Safety				
	Q1	Q2	Q3	Q4	Target
Drug Admin Error Rate (per 10,000 admins)	0.14 (n=3)	0.18 (n=6)			<1

All	Organ and Tissue Donation Referrals				
Missed referral	1	2			0
Referral not Timely	0	1			0

	Nursing Divison Turnover				
	Q1	Q2	Q3	Q4	Target
ED	0	2			<2
Inpatient	0	1			<2
Surgical Service	0	0			<2
TOTAL	0	3			<4

	Patient Experience				
Emergency D	Q1	Q2	Q3	Q4	Target
Q-Reviews	4.72	4.7			4.5
Inpatient	Q1	Q2	Q3	Q4	Target
Q-Reviews	4.74	4.7			4.5
Surgical Servic	Q1	Q2	Q3	Q4	Target
Q-Reviews	4.79	4.83			4.5

ED-Inpt	ughput- Admit Order to Admit Time (Ed-I				
	Q1	Q2	Q3	Q4	Target
Measure #mins Goal <60mins	51% n=30	48% n=65			80%
Avg / Median Mins	88.49 57	156 65			

SONOMA VALLEY HOSPITAL
Board Quality

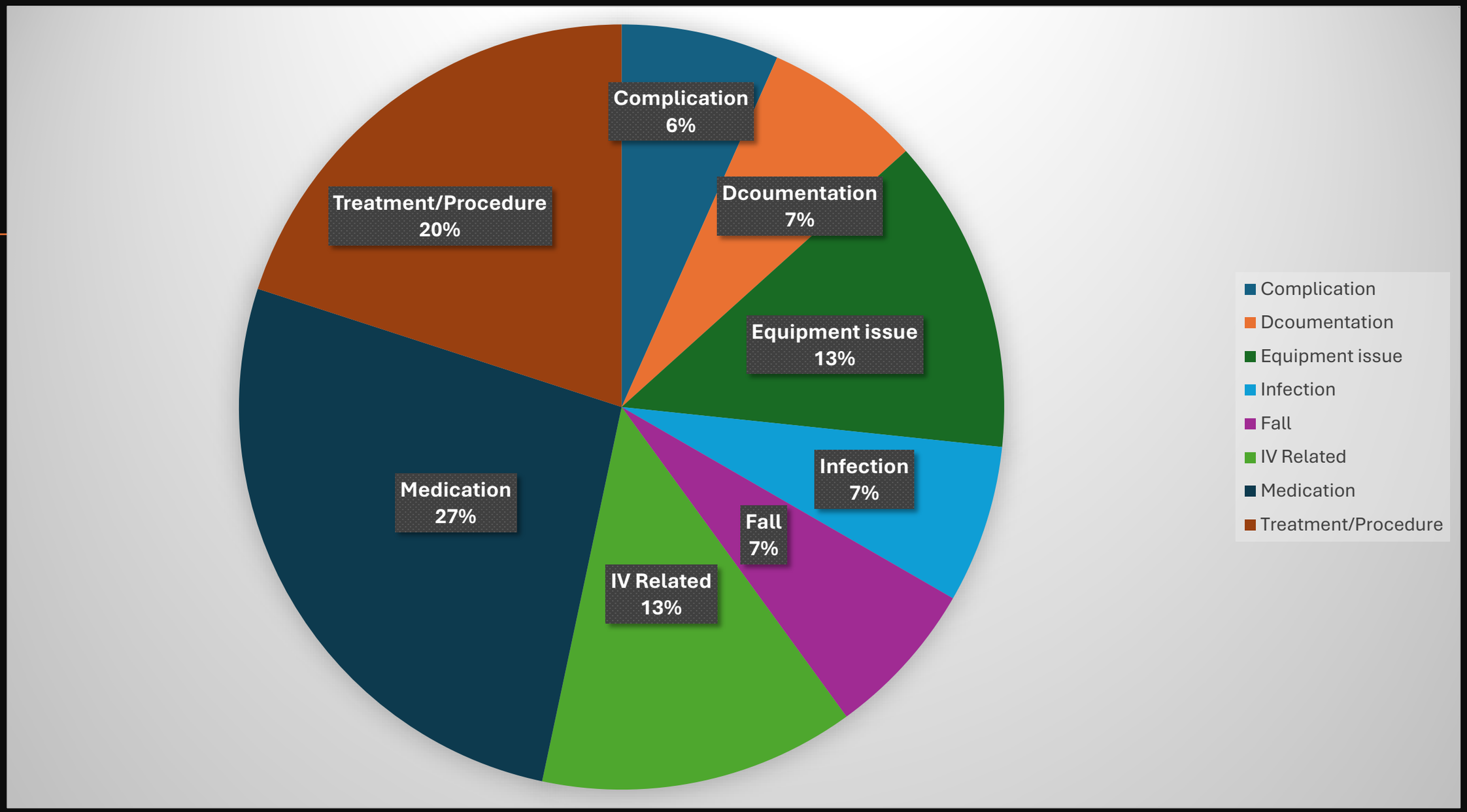
August 27, 2025

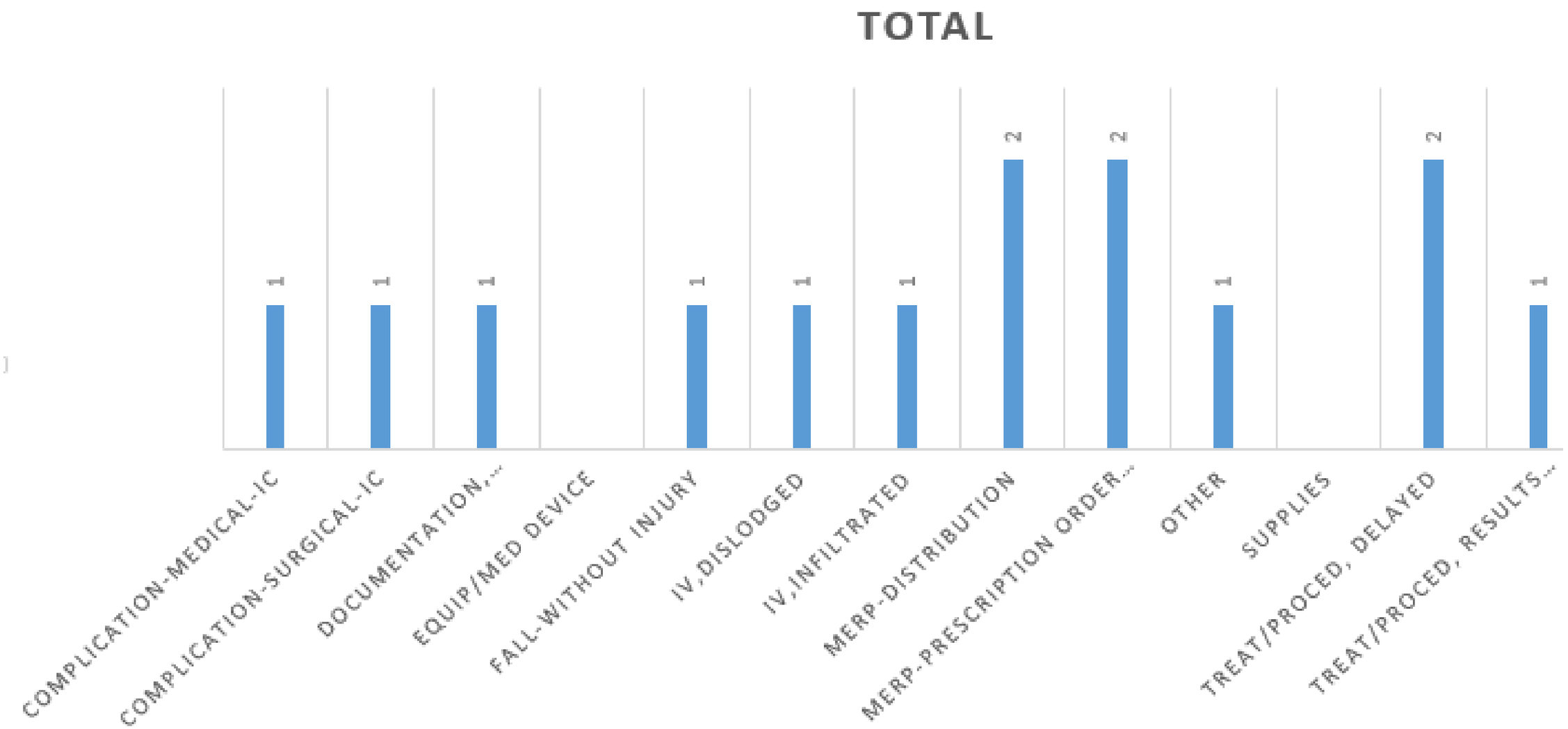
LOUISE WYATT, RN JD

Director of Quality, Risk Management, Patient Safety, Infection Control, Case Management & Regulatory

Risk Management/Patient Safety

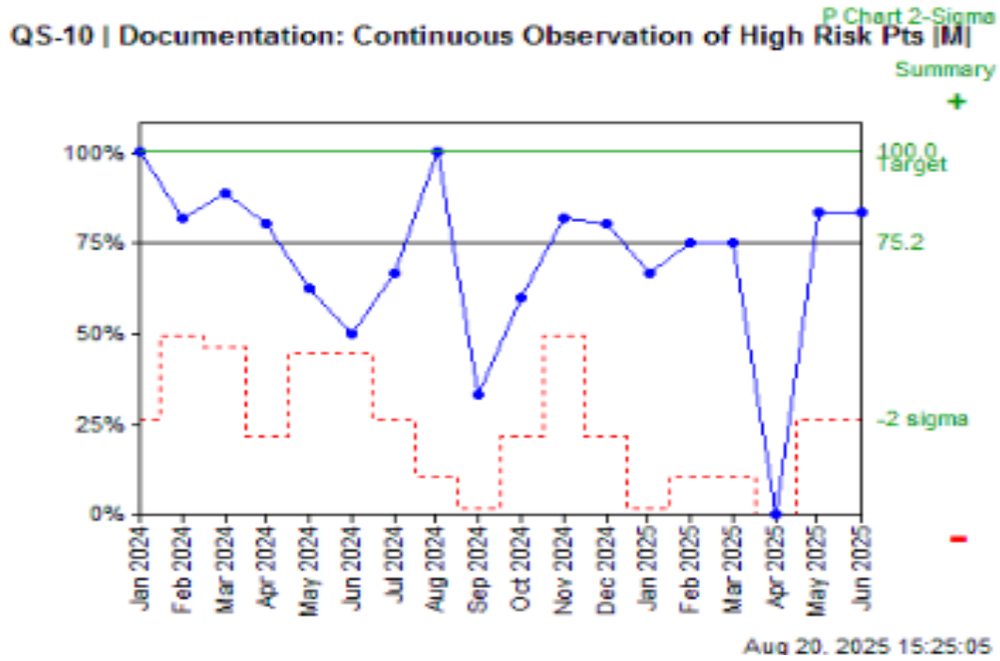
June 2025 RISK MANAGEMENT MIDAS REPORTS –





