Chief Executive Officer
Louis Ward, MHA

Mayers Memorial Hospital District

Quality Committee
Meeting Agenda

February 12, 2019 12:00 p.m.
Boardroom (Fall River Mills)

Attendees

Laura Beyer, Chair, Board Member
Jeanne Utterback, Board Member
Louis Ward, CEO
Dan Dahle MD, Chief of Staff
Candy Vculek, CNO

1	**CALL MEETING TO ORDER**		Chair Beatriz Vasquez			**Approx. Time Allotted**
2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**					
3	**APPROVAL OF MINUTES**					
	3.1	Regular Meeting – January 9, 2019		Attachment A	**Action Item**	2 min.
4	**DEPARTMENT REPORTS**					
	4.1	SNF	Diana Groendyke	Attachment B	Report	10 min.
	4.2	Lab	Chris Hall		Report	10 min.
	4.3	Finance	Travis Lakey	Attachment C	Report	10 min.
	4.4	Volunteer Services	Barbara Spalding	Attachment D	Report	10 min.
	4.5	SNF-Activities	BJ Burkes	Attachment E	Report	10 min.
5	**QUARTERLY REPORTS**					
	5.1	Safety	Val Lakey	Attachment F	Report	10 min.
6	**STANDING MONTHLY REPORTS**					
	6.1	Quality/Performance Improvement			Report	10 min.
	6.2	PRIME	Travis Lakey		Report	10 min.
	6.3	SNF Events/Survey	Candy Vculek		Report	10 min.
	6.4	Infection Control	Coleen Beck		Report	10 min.
7	**ADMINISTRATIVE REPORT**		Louis Ward		Report	10 min.
8	**NEW BUSINESS**					
9	**OTHER INFORMATION/ANNOUNCEMENTS**				Information	5 min.
10	**ANNOUNCEMENT OF CLOSED SESSION**					

	10.1	**Government Code Section 54962:** Chief of Staff Report (Health & Safety Code §32155)	Dr. Dan Dahle, Chief of Staff	Report	
11	**RECONVENE OPEN SESSION** – report closed session action			Information	
12	**ADJOURNMENT:** Next Regular Meeting – March 13 2019 (Fall River Mills)				

Public records which relate to any of the matters on this agenda (except Closed Session items), and which have been distributed to the members of the Board, are available for public inspection at the office of the Clerk to the Board of Directors, 43563 Highway 299 East, Fall River Mills CA 96028. This document and other Board of Directors documents are available online at www.mayersmemorial.com.

Mayers Memorial Hospital District

Board of Directors
Quality Committee
Minutes

January 9, 2019 - 12:00pm
Boardroom (Fall River Mills)

Attachment A
DRAFT

These minutes are not intended to be a verbatim transcription of the proceedings and discussions associated with the business of the board's agenda; rather, what follows is a summary of the order of business and general nature of testimony, deliberations and action taken.

1 **CALL MEETING TO ORDER:** Board Chair Beatriz Vasquez called the meeting to order at 12:11pm on the above date.

BOARD MEMBERS PRESENT:
Laura Beyer, Secretary
Jeanne Utterback, Director

ABSENT:
Jack Hathaway, DOQ

STAFF PRESENT:
Louis Ward, CEO
Ryan Harris, DOO
Diana Groendyke, DON SNF
Candy Vculek, CNO
Theressa Overton, DON, Acute
Amy Parker, Patient Access
Travis Lakey, CFO
Danielle Botorff, Business Office
Sherry Rodriguez, Environmental Services
Coleen Beck, Infection Preventionist
Pam Sweet, Board Clerk

2 **CALL FOR REQUEST FROM THE AUDIENCE – PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**
None

3 **APPROVAL OF MINUTES**

3.1	A motion/second carried; committee members accepted the minutes of November 14, 2018.	Ward/Beyer	**Approved All**

4 **DEPARTMENT REPORTS**

4.1 **HIM**: Submitted written report. No questions or comments.

