SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING AGENDA

Wednesday, March 27, 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. QC Meeting Minutes, 1.23.13 B. QC Meeting Minutes, 2.27.13 C. QC Outstanding Items Log, 3.27.13	Nevins	Inform/Action
4. UPDATED QUALITY COMMITTEE CHARTER	Nevins	Inform/Action
5. QUALITY REPORT	Kobe	Inform
6. ANNUAL ENVIRONMENT OF CARE REPORT	Kobe	Inform
7. CLOSING COMMENTS	Nevins	Inform
8. ADJOURN	Nevins	
9. UPON ADJOURNMENT OF THE REGULAR OPEN SESSION	Nevins	Inform
10. CLOSED SESSION: Calif. Health & Safety Code § 32155 – Medical Staff Credentialing & Peer Review Report	Smith/Amara	Inform/Action
11. REPORT OF CLOSED SESSION	Nevins	Inform

3.A.

QC MEETING MINUTES 01.23.13

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
Wednesday, January 23, 2013
Schantz Conference Room

Committee Members Present	Committee Members Absent	Community Members Present	Administrative Staff Present
Sharon Nevins, Vice Chair Dr. Jerome Smith Dr. Paul Amara Jane Hirsch Dr. Howard Eisenstark John Perez Brenda Epperly		None	Dr. Robert Cohen, Chief Medical Officer Leslie Lovejoy, Chief Quality & Nursing Officer Mark Kobe, Director of Nursing

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
MISSION AND VISION STATEMENTS	*The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.* *The vision of the SVHCD is that:* *SVH will be a nationally recognized, compassionate place of healing known for excellence in clinical quality. We serve as the guide and indispensable link in our community members' health care journey.*		
1. CALL TO ORDER	*Sharon Nevins* 5:00 p.m.		
2. PUBLIC COMMENT *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.*	There was no public comment.		
3. CONSENT CALENDAR:	*Sharon Nevins*		
A. Tracking Report for Uncorrected Items		All in favor; none opposed.	

DRAFT

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
4. CREDENTIALING/PRIVILEGES PROCESS AND QUALITY COMMITTEE CHARTER PROCESS & WORDING	*Dr. Jerome Smith and Sharon Nevins*		
	New ER physician to start on February 3, 2013 and Dr. Smith would like him “expedited” and approved at the next Board meeting on February 7, 2013. The new Staff Coordinator begins on February 12, 2013. The Committee all agreed to hand the Charter Chart to the Board of Directors.	All in favor; none opposed.	
5. UPDATE ON QUALITY TRAINING FOR THE BOARD AND BOARD COMMITTEES	*Sharon Nevins and Jane Hirsch.*		
	Ms. Nevins presented Mr. Howard Eisenstark as a new Community Board member. Ms. Hirsch confirmed that the director of Quality and Safety at UCSF will be attending the Quality meeting on April 24, 2013. Dr. Amara suggested inviting the Medical Executive Committee as well.	All in favor; none opposed.	
6. QUALITY REPORT	*Leslie Lovejoy*	Inform	
	Ms. Lovejoy’s main focus for the month of January was to find a great candidate for the Medical Staff position. Ms. Lovejoy is also interviewing for a Clinical Informatics Trainer who would provide training to physicians and registered nurses.		
7. STUDER GROUP REPORT	*Mark Kobe*	Inform	
	Mr. Kobe made a presentation to the Studer Group. Mr. Kobe reviewed the AIDET process and the Patient Survey results for 2012 (survey results compiled by Press Ganey). The department with the lowest percentile in satisfaction is ACU. Mr. Kobe stated that Michelle Donaldson, Director Surgical Services was already in the process of addressing those areas needing improvement.		
8. QUALITY INDICATORS AND DASHBOARD	*Sharon Nevins and Leslie Lovejoy*		
	Everyone but Dr. Cohen agreed to present the Quality Committee 2013 Dashboard to the Board, *as is*. Dr. Cohen felt the numbers on the report were higher than expected and that he and Dr. Smith could obtain more accurate data for the report prior to giving it to the Board for review.		Ms. Lovejoy, Dr. Smith and Dr. Cohen to improve section C, part 2 on the QC Dashboard.
9. CLOSING COMMENTS	*Sharon Nevins*		
	There were no comments.		

DRAFT

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
10. ADJOURN	6:26 p.m.		
11. UPON ADJOURNMENT OF THE REGULAR OPEN SESSION	*Sharon Nevins*		
13. REPORT OF CLOSED SESSION	*Sharon Nevins*		
	The Quality Committee approved the Credentialing Report to be presented to the Board.		

DRAFT

3.B.

QC MEETING MINUTES 02.27.13

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
DRAFT REGULAR MEETING MINUTES
Wednesday, February 27, 2013
Schantz Conference Room

Committee Members Present	Committee Members Absent	Community Members	Administrative Staff Present
Sharon Nevins, Chair Jane Hirsch Dr. Howard Eisenstark John Perez Brenda Epperly Dr. Jerome Smith Dr. Paul Amara	Bob Burkhart Maida Herbst	Susan Idell	Dr. Robert Cohen, Chief Medical Officer Leslie Lovejoy, Chief Quality & Nursing Officer Gigi Betta, Board Clerk Robin Labitzke, Staff Pharmacist MonicaVats, Intern Pharmacist

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
MISSION AND VISION STATEMENTS	*The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.* *The vision of the SVHCD is that:* *SVH will be a nationally recognized, compassionate place of healing known for excellence in clinical quality. We serve as the guide and indispensable link in our community members' health care journey.*		
1. CALL TO ORDER	*Sharon Nevins* 5:00 p.m.		
2. PUBLIC COMMENT *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.*	There was no public comment.		
3. CONSENT CALENDAR:	*Sharon Nevins*		
A. Prior Meeting Minutes, Jan., 23, 2013 B. Tracking Report for Uncorrected Items	Both items approved together.	**MOTION:** Hirsch, second by Hoffman; all in favor and none opposed.	