June 2025
Events by Number
Total 14

CIHQ Corrective Action Plan Monthly Compliance Condition Level Findings: Continuous Observation of High Risk of Self Harm Patients



DATE	1:1 Observation for High Risk Patie		Percent
Jun 2025	5	6	83%
May 2025	5	6	83%
Apr 2025	0	1	0%
Mar 2025	3	4	75%
Feb 2025	3	4	75%
Jan 2025	2	3	67%
Dec 2024	4	5	80%
Nov 2024	9	11	82%
Oct 2024	3	5	60%
Sep 2024	1	3	33%
Aug 2024	4	4	100%
Jul 2024	4	6	67%
Jun 2024	4	8	50%
May 2024	5	8	62%
Apr 2024	4	5	80%
Mar 2024	8	9	89%
Feb 2024	9	11	82%
Jan 2024	6	6	100%

<u>Issues Identified with Suicide Precaution Monitoring:</u>

1.MD Orders Required for Suicide Precautions

1. Current policy requires a physician's order to initiate suicide precautions.
2. Physicians reported they were previously unaware of this requirement, noting that suicide precautions have historically been initiated by nursing staff without an MD order.

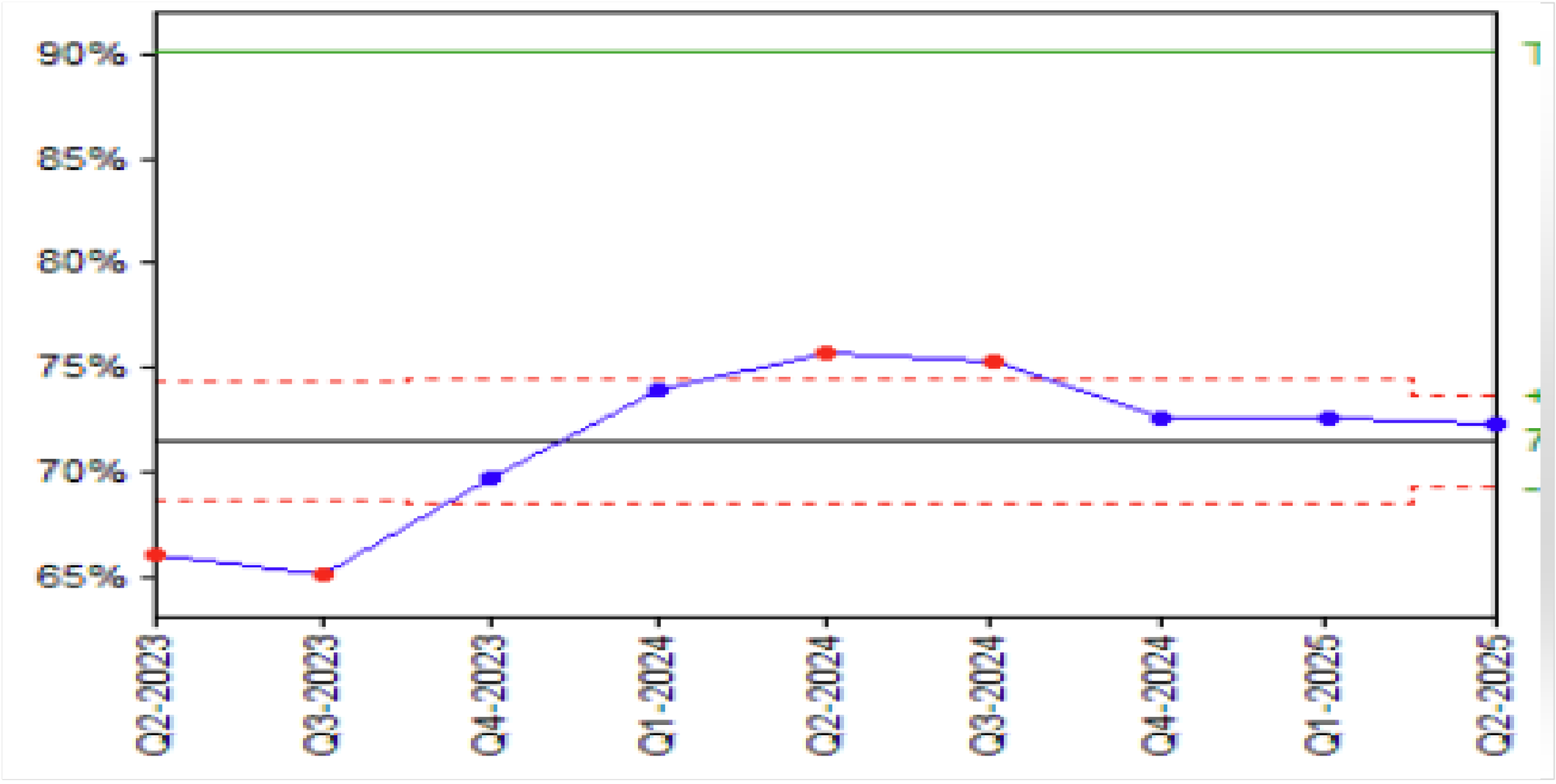
2.Documentation Workflow for Observations