4.2 **Patient Access:** Submitted written report. Errors are due to new staff and system errors.

4.3 **Business Office:** Submitted written report. Most errors are system related.

5 **QUARTERLY REPORTS**

5.1 **Patient Safety First:** No Report. Move to next meeting

5.2 **Workers Comp:** Submitted written report. No questions or comments.

6 **STANDING MONTHLY REPORTS**

6.1 **Quality/Performance Improvement**: Candy reported. Looking at how we track incident reports. Now is a paper process in Acute and through PCC in SNF. The ability to track metrics is suboptimal. Currently implementing an electronic solution that will improve management tracking. Will be able to assign responsibility and follow up.

6.2 **PRIME**: Travis Lakey reported. Reports pulled at the end of 2018 are due for submission the end of March. In the mean timer, we have submitted a question to the state regarding water metrics. If they answer as we expect, we will have met every metric.

6.3 **SNF Events/Survey**: Submitted our response to the survey before Christmas. We are now waiting for acceptance of our Plan of Correction. There were 10 low level tags and we had fixed most of them within a few days. Now, we are tracking data to make sure the issues stay fixed. Expect acceptance any day

6.4 **Infection Control**: Have plans and forms and now working on setting up a process. Consultant will be back 1/21/19 to help. Been tracking the virus outbreak in SNF

7 **ADMINISTRATIVE REPORT**:

- Retail Pharmacy: Opening April 1st. The new pharmacist has already started and is helping to coordinate opening. Still need to get DEA number; Medi-Cal provider number. Now designing the interior of the building with the help of a design firm. Talking with an architect about submitting to county for a permit. Is not OSHPD jurisdiction
- Setting up Employee meetings in the next months
- ICS100 and ICS 200: all staff is required to complete ICS100. Val is setting up training for both in FR and Burney.
- Burney Fire: Met with the Burney Fire Chief to discuss fire readiness at the Burney campus. He said the property is in good shape. We don't see FR as particularly at fire risk.
- Working with IPG to look at needs of the community in case of a large fire event. Will know more later in January
- New Building will open late Summer or Fall
- Implementing 1-Content to store medical data. Will affect every medical care department
- SEMSA: SEMSA has given us 180 day termination notice. They will stop providing ground transportation on 6/25/19 and air support 6/14/19. Met with SEMSA Leadership this morning to work on a plan. No concrete plan has been developed, but ideas are being kicked around. In the next month, we will know if we can work with SEMSA going forward, if not, then we will determine who we can work with. By the full BOD meeting, will have a better picture
- Laundry: Ryan Harris and Sherry Rodriguez submitted written report. We have a history of problems with the linens vendor. We currently pay them $4,500 weekly for linens. Doing our own will save about $170,000 per year and bring more jobs to the community. Will be fully functional February 2.

8 **NEW BUSINESS**:

8.1 Frequency of Department Reports: Committee agreed they want reports from each department 2 times per year.

9 **OTHER INFORMATION/ANNOUNCEMENTS**: None

10 **ANNOUNCEMENT OF CLOSED SESSION**:

10.1 **Government Code Section 54962:**
Chief of Staff Report (Health & Safety Code §32155) Dr. Tom Watson, Chief of Staff Report

MEDICAL STAFF REAPPOINTMENT

1. Chuck Colas, MD – Emergency Medicine
2. Paul Davainis, MD – Emergency Medicine
3. Julia Mooney, MD – Pathology
4. David Panossian, MD – Pulmonary Care
5. Jeremy Austin, MD – Emergency Medicine

MEDICAL STAFF APPOINTMENT

6. Javeed Siddiqui, MD – Infectious Disease (Telemedicine)
7. Eric Stirling, MD – Emergency Medicine
8. Stephen McKenzie, MD – Family Medicine

