Performance Improvement Annual Report July 2013 - June 2014

Prepared by:

Department of Patient Safety & Quality

Brigid Ide, RN, MS, Executive Director, Patient Safety & Quality

Joy Pao, Director, Quality Improvement

Quality Improvement Executive Committee

Mari-Paule Thiet, MD, Chair

Niraj Sehgal, MD, MPH, Chair-Elect

Chief Medical Officer

Josh Adler, MD

UCSF Medical Center

UCSF Benioff Children's Hospital

To the UCSF Community:

We are pleased to present to you the 2014 Performance Improvement Plan Annual Report. This annual report represents the efforts of many people and many hours of committee work in all aspects of performance improvement as we strive to deliver the highest quality of care at UCSF.

The Quality Improvement Executive Committee (QIEC) provides executive oversight of the Medical Center's quality, safety, and performance improvement activities. The QIEC is responsible for the development, implementation, and evaluation of a comprehensive Performance Improvement Plan, and reports findings to the Executive Medical Board. This annual report highlights the accomplishments and areas for improvement.

In summary, we are proud of the accomplishments we achieved this past year as outlined in this report. Specifically, we had remarkable improvements in the following key areas:

- National and California Stages (e.g., UCSF Medical Center ranked #8 in U.S. News & World Report)
- UCSF Medical Center Focus (e.g., Quality and Patient Satisfaction goals for 2014 were all achieved)
- Quality, Mortality and Nursing Focus (e.g., Sepsis, CPR, SSI, and HAPU improvements)
- Benioff Children's Hospital had 10 specialties nationally ranked in the U.S. News & World Report

As we continue to work on strategic Quality Improvement initiatives, this report will serve as the foundation to leverage future operational efficiency and improve patient outcomes. In July 2014, Dr. Niraj Sehgal assumed leadership of the QIEC. We worked together to assure a seamless transition as we face the challenges ahead.

Dr. Adler and I wish to thank all the members of QIEC for their engagement and thoughtful discussions. Additionally, I would like to personally thank Brigid Ide for all of her contributions.

Sincerely,

Mari-Paule Thiet, MD
Chair, QIEC

Josh Adler, MD
Chief Medical Officer

Niraj Sehgal, MD, MPH
Chair-Elect, QIEC

Table of Contents

I. EXECUTIVE SUMMARY 3

II. UCSF HOSPITAL-WIDE QUALITY PROJECTS 5

- MEDICAL CENTER QUALITY GOALS 6
- THE QUALITY LANDSCAPE 7
- THE AMERICAN COLLEGE OF SURGEONS NATIONAL SURGICAL QUALITY IMPROVEMENT PROGRAM (ACS NSQIP) 13
- NURSING-SENSITIVE INDICATORS 14
- FAILURE MODE AND EFFECT ANALYSIS 17

III. SURVEY ACTIVITY 18

- ACCREDITATION AND SURVEY ACTIVITY 19
- THE LEAPFROG GROUP SURVEY 19
- U.S. NEWS & WORLD REPORT:
  - "AMERICA'S BEST HOSPITALS" 21
  - "BEST CHILDREN'S HOSPITALS" 21

IV. QUALITY COMMITTEES REPORTING TO QUALITY IMPROVEMENT EXECUTIVE COMMITTEE (QIEC) 22

- QUALITY COMMITTEE STRUCTURE 23
- ENVIRONMENT OF CARE COMMITTEE 24
- ETHICS COMMITTEE 26
- INFECTION CONTROL COMMITTEE 27
- MEDICAL RECORDS COMMITTEE 31
- PATIENT SAFETY COMMITTEE 32
- RISK MANAGEMENT COMMITTEE 33
- UTILIZATION MANAGEMENT COMMITTEE 34

V. QUALITY COMMITTEES REPORTING TO CLINICAL PERFORMANCE IMPROVEMENT COMMITTEE (CPIC) 37

- ADULT CRITICAL CARE COMMITTEE 38
- CANCER COMMITTEE 40
- CODE BLUE COMMITTEE AND RAPID RESPONSE TEAM 42
- DIABETES AND INSULIN MANAGEMENT COMMITTEE 43
- OPERATING ROOM COMMITTEE 45
- PAIN COMMITTEE 46
- SEDATION COMMITTEE 46

- SURGICAL CASE AND HOSPITAL MORTALITY REVIEW COMMITTEE (SCHMRC) 47
- TISSUE COMMITTEE 47
- TRANSFUSION COMMITTEE 48

VI. QUALITY COMMITTEES REPORTING TO THE BENIOFF CHILDREN'S HOSPITAL QUALITY IMPROVEMENT EXECUTIVE COMMITTEE (BCH QIEC) 50

- BCH PATIENT SAFETY COMMITTEE 51
- BCH CODE WHITE AND RAPID RESPONSE TEAM 52
- BCH MEDICATION COMMITTEE 53
- INTEGRATED PEDIATRIC PAIN AND PALLIATIVE CARE: IP-3 54
- PEDIATRIC TRANSITIONS OF CARE TASK FORCE 55
- THE CALIFORNIA PERINATAL QUALITY CARE COLLABORATIVE (CPQCC) 56

VII. PATIENT EXPERIENCE 57

- MEDICAL CENTER PATIENT EXPERIENCE GOAL 58
- COMPLAINTS AND GRIEVANCES 60
- CULTURE OF EXCELLENCE COMMITTEE 62

VIII. CONTACT INFORMATION AND ACKNOWLEDGEMENTS 64

FY2015 UCSF ORGANIZATIONAL GOALS AND OPERATIONS WORKPLAN

EXECUTIVE SUMMARY

This table represents a high level assessment of key performance indicators reported to Quality Improvement Executive Committee (QIEC) for work completed in Fiscal Year 2014. Details on each are contained in the body of the report.

OUTSTANDING PERFORMANCE

NATIONAL AND CALIFORNIA STAGES

- UCSF Medical Center ranked #8 in U.S. News & World Report: America's Best Hospitals
- UCSF Complex Care Support won the prestigious 2014 CAPH/SNI Quality Leaders/Kaiser Permanente Clinical Systems Development for work with complex high utilizing patients, reducing ED utilization by 25%, and increasing patient's self-reported perception of health.
- Accomplished all DSRIP milestones for FY2014
- Achieved The Joint Commission (TJC) Point of Care Testing program Gold Seal of Approval
- Leapfrog Hospital Safety Score "A" assigned to UCSF Medical Center Parnassus and Mt. Zion
- Recognized by ACS NSQIP for a meritorious composite quality score for 8 surgical outcomes
- Emergency Management Preparedness Program considered best practice by TJC and the CA Hospital Association

UCSF MEDICAL CENTER FOCUS

Organizational **Quality and Patient Satisfaction Goals** for FY2014 were achieved

- Reduced hospital wide central line associated bloodstream infections (CLABSI) by 15% to a rate of 1.36 per 1000 line days
- Increased the percentage of patients discharged before noon by 12% for 6 of 12 months without adversely impacting other metrics and slightly improving patient satisfaction.
- Increased MyChart enrollment to 95,952, well beyond the target of 85,000
- Achieved outstanding level of performance in patient satisfaction Press Ganey Likelihood of Recommending and target level in meeting average HCAHPS domains at the 60th percentile level

Quality and Risk

- Performance in CMS Value Based Purchasing (VBP) Program for 2015 was superior to the national average, resulting in an incentive payment (0.1009% increase in our base operating DRG payment)
- Immediate CPR survival rates 73% compared to 48.5% national benchmark and hospital discharge rates after CPR 27%, also better than the national average of 15.4%
- Sepsis mortality reduced to an average of 12% with 83% bundle of care compliance
- Hand hygiene compliance rate was 92% with over 55, 925 observations
- SSI rates in ten surgical categories were better than the risk adjusted expected rates; all other categories were as expected
- Incidence of CLABSI and CAUTI cases are statistically significantly lower than expected according the National Healthcare Safety Network (NHSN)
- Lowest number of AHRQ Patient Safety Indicators in 4 years
- The Virtual Glucose Management Service demonstrated improved glucose management with an increase in the number of patients in target glucose range and a reduction in patients experiencing hyperglycemia
- No cardiopulmonary arrests in the BCH Medical Surgical areas

	• System-wide Risk Management Award for having the lowest cost Professional Liability program • Expectant Management and Medical Information (EMMI) implemented in over 20 areas **Department of Nursing** • HAPU prevalence rates reduced to 1.03 *(91% of all nursing units outperforming benchmarks)* • Restraint use continues to decline with to a prevalence rate of 2.61, a 47% reduction from 2008 • Beacon Award for Excellence in Northern California - Gold level awarded to 8/11 ICU for sustaining unit performance and patient outcomes **Utilization and Throughput** • Length of stay in the PACU has declined for four consecutive years • Benioff Children's Hospital reduced readmissions on their hospital medicine service from 4.6% in FY2012 to 3.0% in FY2013
SIGNIFICANT ACCOMPLISHMENTS	Benioff Children's Hospital had 10 specialties nationally ranked in the U.S. News & World Report
STRIVING TO IMPROVE	**NATIONAL AND CALIFORNIA STAGES** ▪ Readmission rates for AMI, HF, PN, TKA-THA, COPD within national average rates; CMS measured Hospital-Wide Standardized Readmission Rate greater than expected ▪ UHC rankings fell to a two star level **UCSF MEDICAL CENTER FOCUS** ▪ Reduced patient falls by ~37% since 2008; but there was an increase to 1.74 this year from 1.59 in FY2013. Falls with injury were essentially unchanged from last year ▪ VTE and PE rates remain higher than desired in the NSQIP data ▪ Reported staff injuries increased by 13%

UCSF HOSPITAL-WIDE QUALITY PROJECTS

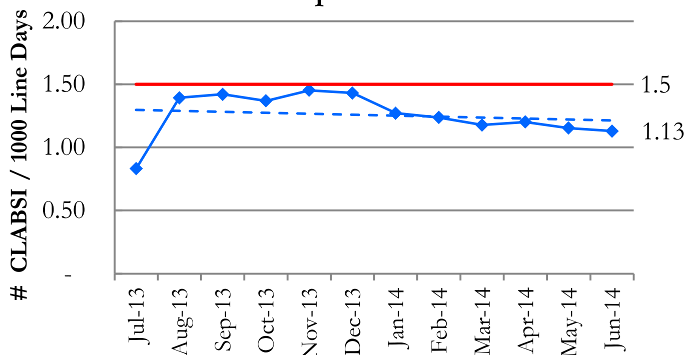
MEDICAL CENTER QUALITY GOALS

Each year the Medical Center sets organization-wide goals covering Patient Safety & Quality, Patient Experience, and Financial Performance for the employee Incentive Award Program. Three quality-focused goals were selected.

REDUCE HOSPITAL-WIDE CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS (CLABSI) BY 15% TO 1.36/1000 LINE DAYS

ACHIEVED:

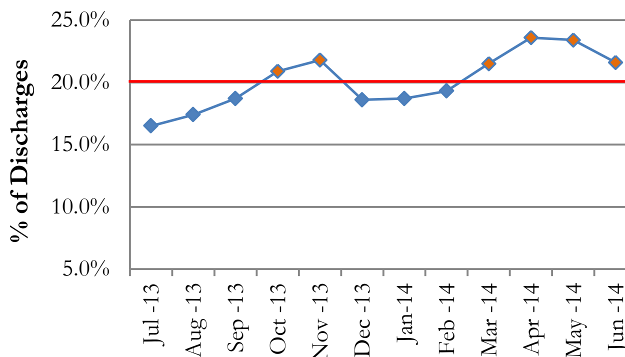
Although the FY2013 CLABSI rate was revised downward to 1.50 CLABSI/1000 central line days during FY2014, a 15% reduction from the new baseline was surpassed; UCSF achieved a 25% reduction in the hospital-wide CLABSI rate in FY2014.



INCREASE PERCENT OF PATIENTS DISCHARGED BEFORE NOON BY 12% FROM 17.6% TO 20% FOR 3 OF 12 MONTHS

ACHIEVED

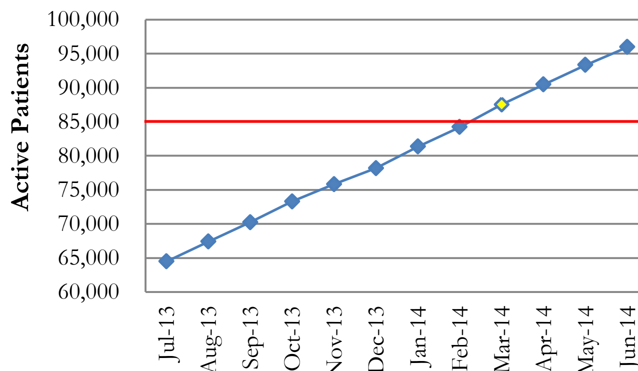
UCSF Medical Center met the goal by achieving >20% of inpatients discharged by noon for 6 out of 12 months.



INCREASE MYCHART ENROLLMENT BY 25,000 TO A TOTAL OF 85,000

ACHIEVED

MyChart attained its target by achieving a final enrollment rate of 95,952 patients during the FY2014 period; 13% over the 85,000 target goal.



THE QUALITY LANDSCAPE

CMS 30-DAY READMISSION MEASURES

Readmission measures are being followed in two CMS programs using Med PAR claims data. The programs differ in time periods and measure methodologies.

1) The Hospital Readmissions Reduction Program (HRRP)[1]

- Focus population and measures include Risk-Standardized Readmission for acute myocardial infarction (AMI), heart failure (HF), pneumonia (PNE), total hip/knee replacement (THA/TKA), and chronic obstructive pulmonary disease (COPD).
- Penalties of up to 2% for FY2014 are applied to all DRG payments when readmission rates for targeted populations are greater than expected. UCSF readmission penalties for FY2014 were negligible. Penalties will increase to 3% for FY2015.

2) The Inpatient Quality Report (IQR)

- Focus population and measures include Risk-Standardized Readmission for AMI, HF, PN, THA/TKA, stroke, COPD), and Hospital-Wide All-Cause Unplanned Readmission (HWR).
- Rates are published on CMS Hospital Compare website: http://www.hospitalcompare.hhs.gov/

30-Day Readmission Measures	HWR	AMI	HF	PN	THA/TKA	COPD	Stroke
CMS Hospital Readmission Reduction Program (7/2010-6/2013)							
UCSF Risk Stratified Excess Readmission Ratio		1.059	1.0028	1.0522	1.0649	1.039	
UCSF Readmission Rate		18.6%	22.2%	17%	5.3%	21.2%	
Hospital Compare – 2014 IQR Program (7/2012-6/2013)							
UCSF Performance	Worse than the National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate
UCSF Standardized Readmission Ratio (SRR)[2]	**1.08**						
UCSF Risk-Standardized Readmission Rate	16.9%	18.6%	22.7%	18.3%	5.4%	21.6%	15.9%
National Observed Readmission Rate		17.8%	22.7%	17.3%	5.2%	20.7%	13.3%

Quality efforts around readmission reduction are led by the UCSF Transitions of Care Steering Committee and have centered around improving hospital discharge practices, implementing a discharge telephone follow-up program, redesigning the roles of the Medicare Transitions Managers, and establishing a post-acute care strategy.

CMS VALUE-BASED PURCHASING (VBP) – FY2015

- The VBP scores are calculated based on baseline period between October and December 2011, and the performance period of October 2012 to December 2013.
- The CMS FY2015 VBP program reflects performance on select clinical process of care measures (Core Measure, 20%), patient experience measures (Hospital Consumers Assessment of Healthcare Providers and Systems, HCAHPS, 30%), outcome (mortality – AMI, HF, PN; AHRQ PSI-90; and CLABSI, 30%) scores and newly added efficiency measure (MSPB[3], 20%). Performance put 1.5% of the UCSF base DRG payment basket update at risk.
- UCSF received a VBP score of 41.382 points; this results in a positive 0.1009425% (increase) in DRG base payment as a result of demonstrating true "value" in the quality care we provide to our patients.

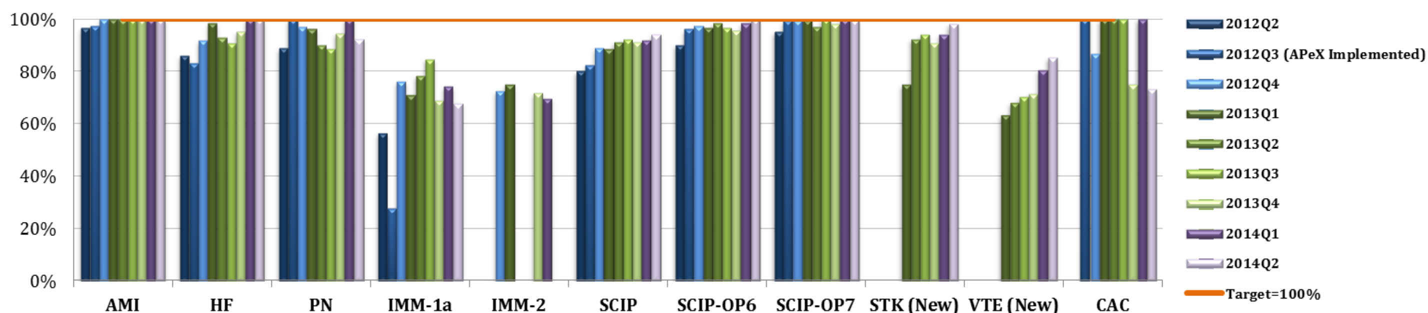
---

[1] *Published July 2014 for FFY2015, with hospital discharges that occurred between July 1, 2010 and June 30, 2013.*
[2] *Standardized Readmission Ratio: Risk-Adjusted Observed versus Expected Ratio*
[3] *Medicare Spending per Beneficiary*

The Quality Landscape (continued from previous page)

CORE MEASURES – INPATIENT AND OUTPATIENT

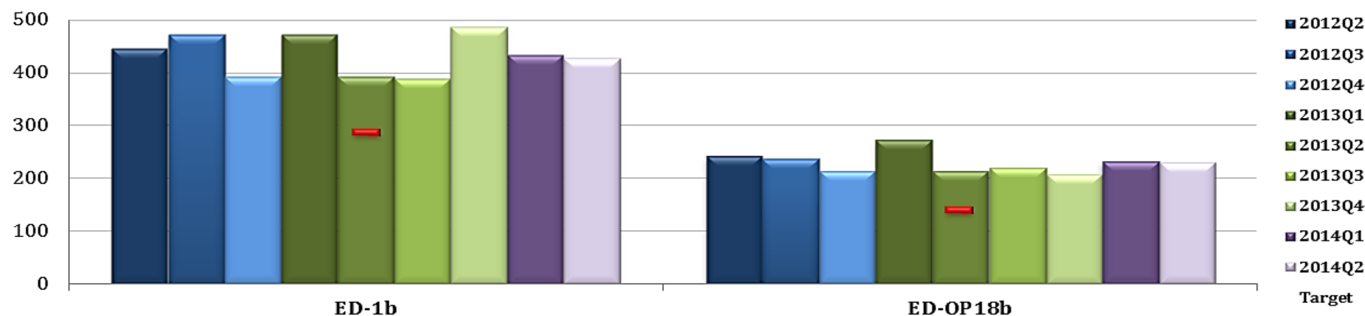
The graph below reflects composite performance for each core measure set (CY quarters):



- **Acute Myocardial Infection (AMI) Measures**
  - Great performance, 100% compliance in composite score continuously for 7 quarters.
- **Heart Failure (HF) Measures**
  - Built appropriate HF discharge language into APeX template: (activity level, diet, discharge meds, F/U appointments, weight monitoring, worsened symptoms).
  - Concurrent case review and staff education.
  - Great performance achieved continuously for the last 6 months (2 quarters), 100% compliance in composite score.
- **Pneumonia (PN) and Immunization Measures (IMM)**
  - Instituted PN Core Measure best practice alerts for ED physician and nursing staff indicating that blood cultures (if ordered) must be collected prior to antibiotic administration.
  - QI Department launched interdisciplinary Immunization Summit in summer of 2014 to reform the work and process flow around immunization for winter 2014-2015. Unit based/aggregate, monthly compliance reports developed by late September 2014 to support this major initiative.
  - IMM-1a-Pneumovax has been discontinued effective FY2015.
- **Surgical Care Improvement Project (SCIP) Measures**
  - Challenge with measure set is primarily with "urinary catheter removal on post-op day 1 or 2" indicator.
  - Implemented a progress note "Smartphrase" to encourage appropriate documentation for urinary catheter removal. Launched APeX "Best Practice Alert" for catheter removal in appropriate patients.
  - Concurrent case review and staff education performed on "urinary catheter removal on post-op day 1 or 2" patients.
  - Continuous and steady trend of improvement with the last quarter reaching 94.23% compliance.
- **Stroke (STK) Measures**
  - Built CMS compliant language into STK discharge and education templates.
  - Concurrent case review and staff education
  - Continuous and steady trend of improvement with the last quarter reaching 98.08% compliance.
- **Venous Thromboembolism (VTE) Measures**
  - Built appropriate VTE Prophylaxis Ordering and Documentation into core order set.
  - Built CMS compliant language for VTE Warfarin teaching and education in staff documentation templates.
  - Build APeX Daily Warfarin Patient list and sent to appropriate staff for follow up.
  - Continuous and steady trend of improvement, moving from 63.5% compliance from the start of the measure set (2013) to the last quarter in FY2014 reaching 85.38% compliance.