1. Observations by RNs, CNAs, or ED Techs must be charted on the designated flow sheet.
2. The appropriate flow sheet is not automatically visible or intuitive; it must be manually searched for and added to each patient chart.

3.Minimum Documentation Frequency

1. Observations must be documented **at least every 1 hour** (q1h) in accordance with policy and safety standards.

Measures	*2024 Results*	*2025 Target*	25-Jan	25-Feb	25-Mar	Q1.2025	25-Apr	25_May	25-Jun	Q2.2025
Documentation Observation of High Risk Patients	**100%**	**100%**	**67%**	**75%**	**75%**	**72%**	**0%**	**83%**	**83%**	**77%**



CIHQ Corrective Action Plan: Policies and Procedures Compliance Condition Level

Finding

- 6 months of continuous compliance is required.
- Target is 90%
- Action plan: Policies and Procedures assignments for presentation and approval at the monthly Policy and Procedure Committee meeting.

Measures	*2024 Results*	*2025 Target*	Q1.2025	Q2.2025
Policies in Compliance for Reviews	**90%**	**90%**	**73%**	**72%**

QUALITY SCORECARD

QTR 1 & 2 2025

Measures	*2024 Results*	*2025 Target*	25-Jan	25-Feb	25-Mar	Q1.2025	25-Apr	25-May	25-Jun	Q2.2025
Risk Adjusted Acute Mortality Rate O/E [M]	*0.70%*	*0.89*	0.72%	0.69%	0.81%	0.74%	0.42%	0.83%	0.00%	0.58
Medicare Risk Adjusted Acute Mortality Rate O/E [M]	*0.70%*	*0.89*	0.71%	0.79%	0.47%	0.71%	0.62%	0.79%	0.00%	0.71%
COPD Mortality Rate |M| 5.6	*8.10%*	*8.5*	0%	0%	0%	0%	0%	0%	0%	0%
Congestive Heart Failure Mortality Rate |M|	*0.00%*	*11.5*	0%	0%	0%	0%	0%	20%	0%	8.30%
Pneumonia Mortality Rate |M|	*4.80%*	*15.60%*	0%	22%	0%	7.10%	0%	0%	0%	0%
Ischemic Stroke Mortality Rate |M|	*0.00%*	*13.80%*	0%	0%	0%	0%	0%	0%	0%	0%
Hemorrhagic Stroke - Mortality Rate (M)	*33.30%*	*0%*	ND	ND	ND	ND	0%	100% (1/1)	0%	100%
Sepsis, Severe - Mortality Rate (M)	*0.00%*	*25%*	25% (1/4)	0%	0%	10%	0%	0%	0%	0%
Septic Shock - Mortality Rate (M)	*30%*	*25%*	43% (3/7)	20%	0%	28.60%	ND	0%	33% (1/3)	0%
PSI 90 (v2023-1) Midas Patient Safety Indicators Composite, ACA per 1000 pt days (M) (Midas calculations based on a Comparative database)	*0*	*0*	0.01	0	0	0.0004	0	0	0	0
PSI 90 (v2023-1) Patient Safety Indicators Composite, ACA - Numerator Volume (M) (Count of encounters that qualify for the numerator of AHRQ measures.)	*0*	*0*	1	0	0	1	0	0	0	0

Mortality and PSI 90

Patient Safety indicators (PSI) is a composite score that ssesses patient safety in a hospital. It summarizes performance across several preventable hospital acquired conditions and complications, such as falls, pressure ulcers, respiratory failure, sepsis rates, pulmonary embolisms or deep vein thrombosis

O/E ratio = observed/expected rate: calculated by dividing the observed number of events by the expected number of events.
Observed means the actual number of events (e.g., deaths, complications) that occurred.
Expected means The number of events predicted based on a risk model or other factors (e.g., patient demographics, disease severity)