REQUEST FOR SPECIAL PROCEDURES

9. Dale Syverson, MD – General Surgery

	A motion/second carried; committee members approved all credentials	Utterback/Ward	Approved All Credentials
11	**RECONVENE OPEN SESSION**: Reported closed session action		
12	**ADJOURNMENT:** 1:34pm - Next Regular Meeting – February 12, 2019 (Fall River Mills)		

Attachment B
SNF

Board Quality Departmental Report Template

Last Quality project reported: IMPLEMENTATION OF WEEKLY 'SKIN & WEIGHTS' COMMITTEE MEETING. PARTICIPANTS: SNF NURSING LEADERSHIP (DON, ADON, CHARGE NURSES, NURSING SUPERVISOR, MDS NURSE), RN WOUND NURSE AND RD. **Update on last Quality project reported:** THIS A VERY SUCCESSFUL WEEKLY MEETING REVIEWING ANY WEEKLY &/OR MONTHLY WEIGHT VARIANCES, INTERVENTIONS TO ADDRESS THE ISSUES, AS WELL AS IN DEPTH DISCUSSIONS ABOUT ANY WOUNDS WITH INTERVENTIONS. AN IDT PROG NOTE IS CREATED CARE PLANS UPDATED, HYDRATION IS ADDRESSED. THIS CREATES A HUGE FOCUS ON ANY	**Current report date to Board Quality:** 2/4/19 **Last report date to Board Quality:** 7/18
What successes have you seen based on the outcome of previous Quality projects? WE HAD NO DEFICIENCIES R/T SKIN & WEIGHTS ON OUR RECENT SURVEY (END OF NOVEMBER 2018) WHEREAS THE PREVIOUS YEAR THERE WERE 9 P/U. OUR RESIDENTS HAVE MUCH LESS PAIN AND REMAIN HEALTHIER DUE TO OUR CURRENT SKIN/WEIGHTS PROGRAM. ALL STAFF ARE MUCH MORE FOCUSED ON THESE ISSUES DUE TO OUR DILIGENT FOLLOW THROUGH.	
What issues have come up in your department relating to Quality? FOLLOW THROUGH ON PROBLEMS, CONCERNS IDENTIFIED BY EMPLOYEES	
PLAN: What plan was implemented to address those issues? THE 'STOPLIGHT REPORT' IS BEING IMPLEMENTED TO ADDRESS THESE CONCERNS EMPLOYEES HAVE ABOUT GETTING PROBLEMS RESOLVED IN A TIMELY MANNER.	
DO: How did the implementation of that plan go? IT IS OCCURRING RIGHT NOW WITH THE 'CREATION' OF RED-YELLOW-GREEN' POSTER BOARDS BEING PUT IN EMPLOYEE AREAS. STAFF WILL BE TRAINED ON HOW TO USE THESE AT THE NEXT STAFF MEETING.	
STUDY: What kind of results did the implementation of the plan yield?	
ACT: What changes were made based on the results of the plan implementation? MORE INFORMATION TO FOLLOW AS WE IMPLEMENT THIS NEW PLAN	

Upcoming Quality Items:	Quality Related Goals for the Department: EVERY RESIDENT WHO REQUIRES A LIFT WILL HAVE THEIR OWN PERSONAL SLING

Data/Graphics supporting project outcomes:

Attachment C
Finance

Board Quality Departmental Report Template

Last Quality project reported:	Current report date to Board Quality:
Finance bi-annual report **Update on last Quality project reported:** Had onsite audit by Wipfli which should be completed by 2/15. The Medicare audit came back with us receiving a small amount and the cost reports were turned in by the 11/30 deadline.	02/12/19 **Last report date to Board Quality:** 07/12/18

What successes have you seen based on the outcome of previous Quality projects?

In finance they aren't really projects but quarterly and annual deadlines for OSHPD, Medicare and Medi-Cal. The recent audits have been successful with a positive bottom line the last few years. I have replaced my AP clerk and have someone hired to train with my Controller for a succession plan.