The Quality Landscape (continued from previous page)

- **Children's Asthma Care (CAC)**
  - Measure tracked by Pediatric Medicine Division and provider feedback is sent when exceptions occur.
  - Reengineered the workflow and modified the electronic health record to ensure every child with a principal diagnosis of asthma is given instructions at discharge on home management of asthma.



- **ED Throughput Measures**
  - ED-OP18b measures the median time from ED arrival to ED departure for discharged ED patients. Average national target is 140 min. UCSF average for the last 9 quarters was 229.5-mins.
  - ED-1b measures the median time from ED arrival to ED departure for admitted ED patients. Average national target is 287.3min. UCSF average for the last 9 quarters was 433.62-mins.
  - Work in this domain is being led by the UCSF ALERT Team.

DSRIP PROGRAM

DSRIP refers to the CMS sponsored **D**elivery **S**ystem **R**eform **I**ncentive **P**ool in the demonstration waiver that provides federal matching funds up to $3.3 billion statewide over five years (FY2011 – FY2015) to help support efforts by county and University of California hospitals to improve quality. This program was set up with the intent to meet the demands associated with the increase in MediCal enrollment due to the Affordable Care Act.

Four focused intervention areas under DSRIP at UCSF are listed below, with quality of care at the center of the work. The following section describes the achievements and activities in FY2014[4]. All of DSRIP milestones were met in 2014, with an achievement value of $58,300,000.

Category	Elements	Achievements and Activities
Category 1: Infrastructure Development	Expanded Primary Care Capacity (Access)	▪ Visit volume target was achieved, with 108,232 primary care visits. ▪ MyChart encounters have been analyzed and a portion is being counted as virtual visits. Work is ongoing to refine data and payment methodologies with payors. This year, primary care providers received over 87,000 requests for medical advice through the MyChart portal.
	Implement and Utilize Disease Management Registry Functionality (Quality)	▪ Diabetes, anticoagulation, pediatric asthma, colorectal, cervical cancer and pediatric immunization screening registries have been created and are in use in all primary care clinics, including pediatric primary care. ▪ These registries continue to drive population health performance improvement interventions at both the clinic and provider levels and provide data for us in our panel management program, for example mammography screening has improved by 10%, from 66% to 76%.
	Enhance Performance Improvement and Reporting Capacity (Quality)	▪ Staff have been hired and trained in business intelligence reporting tools. ▪ QlikView dashboards, analytic and data display tools have been

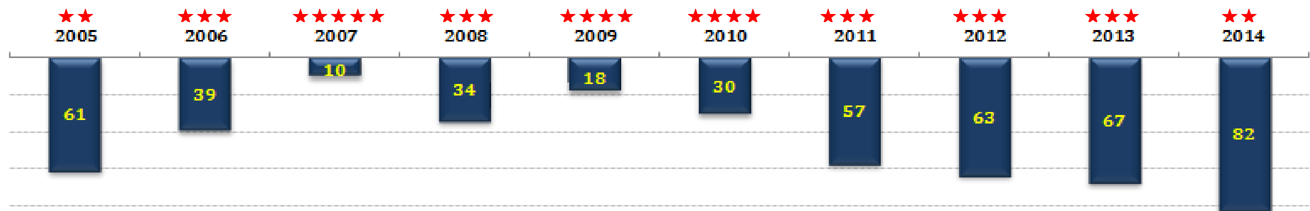
[4] FY2014 = DY 9, Demonstration Year 9

Category	Elements	Achievements and Activities
		developed for real-time access for operational and quality measure data. The DischDash, QualDash and FlashDash are operational and in use.
Category 2: Innovation and Redesign	Expand Medical Homes (Access)	▪ Care Support, our program to provide intensive care management of high utilizer and complex patients has enrolled over 150 complex patients; early results show decreased length of stay, ED and inpatient utilization for patients enrolled in the program. ▪ A primary care best practice retreat was convened and front line staff shared strategies for panel management, co-location of physicians and MAs , and patient experience. ▪ DGIM has received level 3 Patient-Centered Medical Home (PCMH) recognition by the National Committee for Quality Assurance (NCQA), 3 others are planned for FY2015. ▪ Over 1300 high risk seniors and people with disabilities (SPD's) have been assigned providers in UCSF Medical homes.
	Increase Specialty Care Access/ Redesign Referral Process (Access)	▪ E-referrals and smart phrase technology have been successfully implemented in fifteen (15) specialty practices resulting in the redesign of the specialty referral process. ▪ Over 800 E-consults have occurred between PCP and specialty providers in FY2014. This enables primary care providers access to specialty care via a completely electronic interaction, thus eliminating an in person visit for the patient. ▪ E-consults between specialists (i.e. transplant to cardiology) are planned for FY2015.
	Implement/Expand Care Transition Programs (Quality)	▪ Implemented a centralized RN-led discharge telephone call program to: 1) evaluate patients' understanding of their discharge and medication plans; 2) ensure patients are scheduled for appropriate follow-up care; 3) assess for any new or worsening symptoms; and 4) assess patients' overall satisfaction with their hospital visit to UCSF. Currently, 50% of patients discharged home are enrolled in this program, with reach rates of 75%. New services are implemented semi-monthly. ▪ Redesigned the role of the Heart Failure RN coordinator to include populations of AMI, PNA and COPD. Established population-centered workgroups to implement best practices for inpatient and outpatient care. Established real time readmission reviews for AMI and HF. Implemented RN longitudinal follow-up from hospital admission to 30 days post-discharge. ▪ Established a post-acute care strategy workgroup whose goal is to: 1) better understand the post-acute needs of UCSF's admitted patients; 2) identify potential post-acute care agency/facility partners across the Bay area; 3) develop recommendations for arrangements that would ensure adequate capacity for UCSF patients and to facilitate care coordination across the care continuum while retaining the UCSF touch. UCSF has participated in three SNF round table meetings with several of our local partners.
Category 3: Population-Focused Improvement *UCSF reported new metrics reflecting population health*	Patient/Caregiver (PC) Experience (Patient Experience)	▪ UCSF Medical Center has been surveying a random sample of patients in all of the medical center's adult primary care practices since April 2, 2012. ▪ The PC strategies committee has incorporated patient experience metrics and performance targets into their integrated dashboard. Consensus was achieved across all of primary care to increase CGCAHPS scores.
	Care Coordination (Quality)	**Between July 1, 2013-June 30, 2014:** ▪ 0.9% of our primary care patients with diabetes were admitted to UCSF with a primary diagnosis of a short term complication from

Category	Elements	Achievements and Activities
		diabetes ▪ 0.3% of our primary care patients with diabetes were admitted to UCSF with a primary diagnosis of uncontrolled diabetes ▪ 0.3% of our primary care patients were admitted to UCSF with a primary diagnosis of CHF ▪ 0.1% of our primary care patients were admitted to UCSF with a primary diagnosis of COPD
	Preventive Health (Quality)	**Between July 1, 2013-June 30, 2014:** ▪ 77% of our primary care patients were screened for breast cancer ▪ 46% of our primary care patients were immunized for influenza ▪ 87% of our pediatric primary care patients were weight screened (BMI) ▪ 29% of our pediatric primary care patients had a BMI > 85th percentile ▪ 46% of our primary care patients who smoke were given smoking cessation advice/counseling
	At-Risk Populations (Quality)	**Between July 1, 2013-June 30, 2014:** ▪ 48% of our primary care patients with diabetes had an LDL level <100mg/dl ▪ 67% of our primary care patients with diabetes had a Hemoglobin A1C level <8% ▪ 11% of our primary care patients admitted for CHF were readmitted within 30 days ▪ 60% of our primary care patients with hypertension had blood pressure control (<140/90) ▪ 39% of our pediatric primary care patients with persistent asthma were prescribed at least one controller medication ▪ 19% of our primary care patients with diabetes adhered to all elements of the diabetes composite measure
Category 4: Urgent Improvement in Quality and Safety	Improve Severe Sepsis Detection and Management (Quality)	▪ Implemented an APeX early warning sepsis surveillance system; fully implemented across all adult units. ▪ Operationalized a multidisciplinary "code sepsis" team, comprised of a rapid response nurse, a critical care nurse practitioner (NP) and a pharmacist to respond to patients with severe sepsis or septic shock. ▪ Building a pediatric sepsis alert for the ED; and developing early warning sepsis criteria for OB patients. ▪ Current bundle compliance rate on required elements of care on all units is 83% and overall adult hospital mortality from sepsis was reduced to 12% for FY2014p
	Central Line-Associated Bloodstream Infection (CLABSI) Prevention (Infection Control)	▪ UCSF achieved and exceeded reduction targets for CLABSI rates: Acute Care, 1.2%, ICU, 0.7%, and neonatal ICU 1.9%. ▪ Ongoing education continues and re-education has been instituted within Nursing Annual Review. ▪ 99.6% CLIP rate was achieved.
	Surgical Site Infection (SSI) Prevention (Quality and Infection Control)	▪ UCSF has committed to SSI reduction via DSRIP in the following 7 procedures: colon, rectal, small bowel, C-section, knee and hip arthroplasty and appendectomy. ▪ A 26% reduction in SSI in these targeted populations was achieved, with an aggregate SSI rate of 0.64%.
	Hospital-Acquired Pressure Ulcer (HAPU) Prevention (Nursing Care)	▪ Over 300 nurses received pressure ulcer prevention intensive training. ▪ FY2014 HAPU rate was 1.2 %, significantly less than the DSRIP target of 1.7%.

The Quality Landscape (continued from previous page)

UNIVERSITY HEALTHSYSTEM CONSORTIUM (UHC)
2005-2014 QUALITY & ACCOUNTABILITY STUDY RANKING



UHC Quality/Accountability Metric Rank		Ranking									
		2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Overall Composite Rank[5]		**2★ 61**	**3★ 39**	**5★ 10**	**3★ 34**	**4★ 18**	**4★ 30**	**3★ 57**	**3★ 63**	**3★ 67**	**2★ 82**
Overall Composite Score *(higher is better **only** in this row)*		**58.2**	**60.3**	**70.1**	**66.6**	**70.1**	**68.5**	**63.5**	**52.3**	**63.4**	**61**
Mortality	*O:E ratios of selected service lines*	58	29	13	20	36	55	62	63	72	**60**
Effectiveness	*Core Measures and 30-day readmission rates*	12	56	18	21	51	23	41	80	83	**92**
Safety	*Complications of Care : AHRQ PSIs and VTE, CLABSI, CAUTI, SSI*	22	26	16	22	5	11	6	14	4	**49**
Equity	*No disparity of care based on race, gender, payor*	78	1	1	1	1	1	1	86	1	**1**
Patient Centeredness	*Patient satisfaction scores; HCAHPS question + composite*	N/A	5	8	33	1	51	20	31	41	**23**
Efficiency	*LOS and direct cost of 10 service lines*	70	69	61	24	89	95	99	97	96	**103**

Key points regarding UCSF performance and the UHC methodology:

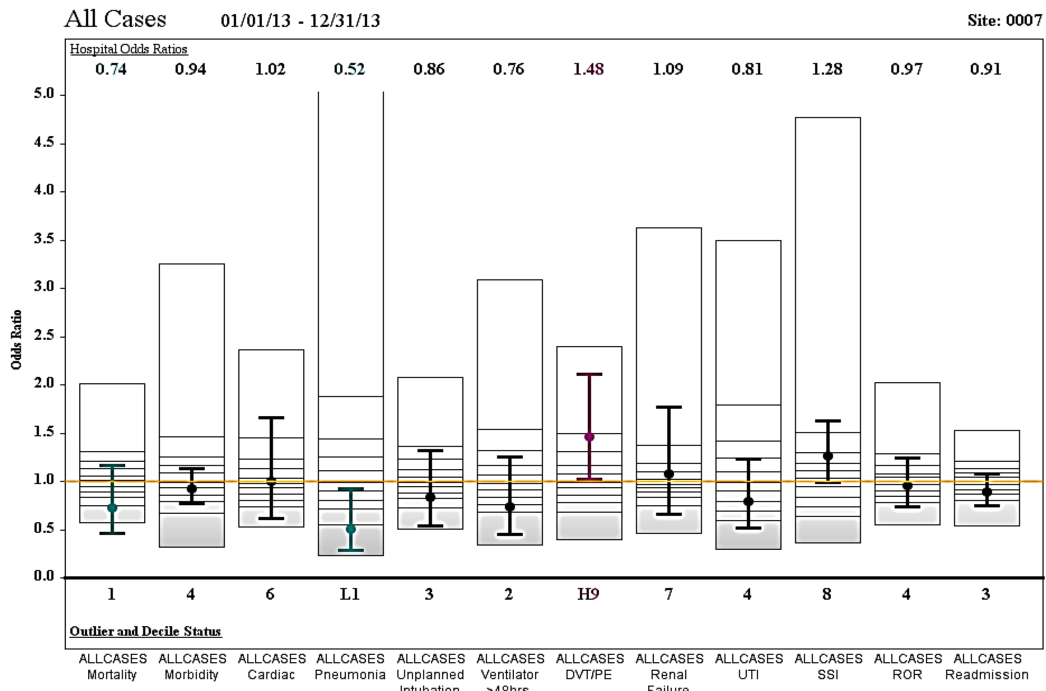
- Metrics contributing to each of these domains changed significantly this year, providing more focus on criteria based metrics such as NHSN device related infections and surgical site infections instead of coding.
- Coding and documentation continued however, to influence the observed to expected metrics. Some progress has been made in this area by the new Clinical Documentation Improvement program which began in October 2012.
- Mortality: This domain is scored using both system level and service-line level Observed: Expected (O: E) mortality ratios of MS-DRG codes in almost all patient service lines except pediatrics and neonatology. Only 4/8 points were obtained primarily due to lack of capture of all comorbid conditions.
- Effectiveness: The score of this measure was impacted by 30 day all-cause readmission rates *(OB, newborns, neonatology and patients <18 years of age were excluded)* and Core Measure performance for AMI, HF, PN, SCIP, SK, PN and Flu Immunizations, and ED Throughput. Points were primarily lost in areas of readmissions, immunization rates and emergency room throughput metrics. Average points accumulated in this area was 5.9 out of 8 possible points.
- Safety: Four AHRQ Patient Safety Indicators (pressure ulcer, iatrogenic pneumothorax, post op hemorrhage/hematoma, post op respiratory failure) were included in addition to infection control measures submitted to NHSN (CLABSI, CAUTI and SSIs) and hospital acquired VTE rates from the core measure abstraction.
- Equity: This reflects the composite scores for AMI, HF, PN and SCIP and ED measures, testing for statistically significant differences in outcomes in 3 equity-based dimensions: gender, race and socioeconomic status (by payor class). We achieved all possible credit in this domain.
- Patient Centeredness: Included 10 specific HCAHPS measures on nurse, physician communication, pain management, communications about medications, cleanliness and quietness, responsiveness of staff, discharge information and overall rating of the hospital and likelihood of recommending. Most indicators achieved 5/8 points with the exception of Pain 4/8 and Medication Teaching 6/8. Overall average points achieved 5/8.
- Efficiency: LOS and direct cost O:E ratios were used for 10 service lines. Performance on this measure is significantly influenced by the Bay Area wage index. By this metric, UCSF is the highest in the UHC cohort. We achieved 1/8 points in this domain.

[5] Lower Ranking is better for all metrics except Composite Score. A star ★ designation describes five UHC performance groups (5★ is best)

THE AMERICAN COLLEGE OF SURGEONS NATIONAL SURGICAL QUALITY IMPROVEMENT PROGRAM (ACS NSQIP)

ACS NSQIP published its semi-annual report for period January through December 2013. In 2013, UCSF refined the NSQIP case selection focus from broad service line categories to specific procedures which provided more useful outcomes data on selected high volume and high risk surgical procedures. This report is based on a total of 657,718 cases in the NSQIP comparative cohort, with 1,496 cases of May – December 2013 at UCSF. The report includes targeted high-risk procedures from *general surgery, vascular surgery, colorectal surgery, gynecologic surgery, neurosurgery, orthopedic surgery, thoracic surgery, and urology*. As a result, more refined outcomes data are available this year. As participation in NSQIP continuously increases, more risk adjusted data is available to reflect an overall view of the care of the surgical patient.

PROCEDURE-TARGETED MULTISPECIALTY NSQIP



UCSF Medical Center has been recognized by ACS NSQIP for achieving a ***meritorious composite quality score*** based on a combination of eight surgical outcomes: Mortality, Cardiac, Respiratory (pneumonia), Unplanned Intubation, Ventilator > 48 hours, Renal Failure, SSI, and UTI for all surgery cases for the performance period of January 2013 through December 2013.

High outlier in 2013, deep vein thrombosis/pulmonary emboli (DVT/PE) continues to offer opportunity for improvement. Interdisciplinary teams are engaged in numerous initiatives focused on reducing this occurrence.

In 2014, new NSQIP-based initiatives became a focus for quality improvement:

- **UC Colorectal Collaborative** - Started in April 2014, the High Risk Colon and Rectal Surgery Intervention Program utilizes the multidisciplinary network of the UC system-wide colorectal surgeons, anesthesiologists, and nurses by creating best practices to aim the improvement of quality and reducing risks and costs for the University and our colorectal patients.
- **Flexibility In duty hour Requirements for Surgical Trainees Study - FIRST Trial** – Started in July 2014, this project's objective is to determine the association between more flexible work hour requirements and difference in post-operative outcomes compared to current resident work hours requirements.

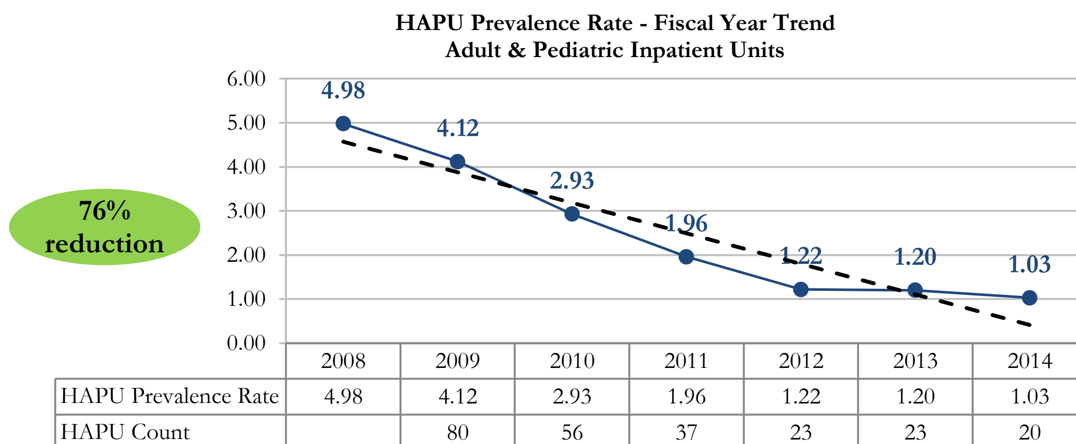
NURSING-SENSITIVE INDICATORS

Nursing-sensitive indicators reflect the structure, process, and outcomes of nursing care and are sensitive to the quality or quantity of nursing care. Examples of structure indicators are nursing skill level, turnover rates, and hours per patient day. Process indicators include assessments and nursing interventions. Examples of nursing-sensitive patient outcomes are hospital-acquired pressure ulcers (HAPU), inpatient falls and restraint use. Central line-associated blood stream infections (CLABSI), catheter-associated urinary tract infections (CAUTI) and ventilator-associated pneumonia (VAP) are also influenced by nursing care but are reported in the Infection Control Committee section of this report.

