SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING AGENDA
Wednesday, January 23, 2013
5:00 p.m. Open Session
(Closed Session will be held upon adjournment of the Open Session)

Location: Schantz Conference Room
Sonoma Valley Hospital – 347 Andrieux Street, Sonoma CA 95476

AGENDA ITEM	RECOMMENDATION	
MISSION STATEMENT *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER	Nevins	
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.*	Nevins	
3. CONSENT CALENDAR: A. Tracking Report for Uncorrected Items	Nevins	Inform/Action
4. CREDENTIALING / PRIVILEGES PROCESS AND QUALITY COMMITTEE CHARTER PROCESS & WORDING	Smith/Nevins	Inform/Action
5. UPDATE ON QUALITY TRAINING FOR THE BOARD AND BOARD COMMITTEES	Nevins/Hirsch	Inform/Action
6. QUALITY REPORT	Lovejoy	Inform
7. STUDER GROUP REPORT	Kobe	Inform
8. QUALITY INDICATORS AND DASHBOARD	Lovejoy	Inform
9. CLOSING COMMENTS	Nevins	Inform
10. ADJOURN		
11. UPON ADJOURNMENT OF THE REGULAR OPEN SESSION	Nevins	Inform
12. CLOSED SESSION: Calif. Health & Safety Code § 32155 – Medical Staff Credentialing & Peer Review Report	Smith/Amara	Inform/Action
13. REPORT OF CLOSED SESSION	Nevins	Inform

3.A.

TRACKING REPORT

Quality Committee					
Outstanding Items Log					
Item# & Topic	**Discussion**	**Follow-up**	**Date Due**	**Complete**	Update/Comments
072512-1 Occupational Health & HR	CDPH returned a directed plan of action	Monthly report on progress in Quality Report until completed.	8/22/12		Work in progress; pending completion certificate
zzzz					

Quality Committee

Outstanding Items Log-Closed

Item# & Topic	Discussion	Follow-up	Date Due	Date Completed	Update/Comments
092211-1	CMS survey identified Humidity monitoring in OR	Monthly report on progress in Quality Report until completed.	40829	10/22/11	Item closed 10/22/11
082511-1 Credentialing Process	Failure in education of Ms Coordinator and failure of CVO contract.	Monthly report on progress in Quality Report until completed.	9/22/11		New Coordinator hired
082511-2 Central Sterile	A TJC citing regarding the potential for cross contamination of instruments. Requires physical plant structural changes in OR.	Monthly report on progress in Quality Report until completed.	9/22/11	11/15/12	Completed & reported off to TJC & CDPH
072512-2 Dishwasher Drain	Drain pipes for diswasher in Nutritional Services	Monthly report on progress in Quality Report until completed.	8/22/12	11/15/12	Completed and reported off to CDPH
072512-3	Skilled Nursing Broken Water Pipe	Monthly report on progress in Quality Report until completed.	9/15/12	11/15/12	Completed & report to CDPH pending

4.

QUALITY COMMITTEE CHARTER

SUBJECT: Quality Committee Charter	
	PAGE 1 OF 7
DEPARTMENT: Board of Directors	EFFECTIVE: 12/1/11
APPROVED BY: Board of Directors (12/1/11)	REVISED:

Purpose:

Consistent with the Mission of the District the Board, with the assistance of its Quality Committee (QC), serves as the steward for overall quality improvement for the District. The QC shall constitute a committee of the District Board of Directors. The Board shall refer all matters brought to it by any party regarding the quality of patient care, patient safety, and patient satisfaction to the QC for review, assessment, and recommended Board action. The QC makes recommendations and reports to the Board. It has no authority to make decisions or take actions on behalf of the District unless the Board specifically delegates such authority.
The QC shall assist the Board in its responsibility to ensure that the Hospital provides high-quality patient care, patient safety, and patient satisfaction. To this end the QC shall:

1. Formulate policy to convey Board expectations and directives for Board action;
2. Make recommendations to the Board among alternative courses of action, including but not limited to physician credentialing, and oversight activities;
3. Provide oversight, monitoring and assessment of key organizational processes, outcomes, and external reports.

Policy:

SCOPE AND APPLICABILITY

This is a SVHCD Board Policy and it specifically applies to the Board, the Quality Committee, the Audit Committee, the Medical Staff, and the CEO of SVH.