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
4. UPDATE ON QUALITY TRAINING FOR THE BOARD AND BOARD COMMITTEES	*Sharon Nevins/Jane Hirsch*		
	The Quality Committee training/presentation (for the Board and the Board Committees) by a UCSF physician is planned for April 2013. Ms. Nevins would like the presentation to target the layperson as well as the medical staff. Please send any comments and/or suggestions about this to Ms. Hirsch.		
5. QUALITY REPORT	*Leslie Lovejoy*		
	Dr. Christiansen has approved the Pharmacy MERP action plan. CDPH has asked for a detailed plan on the move into the new building. The Skilled Nursing Facility received a patient complaint through the Joint Commission. A response to the complaint was provided by Melissa Evans, Director of Skilled Nursing, and it was accepted as satisfactory. Nancy Iredale, Medical Staff Coordinator, began working at SVH on February 12, 2013. Cathe Gagon, RN, joined the Quality Department as Clinical Informatics Trainer. Michelle Donaldson has resigned from her position as Surgery Director and in future, the position will be shared with Palm Drive.		
6. CLOSING COMMENTS	*Sharon Nevins*		
	With regard to the presentation/information sharing to the Board on the Quality Committee, Ms. Nevins and Dr. Jerome Smith proposed that the Committee present the raw data with a story (so it fits into the context of the Hospital). The question was raised about the role of the Medical Records department now that files are electronic. A discussion on the training and use of electronic health records followed. Dr Cohen talked about the integrity and security of the system, about the Hospital's excellent dual-system backup, and that the Hospital is looking into Cloud storage in the future. Furthermore, SVH is very proud to have Order Sets that are evidenced based. SVH received a very positive *Letter to the Editor* from a resident who had emergency surgery with Dr. Scott Perryman. It's a very important testimonial and Dr. Perryman was commended for his excellent service.		

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
7. ADJOURN, REGULAR SESSION	*5:35 p.m.*		
8. UPON ADJOURNMENTOF THE REGULAR OPEN SESSION	*Sharon Nevins*		
10. REPORT OF CLOSED SESSION	*Sharon Nevins*		
	The Quality Committee approved the recommendations of the MEC and the Credentialing Report will be presented to the Board on March 14, 2013. Ms. Hirsch and Ms. Nevins, at Dr. Smith's request, expedited several physicians. Ms. Nevins will follow up with Mr. Burkhart on his future involvement with the Quality Committee.		
11. ADJOURN, CLOSED SESSION	*Sharon Nevins* 5:41pm		

3.C.

QC OUTSTANDING ITEMS LOG

SVH Quality Committee 03.27.13

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

4.

QUALITY COMMITTEE CHARTER

SUBJECT: Quality Committee Charter	
	PAGE 1 OF 6
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:

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 Work Plan 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. 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 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.

ENVIRONMENT OF CARE

Environment of Care

Leslie Lovejoy

Chair, Safety Committee

March 27, 2013

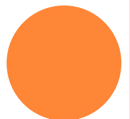
Quality Committee of the Board Report

Environment of Care

The goal of the Environment of Care Program is to provide a safe, functional and effective environment for patients, staff and visitors.

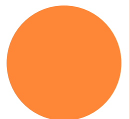
We accomplish this goal through activities that:

- **Reduce and control the environmental hazards and risks;**
- **Prevent accidents and injuries; and**
- **Maintain safe conditions for patients, staff and visitors.**



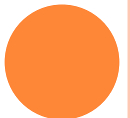
Environment of Care

- Each facility has written plans and programs to design, implement, assess, evaluate and improve these areas. Each plan outlines activities that will reduce hazards in the workplace.
- Performance improvement indicators are developed for each plan and reported quarterly to the Safety Committee.
- On an annual basis, each plan is evaluated for effectiveness and new or continued indicators are developed.
- Safety Committee minutes are publicly posted outside the Cafe.



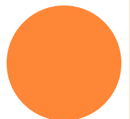
Seven Environment of Care Management Plans

- Environmental Security
- Safety Management
- Fire & Life Safety
- Utilities Management
- Emergency Preparedness
- Medical Equipment Management
- Hazardous Materials



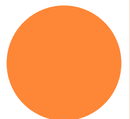
EOC Plan Management

- The Safety Committee has oversight of these plans and the responsibility to ensure that activities are executed.
- The committee meets monthly, plans all drills, conducts monthly safety rounds, conducts an annual Hazard Vulnerability Analysis and develops a mitigation plan to address the top hazards.
- The committee also hears reports from Radiation Safety, Patient Safety, Infection Control and Employee Health.
- Finally, the committee determines the topics for the mandated annual safety training and competencies



2012 Accomplishments

- Successful completion of disaster drills
- 80% of leaders completed the HICS Emergency Management Training
- Successful implementation of a construction orientation program for all construction workers
- Implemented an online MSDS program in conjunction with Marin General
- Improved the Safety Rounds process to ensure documentation of concerns and follow-up
- Hazard Vulnerability Assessment
- Completed Management of Assaultive Behavior Training for ED
- Established a process for redundancy of emergency utilities management



2012 Accomplishments

- Development of a Culture of Safety training program
- Provided Safe Patient Handling Assessment, education, tools and resources identification and added this to annual mandated Safety training