The National Database of Nursing Quality Indicators (NDNQI) and the Collaborative Alliance for Nursing Outcomes Coalition (CALNOC) consolidate valid and reliable data on nursing-sensitive indicators as well as establish benchmarks. UCSF Department of Nursing patient outcomes data are benchmarked against like participating hospitals in California and like hospitals across the nation.

A. HOSPITAL-ACQUIRED PRESSURE ULCERS (HAPU)

91% OF ALL NURSING INPATIENT UNITS OUTPERFORMED THE BENCHMARK FOR HAPUS STAGES 2 AND ABOVE



	2008	2009	2010	2011	2012	2013	2014
HAPU Prevalence Rate	4.98	4.12	2.93	1.96	1.22	1.20	1.03
HAPU Count		80	56	37	23	23	20

PRESSURE ULCER PREVALENCE

One prevalence study is performed each quarter, four days a year. Pressure ulcers are assigned to the unit where the patient was physically located during prevalence study day, not necessarily to the unit in which the patient developed the pressure ulcer. Pressure ulcer prevalence data is benchmarked according to the National Database of Nursing Quality Indicators (NDNQI) criteria. By the end of Fiscal Year 2014, 91% of inpatient units (20 of 22) outperformed the NDNQI mean at least 5 out of 8 rolling quarters for Pressure Ulcers Stages 2 and above. The Department of Nursing also tracks and evaluates pressure ulcers reported through the incident reporting system. Pressure ulcer incidence is not benchmarked.

Both adult and pediatric Pressure Ulcer Prevention committees meet monthly to review HAPU cases and care practices. All nursing units have Nursing Quality Champions that work at the unit-level to reduce pressure ulcer incidence and participate in quarterly Prevalence Studies.

ACCOMPLISHMENTS:

- New beds with improved surfaces were purchased for all Adult Critical Care units.
- UCSF hosted a Pressure Ulcer Prevention Symposium with UC San Diego to share best practices.
- Focused review continues on all Operating Room related HAPUs by Perioperative Services leadership.

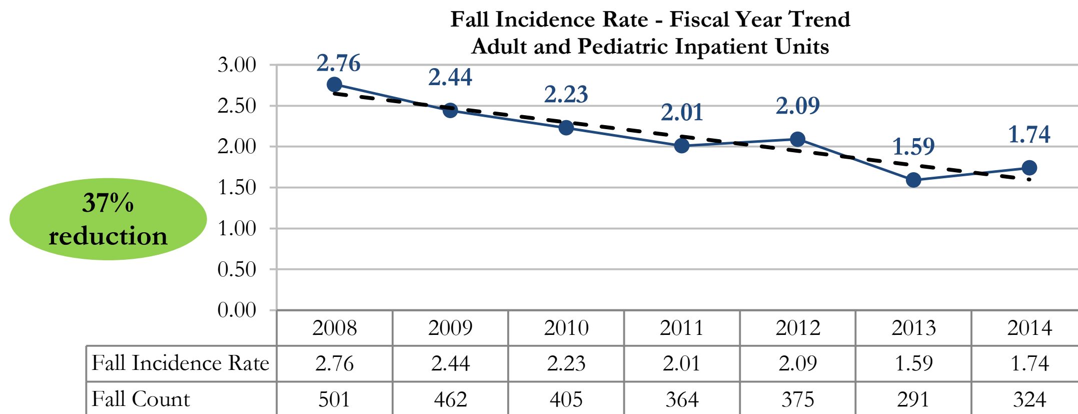
Nursing-Sensitive Indicators (continued from previous page)

- Enhancements to the UCSF electronic medical record system (called APeX) for nursing pressure ulcer documentation were developed to include both daily and weekly components.
- A new consult template was developed for the Wound Care Service that incorporated embedding photos within the wound care service notes.
- Pressure ulcer prevention education continues to be offered to patient care assistants, RNs, and MDs in both pediatric and adult units.
- Pediatric pressure ulcer prevention classes were offered twice a year to all Benioff Children's Hospital (BCH) nursing staff.
- Standardized pressure ulcer photography education occurred across the adult units, including instituting a "Wound Wednesday" to ensure all pressure ulcers are documented with a photograph.
- Adult Critical Care (9/13 ICU) implemented skin carts, began weekly prevalence studies, and collaborated with Respiratory Therapy to reduce bi-level positive airway pressure (BiPAP) pressure ulcers with the use of Mepilex.
- The Emergency Department started placing wound care consult orders and implemented the use of waffle cushions for at-risk patients.

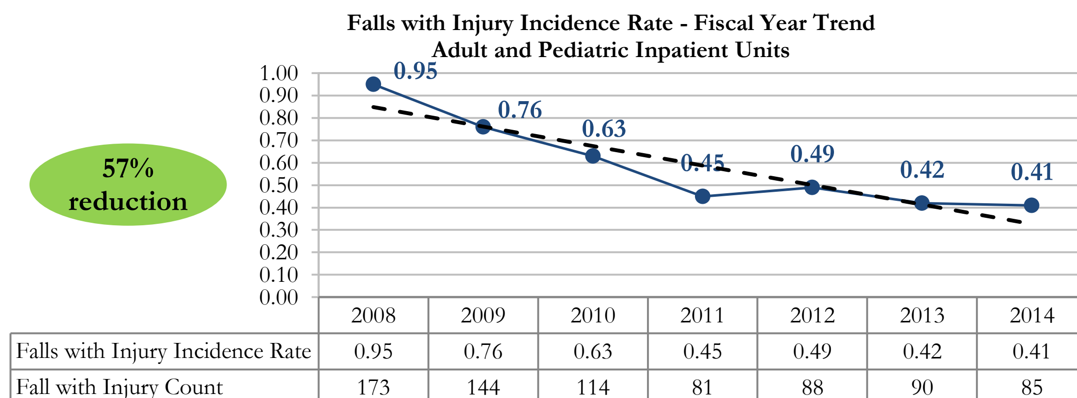
B. FALLS

77% OF ALL NURSING INPATIENT UNITS OUTPERFORMED THE BENCHMARK FOR FALLS WITH INJURY

Since 2008, there has been a 37% reduction in fall rates for adult and pediatric units combined and a 57% reduction in Falls with Injury rates.



	2008	2009	2010	2011	2012	2013	2014
Fall Incidence Rate	2.76	2.44	2.23	2.01	2.09	1.59	1.74
Fall Count	501	462	405	364	375	291	324



	2008	2009	2010	2011	2012	2013	2014
Falls with Injury Incidence Rate	0.95	0.76	0.63	0.45	0.49	0.42	0.41
Fall with Injury Count	173	144	114	81	88	90	85

Nursing-Sensitive Indicators (continued from previous page)

Inpatient falls data are collected via the incident reporting system and is reported out by unit as the incidence of falls per 1000 patient days. By the end of Fiscal Year 2014, 77% of units (17 of 22) had outperformed the NDNQI and CALNOC National means for at least 5 of 8 rolling quarters for Falls with Injury.

Each nursing unit has Nursing Quality Champions who support fall prevention initiatives on their unit and ensure post-fall huddles have been incorporated into unit practice to determine cause and to initiate prevention of fall reoccurrence. The Fall Prevention Committee meets every month to review fall data, any fall with injury and to plan/revise interventions.

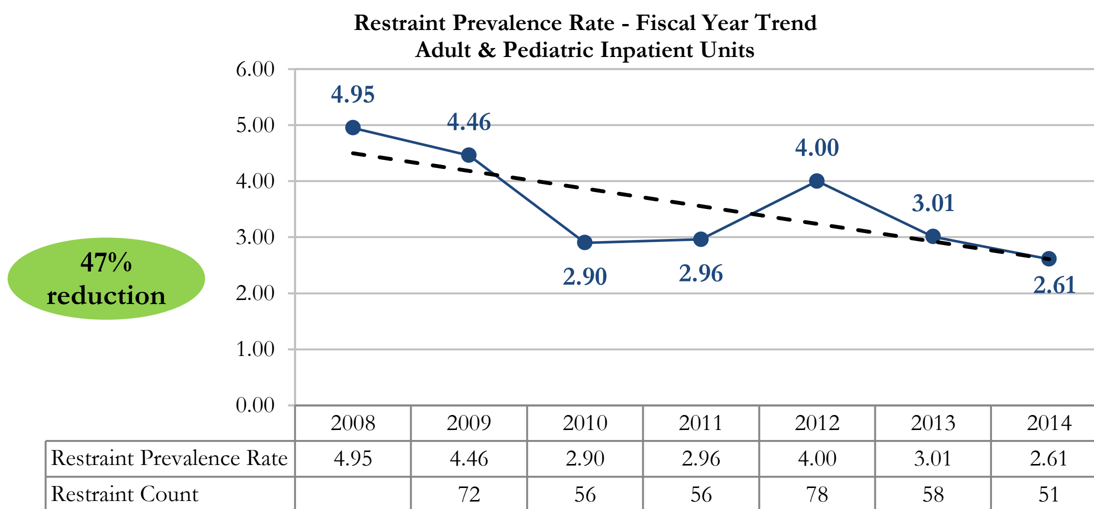
ACCOMPLISHMENTS:

- Hourly rounding by nursing staff established on inpatient units.
- Educated all adult in-patient staff on use of gait belts and standardized unit stock.
- Revised the Post-Fall Huddle form and began preliminary work to implement an online electronic version.
- Continued participation in the UCOP UCLA 5P Fall Prevention grant.
- The Emergency Department re-educated staff on fall assessments and added the ABCS screen, an Institute for Healthcare Improvement (IHI) recommended screening process, to assess a patient's risk for injury from falls.
- Began collaborating with the School of Pharmacy to analyze administration of diuretics and hypnotics in patients who fell.
- Implemented pre-op fall prevention education and patient-signed contracts for planned joint replacement surgery patients on 12 Long Orthopedics, which contributed to a 56% reduction in the number of falls with injury from FY2013 to FY2014.
- 6 Long Pediatric Medical Surgical worked to reduce their falls with injury with hourly rounding and improved patient and parent education to achieve a 75% reduction in the number of falls with injury from FY2013 to FY2014.

C. RESTRAINTS

RESTRAINT USE PREVALENCE

Since 2008, there has been a 47% reduction in restraint prevalence rates for adult and pediatric units combined. Department of Nursing restraint data is obtained from quarterly prevalence studies in which all patients are evaluated for restraint use.



	2008	2009	2010	2011	2012	2013	2014
Restraint Prevalence Rate	4.95	4.46	2.90	2.96	4.00	3.01	2.61
Restraint Count		72	56	56	78	58	51

Nursing-Sensitive Indicators (continued from previous page)

Adult critical care has the highest restraint usage with a patient population at high risk for delirium and agitation which may lead to interference with life-saving treatment. Benioff Children's Hospital's restraint use remains low.

RESTRAINT WORKGROUP

The purpose of the Restraint Workgroup is to facilitate compliance with regulatory standards, review all restraint products on an ongoing basis, and facilitate an auditing process for both violent and non-violent restraint use. The focus of the Restraint Workgroup in Fiscal Year 2014 was to ensure documentation compliance in APeX which involved development and validation of reports as well as updating the flowsheet builds. The workgroup continues to identify opportunities for reductions in restraint use, as appropriate, and to increase awareness about restraint use in general.

ACCOMPLISHMENTS:

- Defined a new process for the use of restraints in the immediate post-op recovery phase and successfully trialed it in the Adult Cardiac Intensive Care Unit (10 ICC).
- Developed APeX reports that track and trend data for all patients in restraints.
- Implemented automated APeX restraint reports that replaced manual chart review during the quarterly prevalence studies so nurses could focus on observational components of survey.
- Explored options for less restrictive alternatives to restraints such as de-escalation techniques for nurses and weighted blankets as a comfort measure for patients with delirium/dementia.
- Reviewed and updated the restraint policy and procedure to reflect changes in regulatory standards.

FAILURE MODE AND EFFECT ANALYSIS

A Failure Mode and Effect Analysis (FMEA) is a proactive methodology used to evaluate a high risk process with the aim to identify and reduce risk.

An FMEA was conducted prior to initiation training for Collection Manager, a new process for specimen labeling and requisitioning of a specimen order. The team consisted of representatives from Nursing, Laboratory, Information Technology, Blood Bank, Respiratory Services, Nursing Information Technology, and Nursing Performance Improvement. A total of 7 potential failure modes were identified. A list of probable effects (consequences) and pre-emptive and remedial actions were developed and are being implemented to reduce risk.

SURVEY ACTIVITY

ACCREDITATION AND SURVEY ACTIVITY

The Department of Regulatory Affairs is responsible for directing all accreditation, licensure and certification activities and patient care-related regulatory compliance of UCSF Medical Center and its licensed facilities (excluding financial and billing compliance activities). During FY2014, the Department of Regulatory Affairs helped to coordinate and respond to a number of Joint Commission and CMS Surveys which were required to maintain licensure and Medicare certification for the organization.

2014 GOLD SEAL OF APPROVAL

THE JOINT COMMISSION (TJC)

In October of 2013, UCSF Medical Center underwent a successful biennial survey by the Joint Commission for the Medical Center's Point of Care Testing program. The survey included a surveyor here for five days reviewing point of care testing practices in both the inpatient and ambulatory setting. The Medical Center remains fully accredited for the next two years. In addition to the Hospital survey, UCSF also successfully completed a disease specific certification survey for VAD (ventricular assist device) Services.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

In April of 2014, CMS conducted a survey into the Medical Center's Privacy practices. The survey included a review of operations governed by the Conditions of Participation for Quality Improvement, Patient Rights and Medical Records. The Medical Center was found to be in compliance with all Condition Level requirements for participation in the Medicare program.

THE LEAPFROG GROUP SURVEY

The Leapfrog Group is a voluntary program aimed at promoting transparency in quality and safety and affordability among the nation's hospitals. The annual survey results are posted on the Leapfrog Group website (www.leapfroggroup.org). UCSF achievement ratings in key practices areas are represented below. Only slight variations exist between the Moffitt/Long and Mt Zion hospital sites, which are evaluated separately. Variation in the Hospital Safety Score between the Moffitt/Long and Mt Zion Hospital settings is related to the different patterns of co-management by the primary service and Intensivist service. At the MZ site, 100% of patients are co-managed. That is not the practice at Moffitt/Long.

	Practice	Leapfrog Metric	Rating
General Information	Preventing Medication Errors	Computerized Physician Order Entry (CPOE) implemented.	
	Appropriate ICU Staffing	24/7 attending coverage and 5 minute call backs.	
	Steps to Avoid Harm	13 National Quality Forum (NQF) Safety Practices – internal analysis of adherence.	
	Managing Serious Errors	Disclosure Policy meets standard.	

	Practice	Leapfrog Metric	Rating
	Safety Focused Scheduling	Based on smooth patient scheduling in the Operating Room (Credit awarded based on usage of 85% or above during prime time).	Substantial Progress
Maternity Care	Rate of Early Elective Deliveries	Normal newborn deliveries performed between 37 & 39 completed weeks gestation.	Fully Meets Standards
	Rate of Episiotomy	Incision made in the perineum during childbirth.	Fully Meets Standards
	Maternity Care Standard Precautions	Screening newborns for jaundice before discharge and preventing blood clots in women undergoing cesarean section.	Fully Meets Standards
	High-Risk Deliveries	Births in which infants are predicted to weigh less than 1500 grams at birth.	Fully Meets Standards
High-Risk Surgeries	Aortic Valve Replacement	Quality of Care- Outcomes Rank	Willing to Report
	Abdominal Aortic Aneurysm Repair	Quality of Care- Outcomes Rank	Fully Meets Standards
	Pancreatic Resection	Quality of Care – Survival Odds	Fully Meets Standards
	Esophageal Resection	Quality of Care – Survival Odds	Fully Meets Standards
Hospital-Acquired Conditions	Reduce ICU infections	Based on 1000 central line days using the National Healthcare Safety Network (NHSN) standards	Some Progress
	Reduce UTI infections	In ICUs	Substantial Progress
	Reduce Hospital-Acquired pressure ulcers	Stage III and IV pressure ulcers (from coded billing data)	Willing to Report
	Reduce Hospital-Acquired Injuries	Falls and other traumatic injuries (from coded billing data)	Some Progress
Resource Use	Length of Stay	Based on Common Conditions; AMI, HF, PN	Some Progress
	Readmissions	Readmissions for Common Acute Conditions; AMI, HF, PN	Substantial Progress
Safety Score	Hospital Safety Score	UCSF rating on the October 2014 Leapfrog Hospital Safety Score report card for both Moffitt/Long and Mt. Zion	A

Progress Towards Meeting Leapfrog Standards			
Willing to Report	Some Progress	Substantial Progress	Fully Meets Standards

U.S. NEWS & WORLD REPORT

"AMERICA'S BEST HOSPITALS"

Every year *U.S. News & World* Report publishes an honor roll of hospitals in the country based on reputation, survival, patient safety and other care measures such as Magnet designation and the use of electronic records. Performance measures on 16 specialties are considered. Results for 2014-2015 were published in July of 2014. UCSF Medical Center was ranked **#8** in the National Top Ten List and is the ***only*** hospital in the top 10 Honor Roll in Northern California.

11 specialties were listed in the National Top 50 List	
#8	Cancer
#5	Diabetes & Endocrinology
#8	Ear, Nose & Throat (**up from #12 last year**)
#25	Gastroenterology & GI Surgery
#12	Geriatrics
#6	Gynecology
#4	Nephrology (**up from #7 last year**)
#5	Neurology & Neurosurgery
#14	Orthopedics
#10	Rheumatology
#6	Urology

"BEST CHILDREN'S HOSPITALS"

The *U.S. News & World Report* survey of "Best Children's Hospitals" attempts to rank children's hospitals across the nation based on 10 pediatric specialty programs that provide care for the most difficult to treat patients. The survey is based on self-reported clinical and operational data, a limited amount of publicly reported data, and a reputational survey sent to 1,500 board-certified pediatric specialists selected from the American Board of Medical Specialties. U.S. News surveyed 183 pediatric centers.

In the 2014-15 rankings, UCSF Benioff Children's Hospital achieved National Ranking in all ten surveyed specialties. We have made significant improvements in the quality measures used in the survey, with an increase from 68% of total points in 2011 to 81% in 2014. US News results are significantly influenced by patient volumes. Despite our small size, UCSF BCH continues to advance in rankings.