RESPONSIBILITY

Physician Credentialing

1. The QC shall ensure that recommendations from the Medical Executive Committee and Medical Staff are in accordance with the standards and requirements of the Medical Staff Bylaws, Rules, and Regulations with regard to: completed applications for initial medical staff and allied health staff appointment; initial staff category assignment, initial department/divisional affiliation; membership prerogatives and initial clinical privileges; completed applications for reappointment of medical staff, staff category; clinical privileges; establishment of categories of allied health professionals permitted to practice at the hospital; the appointment and reappointment of allied health professionals; and privileges granted to allied health professionals.

2. The QC shall, in closed session, on a case by case basis, fully, rigorously, and carefully review the recommendations of the Medical Staff regarding the appointment, reappointment, and privilege delineation of physicians and submit recommendations to the Board for review and action.

Develop Policies

1. The QC shall submit recommendations for action to the Board on draft policies developed by the QC and those developed by the Hospital regarding quality patient care, patient safety, and patient satisfaction.

Oversight

Annual Quality Improvement Plan

1. The QC shall review and analyze findings and recommendations from the CEO resulting from the Hospital's prior year Annual Quality Improvement Plan, including but not limited to a comparison of the plan to actual accomplishments, administrative review, and evaluation activities conducted, findings and actions taken, system or process failures and actions taken to improve safety, both proactively and in response to actual occurrences.

2. The QC shall review the Hospital's Annual Quality Improvement Plan for continuously improving quality, patient safety, and patient satisfaction and submit the analysis with recommendations establishing priorities to the Board for discussion and action. The Hospital's plans should include, but not be limited to, assessing the effectiveness and results of the quality review using metrics and benchmarks, utilization review, performance improvement, implementing and improving electronic medical/health records, professional education, risk management programs, and patient care related activities and policies of the Hospital and/or Medical Staff, as applicable.

Medical Staff Bylaws

1. The QC shall assure that the Medical Staff's Bylaws are reviewed and approved by the Board and are consistent with the District and Hospital Mission, Vision and Values, Board policy, and accreditation standard, prevailing standards of care, and evidence-based practices.

2. The QC shall review the Medical Staff's fulfillment of its responsibilities in accordance with the Medical Staff Bylaws, applicable law and regulation, and accreditation standards and make recommendations to the Board.

Quantitative Quality Measures

1. The QC shall assess and recommend quantitative measures to be used by our Board in assessing the quality of the Medical Staff's and Hospital's services and submit them to the Board for deliberation and action. The recommendations shall include descriptions that show how the organization measures and reports the improvement of patient care, as well as management accountability.

2. The QC shall review all reports by and Hospital responses to accreditation organizations, e.g., Fire Marshals, Environmental Health, State Department of Health Services (DHS), and other external organizations conducting management, programmatic, physical plant audits/assessments/reviews that are directly or indirectly related to the quality of health care delivery in the Hospital (quality patient care, patient safety, and patient satisfaction). Track all uncompleted/open items until remedied/closed by the Hospital, and make recommendations and report to the Board for its action as appropriate. This includes the final OSHPD report on a construction project prior to licensing by DHS, but it does not include on-going OSHPD reviews/inspections/reports while a project is in design or construction. This does not include routine financial audits, unless the audit identifies quality patient care, patient safety, and/or patient satisfaction issues, in which case the Audit Committee shall refer the audit to the QC for its review and recommendations to the Board.

3. The QC shall ensure there is an effective, supportive, and confidential process for anyone (the Medical Staff, other health care professionals; Hospital administration; leaders and staff; patients, and their families and friends; and the public) to bring issues to the QC directly or via the Hospital—as a group, personally or anonymously--in order to promote the reporting of quality and patient safety problems and medical errors, and to protect those who ask questions and report problems.

4. The QC shall review and assess the process for identifying, reporting, and analyzing

"adverse patient events" and medical errors. The QC shall develop a process for the QC to address these quality deficiencies, in the most transparent manner possible, without unnecessarily increasing the District's liability exposure.

5. The QC shall review the assessment of patient needs/satisfaction, and submit this assessment with recommendations to the Board for review and possible action. This may include, but is not limited to CMS Value Based Purchasing information; Press Ganey surveys; reports and comparisons to other hospitals, state and national standards; and patient and/or family complements and complaints.

6. The QC shall review and assess the system for resolving interpersonal conflicts among individuals working within the Hospital environment that could adversely affect quality of care, patient safety or patient satisfaction, and make recommendations to the Board.