What issues have come up in your department relating to Quality?

The issues more relate to depth vs quality as prolonged absences in any one position makes it challenging to complete all work.

PLAN: What plan was implemented to address those issues?

We cross trained our new employee in AP and Payroll in addition to just training with our Controller.

DO: How did the implementation of that plan go?

It went well as our Payroll position was out an extended period of time and our new employee stepped in with some help and handled the task.

STUDY: What kind of results did the implementation of the plan yield?

Very positive as paychecks were on time and any errors were the same manager approval errors that existed before.

ACT: What changes were made based on the results of the plan implementation?

An added emphasis on cross training as we have recently proven the need.

Upcoming Quality Items:	Quality Related Goals for the Department:
2018 Audit	2019 Medicare, Medi-Cal and Hospice Cost Reports. 2019 OSHPD Annual Utilization Report. 2017 Medi-Cal Audit, 2018 Medicare Desk Audit, 2016 DSH Audit,etcetera.

Data/Graphics supporting project outcomes:

noridian
Healthcare Solutions

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January 25, 2019

TRAVIS LAKEY CFO
MAYERS MEMORIAL HOSPITAL
43563 HWY 299 EAST
PO BOX 459
FALL RIVER MILLS CA 96028-0459

NOTICE OF AMOUNT OF PROGRAM REIMBURSEMENT

RE: Provider: Mayers Memorial Hospital
Provider Number: 05-1305
Fiscal Year End: June 30, 2017
Subunits: 05-Z305, 05-6416

Dear Mr. Lakey:

Our determination, made in accordance with 42 CFR 405.1803, is supported by the enclosed adjustment report and the resultant cost report. The amount due to the provider was determined as follows:

Net Amount Due to Provider (Program)	$ 1,038

The amount due to you will be included in a Remittance Advice within 15 days from the date of this letter.

CMS regulations require that interest be recalculated whenever a cost report settlement determination is revised. If your facility was previously assessed interest on a settlement for this cost reporting period, the amount of interest due to the Medicare Program will be recalculated. If we determine that there has been an overpayment of interest, the amount overpaid will be refunded on a future Remittance Advice.

If your facility has an approved Extended Repayment Plan prior to determination of this underpayment, you will have fifteen (15) calendar days from the date of this letter to submit a written statement explaining why we should not apply this underpayment to the Extended Repayment Plan per 42 CFR 405.374(a).

A CMS Medicare Administrative Contractor

Noridian Healthcare Solutions LLC

CMS

Attachment D
Volunteer Svc.

Board Quality Departmental Report Template

Last Quality project reported:	**Current report date to Board Quality:**
Update on last Quality project reported: Since my last update, I have decided to do a bi-annual newsletter to volunteers to open another communication line. This gives them updates on changes as they pertain to them and informs them of updating their TB and Flu vaccinations along with any new informative news.	**Last report date to Board Quality:**

What successes have you seen based on the outcome of previous Quality projects? In the past, we always set-up mini clinics for volunteers - this worked as we had a set day/time to advertise to them, when staff changed, so did this. It worked better than the inconsistent way we do it now.

What issues have come up in your department relating to Quality?

I have had a couple of issues. 1st, it has been hard to get volunteers their TB tests and flu shots this past year. The hours of availability to get these done has been inconsistent and not clear on times they can get them done. It has been frustrating to the volunteers for sure. 2nd, taking a volunteer application and immediately processing.

PLAN: What plan was implemented to address those issues?

1st-I have asked other nurses if they would be able to administer these vaccines to volunteers and they have said they would talk with the pharmacy to get the supplies needed. 2nd- I have decided to make two points of contact with a persons who wish to volunteer to make sure of their commitment. I have run a background check at the expense to Mayers and yet they do not volunteer. Just trying to make double sure before going through the application process.

DO: How did the implementation of that plan go?

All the Hospice volunteers were able to get their vaccines done and many others as times/dates were communicated to me and then to them.