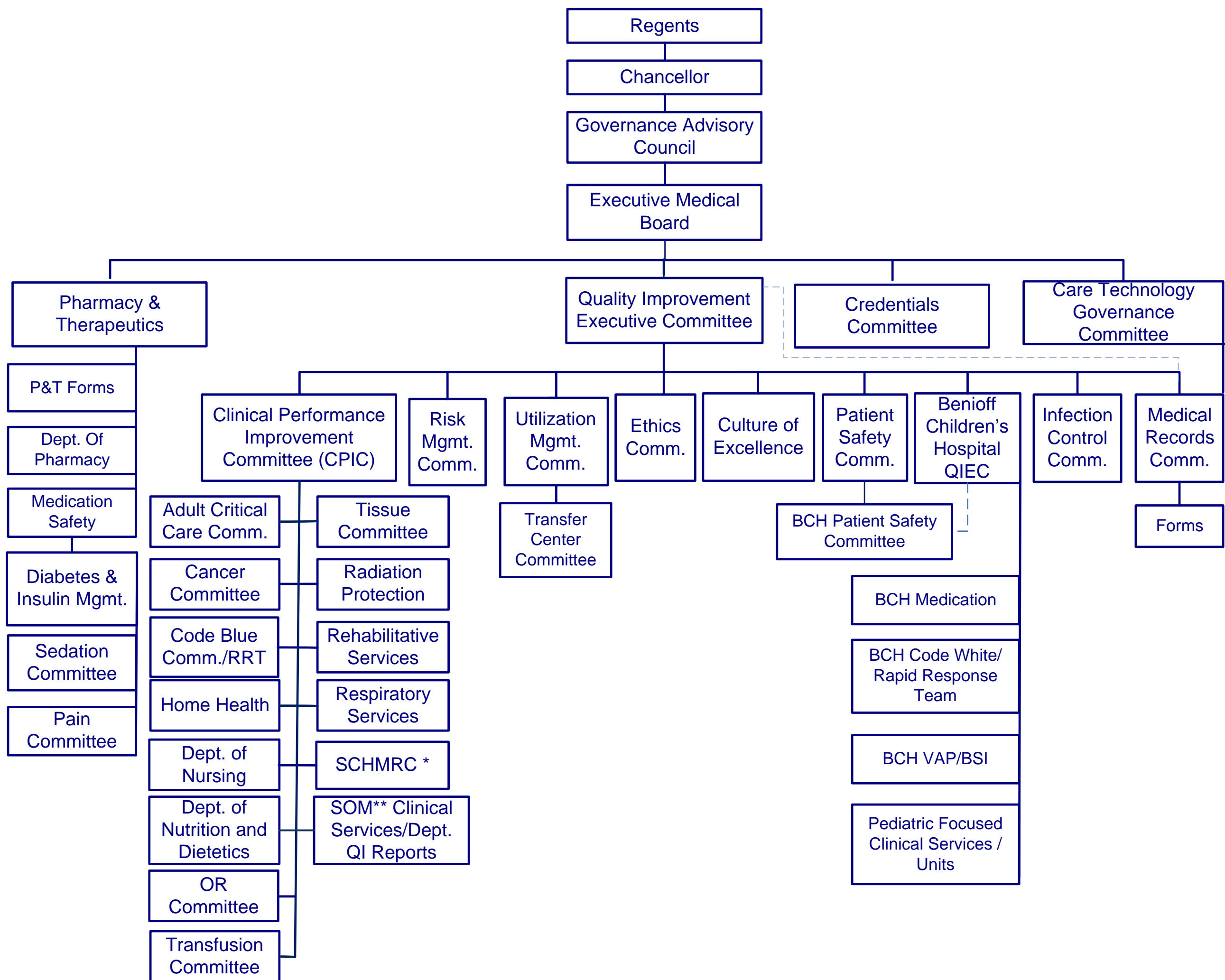
Nationally Ranked Specialties	
#25	Cancer
#23	Cardiology & Heart Surgery
#10	Diabetes & Endocrinology
#18	Nephrology
#21	Gastroenterology & GI Surgery
#21	Neurology & Neurosurgery
#26	Neonatology
#28	Orthopedics
#45	Pulmonology
#12	Urology

QUALITY COMMITTEES REPORTING TO QUALITY IMPROVEMENT EXECUTIVE COMMITTEE (QIEC)

QUALITY COMMITTEE STRUCTURE

The Quality Improvement Executive Committee (QIEC) provides executive oversight of the Medical Center's quality, safety and performance improvement activities. The QIEC is responsible for the development, implementation, and evaluation of a comprehensive Performance Improvement Plan (Policy 1.02.07), and the Patient Safety Plan (Policy 1.02.17) and regularly reports findings to the Executive Medical Board. The QIEC provides executive oversight and integration of the work of the quality committees: Clinical Performance Improvement Committee (CPIC), Risk Management Committee, Utilization Management Committee, Ethics Committee, Medical Records Committee, Patient Safety Committee, Infection Control Committee, Benioff Children's Hospital Quality Improvement Executive Committee, and the Culture of Excellence Committee.

Committees reporting to QIEC include residents and fellows within their membership to seek input and engage housestaff in quality improvement.



ENVIRONMENT OF CARE COMMITTEE

EOC SAFETY PROGRAM

The UCSF Medical Center's Safety Program is intended to reduce the risk of injury to patients, employees, and visitors of UCSF Medical Center. This program is executed by encompassing many different safety disciplines, working groups, and committees in its ultimate goal of "Protecting People Better." The Medical Center Safety Program concentrated the majority of its efforts on developing compliance projects around safe patient handling; and updating policies and plans as the EOC Safety program increases its scope into Mission Bay Hospital and Clinics.

For FY2015, the safety office plans to build out and transition to the updated Safety Round software that uses a sophisticated web base mobile application platform that will enable the safety round team to use mobile devices when conducting safety rounds, this will streamline the inspection process as well as the final reporting. A second Safety Round program improvement project will be to establish work flows around documenting corrective action plans for safety round deficiencies using our current incident reporting system. This will achieve several objectives including; introducing a centralized method for tracking; hold responsible parties accountable for documenting follow-up; and leverages an existing IT platform in which staff have been trained on and are familiar with. The safety office will also be developing EOC Safety programs at Mission Bay and has successfully hired a Safety Manager that will oversee all EHS services and the EOC program.

Safety Round Compliance Trends – Patient Care Areas	2013Q1	2013Q2	2014Q3	2014Q4	
	% Yes	% Yes	% Yes	% Yes	Total %
EOC – Safety Round Compliance	93%	87%	91%	90%	90%

For FY2015, the safety office has successfully hired a Safe Patient Handling and Mobility Coordinator who will help oversee next years planned activities that will include but is not limited to the following:

- Improvement project to convert from non-disposable sling accessories to disposable slings
- Develop and implement Mission Bay SPH training program
- Launch new UCOP SPHM online training module
- Develop new APeX enhancements for documenting patient mobility needs
- Assist capital projects program team in the new construction of ceiling lifts in our ICUs and acute care units
- Return on investment analysis for the current Atlas Lift Coach Program and development of a future work plan

INJURY AND ILLNESS REDUCTION PROGRAM

For FY2013-2014, the medical center experienced an increase in overall reported injuries of 13% compared to the year before. The majority of these injuries included ongoing medical treatment and some period of modified duty, but did not result in lost time. There were no serious injuries requiring reporting to outside agencies. The main priorities for injury prevention during FY2014 included efforts to reduce injuries related to patient handling, largely driven by increasing injury numbers in the previous two years, along with the passage and implementation of California law AB 1136, the Hospital Patient and Health Care Worker Injury Protection Act.

Incident Type	FY2013	FY2014	% change
Slips and Falls	58	72	24%
Body Positioning or Mechanics	94	59	-37%
Incidents Related Patient Handling	58	85	57%
Workstation Related Repetitive Stress	88	124	41%
All Other	116	108	-7%

Overall, the goal remains to reduce the reported injuries and create a safer workplace for all UCSF Medical Center employees. The committee will be looking at several strategies to improve the way that injuries are investigated and interventions implemented. The medical center has established injury reduction as an organizational goal as part of the FY2015 Workplan, targetting a 5% reduction over the next two years. An executive injury reduction task force has been assembled to facilitate the successful achievement of that goal.

Environment of Care Committee (continued from previous page)

RADIATION SAFETY OFFICER REPORT

UCSF announced on October 4, 2013 that our radiation dosimetry vendor, Mirion, had incorrectly analyzed "all energies" film badges worn by UCSF employees between 2002 and 2013. Following months of concerted effort between UCSF radiation safety, legal counsel, administration, local unions and the vendor, the dosimetry records were corrected and affected individuals notified by May 2014. There were no instances of recalculated exposure reports for UCSF workers exceeding occupational radiation exposure limits. UCSF officially switched dosimetry vendor to Landauer in April 2014. Main goal for FY2015 is to continue preparations for the new Medical Center at Mission Bay, including testing and registration of radiation producing machines as they arrive, and ensure the hospital is ready to open by February 2015.

EMERGENCY MANAGEMENT (EM)

This past year, EM continued to provide Hospital Incident Command System (HICS) and personal preparedness training to staff through NEO, Medical Resident Training, the development of take home reference materials and through activating HICS three times to respond to the following emergencies: Mt. Zion Power Outage, Contingency Strike Fall 2013, and Contingency Strike Spring 2014. EM also successfully hired an Emergency and Continuity Manager and has plans to grow their department to include a Drills and Training manager as well as an EM analyst to support a growing demand on their services. EMs primary goal for FY2015 is to create and establish the Mission Bay Hospital Command Center (HCC) and to continue to expand its policies, protocols and training programs to encompass Mission Bay.

SECURITY

This past year, Security has been closely involved in the design and implementation of security protocols throughout the Mission Bay Hospital Campus that has included but not limited to helping to design the infant security system, badging protocols, access protocols, and the CCTV surveillance systems, etc. Security also hired and trained ~40 additional staff for Mission Bay and took over security services from the General Contractor in May 2014. For Parnassus, to address an increase in service demand, Security increased their rounding efforts in the Emergency Department for "at risk" patients. To build on this effort, Security will be developing a specialized ED II advanced officer placement post for FY2015 where officers will receive advanced training in working with a "high risk" population and their families who are in crisis. Additional support and training will be provided in communication techniques and physical awareness including handcuffing.

UTILITIES MANAGEMENT

The Facilities Management Program continues to design and implement processes that promote a safe, controlled and comfortable environment of care by the provision, maintenance, and operation of adequate and appropriate utility services and infrastructure. Some of the key process that were developed and implemented this year include

- **Water Management** - Facilities development of an enterprise-wide response to ASHRAE 188 turned into a successful initiation of a true "water management plan" supported by a structured multi-departmental team of hospital leaders and experts in the Infection Control, Clinical, Safety, EH&S, Hospitality, Engineering, Consultants and Industry Experts. The management plan is a custom configuration of a Hazard Analysis and Critical Control Points (HACCP) program which aim to greatly reduce our risk based, site-specific infrastructure and patient-population based metrics.
- **Aerosol Transmissible Disease Program** - Facilities endeavored on a house-wide survey of patient rooms capable of meeting the new standard. With a somewhat reduced scope of available rooms under the new guidelines, and a strict regimen of Cal-OSHA mandated healthcare worker protections in place it became mandatory to create a streamlined process for both delivering the protections as well as documenting the results within an intra-departmental platform. Working with multi dicipinary team, Facilities built a single-portal web entry Work Order process based on the following "work order in/work order out" principle that triggers the required daily verifications within the Facilities Department. Nursing Supervisors are cross referencing precaution orders and negative pressure rooms daily to ensure compliance.

Environment of Care Committee (continued from previous page)

- **Call Center, 3D BIM Integration & Maximo** - With a 3.2 million dollar development of the Maximo Computerized Maintenance Management System (CMMS) well underway (Safety, Complinace, Asset Control & Work Order management) as a joint-project of Campus and Medical Center Facilities, we took the initiative to put together our own Medical Center Facilities "Maximo Development Team" which is on a trajectory for completeion two months early and on-budget. Building on this platform facilities has begun working on a proof of concept with our Mission Bay delivery team to integrate the 3D BIM model program of our Mission Bay Energy Center and has begun integrated into the Service Now-based Work Order system which is an essential building block for a succesful centralized call center concept.

ETHICS COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:

- Continued educational series at ethics meetings and with various staff and physician groups
  - Attempts to increase awareness among patients and staff
- Updated policies included: Organ Donation, Donation after Cardiac Death (DCD)
- Unilateral Nephrectomy Policy as part of Living Donor Procedures
- Ethics Consultations:
  - 40 consultations July 2013-June 2014
  - 33 adults, 7 children/newborns
  - Consults: Medicine 19, Pediatrics 5, 11 other services with at least one consultation

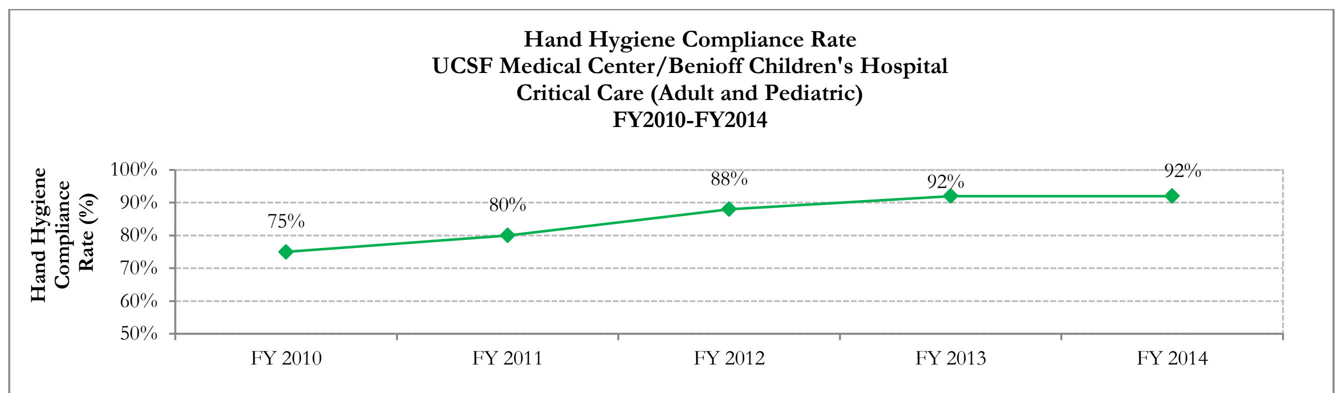
THEMES AND CHALLENGES:

- Limitation of life-sustaining therapies interpretation and education including current policies
- Increased move toward integration into daily rounding
- Increased questions regarding utilization of resources
- Rotating team structure and application to patients with ethical concerns including initial result of 2013 pilot on medicine

INFECTION CONTROL COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:

- Prepared infection data for "QualDash", an interactive dashboard that includes device-related, surgical site, and multi-drug resistant organism infection rates, as well as infection prevention bundle compliance rates by unit and service.
- Directed hand hygiene compliance monitoring and improvement efforts. The average annual compliance rate was 92% based on 55,925 observations.
- Oversaw infection prevention programmatic elements in Nutrition and Food Services, Sterile Processing, Facilities Management, Pharmacy, Hemodialysis, Hospitality, and Nursing.
- Tracked and reported *Clostridium difficile* infection (CDI) prevention bundle compliance; identified and targeted locations for more aggressive prevention efforts. An alternative environmental cleaning product was trialed with equivocal results. A case-control study to identify risk factors for CDI among surgical patients was performed and identified a significant association between Ertapenem prophylaxis and development of CDI.
- UCOP Healthcare Epidemiology Collaborative SSI reduction grant milestones include development and partial implementation of pre-, peri- and post-operative bundles for patients undergoing arthroplasty, spine and colorectal surgery. Educational materials for patients regarding surgical risk, CHG bathing and wound care were completed.



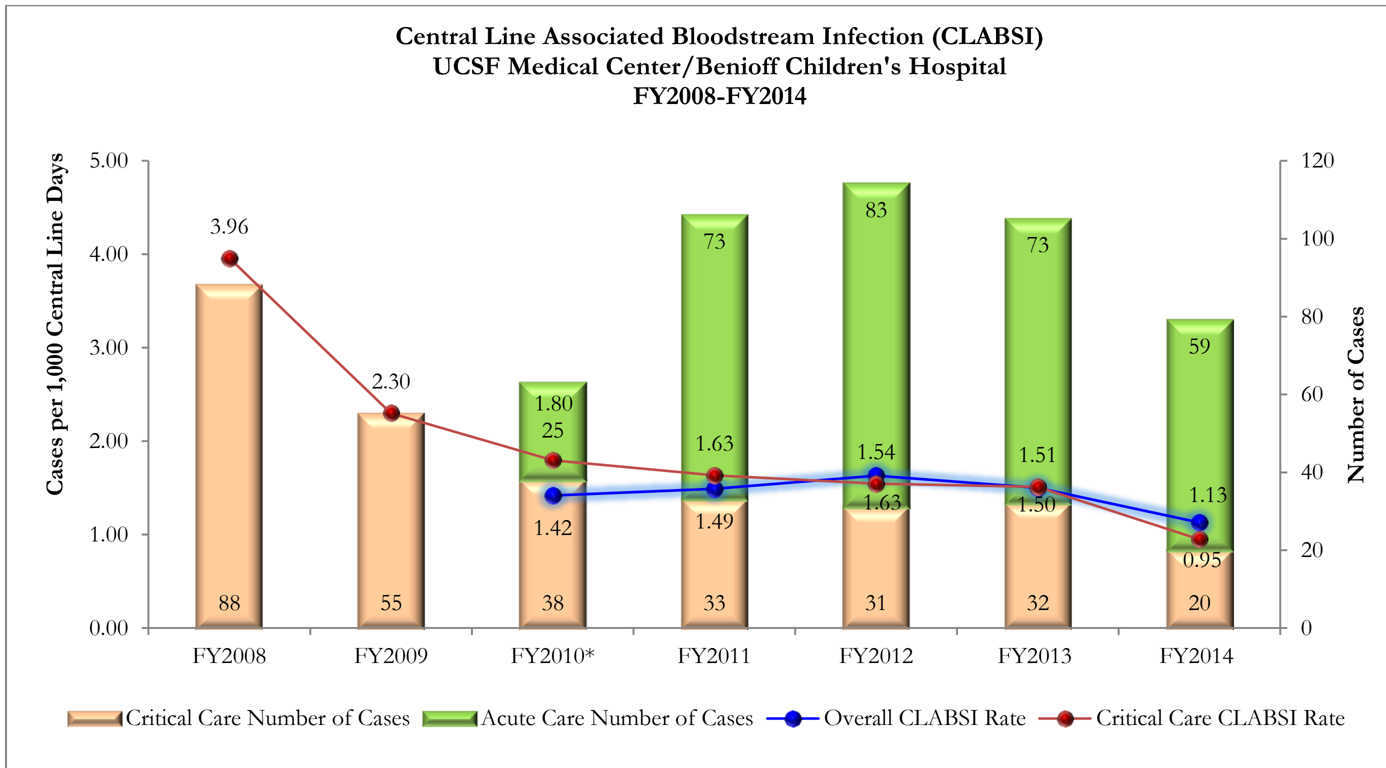
▪ DEVICE-RELATED INFECTION SURVEILLANCE

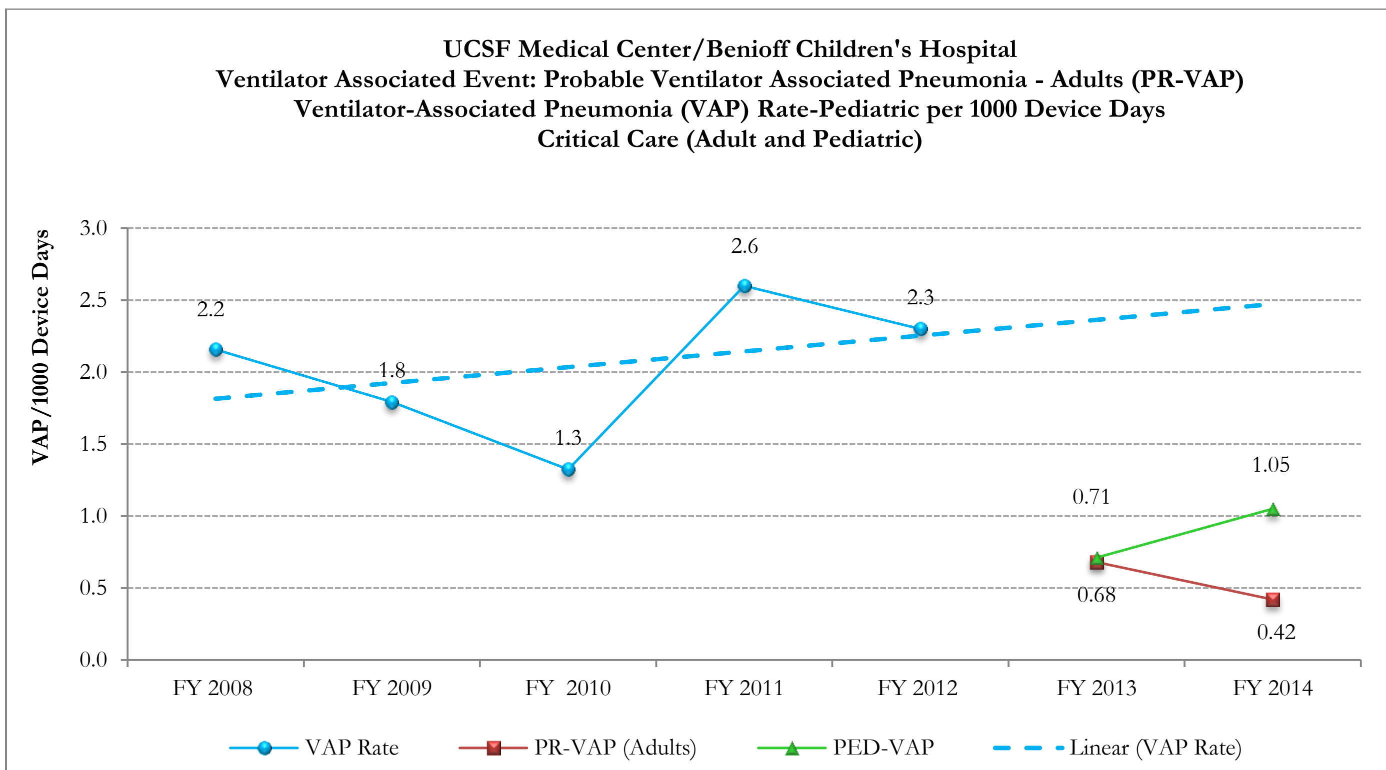
Device-related infections (DRI) include Central Line-Associated Bloodstream Infection (CLABSI), Ventilator-Associated Pneumonia (VAP) and Catheter-Associated Urinary Tract Infection (CAUTI). The numbers of CLABSI and CAUTI at UCSF are statistically significantly lower than expected according to the National Healthcare Safety Network's (NHSN) Standardized Infection Ratio (SIR), a predictive, risk-adjusted modeling tool utilizing national comparative data. No SIR is calculated for VAP. Strategies to reduce DRI are based upon evidence-based national and professional guidelines and discoveries from investigation of UCSF DRIs, as sanctioned by the DRI Committee, a subcommittee of the Infection Control Committee. Adherence to "bundled" care elements is audited and reported to unit-based clinical leaders. Significant reduction strategies implemented in FY2014 include: extension of chlorhexidine bathing (CHG bathing) for CLABSI reduction in all adult and pediatric critical care and acute care units; adoption of antimicrobial line locks in selected patient populations; adoption of suture-less securement for PICC lines in adult hospital; continuation of Culture of Unit-Based Safety (CUSP) case review; improved implementation and documentation of oral care for ventilated patients; and improved daily assessment of need for urinary catheter.