Measures	*2024 Results*	*2025 Target*	25-Jan	25-Feb	25-Mar	Q1.2025	25-Apr	25-May	25-Jun	Q2.2025
RM ACUTE FALL- All (M) per 1000 patient days	*2.94*	*3.75*	3.17	3.25	0	2.08	0%	0%	0%	0%
RM ACUTE FALL- WITH INJURY (M) per 1000 patient days	*1.1*	*3.75*	0	0	0	0	0%	0%	0%	0%
Rx-ADEs-High Risk Med Errors Per 10,000 Doses (M)	*0.03*	*1.13*	0%	0%	0%	0%	.10	0.08	0.9	0.9
Rx-Administration Errors Per 10,000 Doses Dispensed	*0.45*	*1*	0.1	0.1	0.19	0.14	0%	0.33	0%	0.18

1. FALLS
2. MEDICATION ERRORS

Infection Control

Measures	*2024 Results*	*2025 Target*	25-Jan	25-Feb	25-Mar	Q1.2025	25-Apr	25-May	25-Jun	Q2.2025
IC-Surveillance| HAI-C.DIFF Inpatient infections SIRs |M|	*2*	*1*	0	0	0	0	0	0	0	0
IC-Surveillance| HAI-CAUTI Inpatient infections SIRs |M|	*0*	*1*	0	0	0	0	0	0	0	0
IC-Surveillance| HAI-CLABSI Inpatient infections SIRs|M|	*0*	*1*	0	0	0	0	0	0	0	0
IC-Surveillance| HAI-MRSA Inpatient infections SIRs|M|	*0*	*1*	0	0	0	0	0	0	0	0
IC-Surveillance| HAI-SSI infections SIRs|M|	*0*	*1*	0	0	0	0	0	2	0	2
QA-02 | Hand Hygiene Practices Monitored % of compliance|M|	*90%*	*90%*	98	92	82%	91%	96%	92%	94%	94%

INFECTION

HAI – SSI: 2 readmits following surgery.

LAB/TRANSFUSIONS

BLOOD CULTURES

Measures Lab Transfusions	*2024 Results*	*2025 Target*	25-Jan	25-Feb	25-Mar	Q1.2025	25-Apr	25_May	25-Jun	Q2.2025
Lab | Transfusion Effectiveness (M)	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	100%	100%	100%	100%
Lab | Transfusion Reaction (M)	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	0%	0%	100%	100%
Blood cultures										
Blood Cultures -Contamination Rate |ED RN| (M)	*3%*	*3%*	2.70%	1.30%	5% (7/139)	3%	4.20% (5/120)	1.90%	2.40%	2.90%
Blood Cultures -Contamination Rate |LAB| (M)	*2%*	*3%*	0%	0%	0%	0%	1.20%	2.90%	0%	1.50%
Blood Cultures -Total Contamination Rate (M)	*3%*	*3%*	1.80%	1.00%	3.30% (7/209)	2.00%	2.80%	2.30%	2.40%	2.50%

STROKE

Measures	*2024 Results*	*2025 Target*	25-Jan	25-Feb	25-Mar	Q1.2025	25-Apr	25-May	25-Jun	Q2.2025
CDSTK-03|Median- Code Stroke Called |M| elapsed time (mins)	*5*	*10*	1	8	8	2	1	6	1	2
CDSTK-04|Median- Door to Phys Eval |M| elapsed time (mins)	*1*	*10*	0	2	0	0	0	2	1	0
CDSTK-05|Median- Door to CT Scanner |M|elapsed time (mins)	*9*	*25*	1	8	11	6	2	8	2	3
CDSTK-06|Median- Neuro Consult Contacted |M| elapsed time (mins)	*25*	*30*	8	14	20	14	12	24	7	12
CDSTK-07|Median- CT Read by Radiology |M| elapsed time (mins)	*26*	*45*	15	30	31	22	19	26	18	20
CDSTK-08|Median- Lab Results Posted |M| elapsed time (mins)	*25*	*45*	20	21	26	21	19	34	16	22
CDSTK-10|Median- Door to EKG Complete |M| elapsed time (mins)	*29*	*60*	21	28	25	25	22	30	22	22
CDSTK-11|Median-Door to tPA Decision |M| elapsed time (mins)	*31*	*60*	19	34	30	30	14	36	24	24
CDSTK-12|Median-Door to tPA |M| elapsed time (mins)	*74*	*60*	48	ND	ND	48	41	ND	29	39

Average Length of Stay (ALOS) AND Readmissions

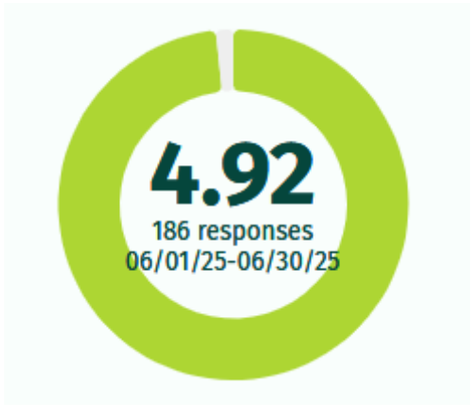
O/E ratio = observed/expected rate: calculated by dividing the observed number of events by the expected number of events.
Observed means the actual number of events (e.g., deaths, complications) that occurred.
Expected means The number of events predicted based on a risk model or other factors (e.g., patient demographics, disease severity)
Mean is dataset is the sum of all values divided by the total number of values. It's the most used measure of central tendency and is often referred to as the "average

