ALAMEDA COUNTY MEDICAL CENTER
Highland Campus • Fairmont Campus
John George Psychiatric Pavilion • Ambulatory Healthcare Services

QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING

Thursday, January 19, 2012

Central Administration Offices Located at Highland Hospital
1411 East 31st Street, Oakland, CA 94602
Barbara L. McElroy, Clerk of the Board
(510) 437-8468

MINUTES

TAB #1 CLOSED SESSION

OPEN SESSION: THE MEETING WAS CALLED TO ORDER AT 4:42 PM.

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT:

Barbara Price, Daniel Boggan, Jr., Valerie D. Lewis, Esq., Anthony Slimick, and Barry Zorthian, MD.

NON-VOTING MEMBERS PRESENT:

Lyn Berry, MD and Taft Bhuket, MD.

TAB #2 ACTION: Approval of Minutes

ACTION: A motion was made, seconded, and unanimously approved the Minutes from the October 20, 2011 and November 17, 2011 Quality Professional Services Committee Meetings as presented.

MOTION: Trustee Slimick
SECOND: Trustee Tate

TAB #3 ACTION: Medical Staff / Organizational Policies and Procedures

Kerin Bashaw, VP, Quality, presented the following policies and procedures for adoption by the Committee:

A. **December Policies:**
   1. Pneumococcal and Influenza Vaccine
   2. External Jugular Access

3. Scope of Service: Women's Services - Newark
4. Scope of Service: Dental Services
5. Scope of Services: Women's Services - Eastmont
6. Standard Precautions
7. Transmission Based Precautions
8. Sterilization and Disinfections
9. Catheter Associated Urinary Tract Infection (CAUTI) Prevention
10. Occurrence Reporting
11. Sentinel Event
12. California Department of Public Health Notification of Unusual Occurrences and Infectious Diseases
13. Medical Staff Peer Review
14. Credentialing and Privileging of Practitioners

B. **January Policies:**
1. Traffic Control
2. Civil Disturbance and Crowd Control
3. Code Silver Weapons
4. Standards of Patient Care, Treatment, and Services
5. Standards of Nursing Practice
6. Standards of Practice to Improve Nursing Dependent Patient Outcomes
7. Eyewash Facilities
8. Code Gray – Security/Safety Stat
9. Medical Equipment Management Plan
10. Interim Life Safety Measures Policy
11. Patient Complaints/Grievances/Patient Affairs
12. Policies, Procedures, and Plans: Management and Organization
13. Formulary

Kerin Bashaw, VP Quality, also recommended that consideration be given to asking the Board of Trustees to delegate approval authority for policies and procedures to the Quality Professional Services Committee as the Committee meets more frequently than the Board of Trustees. Ms. Bashaw added that the benefit of QPSC approving policies and procedures would be the ability to have more rapid change within the organization. Douglas B. Habig, General Counsel, clarified that changing the authority of approval would require a Bylaw change of the Board of Trustees and would need to be referred to the Governance Committee for action.

ACTION: A motion was made, seconded, and unanimously approved to refer the request of having the Quality Professional Services Committee approve Policies and Procedures to the Governance Committee for review.

MOTION: Trustee Boggan
SECOND: Trustee Slimick

Further discussion ensued with regards to the approval process.

ACTION: A motion was made, seconded, and unanimously approved to adopt the Organization Policies and Procedures as presented with minor revisions requested by Trustee Zorthian to be referred to Quality for revision.

MOTION: Trustee Slimick
SECOND: Trustee Boggan

Kathleen Clanon, MD, Quality Department, and Joe Walker, MD, Chair, Department of Psychiatry, were both en route to the meeting. Trustee Price moved onto TAB #6 – Chief Medical Officer Report. Sang-ick Chang, Chief Medical Officer had nothing to report.

TAB #7 REPORT: VP, Quality

Ms. Bashaw reported on the regulatory visits and accreditation status. In the last two months there have been approximately 17 accreditation/regulatory reviews and associated visits. She provided the following summaries:

On November 23, 2011, the California Department of Public Health (CDPH) made a visit to ACMC to investigate a self-reported breach of confidentially. There had been high profile patients in the hospital and some members of the staff had viewed their medical records inappropriately. The staff had no clinical or business reason to be in the chart and access information. ACMC was proactive and self-reported the incident to CDPH. Outcome of the investigation by CDPH is still pending.

On November 29, 2011, the Joint Commission triennial survey team arrived at ACMC. Overall, the survey was successful. Ms. Bashaw outlined the survey and the findings that were identified and the correction process for each finding. It was also noted that The Joint Commission was very complimentary of our Harm Reduction Team (HRT) program and achievements. They felt it was innovative and that ACMC should share the success of the teams and publish.