The aggregate CLABSI rate declined from the baseline.

- SIR (observed to expected ratio) was statistically significantly lower than expected or 0.547.
- The critical care and acute care CLABSI rates, which include both adult and pediatric patients, declined.
- The Neonatal Intensive Care (ICN) declined slightly for the year.
- The Central Line Insertion Practice (CLIP) milestone to achieve the 97.9% compliance target was surpassed.

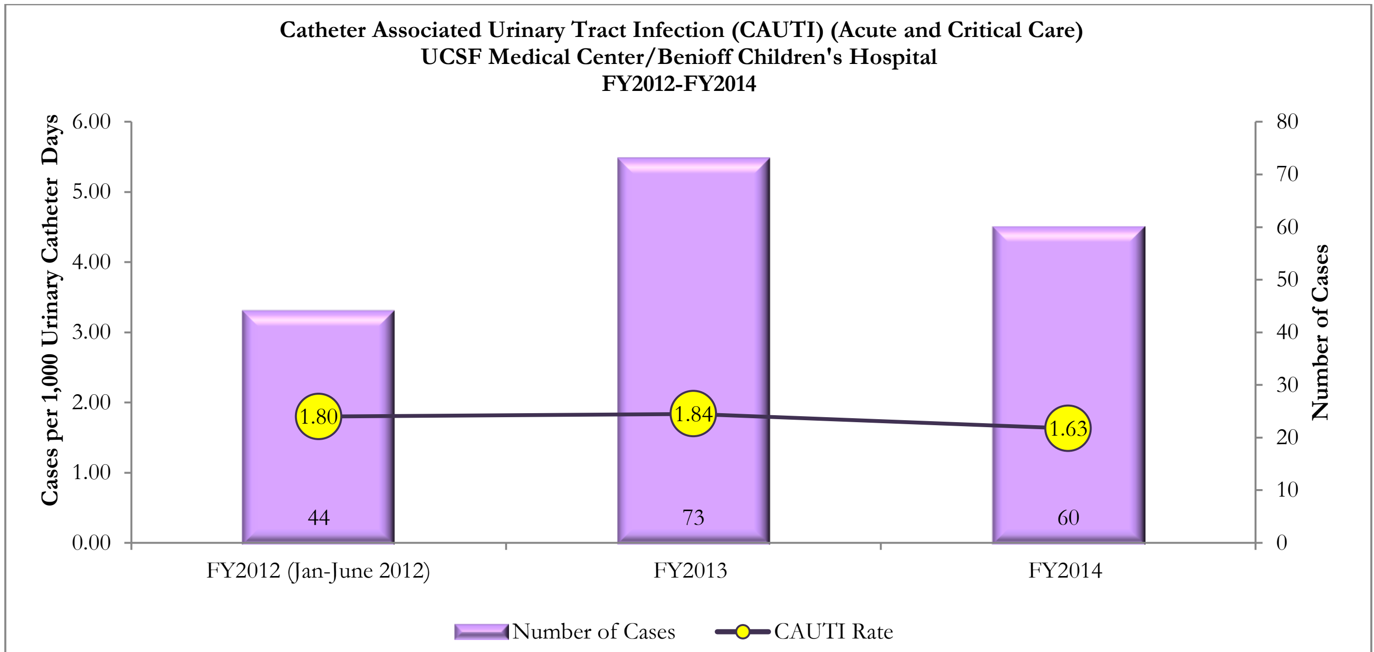
Infection Control Committee (continued from previous page)





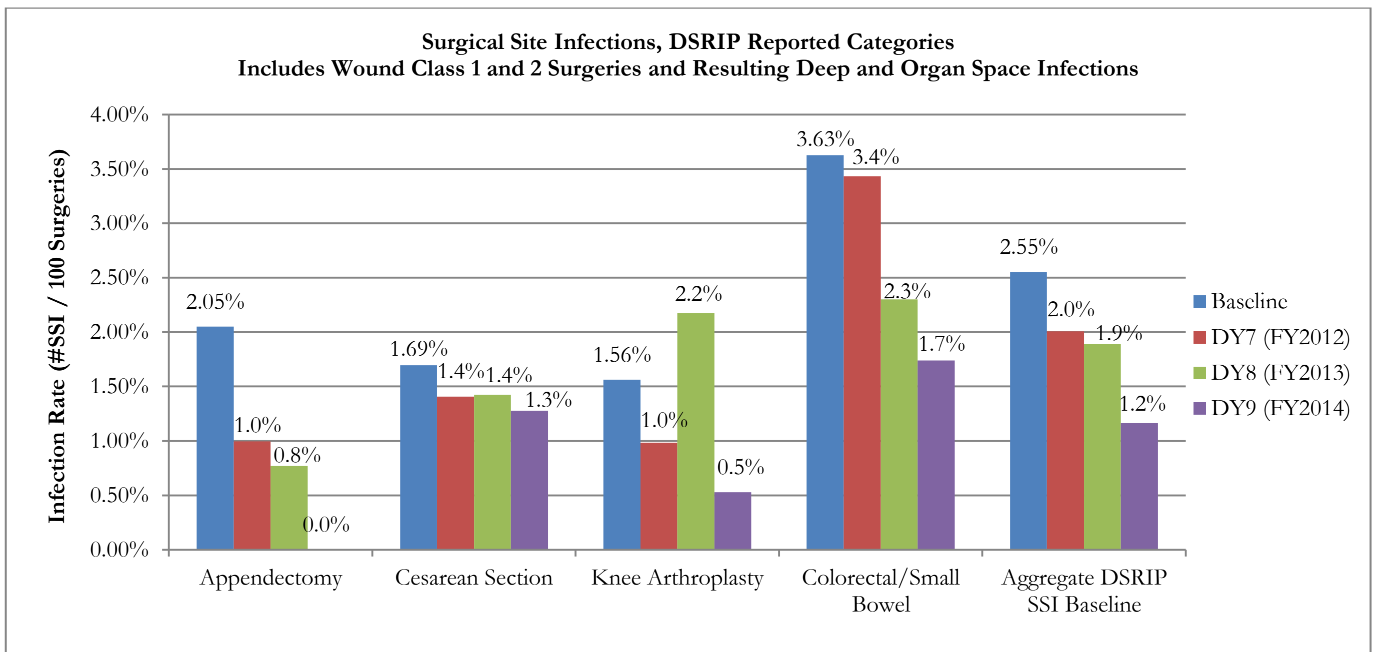
As of July 2013 VAP is no longer evaluated in adult patients. Probable VAP is currently reported for adult patients based on NHSN Ventilator-Associated Event (VAE) criteria. The Pr-VAP rate declined in FY2014. Pediatric VAP increased slightly in FY2014.

Infection Control Committee (continued from previous page)



- **SURGICAL SITE INFECTIONS (SSI) PER 100 SURGERIES FY2014**

Surgical Site Infection (SSI) surveillance is conducted for 31 surgical categories, 29 of which are required by and reported to the California Department of Healthcare Services through NHSN. Performance, as measured by Standardized Infection Ratio (SIR), is significantly better than predicted in ten categories for FY2014; performance in all other categories was not significantly different from predicted. FY2014 corresponded to DSRIP demonstration year 9. UCSF DSRIP milestone target was to reduce the aggregate SIR for selected categories of surgery by 5% relative to the DY8 performance. UCSF surpassed that milestone target, reducing the SIR by 26% with significantly fewer SSI than predicted in the targeted categories.



Infection Control Committee (continued from previous page)

SSI MANDATORY REPORTING FY2014 WITH STANDARDIZED INFECTION RATIO (SIR)*

	Overall						Adult			Pediatric		
Category	# SSI	# of Procedures	Rate	SIR FY2014	p-value FY2014	95% Confidence Interval	# SSI	# of Procedures	Rate FY2014	# SSI	# of Procedures	Rate FY2014
Abd Aortic Aneurysm	1	36	2.8	0.540 (ND)	0.6051	0.027, 2.665	0	26	0	1	10	10
Appendectomy	1	181	0.6	0.208 (ND)	0.0551	0.010, 1.024	1	131	0.8	0	50	0
Biliary Surgery	19	392	4.8	0.436 (-)	0.0000	0.270, 0.667	18	376	4.8	1	16	6.3
Cardiac Surgery	3	330	0.9	0.523 (ND)	0.2506	0.133, 1.422	0	174	0	3	156	1.9
CABG, 2 Incisions	0	88	0.0	0.000 (ND)	0.1021	, 1.313	0	87	0	0	1	0
CABG, 1 Incision	0	2	0.0	.	.		0	2	0	0	0	0
Gallbladder Surgery	0	463	0.0	0.000 (-)	0.0096	, 0.645	0	450	0	0	13	0
Colon Surgery	24	391	6.1	0.794 (ND)	0.2551	0.521, 1.163	24	351	6.8	0	40	0
Craniotomy*	21	1316	1.6	0.506 (-)	0.0007	0.318, 0.768	20	1214	1.6	1	102	1
C-Section	12	554	2.2	0.893 (ND)	0.7256	0.484, 1.518	12	554	2.2	0	0	0
Spinal Fusion	9	973	0.9	0.331 (-)	0.0001	0.161, 0.607	8	931	0.9	1	42	2.4
Fracture Reduction	2	309	0.6	0.379 (ND)	0.1358	0.064, 1.254	2	272	0.7	0	37	0
Gastric Surgery	1	237	0.4	0.104 (-)	0.0008	0.005, 0.512	1	218	0.5	0	19	0
Hip Prosthesis	9	465	1.9	1.234 (ND)	0.5109	0.602, 2.264	9	460	2	0	5	0
Heart Transplant	1	22	4.5	.	.		1	22	4.5	0	0	0
Abd Hysterectomy	3	295	1.0	0.552 (ND)	0.3025	0.141, 1.504	3	295	1	0	0	0
Knee Prosthesis	3	364	0.8	0.774 (ND)	0.7152	0.197, 2.107	2	360	0.6	1	4	25
Kidney Transplant	6	366	1.6	0.500 (ND)	0.0660	0.203, 1.040	6	354	1.7	0	12	0
Laminectomy	4	982	0.4	0.416	0.0514	0.132, 1.004	4	967	0.4	0	15	0
Liver Transplant	15	154	9.7	0.519 (-)	0.0052	0.302, 0.838	15	147	10.2	0	7	0
Kidney Surgery	4	445	0.9	0.644 (ND)	0.3906	0.205, 1.553	4	419	1	0	26	0
Ovarian Surgery	0	490	0.0	0.000 (ND)	0.0741	, 1.151	0	480	0	0	10	0
Pacemaker Surgery	2	261	0.8	.	.		2	225	0.9	0	36	0
Rectal Surgery	2	148	1.4	0.095 (-)	0.0000	0.016, 0.314	2	138	1.4	0	10	0
Refusion of Spine	6	202	3.0	0.638 (ND)	0.2656	0.259, 1.327	6	199	3	0	3	0
Small Bowel Surgery	7	453	1.5	0.182 (-)	0.0000	0.080, 0.361	7	408	1.7	0	45	0
Spleen Surgery	0	48	0.0	0.000 (ND)	0.3268	, 2.679	0	45	0	0	3	0
Thoracic Surgery	2	418	0.5	0.211 (-)	0.0051	0.035, 0.698	2	354	0.6	0	64	0
Vaginal Hysterectomy	1	81	1.2	0.915 (ND)	1.0000	0.046, 4.515	1	81	1.2	0	0	0
Ventricular Shunt*	5	371	1.3	0.304 (-)	0.0013	0.111, 0.673	4	301	1.3	1	70	1.4
Abdominal Surgery	6	989	0.6	0.212 (-)	0.0000	0.086, 0.440	4	901	0.4	2	88	2.3
TOTAL	169	11826	1.4	0.429 (-)	0.0000	0.368, 0.498	158	10942	1.4	11	884	1.3

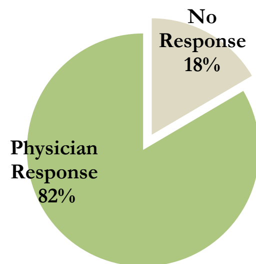
Rate = Number of SSI/100 Surgeries. Data shown are those reported to the National Healthcare Safety Network (NHSN) database per California requirement.
* SIR = Standardized Infection Ratio = # Observed SSIs / # Predicted SSIs.
(+) = significantly higher than predicted; (-) = significantly lower than predicted; (ND) = no statistically significant difference between observed and predicted.
No SIR is calculated when ≤ 1 SSI is predicted.
*Categories are excluded from state required reporting and are submitted to NHSN for SIR determination only.
Surgical categories are defined by NHSN based on ICD-9 codes. SSI identified using NHSN surveillance criteria; cases reviewed and confirmed as necessary by an Infectious Disease physician.

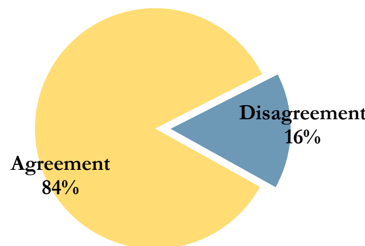
MEDICAL RECORDS COMMITTEE

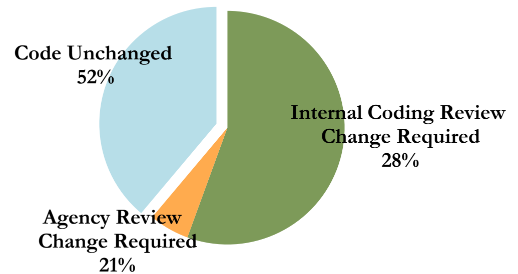
ACTIVITIES AND ACCOMPLISHMENTS:

AHRQ Patient Safety Indicators

- Lowest number of FY2014 AHRQ PSI in over 4 years (128 compared to an average of ~250 in preceding years)
- Sustained physician engagement with a cumulative response rate of 83% to queries regarding these potential complications
- Decreased rates of physician disagreement with coding at 16% of all queries down from 40%
- When physicians disagree, increased rate of Patient Safety Indicators requiring recoding to 64% up from 49%
- Created guidelines for the query of physicians and the coding of complications with service stakeholders







FY2014 Outcome of AHRQ Patient Safety Indicator queries and resulting changes to coding

- Maintained excellent compliance with required documentation: Informed Consent, Operative Procedures, History and Physical, and Discharge Summary

MEDICAL RECORD COMPLIANCE

Documentation	Metric	Performance
Operative Reports	Timely (30 min post-procedure)	89%
	Findings	100%
	Post-Operative Diagnosis	100%
	Estimated Blood Loss	100%
History and Physical	Performed before Surgery	100%
	History of Present Illness	100%
	Past Medical History	99%
	Review of Systems	98%
	Current Medications / Allergies	98%
	Plan of Care	99%
Discharge Summary	14-day Completion	100%
	Hospital course	100%
	Disposition	95%
	Diet/Activity	95%
	Discharge medications	95%
	Follow up plans	99%
	Discharge Diagnosis	98%

- Transitioned manual audit to automated audit for many of documentation requirements
- Provided feedback of service level performance quarterly to Service Directors

PATIENT SAFETY COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:

- Revised the Central Venous Catheter Insertion and Removal electronic learning module for faculty and trainees
- Launched improvement efforts and developed monitoring tools to assure patient safety related to: central line insertion, communication of critical test results and compliance with the universal protocol
- Conducted AHRQ Culture of Safety Survey with the Radiology Department and disseminated results
- Coordinated educational events to celebrate National Patient Safety Week including Patient Safety Grand Rounds and poster presentations
- Conducted assessment of organizational alignment with practices recommended in The Joint Commission Sentinel Event Alerts on Medical Device Alarm Safety and Preventing Unintended Retained Foreign Objects
- Initiated committee structure and organizational response to The Joint Commission National Patient Safety Goal on Alarm Management
- Conducted Joint Commission High Reliability Self-Assessment with senior leadership and took actions to improve reliability
- Coordinated survey assessment, results dissemination, and action planning

EVENT REVIEW AND SAFETY IMPROVEMENT:

- Conducted 22 Root Cause Analyses (RCAs) with 87 action plans developed
- Evaluated sustainability of action plans associated with 9 RCA/patient safety events occurring in the last 3 years. Out of the 9 events reviewed, 5 had sustained implementation of improvements.
- Disseminated key learnings and improvements of selected RCA and adverse events

INCIDENT REPORTING: A total of 9459 incident reports were filed in FY14. Serious events were reviewed weekly by the Patient Safety Committee. A new incident reporting system was implemented in November 2013.

RCA Event Types FY2014	Count
Air Embolism	1
Fall Death/Serious Injury	1
Medication Error	3
Other	6
Procedural Complication	1
Retained Foreign Body	3
Specimen Issue	1
Stage 3/4 Decubitus Ulcer Acquired after Admission	1
Unexpected Death	3
Wrong Site Surgery	1
Wrong Surgery/Procedure Site	1
Total	**22**

Focus Areas of RCA Action Plans FY2014	Count
Adequacy of technological support	9
Availability of information	2
Care planning process	7
Communication among staff members	30
Communication with patient/family	1
Competency assessment/credentialing	2
Continuum of care	7
Equipment maintenance/management	1
Medication management	4
Orientation and training of staff	5
Patient observation procedures	3
Physical assessment process	2
Physical environment	1
Policies	9
Security systems and processes	1
Staffing levels	1
Supervision of staff	2
Total	**87**

RISK MANAGEMENT COMMITTEE

SYSTEM-WIDE RISK MANAGEMENT AWARD 2003-2013

UCSF Medical Center received this award for having the lowest cost Professional Liability program for the past 10 year period (22% lower compared to the 4 other UC Medical Centers). Calculation of this award involved analyzing the exposures and ultimate loss projections for the 10-year period, 2003-2013, and calculating a 10-year exposure-weighted average. Strengths of the program include: Early resolution of liability cases before litigation, close working relationship with Patient Relations to thoroughly respond to patient complaints, and the retrospective review process.

CASE REVIEWS

Reviewed 17 cases in litigation and coordinated risk reduction strategies in the following areas:

- Issues related to attending supervision of residents, post-surgical orders, hand-off and nursing documentation
- Informed consent related to surgery and recognition of complications
- Issues related to obstetrical care: allegations of delay in recognition of fetal distress and delay in performing C-sections resulting in birth injury
- Complications and allegations of negligence related to the performance of knee replacement surgery
- Complications and allegations of negligence related to heart transplant surgery resulting in blindness
- Communication and coordination of care between non-UCSF and UCSF providers
- Placement and documentation related to IV's to avoid infiltration and nerve injury
- Issues related to medication refills in outpatient setting to reduce the incidence of medication errors
- Issues related to the prevention of surgical site infections
- Informed consent related to the placement of an IUD
- Post-operative management of IV line to avoid air embolus.

PROCESS CONSULTATION AND REVIEW

- **Telehealth:** Reviewed and approved consent process for Telehealth; reviewed and obtained clarification related to e-consultations process, both internal and external.
- **Review of Obstetrical-Related Professional Liability Claims and Risk Factors:** Reviewed case data for the last 8 years to identify trends and possible risk reduction strategies related to obstetrical care.
- **Review of Risk Profile for Affiliation Program at Highland Hospital**
- **Consent Process:** Provided input related to an initiative to increase the frequency of consent form completion before the day of surgery.
- **Policy Review:** Reviewed and approved the following policies: Disclosure of Adverse Event, Patient's Right to Refuse Treatment.
- **Allocation of Professional Liability Claims:** Reviewed and approved process for Allocation of Professional Liability settlements for purposes of licensing board reporting determination.
- **Review of Litigation Coordination Meeting Process:** Reviewed and approved the litigation coordination meeting process the purpose of which is to education and support providers involved in litigation.