Measures	*2024 Results*	*2025 Target*	25-Jan	25-Feb	25-Mar	Q1.2025	25-Apr	25-May	25-Jun	Q2.2025
Acute Care Risk-adjusted Average Length of Stay, O/E Ratio |M	*0.86*	*0.99*	0.9	0.99	1.01	0.97	1.01	1.02	1.11	1.04
Inpatients Risk-adjusted Average Length of Stay, O/E Ratio |M	*0.86*	*0.99*	0.9	0.98	0.97	0.93	1.01	0.96	1.11	0.91
Medicare Risk-adjusted Average Length of Stay, O/E Ratio |M	*0.79*	*0.99*	0.82	0.97	0.97	0.9	1.09	0.92	0.97	0.99
Acute Care - Geometric Mean Length of Stay |M	*3.59*	*2.75*	4.15	2.85	3.26	3.22	3.4	2.94	2.97	3.1
30-DV Inpatients - % Readmit to Acute Care within 30 Days (M	*6.39*	*15.30%*	13.43%	6.35%	7.14%	9.00%	4.41%	8.93%	7.58%	7.41%
COPD, CMS Readm - % Readmit within 30 Days, ACA (M	*7.10%*	*19.50%*	0.00%	40%	0.00%	22.20%	0%	16.7	50%	16.70%
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	*13.50%*	*21.60%*	0%	0%	0%	0%	0%	0%	33.30 %	10%
Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M	4.00%	*4.00%*	0%	0%	0%	0%	0%	0%	0%	0%
PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M	*7.10%*	*13.60%*	8.30%	0%	0%	8.70%	0%	20%	12.50 %	12.50%
Sepsis, Simple - % Readmit within 30 Days (M)*	*0.03%*	*0.00%*	0.27% (3/11)	0%	0%	0.14%	0.14% (1/7)	0.20% (1/5)	0.08% (1/12)	0.12%
Sepsis, Severe - % Readmit within 30 Days (M)	0%	12%	0%	0%	0.30%	0.10%	0.50%	0%	0.00%	0.20%
Septic Shock - % Readmit within 30 Days (M)	*0.20%*	*13.30%*	0%	0%	0.50%	0.20%	0%	0%	0.20%	0.20%

Measures Core OP (Outpatient Measures)	*2024 Results*	*2025 Target*	25-Jan	25-Feb	25-Mar	Q1.2025	25-Apr	25_ May	25-June	Q2.2025
Core OP 22 ED LWBS Emergency Dept Left Without Being Seen (M	*0.30%*	*2.00%*	0.40 %	0.40%	0.40%	0.40%	0.60%	0.60%	0.10%	0.40%
Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)	*97%*	*80%*	100%	100%	ND	100%	100%	100%	100%	100%
Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M	100%	*88%*	100%	100%	100%	100%	100%	100%	100%	100%
Core OP 18b Median Time ED Arrival to ED Departure - Reporting Measure (M	*140*	*132*	154	120	105.5	126	76	113	107	106
Sep 1 – Bundle Compliance										
SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock (M)	*80%*	*81%*	100%	100%	50% (1/2)	93.80%	100%	100%	80% (8/10)	78.60%
SEPa - Severe Sepsis 3 Hour Bundle (M	*89.30%*	*94%*	100%	100%	100%	100%	100%	100%	100%	100%
SEPb - Severe Sepsis 6 Hour Bundle (M)	*89.30%*	*100%*	100%	100%	100%	100%	100%	100%	100%	100%

Q Reviews – June 2025

Hand and Physical therapy

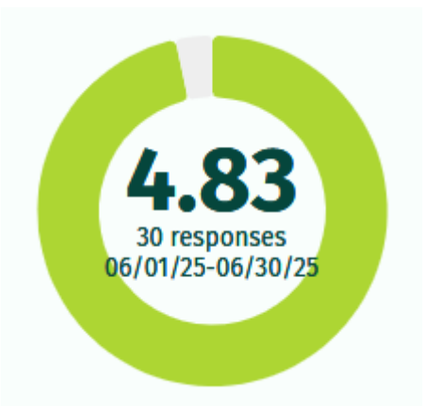


Emergency

Inpatient

Medical Imaging

Outpatient Surgery



WRAP UP/ QUESTIONS

Document Tasks By Committee

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

Sonoma Valley Hospital

Run by: Wyatt, Louise (lwyatt)
Run date: 08/20/2025 11:18 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: 2

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

Committee Members: **Newman, Cindi (cnewman), Reese, Whitney (wreese)**

Current Approval Tasks (due now)

Document	Task/Status	Pending Since	Days Pending
NEW: Age-Friendly Health System (AFHS) *Patient Care Policy*	**Pending Approval**	8/19/2025	1

Summary Of Changes: **NEW POLICY: The purpose of this policy is to establish a standardized approach to delivering safe, evidence-based, and person-centered care to older adults in alignment with the Age-Friendly Health System Centers for Medicare and Medicaid Services Inpatient Quality Reporting (AFHS CMS IQR) domains.**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**

Lead Authors: **Spear, Becky (rspear)**

Approvers: **Wyatt, Louise (lwyatt) -> 01 P&P Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Document	Task/Status	Pending Since	Days Pending
Patient Grievance and Complaint Policy *Patient Rights Policies (PR)*	**Pending Approval**	7/17/2025	34

Summary Of Changes: **Reviewed. No changes.**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**

Lead Authors: **Wyatt, Louise (lwyatt)**

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

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
HEALING HERE AT HOME

NEW POLICY Document Cover Sheet
AGE-FRIENDLY HEALTH SYSTEM

DEPARTMENT: Organizational

NEW POLICY
WHY: To formalize Sonoma Valley Hospital's commitment to being an Age-Friendly Health System (AFHS) and align with Center for Medicare and Medicaid (CMS) Inpatient Quality Reporting (IQR) domains.