The Committee inquired as to how the staff was going to be acknowledged for their hard work. Ms. Bashaw shared that staff were to be recognized at the upcoming Employee Forums in February 2012.

On December 9, 2011, CDPH arrived a week after the Joint Commission to investigate a self reported issue that involved the cleaning process for our endoscopes.

On January 9, 2012, the state returned representing CMS and conducted a situational validation survey to more closely evaluate the cleaning process for our

endoscopes and other items requiring high level disinfection. A final report is still pending.

On January 10, 2012, CMS/OBRA/SNF annual survey arrived at the Fairmont Campus. Mr. Manns headed up the survey at Fairmont. The final report is still pending.

Mr. Manns added that an additional survey, Life Safety Component, had occurred earlier this afternoon. The survey process went well. It was noted during the survey that our records were impeccable and the Disaster Manual was "awesome".

Discussion ensued regarding the survey process, what other surveys may occur in the near future and education of staff for readiness.

The Committee requested staff to follow-up on the process of tracking Policy & Procedure changes and how they are implemented. They asked that the answer be brought back to the next QPSC meeting.

TAB #4 UPDATE: Harm Reduction Team Updates

Kathleen Clanon, MD, Quality Department, presented the Harm Reduction Team updates. Phase 1 has been completed as of December 31, 2011. We are in the process of harvesting the last pieces of data to present at the February QPSC meeting. Dr. Clanon asked if the HRT Update could have more time on the agenda to present their findings in February.

The wrap up of Phase 1 findings will include a PowerPoint, a 3 – 4 minute movie which Dr. Clanon asked the Trustees if they would be willing to be included in the filming of the movie as it is important to note the involvement of the Board. Finally, a book will be published that will detail the discussions of the strategies used to approach situations.

The Committee asked what the purpose and audience of the documentation would be. Dr. Clanon explained that it is important that these new ideas become standard practice through spreading and imbedding. Additionally, the Joint Commission surveyors urged staff to publish findings of the HRT program which would benefit ACMC's reputation nationally. The HRT project provides tools to implement principles that can be shared at conferences.

Mr. Lassiter commented that the process of implementing the Harm Reduction Team project has had a major impact on the organization by galvanizing staff in a fairly short period of time (18 months); it is a sentinel moment for the organization.

Dr. Clanon ended the presentation with the next steps; spreading & imbedding noting that although it is not as exciting, it is important and will continue and maintain the improvements.

TAB #5 REPORT: Medical Executive Committee

Lyn Berry, MD, President, ACMC Medical Staff, introduced Joe A. Walker, M.D., Chair Department of Psychiatry. Dr. Walker gave an annual report presentation to the Committee on the Psychiatry Department of ACMC. An overview of the presentation included the following topics: composition of department, quality enhancements, workforce development, individual accomplishments, service enhancements, fiscal stewardship, community image enhancements, and growth/ access to care.

The Committee asked Dr. Walker what he felt were the biggest challenges going forward Dr. Walker indicated maintaining the enthusiasm of the team is probably the most important area of focus. The Harm Reduction Team has been a means of developing enthusiasm amongst the staff.

Guy Qvistgaard, Hospital Administrator JGPP, added that another challenge is the need for more beds. More beds will allow JGPP to increase revenues, patient satisfaction, and staff morale by developing a psychiatric ICU.

The Committee complimented both Mr. Qvistgaard and Dr. Walker for the clinical and administrative expertise and focus that they have provided John George Psychiatric Pavilion.

TAB #8 INFORMATION: Issue Tracking & Follow-up

The new form for tracking issues was discussed. Ms. Bashaw reported that all issues were resolved except for the issue of the scheduling of the MEC meeting and QPSC with regards to the credentialing report. Discussion ensued to resolve the issue to provide adequate time to review the materials.

The resolution was to include the preliminary credentialing report in the agenda packet. If there were any changes made to the report at the Med Exec meeting those changes would be provided to the Clerk of the Board in the original document but in tracking mode to identify any changes. The Clerk of the Board would upload the revised credentialing report to BoardEffect as an addendum as soon after the Med Exec meeting to allow the Committee a day to review the new information.

TAB #9 REPORT: Legal Counsel's Report on Action Taken in Closed Session

Douglas B. Habig, General Counsel, reported that in Closed Session the Committee considered confidential peer review matters and approved credentialing.

Public Comments: None.

Board of Trustees Remarks: None.

ADJOURNMENT: The meeting adjourned at 6:25 pm.

Respectfully Submitted,

Barbara L. McElroy
Clerk of the Board

APPROVED AS TO FORM:

Reviewed by: _____
Douglas B. Habig, Esq.,
General Counsel