FUTURE PLANS:

- Review the work of an OB-related task force
- Develop effective methods for communicating professional liability trends and implications of risk management activity as it affects patient safety.

UTILIZATION MANAGEMENT COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:

The primary areas of focus for UM committee in FY2014 were to 1) monitor length of stay and outlier patterns; 2) provide interpretation, updates and guidance on the new Medicare "Two Midnight Rule" 3) oversee patient flow efforts (ED door to floor, Discharge by Noon Initiative etc.); 4) oversee Transfer Center activities; and 5) oversee the transition to the TAR-Free process for MediCal patients at UCSF Medical Center.

TWO MIDNIGHT RULE

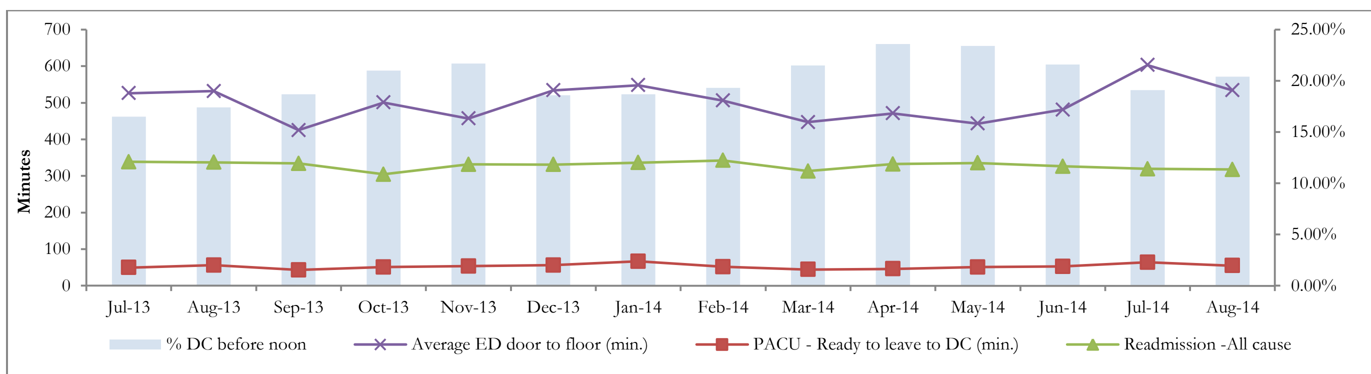
On October 1, 2013 Medicare revised the standard for determining medical necessity for inpatient admission to a hospital. In general, if a physician believes, documents and justifies that a patient will require at least two midnights of hospital based care, that case is generally appropriate for an inpatient stay. Likewise, if a patient is not expected to require at least two midnights of care, those patients are generally appropriate for outpatient (ONB) or Observation (OBS). There are few exceptions to this rule (e.g. the Medicare Inpatient Only List, patient death, and AMA discharge). This new ruling required process and APeX changes, combined with extensive educational efforts. Hospitals around the country are in the "Probe and Educate" phase of the Two Midnight Rule implementation. UCSF has undergone one Probe and Educate review during which 14% of the UCSF cases were determined to be incorrectly classified, which was noted as one of the lowest rates of all the Probe and Educate reviews. The second Probe and Educate review is currently underway.

PATIENT FLOW

Patient flow continues to be a challenge for UCSF, particularly during high census periods when flow is the most critical. The organization successfully met the goal of increasing the percentage of cases discharged by noon to 20% or greater for at least three months of the fiscal year. In fact, this goal was met for six months of the fiscal year. An analysis was completed to determine if the Discharge before Noon initiative was having unintended negative consequences in length of stay, readmissions, or patient satisfaction. The results of that analysis indicated that patient satisfaction was slightly improved, none of these factors showed a negative impact, and ED door to floor was minimally improved on the months that the discharge before noon results were most positive. Efforts to sustain and improve the percentage of discharges before noon continue into FY2015.

DISCHARGE BEFORE NOON IMPACT TREND

Measure	*Jul-13*	*Aug-13*	*Sep-13*	*Oct-13*	*Nov-13*	*Dec-13*	*Jan-14*	*Feb-14*	*Mar-14*	*Apr-14*	*May-14*	*Jun-14*	*Jul-14*	*Aug-14*
% DC before noon	16.50%	17.40%	18.70%	21.00%	21.70%	18.60%	18.70%	19.30%	21.50%	23.60%	23.40%	21.60%	19.10%	20.40%
Average DC time	3:01 PM	2:59 PM	2:52 PM	2:48 PM	2:44 PM	2:51 PM	2:47 PM	2:44 PM	2:39 PM	2:31 PM	2:34 PM	2:36 PM	2:43 PM	2:41 PM
LOS Index	1.13	1.14	1.15	1.16	1.13	1.12	1.10	1.14	1.11	1.09	1.08	1.17	1.10	1.10
Average ED door to floor (min.)	526	532	425	501	457	534	548	506	447	471	443	481	603	534
PACU - Ready to leave to DC (min.)	49.75	56.35	42.94	50.90	53.74	56.14	66.48	51.94	44.47	46.33	50.85	52.60	63.98	55.01
ICU ALOS (except ICN)	4.97	4.84	5.93	4.84	4.99	5.68	5.42	5.72	4.94	5.25	4.99	6.71	5.18	5.08
Readmission – All cause	12.09%	12.05%	11.94%	10.88%	11.84%	11.82%	12.02%	12.23%	11.18%	11.88%	11.99%	11.65%	11.41%	11.35%
Patient Satisfaction - DC	84.9	84.6	83.0	85.5	85.2	83.7	84.5	85.5	85.3	85.2	85.1	85.8	83.3	86.0
Surgery Volume - Inpatient	1169	1131	1023	1099	941	984	1083	1016	1038	1087	1056	1157	1101	1037



Utilization Management Committee (continued from previous page)

ACCOUNTABLE CARE ORGANIZATIONS (ACO)

UCSF has established 3 commercial ACOs for the following populations: 1) City and County of SF (CCSF) employees insured through Blue Shield of CA; 2) University of CA employees insured through HealthNet Blue and Gold and 3) members of Anthem Blue Cross PPO in SF and the surrounding area who are attributed to us based on past utilization with primary care or specialty care. For our first two ACOs, our provider partners include UCSF Medical Center, Hill Physicians Medical Group, and Dignity Health. Our clinical associates, One Medical Group, Golden Gate Pediatrics and Mt. Tam pediatrics are partners in all three ACOs. Through these ACOs we are caring for approximately 30,000 patients, and 42% of them receive their primary care through UCSF Health.

The goal in all of the ACOs is to provide higher quality care at a lower total cost for the population of patients. Interventions include:

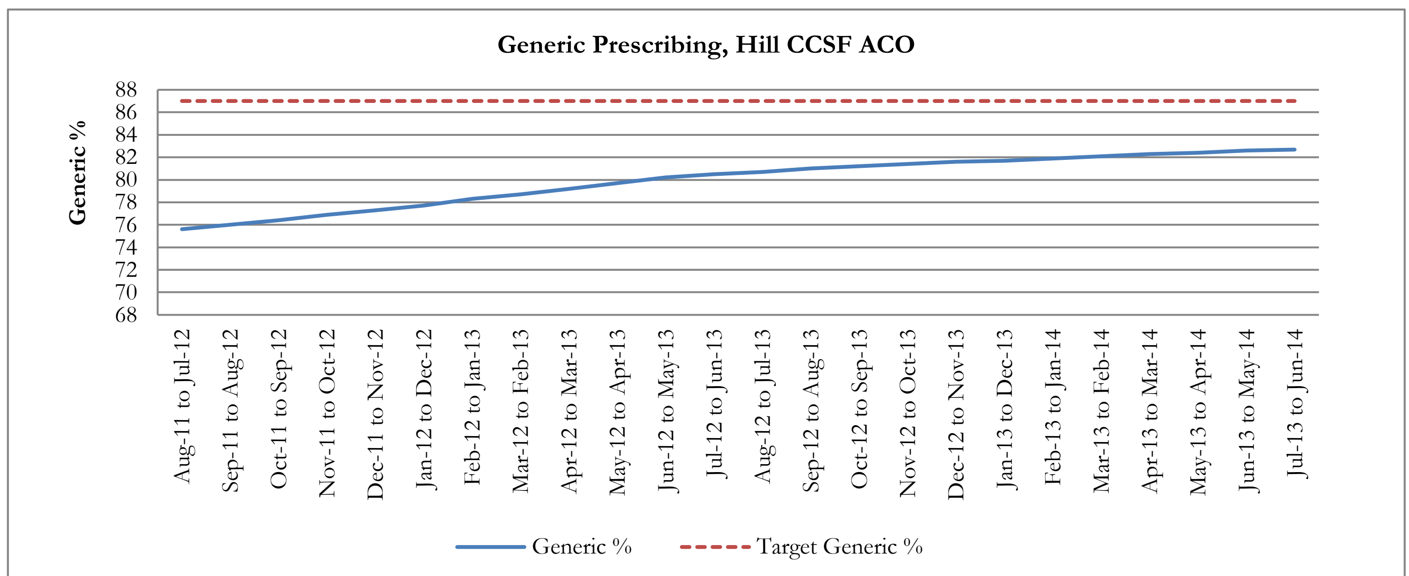
- Care Transitions Manager for ACO inpatients to assist with LOS management, transitions of care and coordination across the continuum of care
- Ambulatory Care Management and Navigation for patients with chronic conditions to help develop care plans in coordination with primary care
- Increased PCP, urgent care and behavioral health access
- Increased involvement of pharmacists in the care of patients to improve quality of care and generic use

City and County of SF - BlueShield ACO

Despite the risk score of this population steadily increasing over the last 2 years, the ACO has continued to have improvement in hospital days/1,000, average LOS, and generic prescribing.

Metric (Source: BlueShield ACO Dashboard)	**FY2013 (July 2012 – June 2013)**	**FY2014 (July 2013 – June 2014)**	**% Change (FY2014 vs. FY2013)**
Risk Score (DxCG, concurrent)	1.79	1.96	+9.5% ↗
Average LOS	5.63	4.66	-17.2% ↘
Days per 1,000	325.2	281.8	-13.3% ↘

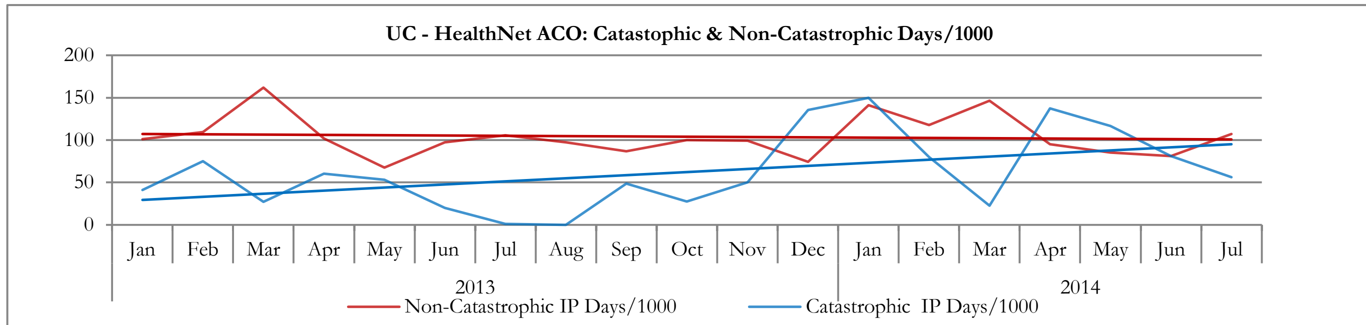
We have focused on increasing generic utilization by partnering with Hill Physicians Medical Group and implementing Virtual Pharmacists in some of our Primary Care Clinics. We are also partnering with community pharmacists through the Blue Shield-Walgreens Medication Therapy Management (MTM) program, which allows retail pharmacists to meet face-to-face with patients and provide targeted comprehensive medication reviews.



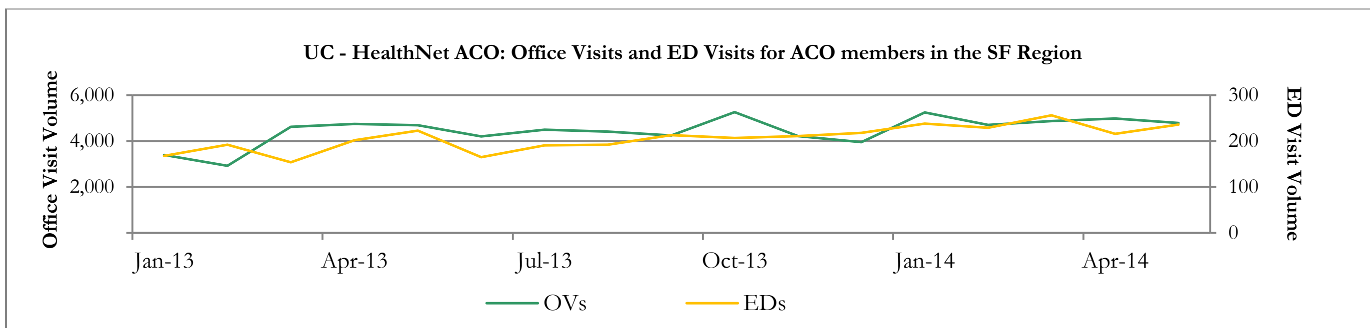
Utilization Management Committee (continued from previous page)

University of California – Health Net Blue and Gold ACO

Over the last year, this ACO has seen an increase in catastrophic admissions (admissions that are greater than 8 days in length of stay). Controlling for this, there has been a slight reduction in hospital days/1000 for non-catastrophic cases.

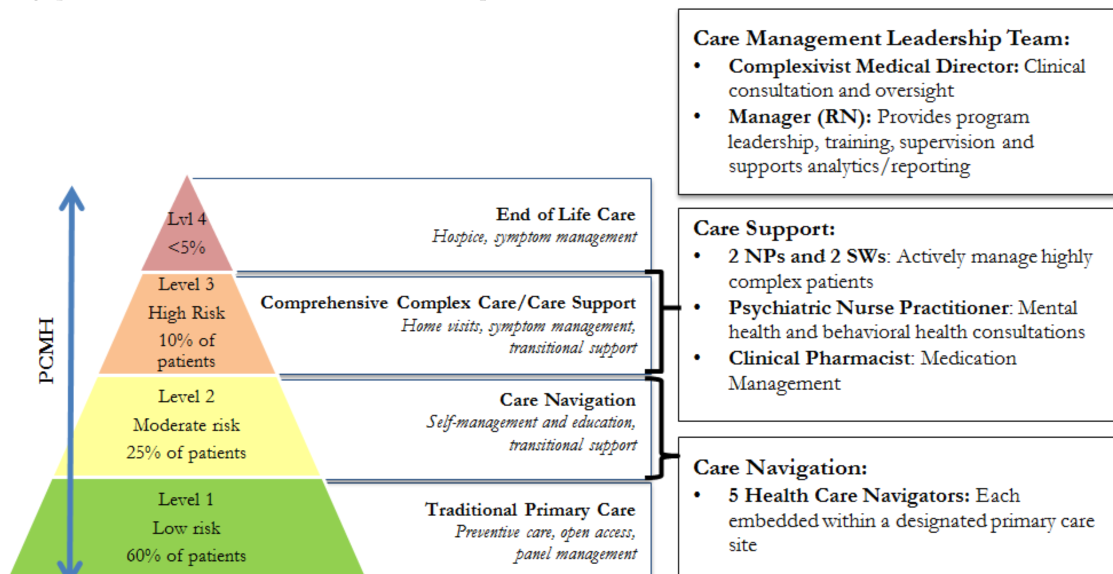


For both above ACOs, we have tried to decrease ED utilization by increasing access to Primary and Urgent Care. While we have shown an increased use of outpatient visits, we have not yet seen a sustained decrease in ED use.



Anthem Blue Cross ACO

Our goal in the Anthem ACO is to engage patients with 2 or more chronic conditions and a high risk of admission or ED utilization into outpatient care management. To do this we have developed an ambulatory care management team that will work with primary care patients, in-person and telephonically, to self-manage chronic conditions and to problem solve challenges in making behavioral and lifestyle changes. This team's goal is to engage at least 550 high risk patients in personalized care plans. We will be tracking quality of care and costs of care for these patients.



QUALITY COMMITTEES REPORTING TO CLINICAL PERFORMANCE IMPROVEMENT COMMITTEE (CPIC)

ADULT CRITICAL CARE COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:

Critical Care Division

- **ICU Delirium Committee** - Transdisciplinary team with ICU pharmacist, PT, OT, Speech Therapy, Nursing, CNS, ICU faculty and fellows.
  - Sponsored ICU Delirium Symposium and introduced Management and Treatment Bundle in July 2013.
  - CAM-ICU Screening: Increased screening among adult ICU patients with 76% screened in 2013 vs. 68% screened in 2012.
- **RN report script** - Developed for ICU rounds with the aim of improving the following:
  - Communication about patient status & needs
  - Collaboration with teams on plan of care
  - Efficiency in meeting patient care needs
- **Interventions to reduce Pressure Ulcers (PU) to zero**
  - 10 ICC collaboration with OR to initiate pressure reduction bed surfaces for post-op patients.
  - 9/13 ICU weekly Skin Champion Day to improve PU photography, coach RN staff on treatment and prevention interventions.
- **Proning for ARDS -** Protocol developed for adult ICUs to implement early prone positioning for severe ARDS patients.
  - Four patients were evaluated for treatment with prone positioning, one patient received prone positioning; duration approximately 48 hours.
- **The ICU Palliative Care Committee** - An interdisciplinary workgroup comprising all disciplines practicing in adult critical care at Mt. Zion and Parnassus has convened bimonthly. Issues examined in the past fiscal year include:
  - Implementation of new Pain, Agitation, and Delirium guidelines
  - Ethical analysis of challenging cases
  - Withdrawal of mechanical circulatory support

8/11 ICU

- **Beacon Award Gold level** - The Beacon Award for Excellence lauds North American hospital units that employ evidence-based practices to improve patient and family outcomes. Recipients of a Gold Beacon Award demonstrate excellence in sustained unit performance and patient outcomes.
- **CAUTI reduction project**
  - All staff trained on sterile specimen collection, Foley catheter care, and CAUTI prevention measures.
  - Charge nurses round daily and review Foley catheter utilization.
  - Cases reviewed
- **ICU management/consult** - All patients in 8/11 ICU now receive mandatory Critical Care consults.

9/13 ICU

- **Project Emerge** - GB Moore grant funded PI project in 9/13 ICU. Goals are to reduce preventable harms, increase patient and family engagement and reduce health care costs.
- **Patient Family Advisory Council (PFAC)** - Former 9/13 ICU patients/families consulting to improve ICU family experience.
- **Comprehensive Unit Based Safety Program (CUSP)** - Safety program launching in 9/13 ICU in November 2014.
- Built phase 1 of a website designed to provide clinicians, patients, and families with the information they need to improve outcomes and experience (http://criticalcareinnovationsgroup.org/)
- **ICU Early Mobilization -** Approximately 800 patient consults in FY2014.

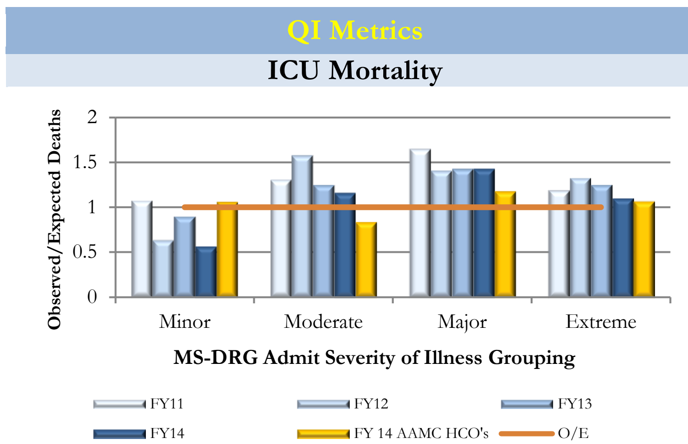
Adult Critical Care Committee (continued from previous page)

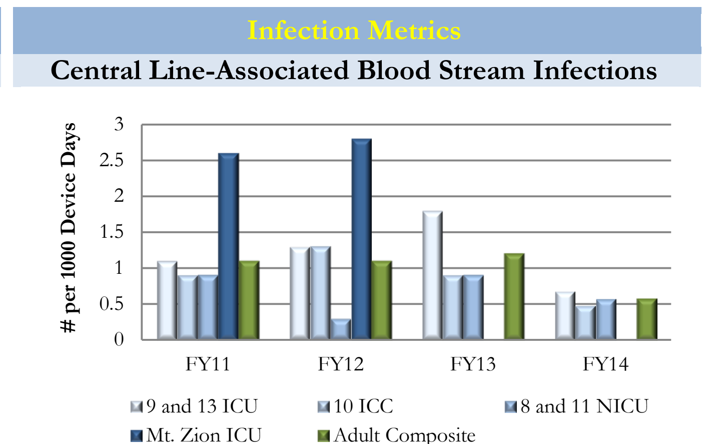
<u>10 ICC</u>

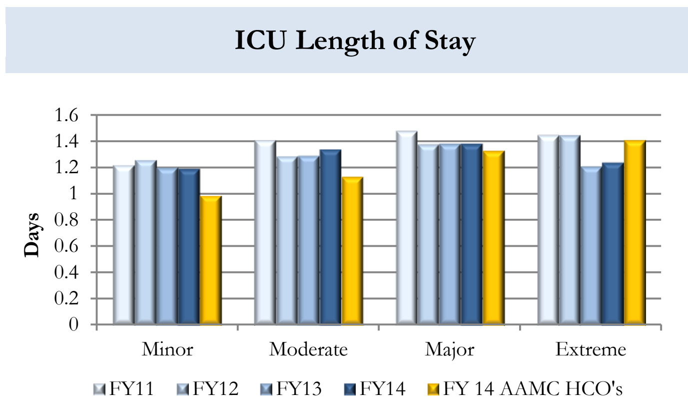
- **Interdisciplinary OR handoff** - Evidence-based fellowship project to improve interdisciplinary OR handoff at the bedside
- **Restraint use reduction** - Post-op recovery project to reduce restraint use. Defined standards for recovery after surgery and have reduced restraint use Oct 2013 to June 2014.

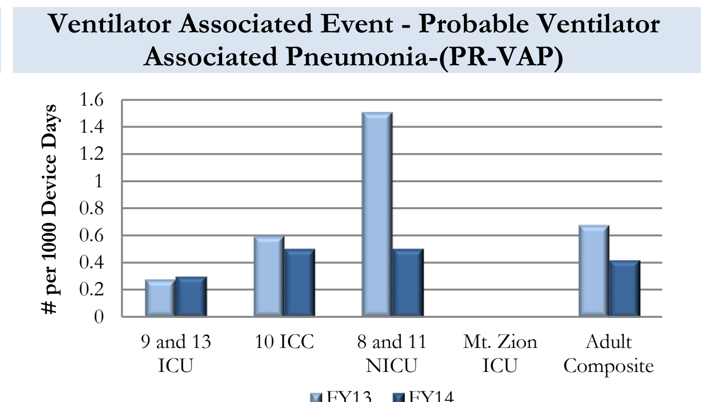
ONGOING MONITORING AND QI:

- The incidence of CLABSI fell to 0.58 per 1000 line days, down from 1.2 in FY2013 and 1.1 in FY2012 & FY2011; incidence of VAE [Ventilator Associated Event: Probable Ventilator Associated Pneumonia (PR-VAP)] has decreased to 0.42 per 1000, down from 0.68 in FY2013, due to focused efforts to prevent this complication of care.
- ICU mortality index (observed rate/expected rate) in all patients with an ICU stay has decreased for the minor and moderate and extreme severity of illness (SOI) groups, while it is unchanged for the major SOI groups. Mean ICU length of stay is similar to that of the AAMC Teaching hospitals.









CANCER COMMITTEE

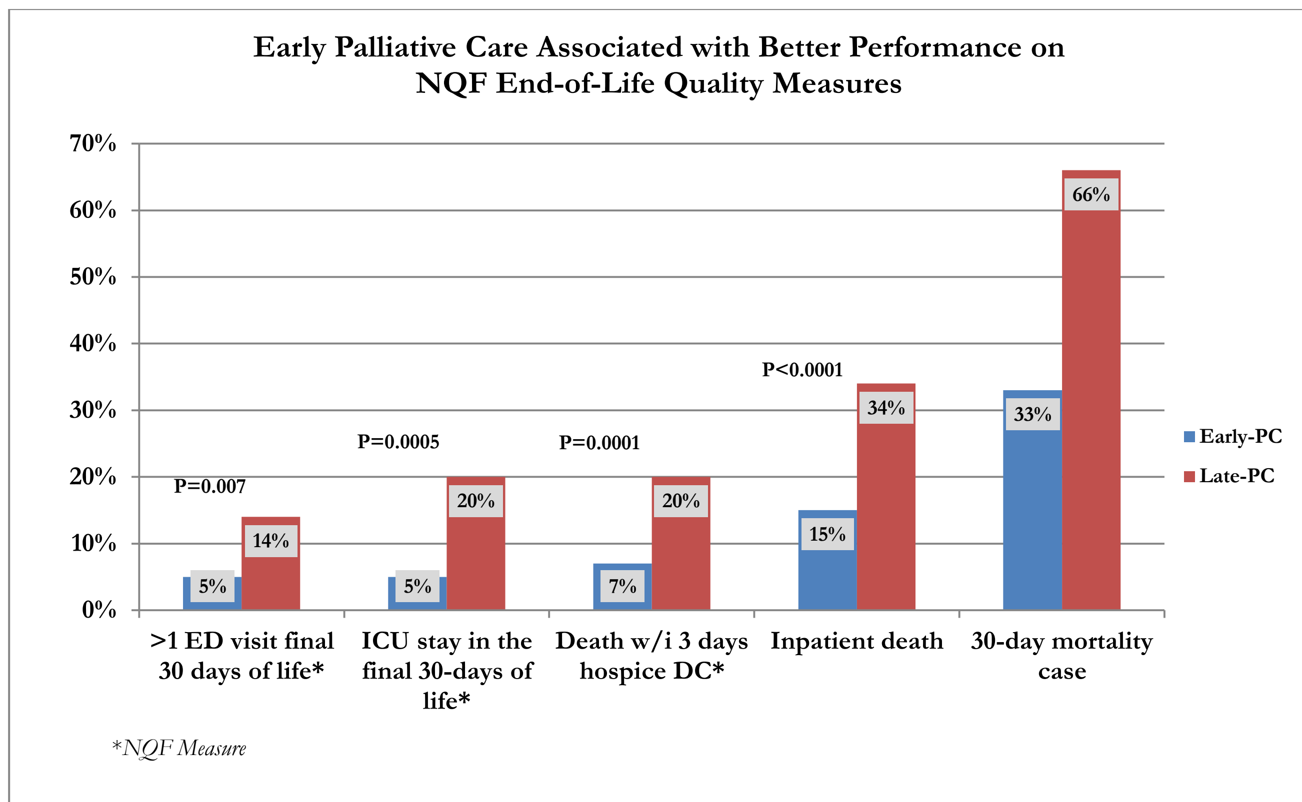
Cancer Committee oversees compliance with Commission on Cancer (CoC) accreditation standards and has focused on the following goals in FY2014:

- Assessment of compliance with Palliative Care Guidelines Recommended by the National Quality Forum (NQF)
- Implementation of an Oral Chemotherapy Order Writing Policy

NOTABLE HIGHLIGHTS:

Effects of Early Palliative Care (PC) Services on NQF End-of-Life Quality Measures:

- Solid tumor patients with cancer and known cause of death from 2010-2012 were identified for study (N=978)
- In-depth review of 298 patients who had some contact with specialty palliative care (PC) services
- Patients divided into 2 groups: those referred to PC services > 90 days prior to death (Early-PC) vs. those referred to PC services < 90 days prior to death (Late-PC)
- Evaluated outcomes in the 6 months preceding death in patients with early vs. late PC referrals



FINDINGS:

- Patients referred to Early-PC had significantly better outcomes on the NQF measures vs. Late-PC with fewer visits to the ED in the last 30 days of life; fewer ICU stays within 30 days of end of life; fewer deaths within 3 days of discharge to hospice; and fewer inpatient deaths.
- Specialty PC services appears to be underutilized in advanced cancer patients at UCSF
- Early PC associated with significant inpatient cost savings with modest increase in outpatient cost
- Early PC is most appropriately delivered in the outpatient setting

Cancer Committee (continued from previous page)

NATIONAL CANCER DATABASE (NCDB) QUALITY METRIC PERFORMANCE

The National Quality Forum (NQF) brought public and private payers together with consumers, researchers, and clinicians to broaden consensus on performance measures for breast and colorectal cancer. The performance rates shown below from the Rapid Quality Reporting System (RQRS) match the specifications of the breast, colon and rectal cancer care measures endorsed by the NQF in April, 2007. The UCSF Cancer Registry submits cases to the RQRS on a monthly basis. The CoC has instituted the RQRS as a facility feedback mechanism to promote awareness of the importance of charting and coding accuracy in line with evidence based practice guidelines. In light of the national movement towards Pay for Performance, these reports provide CoC-approved programs with the ability to examine program-specific breast, colon and rectal cancer care practices. The goal at UCSF Medical Center is to achieve ≥ 90% compliance across all measures. New guidelines specific for GYN cancers will be debuted in 2015.

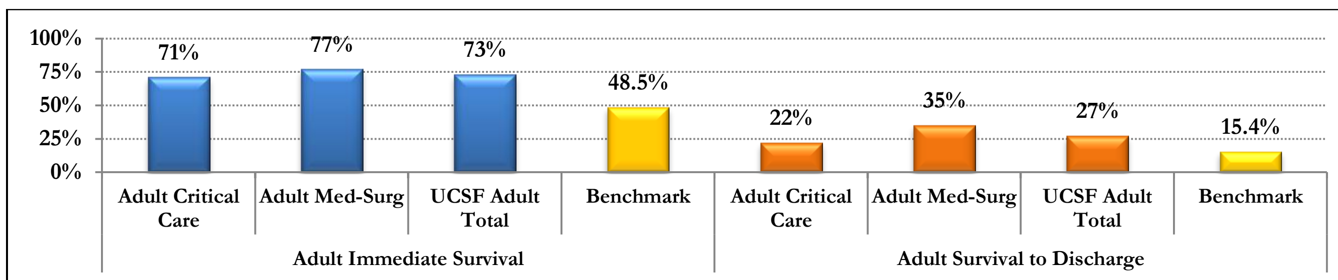
Select Breast & Colorectal Measures		Performance
BREAST	Radiation therapy is **administered** within 365 days of diagnosis for women < 70 receiving breast conserving surgery for breast cancer.	100% 90% 80%; 2007 2008 2009 2010 2011 2012 2013 (prelim)
	Combination chemotherapy is **considered or administered** within 120 days of diagnosis for women < 70 with AJCC T1c N0 M0, or Stage II or III ERA and PRA negative breast cancer.	100% 90% 80%; 2007 2008 2009 2010 2011 2012 2013 (prelim)
	Tamoxifen or third generation aromatase inhibitor is **considered or administered** within 365 days of diagnosis for women with AJCC T1c N0 M0, or Stage II or III ERA and/or PRA positive breast cancer.	100% 80% 60% 40%; 2007 2008 2009 2010 2011 2012 2013 (prelim)
COLON	Adjuvant chemotherapy is **considered or administered** within 120 days of diagnosis for patients < 80 with AJCC Stage III (lymph node positive) colon cancer.	100% 90% 80%; 2007 2008 2009 2010 2011 2012 2013 (prelim)
	At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.	100% 90% 80%; 2007 2008 2009 2010 2011 2012 2013 (prelim)
RECTUM	Radiation therapy is **considered or administered** within 180 days of diagnosis for patients < 80 of with clinical or pathologic AJCC T4N0M0 or Stage III receiving surgical resection for rectal cancer.	100% 80% 60% 40%; 2007 2008 2009 2010 2011 2012 2013 (prelim)

CODE BLUE COMMITTEE AND RAPID RESPONSE TEAM

ONGOING MONITORING AND QI:

The Code Blue Committee provides oversight for the Clinical and Operational Code Blue Subcommittees, the Code Blue Debriefing Process, the Pediatric Emergency Team ("Code White"), and the Rapid Response Team (RRT) and closely monitors relevant QI metrics:

- UCSF adult cardiopulmonary arrest (CPA) outcomes exceed the national benchmark. Immediate CPR success rate was 73%, compared with the benchmark of 48.5%.
- UCSF adult CPA survival to hospital discharge rate is 27%, significantly better than the national benchmark of 15.4%.



ACTIVITIES AND ACCOMPLISHMENTS:

- The RRT facilitates a debriefing for all code blue events in the medical-surgical units of M-L hospital. Many cases were referred for further M&M/QI Committee review as appropriate.
- The Code Blue committee and members were active in policy planning for Mount Zion and Mission Bay Code Blue response after February 1, 2015.
- The Committee coordinated the purchase of new defibrillators for Mission Bay, with plans to replace those throughout the Medical Center in the future.
- As of June, 2014, all Code Blue events reported by RRT in RL Solutions (Incident Reporting system) in order to have real-time communication of code blue system and process issues.
- Advanced Resuscitation Training (ART) - UCSF joined the other UC campuses in creating an ART infrastructure supported by a UCOP grant.

RAPID RESPONSE TEAM (RRT)

- A monthly dashboard is produced for the Moffitt-Long Adult RRT. Data elements reported are call volume, reason for call, outcome of call, calls by nursing unit, calls by shift and code team activations.
- FY2014 RRT call volume averaged 210 calls per month (increased 9% from 192/month in FY2013), not including vascular access related calls which averaged 152 calls per month. The high volume units were: 14M (19%), 10CVT (15%), 14L (12%) and 13L (11%).

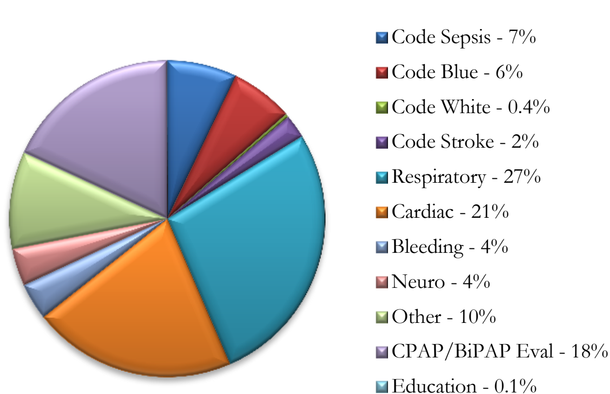


Figure 1 shows the distribution of the reasons for the RRT calls. Respiratory concerns continue to be the predominate reason, followed by other concerns, cardiac concerns and CPAP/BiPAP evaluation.

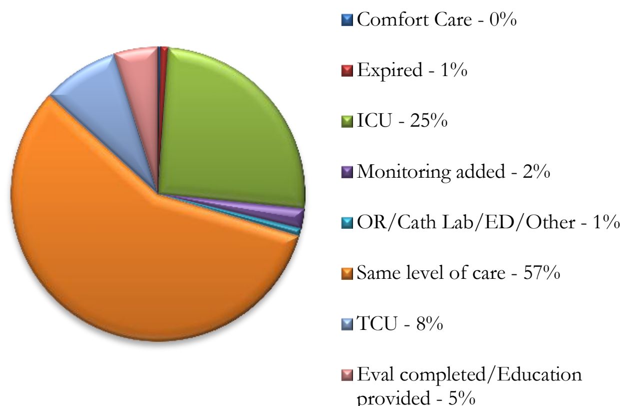


Figure 2 shows the outcomes of the RRT calls in FY2014 57% of the patients were stabilized in place and did not require transfer. 33% percent were transferred to a higher level of care.

DIABETES AND INSULIN MANAGEMENT COMMITTEE

MAJOR ACTIVITIES AND ACCOMPLISHMENTS:

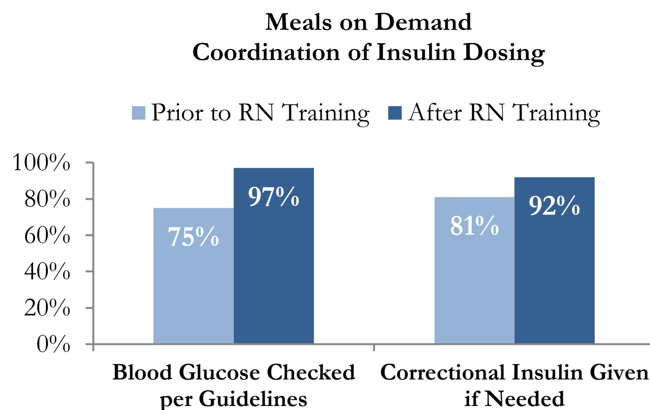
- **Meals on Demand Program** - This program provides patients receiving insulin the option to participate in room service (on demand) meal delivery from Nutrition and Food Services. Providing patients the freedom to request meals on demand requires timely communication between Food Services and the RN caring for the patient, and poses challenges in coordinating appropriate and safe insulin administration. An algorithm that assists the nurse in deciding when insulin should be administered for these nontraditional meal times and attendant training were developed for all nursing/dietary/pharmacy providers.
- **Virtual Glucose Management Service (vGMS)** - In 2012, we developed a Daily Glucose Report, a Glucose/Insulin Flowsheet, a Glucose Management Note, and launched the vGMS in May 2013. Our vGMS allows us to remotely identify all adult inpatients with poor glycemic control and then remotely instruct the patient's provider on recommended patient specific insulin dosing changes. The vGMS monitors and makes insulin dose recommendations daily. As a result of the glucose management notes the number of patients on this list decreased by over 50%. This led to health care providers improving their glucose management skills. In a June 2014 survey 81% (78 of 96) inpatient Providers reported finding the vGMS helpful to them with 76% (75 of 99) implementing recommendations "often" or "always". Eighty three percent (81 of 98) noted subsequent improvement in blood glucoses occurring "often" or "always". In less than 40 minutes per day, the virtual Inpatient Diabetes Service enhances inpatient glycemic control, promotes patient specific insulin dosing changes and decreases health care provider therapeutic inertia.

- Sixteen unique APeX insulin order sets for inpatient adults, pediatrics and obstetrics continue to be used and updated.
- A new Insulin Supplies "Smart" Order Set for APeX ensures all adult patients discharged to home on insulin, receive appropriate insulin prescriptions and equipment and glucose monitoring supplies.
- Updated glucometric reports measure performance improvement initiatives through monitoring and auditing of blood glucose values for patients on the three most frequently used insulin protocols.

AUDITS AND MONITORING:

Meals on Demand

A chart audit of one nursing unit showed that RN use of an Insulin Decision Tree algorithm improved appropriate timing for glucose checks and insulin dosing.



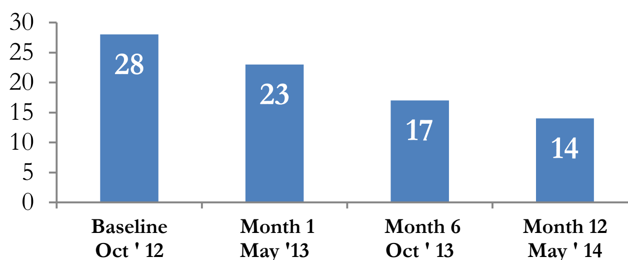
'here was a **30 % increase in checking patient blood lucoses and a 14% increase in administration of orrectional insulin per guidelines** after development nd training on a SQ Insulin Decision Tree algorithm.

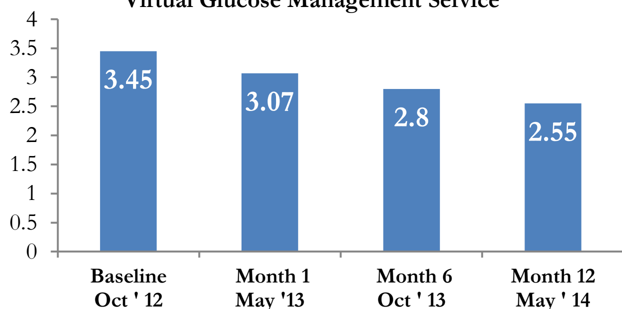
Diabetes and Insulin Management Committee (continued from previous page)

Glucometric Reports

Following are graphic representations showing continued performance improvement in management of blood glucoses in patients receiving subcutaneous insulin for FY2014. Largely attributed to the virtual Glucose Management Service, there were both significant reductions in the average number of patients experiencing hyperglycemic excursion (defined as two or more glucoses ≥ 225 mg/dL) and the number of patient days, as well as an increase in percentage of blood glucoses within the targeted range of 71 -< 181 mg/dL.