Hospital Policies

1. The QC shall assure that the Hospital's administrative policies and procedures are reviewed and approved by the appropriate Hospital leaders and that the policies and procedures are submitted to the Board for its action are consistent with the District and Hospital Mission, Vision and Values; Board policy; and accreditation standards.

2. The AC shall assure that the Hospital's policies and procedures relative to quality, patient safety, and patient satisfaction are reviewed and approved by the appropriate Hospital leaders and the policies and procedures submitted to the Board for its action are consistent with the District and Hospital Mission, Vision and Values, Board policy, and accreditation standards, prevailing standards of care, and evidence-based practices.

Other

1. Perform other duties related to high-quality patient care, patient safety, and patient satisfaction as assigned by the Board.

Annual QC Work Plan

The QC shall develop an Annual QC Work Plan comprised of the required annual activities and additional activities selected by the QC. The Annual QC Work Plan shall be reviewed and acted on by the Board after considering the CEO's work plan to support the QC.

Required Annual Calendar Activities:

For Calendar Year 2012

1. The QC shall submit the CY 2012 Work Plan to the CEO no later than the first week in January.

2. The QC shall submit its Work Plan and the CEO's Work Plan to the QC Board for its review and action no later than the February Board meeting.

3. The QC shall review the adequacy of financial and human resources currently allocated for maintaining high-quality care, patient safety, and patient satisfaction in April, in advance of the annual budget process and provide an assessment to the Board and CEO with recommendations for action.

4. The QC shall review and assess all Board policies regarding quality, including the QC Charter, and makes recommendations to the Board for action in December.

For Subsequent Calendar Years

1. The QC shall review the adequacy of financial and human resources currently allocated for maintaining high-quality care, patient safety, and patient satisfaction in April, in advance of the annual budget process and provide an assessment to the Board and CEO with recommendations for action.

2. The QC and CEO Work Plans shall be submitted to the Board for its review and action no later than December.

3. The QC shall report on the status of its prior year's work plan accomplishments by December.

4. The QC reviews and assesses all Board policies regarding quality specifically including the QC Charter, and makes recommendations to the Board for action in December.

QC Membership and Staff

The QC shall have seven voting members and three non-voting public member alternates appointed pursuant to Board policy. Pursuant to Health and Safety Code Section 32155, based on the need for Medical Staff quality assessments, Physician Credentialing and Privileges are discussed and action is taken in Closed Session without the QC public members and alternates. Hospital employees who staff the QC are not voting members of the QC. QC membership is:

- Two Board members one of whom shall be the QC chair, the other the vice-chair. Substitutions may be made by the Board chair for Board QC members at any QC meeting--for one or both Board members.

- Two designated positions from the Medical Staff leadership, i.e., the President and the President-Elect. Substitutions may be made by the President for one Medical Staff member at any QC meeting.

- Three members of the public. In addition, substitutions may be made at all QC meetings from three prioritized non-voting members of the public as alternate public members. Alternates shall attend closed session QC meetings and vote as QC members when substituting for a voting public member. Alternates may attend QC meetings as non-voting alternates and fully participate in the open meeting discussions.

Staff to the QC include the Hospital's Chief Medical Officer (CMO), Chief Nursing Officer (CNO), and the Director of Quality and Resource Management who shall be the lead staff in support of the QC Chair for meetings, documents, and activities. Staff is expected to attend the QC meetings. The CEO may attend all QC and subcommittee meetings and shall be a resource at the QC meetings upon request of the QC Chair.

Frequency of QC Meetings
The QC shall meet monthly, unless there is a need for additional meetings.

Public Participation
All QC meetings shall be announced and conducted pursuant to the Brown Act. Physician Credentialing and Privileges are discussed and action is taken in QC Closed Session without the QC public members and alternates, or the general public.

The general public, patients and their families and friends, Medical Staff, and Hospital staff are always welcome to attend and provide input. Other Board members may attend but may not comment as it may be a Brown Act violation.

Narrowly focused and short term ad hoc subcommittees may meet to address specific issues that will be brought to the QC for review and referral to the Board for its deliberation and action. Subcommittee meetings are not subject to the Brown Act.

Reference:

POLICY HISTORY
December 1, 2011--Board Policy regarding the QC was first adopted.

FREQUENCY OF REVIEW/REVISION

This shall occur annually or more often if required. If revisions are needed they will be taken to the Board for action.