STUDY: What kind of results did the implementation of the plan yield?

We were able to capture most all active volunteers and get them up to date on immunizations. I did not get response back from some requests.

ACT: What changes were made based on the results of the plan implementation?

I do hope that some of these inconsistencies will change this year. We should have learned from the situation this past year.

Upcoming Quality Items:	Quality Related Goals for the Department:
Updating volunteer records Communication	Making sure we stay compliant with all volunteers on their immunizations on a timely basis. Update all records, categorize files in preparation of a possible survey

Data/Graphics supporting project outcomes:

Attachment E
SNF Activities

Board Quality Departmental Report Template

Last Quality project reported: Transportation issues for residents related to only one van for both facilities. New programs **Update on last Quality project reported:** Van: Received new van for facility use. New Programs: Sr. TV: Development of Senior TV Face time for residents.	**Current report date to Board Quality:** 02/12/19 **Last report date to Board Quality:** 01/12/18

What successes have you seen based on the outcome of previous Quality projects?

Van: Increase in opportunities for residents medical appointments and recreational outings. Decrease in van repairs. Sr. TV: Positive response to special channels Senior TV has to offer. Face time: Excitement verbalized by some families for the opportunities face time will offer.

What issues have come up in your department relating to Quality?

Van: There have been several mechanical issues that required the van to be out of service. Programs: Sr. TV required multiple trainings by their company for our IT department and additional software needed for program.
Face time: There are some families that do not have the needed equipment to use face time. Privacy during program use have been addressed.

PLAN: What plan was implemented to address those issues?

Van: Regular scheduled maintenance and other repairs as needed. Sr. TV: Continued education and implementation as needed. Face time: Purchase of rolling table for tablet during individual use.

DO: How did the implementation of that plan go?

Positive responses for all three projects

STUDY: What kind of results did the implementation of the plan yield?

Increase in quality of residents activities through availability of transportation and increased quality time with family.

ACT: What changes were made based on the results of the plan implementation?

New activity schedules and calendars offering these programs. Note: Face time is in implementation stage at this time.

Upcoming Quality Items:	Quality Related Goals for the Department:
Education for staff in advanced education in the field of activities.	Increased knowledge of development and implementation of new resources as they become available.

Data/Graphics supporting project outcomes:

Attachment F
Safety

Board Quality Departmental Report Template

Last Quality project reported: First Responder Awareness (FRA) HazMat Training; Disaster Preparedness **Update on last Quality project reported:** Continued FRA training for Maintenance, Environmental Services and Chiefs Participated in the Statewide Drill Developed new Emergency Preparedness Training for staff	**Current report date to Board Quality:** 02/12/19 **Last report date to Board Quality:** 10/10/18

What successes have you seen based on the outcome of previous Quality projects?

Through the variety of EP trainings over the last 6 months, we have seen an increase in the interest from staff about being involved in EP. We are beginning to have specific department personnel expand knowledge and continue education. Additionally, we completed the Emergency Preparedness portion of the Fire, Life Safety survey and had minor corrections to be made. Education and training is seeing results.

What issues have come up in your department relating to Quality?

Lack of time and resources to get staff trained. These are important issues, as we are surveyed on EP now.

PLAN: What plan was implemented to address those issues?

We are working on a training plan to be implemented in orientation and re-orientation. We are identifying those that need specific training. We are making sure ALL management is trained and designates a member of their staff to serve on safety committee and be a part of furthering and developing our EP program

DO: How did the implementation of that plan go?

In progress

STUDY: What kind of results did the implementation of the plan yield?

So far the results have been positive, as noted by the successful survey. We trained over 100 staff in ICS100/200 and our EP Program.

ACT: What changes were made based on the results of the plan implementation?

None so far as we are still in the process.

Upcoming Quality Items:	Quality Related Goals for the Department:
Management EP training	Training of designated staff in each department

Data/Graphics supporting project outcomes: