QUALITY COUNCIL
June 21, 2016

**CO-CHAIRS:** Will Huen, Susan Ehrlich
**ATTENDANCE:**
**Present:** Susan Brajkovic, Max Bunuan, Terry Dentoni, Susan Ehrlich, Thomas Holton, Aiyana Johnson, Jay Kloo, Tina Lee, Jim Marks, Kim Nguyen, Troy Williams, David Woods
**QM/KPO Staff:** Jenny Chacon**,** Emma Moore, Jessica Morton, Jignasa Pancholy, Leslie Safier, Justin Weber
**Excused**: Margaret Damiano, Todd May, Lann Wilder
**Guests:** David Dao**,** Dana Freiser, Kala Garner**,** Leslie Holpit, Roger Mohamed (for Margaret Damiano), Bruce Occcena
**Absent:** Brent Andrew, Jenna Bilinski, Sue Carlisle, Jeff Critchfield, Virginia Elizondo, Karen Hill, Will Huen, Valerie Inouye, Shermineh Jafarieh, Yvonne Lowe, Iman Nazeeri-Simmons, Basil Price

| AGENDA ITEM | DISCUSSION | DECISION/ACTION |
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| **I. Call To Order** | Susan Ehrlich and Troy Williams called the meeting to order at 10:05AM. | Informational. |
| **II. Minutes** | The minutes of the May 21, 2016 meeting were reviewed by the committee. | The minutes were approved. |
| **III. Policies and Procedures** | Cheryl Kalson presented the Policies and Procedures for approval.<br><br>**<u>Administrative Policies</u>**<br>**Policy-1.23: Autopsy Authorization**<br>No changes.<br><br>**Policy-2.02: Prioritization of Intensive Care Unit Beds**<br>No changes.<br><br>**Policy-3.04: Medical Emergency Response Team (MERT)**<br>Revisions included locations MERT will no longer respond to for medical emergencies, and clarified orientation and rounding requirements. Terry Dentoni indicated that there were recent changes made to policy by nursing 3.04 that should be reflected in the policy.<br><br>**Policy-3.13: Employee code of conduct**<br>Minor changes. Todd May recommended having the Medical Executive committee (MEC) review the policy to ensure organizational alignment. | Administrative Policies and Procedures were tentatively approved, pending inclusion of the most recent version of Policy 3.04 MERT.<br><br>Terry Dentoni to forward most updated version of Policy 3.04 (MERT) to Cheryl Kalson. |

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| | **Policy-3.24: Cytotoxic Agents: Preparation, Delivery, Disposal and Spill Management**<br>Revisions included types of resistance testing required for protective gowns, availability of spill kits, and chemo/pharmaceutical waste disposal procedures.<br><br>**Policy-4.07: Investigational Drug Policy**<br>No changes.<br><br>**Policy-8.06: Bloodborne Pathogen Exposure: Patient as the Source**<br>Minor changes**.**<br><br>**Policy-8.10: HIPPA Compliance: Administrative Requirements**<br>Minor Changes to align ZSFG and DPH-wide policies. | |
| **IV. Performance Measures**<br><br>**a. Interpreter Services** | Aiyana Johnson and Bruce Occena presented the department report.<br><br>**<u>Accomplishments:</u>**<br>• The development of a specific hiring list for interpreters within a 12 month timeframe was cited as an accomplishment. This will allow interpreter services greater access to a pool of qualified interpreters.<br><br>**<u>Challenges:</u>**<br>• Interpreters Services does not have the ability to identify the number of total Limited English Proficient (LEP) patients to ensure it is meeting patient language needs.<br><br>**<u>Highlights of the Interpreter Services PI Indicators:</u>**<br>***Developing People***<br><u>TITLE: Restructuring Interpreter Services Department</u><br><u>AIM: By December 2017, reduce the vacancy rate from 26% to 6%.</u><br><u>STATUS: In progress.</u><br>• Current vacancy rate is 32%. Proposed countermeasures included working with Human Resources to create of new eligible list on April 2016 to hire more interpreters in the | Interpreter Services leadership to work with labor to explore feasibility of creating a specific Interpreter job classification for more targeted recruitment. |

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| | Health Worker II classification. Special language conditions were added to expedite and target recruitment for this DPH-wide classificaiton.<br><br>Susan Ehrlich asked about the percentage of interpreter minutes used that are DPH staff compared to contracted services. Bruce Occena reported that approximately 50% of interpreter services utilized are in-person (DPH staff) and the other half are through the use of contracted interpreter services. Filling staff vacancies will result in cost-savings, up to $1.2 million per year, by decreasing reliance on contracted services to meet language needs.<br><br>***Care Experience***<br><u>TITLE: Access to Interpreter Services in Building 25</u><br><u>AIM: By December 2016, 100% of Limited English Proficient (LEP) patients surveyed, who requested an Interpreter, will report being connected to an interpreter by phone or videoconferencing (VMI).</u><br><u>Status: Not met.</u><br>• Funding constraints resulted in only 63% of patient care rooms being fully equipped with interpreter technology, such as dual handsets or VMIs.<br>• Examples of Interpreter technology distribution rates include: Birth Center 55%; Intensive Care Unit (ICU) 53%; and Medical/Surgical (MedSurg) Units Floors 4-7 with an overall distribution of 58%.<br>• No standardized protocols, for all staff levels, on usage, location and cleaning of Interpreter technology equipment exist.<br><br>There was a discussion regarding the quality monitoring process of external and internal interpreter services. Bruce Occena indicated that Interpreter Services does not have the capacity to proactively audit its services but are responsive to all complaints. However, the updated technology in the new facility enables patients to provide real-time patient feedback on their satisfaction with their care, which includes satisfaction with Interpreter Services. This data will help identify area for improvement. | Develop guidelines for providers and staff on usage of VMI and dual phones including sanitation protocols, reboot time, best modality practice, etc. and update Quality Council by December 2016<br><br>Proposed Watch metrics were moved to Drivers category. |

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| | **DRIVER METRICS**<br>***Care Experience***<br>TITLE: Equipping Building 25 with Optimal Interpreter Services technology<br>AIM: By June 2017, Equip Building 25 with interpreter technology from 63% rooms equipped to % deemed optimal.<br><br>TITLE: LEP Patients Connected to Interpreter<br>AIM: By June 2017, 100% of LEP patients requesting an Interpreter will be connected.<br><br>TITLE: Locating Interpreter Equipment<br>AIM: By June 2017, 100% of staff and patients will be able to locate an available interpreter phone or VMI with no unnecessary delays.<br><br>TITLE: Staff and Provider satisfaction with Interpreter Technology.<br>AIM: By June 2017, 90% of Staff and providers will be satisfied with interpreter technology.<br><br>***Developing People***<br>TITLE: Interpreter Vacancy Rate<br>AIM: By June 2017, reduce the vacancy rate from 32% to 6%.<br><br>TITLE: Manager Investment<br>AIM: By June 2017, increase the number of managers who report feeling professionally developed (invested), as reported by the staff engagement survey from 43.6% to 60%.<br><br>TITLE: Balanced Workload<br>AIM: By June 2017, Increase the percentage of staff who report a more balanced workload, as reported by the staff engagement survey, from 50% to 60%. | Proposed 12 month performance measures reviewed and approved.<br><br>Continue to monitor contracts for compliance. |

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| | ***Contract Measures:***<br>Contractor: Language Line<br>AIM: Time to connect to an interpreter will be < 1 minute.<br>Status: Goal met.<br><br>Contractor: Language Line<br>AIM: User dissatisfaction with service will be <1%<br>Status: Goal met. | |
| **V. A3 Presentation Race, Ethnicity and Language (REAL)** | Jenny Chacon presented an A3 on improving the collection and integrity for Race, Ethnicity and Language (REAL) data.<br>.<br>**Highlights of A3 Presentation:**<br>• ZSFG is part of a SF Network-wide PRIME workgroup to improve REAL data integrity that is collected by front-line staff (e.g. enrollment, registration and call center staff) for decreasing health disparities and inequities.<br>• REAL data improvement efforts are being driven by the payment program Public Hospital Redesign Incentives in Medi-Cal (PRIME), which is part of the new California Medi-Cal Waiver (Medi-Cal 2020).<br>• Current Information systems (IS) do not have the infrastructure to collect or stratify by detailed race and ethnicity for PRIME compliance or quality reporting.<br>• Proposed countermeasures included: assessment of current data collection workflow, Lifetime Clinical record (LCR) modifications, REAL data collection standardization, front line staff training, and ongoing data integrity monitoring.<br><br>There were questions about the feasibility of accomplishing the proposed countermeasures by September 2016. Jenny Chacon indicated that these targets were set to meet PRIME baseline data reporting requirements due in September 2016. | Update Quality Council on status of data collection after IS upgrades and trainings implemented in Fall 2016 in November 2016. |

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| **VI. Patient Safety Countermeasure Summary** | Tom Holton presented a countermeasure summary on Falls with Injuries.<br><br><u>Highlights of Falls Countermeasures Summary Report:</u><br>• From January 2016-June 2016, there have been approximately 43 falls with injury. Seven of the injuries were classified as major; three of the major injuries occurred on Med-Surg, 2 occurred in the Emergency Room, and 1 was within the outpatient setting.<br>• ZSFG patients who experienced previous falls during the same hospitalization accounted for 23% of cases. | Restructure of organizational falls taskforce and focus on falls prevention and management of a patient after the fall.<br><br>Conduct falls rounds to ensure compliance with falls program.<br><br>Develop standard work for falls prevention. |
| **VII. Close Observation Quarterly update** | Leslie Holpit and Dana Freiser presented the quarterly close Observation update.<br><br>**<u>Highlights from Code Green/Close Observation Quarterly update:</u>**<br>• A root cause analysis for at-risk patients was presented. Root causes for decreased safety for at-risk patients were considered within the following areas: Close Observation, AeroScout Activation and Discontinuation, Level One to Three responses, and Code Green responses.<br>• An "At-Risk Patient Safety System" performance metric dashboard, from January 2016 to May 2016, was reviewed. Areas of improvement for patient system metrics included:<br>o **Order Compliance % of Close Observation Order Forms Completed Correctly:** In May, compliance decreased to 65% compared to 70% the previous month.<br>o **Response to an At Risk Patient Leaving-# of False Alarms.** There was an upward trend of 31 activations from 15 in April (goal 0). There are certain rooms in Building 25 where Aeroscout alarms are activated through the wall. | Code Green Committee to present progress at September 2016 Quality Council meeting. |

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| | • Dana Freiser reported that the Code Green Committee is being reorganized to ensure a more comprehensive approach managing At-Risk patients. It will be renamed the At-Risk Patient Safety System Committee and will focus on contributing factors such as Aeroscout, Close Observation and Code Green. The group is currently reassessing its committee membership and areas of focus. | Restructure the Code Green Committee to identify and manage the care of at-risk patients. |
| **VIII. Regulatory Update** | Jay Kloo presented the Regulatory update.<br><br>**<u>Highlights of Regulatory Report:</u>**<br>• CMS/Joint Commission Conditions of Participation Survey: A full accreditation validation survey is anticipated within 3-6 months post move to Bldg. 25.<br>• The Joint Commission Triennial Accreditation Survey is anticipated within the next 12 months. | Continue monthly regulatory updates. |
| **VIII. Announcements** | There were no announcements. | |
| **Next Meeting** | **The next meeting will be held<br>July 19, 2016 in 7M30<br>10:00am-11:30am** | |