OWNER:
Chief Executive Officer

AUTHORS/REVIEWERS:
Geriatric Nurse Practitioner
Chief Nursing Officer
Director of Quality
AFHS Multidisciplinary Committee
Board Quality Committee

Policy Name: Age-Friendly Health System (AFHS)		Policy#: PC8610-2411 Origination Date:11/2024
Department: Medicine, Nursing	Review Dates: Revision Dates:	
Scope: Organizational	Effective Date: BOD Approval Dates:	

PURPOSE:
The purpose of this policy is to establish a standardized approach to delivering safe, evidence-based, and person-centered care to older adults in alignment with the Age-Friendly Health System Centers for Medicare and Medicaid Services Inpatient Quality Reporting (AFHS CMS IQR) domains.

POLICY:
Sonoma Valley Hospital ("the hospital") is fully committed to maintaining and promoting its status as an Age-Friendly Health System. To achieve this, the hospital will adopt and implement the "4Ms" framework – What Matters, Medications, Mentation, and Mobility – in all areas of patient care defined in the following Age-Friendly Health System protocol. This implementation will align with an support compliance with the Centers for Medicare and Medicaid Services (CMS) Inpatient Quality Reporting (IQR) program requirements related to age-friendly care.

SCOPE:
This policy applies to all hospital staff, including physicians, nurses and allied health professionals, care coordinators, and administrative personnel across inpatient settings.

DEFINITIONS:

4Ms Framework

1. **What Matters**: Know and align care with each older adult's specific health outcome goals and care preferences including but not limited to end of life care, across care settings.
2. **Medication**: if medication is necessary, use Age Friendly medication that does not interfere with What Matters to the older adult, Mobility or Mentation across settings of care.
3. **Mentation**: Prevent, identify, treat and manage dementia, depression, and delirium across settings of care.
4. **Mobility**: Ensure that older adults move safely every day in order to maintain function and to align with What Matters.

PROCEDURE:

1. **Patient Identification:** identify all patients aged 65 and older at admission or during initial evaluation.

2. **Assessment Using the 4Ms Framework:**
    a. **What Matters:** Objective is to ensure that care aligns with each patient's health priorities, goals and preferences.
        i. Initial Assessment:

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1. During admission, the attending physician or designated clinician initiates a discussion with the patient (and/or family or caregiver, as appropriate) to identify "What Matters."
2. Document the patient's goals and preferences in the electronic health record (EHR) in the Advanced Care Planning note, including any specific life goals, values, or advance directives.
3. If the patient cannot communicate, involve family or legally authorized representatives.

ii. Change in Condition:
1. Update the "What Matters" documentation if any new information or changes occur.

b. **Medications:** Objective is to minimize potentially inappropriate medications (PIMs) and ensure medication safety.
i. Pharmacist Review:
1. Upon admission, a pharmacist reviews the patient's medication list, using criteria for PIMs in older adults (e.g., Beers Criteria).
2. Identify any PIMs or medications with risks for adverse effects, drug-drug interactions, or duplication.
3. Documentation of the medication review and any PIMs will be included in the patient's EHR.
ii. Notification of Physician:
1. For any identified PIMs or other medication-related concerns, the pharmacist uses secure messaging to notify the attending physician.
2. The message includes identified PIM, potential risks, and any suggested alternatives.
3. The physician reviews and documents any changes or rationales for continuing current medications.

c. **Mentation:** Objective is to identify and manage delirium to optimize mentation and cognitive health.
i. Initial Screening:
1. Conduct a baseline assessment for delirium within 12 hours of admission using the Confusion Assessment Method (CAM) tool.
2. Nurses trained in the CAM will perform this assessment.
3. Document findings in the appropriate EHR flowsheet.
ii. Ongoing monitoring:
1. Reassess patients using the CAM every shift or sooner as needed if there is a change in condition.
2. Document findings in the appropriate EHR flowsheet.
iii. Positive Screening Follow-up:
1. If a CAM assessment is positive, notify the physician promptly.