6.

QUALITY REPORT

T0: Sonoma Valley Hospital Care District Board Quality Committee
FROM: Leslie Lovejoy, Director, Quality and Resource Management
DATE: 1/23/2013
SUBJECT: Quality Report

January Priorities

1. Regulatory Compliance
2. Staff Vacancy interviews
3. Quality Committee Dashboard and Work Plan
4. Annual Report Quality Report

1. We received further requests from Dr. Christensen regarding the submitted amended Plan of Correction for the Pharmacy survey. The issues appear to be date and added plan details related with the exception of the issue of secure storage of IV saline in the ICU. We will be sending our amended (part 2) plan the week of the 13th. Hopefully that will suffice. We had three self reported HIPAA citations regarding incorrect faxing from medical records. The plans were submitted and approved. I sent the new building plans and OSHPD permits to CDPH as well as the OSHPD permit for the wall mounting of the computers in patient rooms.

2. Dr Smith and I interviewed three candidates for the Medical Staff Coordinator role and selected a highly qualified candidate that will be joining us within the next 5 weeks. I am also interviewing for a Clinical Informatics Trainer who will fill a much needed role in developing and implementing ongoing training in the electronic health record and other It applications for all departments of the organization. This position will also provide orientation and on-the-floor coaching to continually improve our skills in the electronic world. The long term vision for this position is that it will be a shared position with Palm Drive Hospital. I hope to have selected a candidate before our meeting.

3. I have attached an initial draft of the 2013 dashboard and the final Work Plan. In addition, I have attached a summary sheet of all regulatory quality performance indicators that we submit to the Centers for Medicare Services.

4. I have also attached the article that I submitted for the Annual Report.

5. Topic for Discussion: Patient Satisfaction Data (Mark Kobe)
Quality Performance Indicators & Dashboard (Leslie Lovejoy)

Quality Innovations: Making a Difference in the Patient Experience

Sonoma Valley Hospital is always looking for ways we can improve the services we provide. Here are two ways in which we have improved our patient's experience when they come to Sonoma Valley Hospital.

In the past year, we have taken a look at increasing our efficiency in providing Outpatient Laboratory and Admitting Services. Using best practice performance improvement strategies, the Admitting Department reduced its wait time from an average of 8 minutes to an average of 4 minutes while the Laboratory reduced their wait time from an average of 15 minutes to an average of 7 minutes. By working together and making some simple changes in how we do things, we are proud to say the average time it takes for a community member to have a lab test drawn is less than 15 minutes.

The Admitting and Surgery team also streamlined the process of coming to the hospital for morning surgery. Using best practice strategies, the team simplified the communication between physician offices and surgery scheduling; created a fast track process for obtaining insurance pre-authorization, scheduling requests and physician orders; and implemented pre-registration so that community members do not have to stop in Admitting before going to the Surgical Services Department. The changes have significantly reduced the incidence of missing information, the need to clarify orders, extra phone calls and delays in registration.

These are the kinds of innovations that create for our patients a sense of comfort and confidence at first contact, and when they feel most vulnerable, setting and maintaining the tone for their hospital experience. Our continued innovation lets our patients know we're listening to them and we're putting their needs first.

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

8.

QUALITY DASHBOARD

BOARD QUALITY COMMITTEE DASHBOARD 2013

The following are quality and patient safety indicators selected by the Board Quality Committee for quarterly reporting as part of the oversight mandate for ensuring that the organization has an effective quality assurance and performance improvement program (QAPI).

1. Surgical Services Volumes by Service:

Service	2012	1Q13	2Q13	3Q13	4Q13
OB/GYN	IP 64 OP 62				
Opthamology	IP 0 OP 209				
General	IP 142 OP 118				
Orthopedics	IP 324 OP 466				
Pain Management	IP 1 OP 144				
Breast/Plastics	IP 4 OP 15				
Spine	IP 4 OP 2				
Urology	IP 9 OP 32				
Vascular	IP 2 OP 17				
Podiatry	IP 4 OP 58				
Endoscopy	IP 97 OP 331				