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2. Initiate delirium prevention nursing interventions order set in the EHR.

d. **Mobility:** Objective is to maintain or improve functional mobility to prevent deconditioning and falls.
   i. Initial Assessment:
      1. On admission, assess each patient's mobility using the Johns Hopkins Highest Level of Mobility (JH_HLM) scale and document in the appropriate EHR flowsheet.
      2. This assessment is performed by physical therapist or nursing staff trained in the JH-HLM tool.
   ii. Daily Mobility Support:
      1. Set daily mobility goals for each patient based on JH-HLM scores and document them on the Mobility Care Board.
      2. Nursing and physical therapy staff collaborate to ensure the patient reaches their daily mobility goals, adjusting as needed.
   iii. Re-assessment and Care Planning:
      1. Re-assess mobility once per shift and document in the appropriate EHR flowsheet.
      2. Notify the physician and interdisciplinary team if there is a significant decline in mobility or if additional support is required.

e. **Malnutrition:** Objective is to identify, prevent, and treat malnutrition in older adults to support recovery, enhance quality of life, and reduce risk for complications such as falls, infections, and delayed wound healing.
   i. Initial Assessment:
      1. On admission all patients are screened for nutritional risk within 24 hours by nursing staff using pre-established criteria in the EMR. If a nutrition risk is identified, patients are referred to a Registered Dietitian (RD) within 24 hours. The RD must respond within 2 days, completing a nutrition assessment and documenting findings in the EMR.
      2. Nutritional risk factors include significant unplanned weight loss, poor intake, gastrointestinal symptoms, advanced pressure ulcers, and use of enteral or parenteral nutrition.
   ii. Ongoing Monitoring and Follow-up:
      1. The RD determines the patient's nutrition risk level (high, moderate, or low) and prioritizes follow-up accordingly:
         a. **High risk**: seen within 2 days
         b. **Moderate risk**: within 4 days
         c. **Low risk**: within 7 days
      2. Risk levels may be adjusted at any time based on clinical judgment. Nutrition assessments and reassessments follow

established protocols, with all recommendations communicated to the care team.

3. **Interdisciplinary Communication and Documentation**
    a. EHR Documentation: Ensure all 4Ms – What Matters, Medications, Mentation, and Mobility – are documented in the designated sections of the EHR for easy access by the care team.
    b. Team Meetings: Integrate discussions of the 4Ms into interdisciplinary team rounds or case conferences to facilitate coordination of care.
    c. Ensure care is person-centered and aligns with the patient's "What Matters."

4. **Discharge Planning:** Incorporate the 4Ms into discharge planning to ensure continuity of care, including documentation of the 4Ms and nutritional needs in the Discharge Summary. Forward the Discharge Summary to the patient's Primary Care Provider and post-acute care facility if patient is not discharged home.

5. **Staff Education and Training:**
    a. All relevant staff will receive training on Age-Friendly practices and the "4Ms" Framework during onboarding and through ongoing continuing education programs.

6. **Patient and Family Engagement:**
    a. The hospital will foster active engagement of older adults and their families/care partners in the care process, ensuring their voices and preferences guide treatment decisions.

7. **Sustainability:**
    a. The hospital will ensure continuous compliance with the Age-Friendly Health System protocols by monitoring outcomes.
    b. The hospital will maintain active participation in the Age-Friendly Health System initiative, ensuring alignment with the latest standards and best practices as defined by the IHI.
    c. The hospital will monitor and maintain compliance with relevant CMS requirements, including any Age-Friendly-related quality measures, to support reimbursement and regulatory alignment.

8. **Data Collection and Reporting:** Data will be gathered from the EHR.
    a. Age-Friendly Health System Committee: a committee consisting of clinical leaders, quality improvement staff, and interdisciplinary team members will meet regularly to review relevant data, focusing on the "4Ms" framework and AFHS CMS IQR.

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b. Reporting to the Board Quality Committee: Quarterly Reports: The AFHS Committee will report to the Board Quality Committee on a quarterly basis key data findings, analysis, and recommended actions for improvement.
c. Metrics for Success may include the following
    i. Process Measures
        1. % of older adults with What Matters Documented
        2. % of older adults assessed for high-risk medication use
        3. % high risk medications with pharmacist/clinician review
        4. % of older adults on any of the targeted medications *(Benzodiazepines, anticholinergics, opioids)*
        5. % of older adults assessed for delirium
        6. % of older adults assessed for Mobility
        7. % of older adults mobilized at least 3 times/day (as appropriate)
        8. % of older adults being assessed for all 4Ms
    ii. Outcome Measures
        1. 30-day all-cause readmission
        2. Average length of stay
        3. Discharge disposition: % of older adults discharged back to home
        4. % of older adults with diagnosis of delirium
        5. Falls rate
        6. Pressure ulcer rate

9. **Continuous Improvement**
    a. The AFHS Committee will track the implementation of changes and interventions. Success will be measured through improved metrics and outcomes will be shared with all relevant staff.
    b. The Committee will adjust action plans as necessary, with the goal of achieving sustained improvements in older adult care.

10. **Compliance and Reporting**
    a. Noncompliance with this policy will be reviewed by the Quality Improvement Team.
    b. Reports will be submitted to CMS as required under quality improvement programs.
    c. Annual reports on Age-Friendly Health System implementation and outcomes will be shared with executive leadership and relevant regulatory bodies.

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Chief Medical Officer

AUTHORS/REVIEWERS:
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AFHS Multidisciplinary Committee
Medical Director of Patient Care Services
Chief Nursing Officer
Director of Quality
Board Quality Committee

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