IP = Inpatient OP = Outpatient

2. Emergency Department Patient Throughput: Patient Safety

a. Time from presentation to the ED to time seen by MD

Core OP-20 - Mean Time Door to Diagnostic Eval by a Qualified Personnel	25.851 minutes
Core OP-20 - numerator	13701
Core OP-20 - denominator	530

b. Time from decision to admit to bed on inpatient unit

Core ED-2a - Admit Decision Time to ED Departure Time - Overall Rate	72.371 minutes
Core ED-2a - numerator	10132
Core ED-2a - denominator	140

c. Time to transfer to another facility by DX: AMI, STROKE

Time to transfer to another facility by DX: AMI

Core OP-3b - Mean Time to Txfer to Fac for Acute Coronary Intervention	78.5
Core OP-3b - numerator	628
Core OP-3b - denominator	8

Time to transfer to another facility by DX: STROKE

Core OP-3b - Mean Time to Txfer to Fac for Stroke	205.4
Core OP-3b - numerator	5135
Core OP-3b - denominator	25

3. Hospital Acquired Infections: Quality Patient Outcomes and Safety

Indicator	Q4 2011	Q1	Q2	Q3	Q4	Recommendations/Actions
(NHSN) means the indicator is a requirement of California Department of Public Health (CDPH) and Senate Bill 1058 Mandated Reporting. Data is entered into the National Healthcare Safety Network (NHSN) system for public reporting.						
CLABSI (NHSN) (CMS Never Event) *# Central Line Associated Bloodstream Infections (CLABSI)/central line days*	**0** 0/140	**0** 0/127	0 0/65	**0** 0/103		**Benchmark: 1 per 1,000 central line days**
CDI (NHSN) *#Inpatient Hospital Acquired infections due to C. difficile*	**0** 0/1360	**0.8** 1/1141	**0** 0/1153	**0.8** 1/1175		**Benchmark: 1 per 1,000 patient days**
MRSA Bloodstream Infections (NHSN) *#bloodstream infections due to MRSA (incidence measure-not necessarily HAI)*	**0** 0/1360	**0** 0/1141	**0** NOT HAI 1/1153	**0** 1175		**Benchmark: 1 per 1,000 patient days**
VRE Bloodstream Infections (NHSN) *#Hospital Acquired bloodstream infections due to VRE*	**0** 0/1360	**0** 0/1141	**0** 0/1153	**0** 0/1175		**Benchmark: 1 per 1,000 patient days**

Hip: Deep or Organ/Space Surgical Site Infections (NHSN) *# infections/ # Total Hip Cases*	**0** 0/6	**0** 0/7	**0** 0/17	**0** 0/15		**Benchmark: 1 per 100 operations**
Knee: Deep or Organ/Space Surgical Site Infections (NHSN) *# infections/ # Total Knee Cases*	**0** 0/13	**0** 0/19	**0** 0/13	**0** 0/10		**Benchmark: 1 per 100 operations**
Overall Surgical Site Infections (SSI) *Total # SSI/Total # surgeries*	**1.20%** 5/402	**0%** 0/401	**1%** 4/393	**0.25%** 1/393		**Benchmark: 1% (SVH trended data)**
Ventilator Associated Pneumonia (VAP) *# Ventilator Associated Pneumonia/ # vent days*	**0** 0/52	**0** 0/18	**0** 0/57	**0** 0/67		**Benchmark: 1 per 1,000 ventilator days**
Hospital Acquired Pneumonia (HAP) *# hospital acquired pneumonia/# patient days*	**0.7** 1/1360	**0** 0/1141	**0** 0/1153	**0.8** 1/1175		**Benchmark: 1 per 1,000 patient days**
Inpatient Hospital Acquired Catheter Associated Urinary Tract Infections (CA-UTI) (CMS Never Event) *# inpatient CAUTI/# catheter days*	**0** 0/222	**0** 0/432	**0** 0/333	**0** 0/364		**Benchmark: 2 per 1,000 catheter days**

4. Patient Satisfaction: Quality Patient Experience

Indicator	YTD11/2012	1Q13	2Q13	3Q13	4Q13
Noise level in and around rooms	Mean = 75.3				
Explanations re: tests and treatments	Mean = 87.1				
Likelihood to recommend	Mean = 89.6				

5. Readmissions Rates: Quality Patient Outcomes

We can only capture data for patients who return to this hospital within 30 days. CMS publishes reports that include other hospital admissions.

Medicare Only	YTD 11/2012	1Q13	2Q13	3Q13	4Q13
All diagnoses	60 Patients				
Same Diagnosis	18 Patients				
By DRG **AMI** **CHF** **PNE** **COPD**	 1 Patient 1 Patient 1Patient 0 Patient				