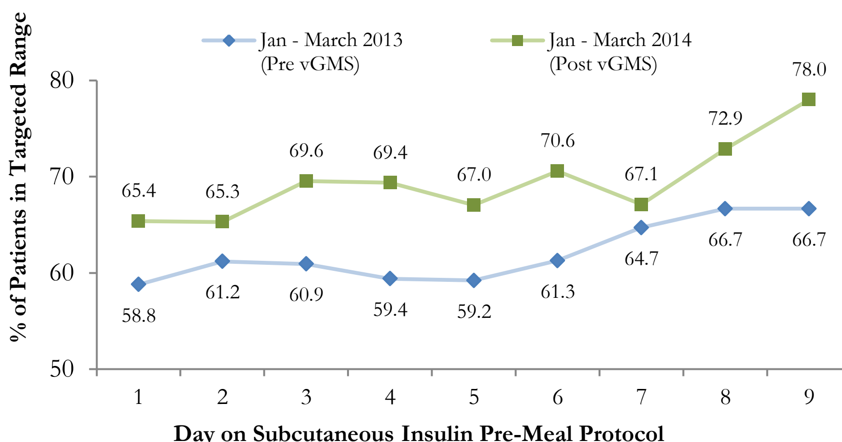
The average number of patients per day experiencing hyperglycemic excursions* declined significantly. **After one year, the number of patients on the daily list was reduced by 50%.** In 8/2014, there were 4 days with < 6 adult patients listed on the report These reductions occurred in all services including medicine, general surgery, transplantation and hematology/oncology. **Defined as two or more glucoses ≥ 225 mg/dL in 24 hours.*





With implementation of vGMS insulin dosing recommendations **patients spent fewer consecutive days with two or more glucoses ≥ 225 mg/dL.**

There was **significant improvement in the percentage of glucoses within the targeted range of 70 - <181 mg/dL** by day on protocol. There was corresponding reduction in patients with glucoses both >180 mg/dL and >225 mg/dL.

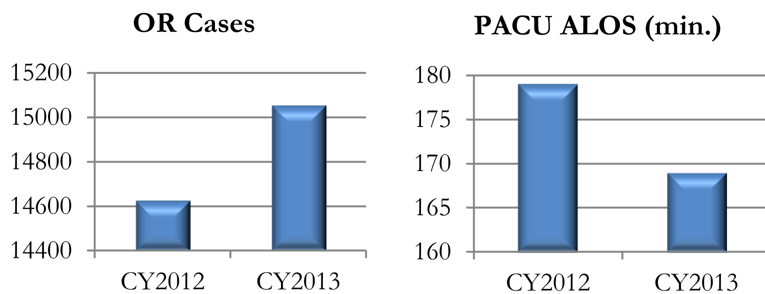


OPERATING ROOM COMMITTEE

PERFORMANCE IMPROVEMENT ACTIVITIES AND ACCOMPLISHMENTS:

- 48% reduction in hospital acquired pressure ulcers associated with perioperative care in FY2014.
- In the Pre-Op area, an alert system was implemented to notify physicians of incomplete documentation. Records complete on arrival increased from 49% to greater than 97%.
- Revised policies on OR Fire Safety, Airway Fire Management, Laser Safety, and Radiation Safety are increasing the safety of surgical patients.
- To reduce the risk of hospital acquired infections, a new policy on pre-op chlorhexidine bathing has been implemented and guidelines for professional attire in the OR were developed. To reduce unnecessary traffic in and out of the rooms, policies on visitors and sales representatives in the ORs have been issued.

MOFFITT/LONG OPERATING ROOMS - INCREASED PRODUCTIVITY



While surgical case volume at the Moffitt/Long increased by 3%, the average length of stay (ALOS) in the Post-Anesthesia Care Unit (PACU) has decreased by an average of 10 minutes in CY2013. PACU ALOS has decreased for more than 3 consecutive years due to continuous improvements in patient management systems.

Volume and PACU ALOS remained stable at Mount Zion and the Ambulatory Surgery Center.

POST-OPERATIVE DEBRIEFING PILOT PROGRAM

Checklist driven, pre-operative multidisciplinary briefings are now standard practice with proven patient safety benefit. Gynecology has an established practice of post-op debriefing to identify patient safety and efficiency issues. Neurosurgery and Pediatrics are participating in a pilot program to assess the value of post-op debriefings in their surgical services. Between May and June of 2014, Neurosurgery increased post-op debriefings from 51% to 81% of their cases and a number of performance improvement opportunities have already been identified. Electronic documentation tools are being developed and the program will be extended to other services.

ENHANCED RECOVERY AFTER SURGERY (ERAS) PROGRAM

ERAS is a new multimodal perioperative care piloted at Mount Zion by colorectal surgery. Designed to achieve early recovery for patients undergoing major surgery, the program represents a paradigm shift in traditional perioperative care with a focus on evidence-based best practices. The comprehensive program encompasses all areas of the patient's hospitalization. Preliminary data indicates the average length of stay has been reduced by 1.38 days with the ERAS program.

SUPPLY PROCESSING & DISTRIBUTION (SPD) SCORECARD

Operating Room equipment sterilization and reprocessing quality metrics are summarized in the SPD Scorecard. All measures met or exceeded target except one instance of missing documentation of monthly sterilizer cleaning.

SPD Scorecard			
Measure	**FY2014**	**Target**	
Immediate Use Steam Sterilization (IUSS)	8%	12%	
IUSS Loads with Implants	0%	0%	
# of Failed Biologic Tests Resulting in Recall	0%	0%	
Sterilizer Cleaning 1x/month	100%	100%	
OR Accuracy	95%	93%	
Case Cart QA	99%	93%	

PAIN COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:

- The Pain Management Committee was restructured with the intent of being more productive and purposeful with increased and balanced participation across the medical center.
- The "Pain Newsletter" continues to be regularly disseminated campus wide and posted on the NIH Portal as a part of the NIH Pain Consortium Center of Excellence in Pain Education Program.
- The Committee has worked with the APeX team to develop a detailed "Opioid/Naloxone Use Report" that will enable us to better understand the context of Naloxone use at UCSF.
- The Acute Pain Consult Service expanded: (1) Parnassus-the highest volume consult service at UCSF; (2) Mount Zion-has seen a 100% increase over the past 2 years.
- The UCSF Inpatient Chronic Pain Consult Service expanded to be available 7 days a week, 24 hr/day.
- The Pain Resource Nurse group was reinstituted; 40 nurses from all areas of the medical center were designated to act as leaders/resources for their areas in pain management.

CLINICAL ACHIEVEMENTS:

- Multimodal pathways and Enhance Recovery After Surgery (ERAS) pathways (analgesic pathways) have expanded to include: Colorectal, Gynecology Oncology, Orthopedic Oncology, Ortho Spine, Urology and Radiation Oncology.
- Developed and published guidelines for Neuraxial Anesthesia and Antithrombic Management.
- Ketamine
  - Use of low dose ketamine was expanded to all Acute Care Floors
  - Ketamine use with doses up to 10 mcg/kg/min was approved for Palliative Care patients
- Intrathecal Pump Policy was created to outline procedures related to implanted intrathecal pumps.
- Opioid equivalency table was developed and approved by Pharmacy and Therapeutics Committee.
- CADD-Solis infusion pumps were purchased and will be instrumental in providing improved regional anesthesia.
- OnQ (Elastomeric Infusion) Pump use was initiated at the Orthopedic Institute, with planned expansion to ML in FY2015.

SEDATION COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:

- The Committee completed work with the UCSF APeX team modifying the Sedation Narrator for improved real-time documentation during procedural sedation. The Narrator was crafted to allow improved workflow with a streamlined interface. Planned to be rolled out to all Sedation areas, November 2014.

Sedation Narrator
Refresh | Tx Team | SmartSets | References | Enter/Edit Results | Data Validate | Print AVS | Questionnaires
Expand All | Collapse All
Event Log | Patient Summary | Orders
Documentation Start Time
Staff | Add/Remove Staff
Pre-Procedure Documentation
Pre Procedure Verification Checks
Pre Procedure Clinical Assessment (MD/NP)
Mod Aldrete Pre-Procedure
Pre Procedure Equipment Check
Adult Vitals/Sedation/Pain
Ped-Neo Vitals/Sedation/Pain
Weight (if not already documented)
Final Time Out
Intra-Procedure Documentation
Post-Procedure Documentation
Documentation End Time
Quick Note
Show: Deleted | Status Changes
Pre Procedure Verification Checks
Time taken: 13:03:17 | 10/13/2014
Show: Row Info | Last Filed | All Choices
Add Row | Add Group | Values By
Pre-Procedure Verification Checklist
Verify patient identity | Yes
Verify procedure and site marking | Yes
History and Physical completed within last 30 days | Yes | N/A
Interval update of History and Physical if more than 24 hours old | Yes | N/A

- The Committee worked to modify the Sedation Procedure to create improved alignment of sedation areas with inpatient nursing (age appropriate sedation scale use for assessment), the PACU (universal discharge criteria) and the ASA guidelines (Intra-procedure documentation at least every 5 minutes).
- The Committee began work to revise the Physician and Nurse Practitioner credentialing process, to be available through the UCSF Learning Management System.
- The Committee continues to monitor quarterly sedation process and outcomes for all non-operating room areas performing procedural sedation. There were 13, 487 sedation procedures performed during FY2014 in NORA areas with an overall adverse outcome rate of 0.0015% for FY2014 as compared to 0.002% in FY2013 and 0.0032% in FY2012.

SURGICAL CASE AND HOSPITAL MORTALITY REVIEW COMMITTEE (SCHMRC)

ACTIVITIES AND HIGHLIGHTS:

- 100% of all deaths (678) were reviewed and rated
- 95% of all deaths were reviewed within 3 months; 75% of cases reviewed within 2 months of event date
- UHC O:E mortality reports presented and reviewed at committee meetings
- Successful implementation and use of an on-line case review database to capture ratings and systems issues
- Membership now includes the manager of Patient Safety to enhance reporting and follow-up of systems issues
- Systems issues identified by the Committee are referred to the Patient Safety Committee, operational departments or Department Chairs for follow-up. Major areas of focus include:
  - Physician notification of abnormal EKGs
  - Checklist of clinical review triggers for patients experiencing extended stays in intensive care units
  - Appropriate use of 911/EMS for transfer of patients
  - Central line insertion procedures
  - Nursing assessments and procedure for escalation of clinical issues
  - Use of tPA in post-surgical patients

PENDING PROCESS CHANGES FOR FY2015:

- Strengthen and revise the peer review component by linking back to the department chair and the re-credentialing process.

TISSUE COMMITTEE

The charge of the Tissue Committee is to assist with the development of policies and practices, and act as an oversight body for procurement, issuance, and handling of tissues to assure institutional compliance with T JC. This report is for calendar year 2013.

TISSUE SAFETY HIGHLIGHTS:

- **TJC Compliance**
  Tissue licensed groups include: Pedi BMT, Adult BMT, Donor Milk Bank, Surgical Implant Services (3 sites), and Center for Reproductive Health. All performed a self-audit of TJC compliance, and reported full compliance. The Department of Regulatory Affairs also audited several operations with overall good compliance. A TJC inspection took place in 2013 for 4 tissue banks, and no issues were identified.
- **Recalled Tissue Products**
  The Department of Material Services reported that there were no tissue product recalls which affected the medical center inventory of tissue products.
- **Sterility of Hematopoietic Stem Cell Products**
  Adult Bone Marrow Transplant Laboratory reported positive cultures at 1.07% (4 out of 372) in 2013. Pediatric Blood and Marrow Transplant Laboratory reported positive cultures at 1.2% (2 out of 168). Both groups are below the target threshold of <5% positive cultures.
- **Milk Bank**
  The donor milk bank has been operating with a tissue bank license since 2012. The milk is procured from volunteers, and donors are tested at least biannually with a battery of infectious disease testing following AABB guidelines. There were no product recalls from the supplier in 2013.

Tissue Committee (continued from previous page)

- **Blood Bank Oversight of Solid Organs and Vessels for Transplantation**
  Blood bank brought into inventory (organ or proxy card), verified ABO compatibility, and issued organs and/or transplant records for 459 organs in 2013 (287 kidneys, 13 pancreas, 142 livers, 11 lungs, 6 hearts). Turn-around times average < 12 minutes. Vessels are being stored and issued from Blood Bank in 2014.
- **Donor Tissue Infection Management, Adverse Events**
  Infection Control is able to identify those patients with an implant/transplant who meet National Healthcare Safety Network (NHSN) criteria for Surgical Site Infection (SSI), though whether that infection is as a result of the transplanted or implanted tissue or mechanics is difficult to determine in the absence of a demonstrated organism (e.g., DNA strain typing) of the transplanted/implanted item. SSI occurred in 90 cases where implants (includes non-biological) were used; 1.67% SSI rate for patients with implants (90 SSI in patients with implants/5400 operations where implants were used). The rate of SSI in patients where no implants were used was 2.17% (88 SSI in patients without implants/4046 operations where no implants were used).

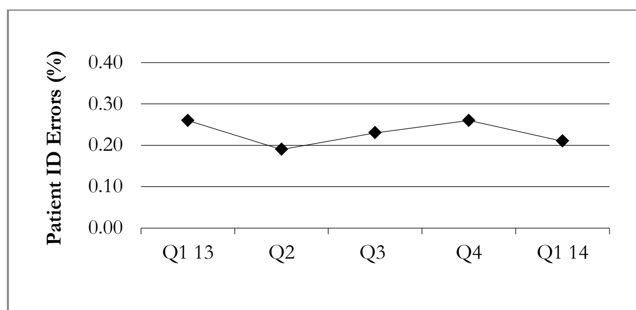
NEXT STEPS FOR FY2014-2015:

- Assist Tissue groups moving to Mission Bay (Milk bank, Pedi BMT, Reproductive, Surgical Implant) as needed for regulatory compliance
- Continue to provide a forum to share best practices at quarterly Tissue committee meetings

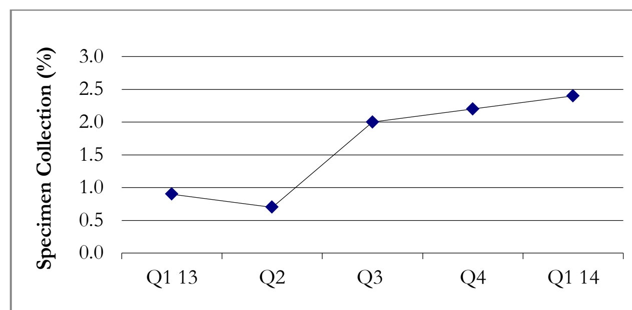
TRANSFUSION COMMITTEE

SPECIMEN ERRORS

The Blood Bank monitors specimen errors including near misses. As specimen collection and labeling errors were showing no decline despite significant retraining and other interventions, the Transfusion Committee collaborated with the Clinical Performance Improvement Committee, Department of Nursing, and the Patient Safety Committee in a system-wide effort to study the issues and identify solutions. Collection Manager, an electronic module for accurate specimen collection and labeling, was recently implemented at several locations to address specimen errors. Full representation is planned for FY2015.



Labeling errors with potentially serious adverse impact to recipient, discovered prior to testing and blood product selection/issue.



Specimen errors e.g., unsigned specimens or the wrong tube type. Specimens are rejected by the Blood Bank.

RBC TRANSFUSION GUIDELINES AND APEX CDS TOOL

Transfusion Committee reviewed AABB guidelines for RBC transfusion, obtained consensus from diverse clinical teams, incorporated requirements from interventional cardiology to satisfy standard of care in that setting; and made recommendations for RBC transfusion thresholds for adult patients. Guidelines endorsed by the UCSF Transfusion

Transfusion Committee (continued from previous page)

Service were adapted by the UCSF Caring Wisely and APeX teams for the design and content of a CDS tool for providers, with readily accessible hyperlinks to the guidelines and pertinent literature. This tool was successfully launched in October 2014 and is expected to reinforce appropriate RBC ordering practice, further reduce blood product utilization and decrease costs. APeX tools for capturing metrics will be developed and used for monitoring usage trends and identifying areas requiring targeted intervention.

TRANSFUSION SERVICE PROTOCOLS:

- **APeX-generated blood product pick up slips**: Redesigned in response to request from Patient Safety Committee. Improvements decrease ordering errors and bed-side nursing errors related to transfusions.
- **Blood product labeling errors**: Monitoring of batch printing of labels has decreased errors. Errors on modified labels will be further decreased by implementation of 'full face' labels in November 2014.
- **Laboratory Information System (LIS) upgrade:** LIS vendor is developing an electronic QA alert that triggers if blood products are allocated or issued prior to completion of testing for 2 independent ABOs.
- **Weak D testing of newborns:** A new QA report to accurately flag newborn samples was designed and two new checklists were implemented to ensure Rh negative mothers receive Rhogam, when appropriate.
- **Blood product selection for ABO-mismatched organ transplant:** Refinements were made to SOPs, notification forms and real-time communication between BB and Transplant Coordinators.
- **Massive Transfusion Protocol**: Refinements were made to Transfusion Service process for MTP; protocol posted on intranet and shared with providers, house staff and Nursing with a recommendation to incorporate material in new employee training/competency checklist and in APeX educational materials.

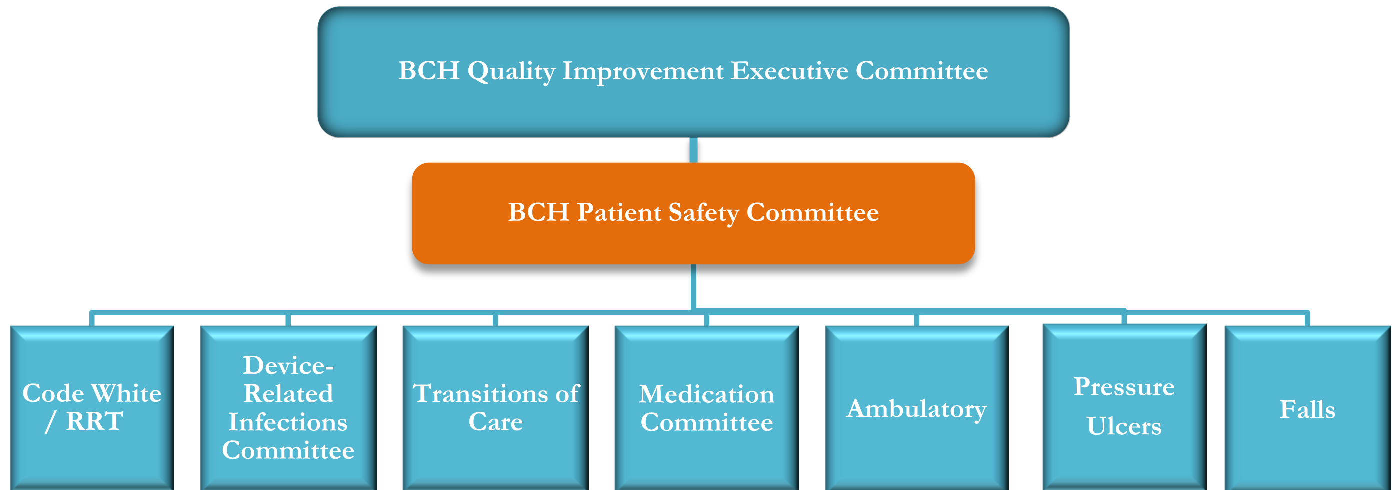
SOLID ORGAN TRANSPLANTATION PROCESS IMPROVEMENT:

- *Phases I-V:* Solid Organ Transplant Working Group developed a process and implemented these in 2012 and 2013
- *Phase VI:* Design and implementation of processes for storing, issuing and tracking disposition of vessels, to meet CMMS/UNOS requirements was successfully implemented in Feb 2014.

QUALITY COMMITTEES REPORTING TO THE BENIOFF CHILDREN'S HOSPITAL QUALITY IMPROVEMENT EXECUTIVE COMMITTEE (BCH QIEC)

BCH PATIENT SAFETY COMMITTEE

The Benioff Children's Hospital Patient Safety Committee (BCH PSC) provides oversight for the full range of patient safety issues and initiatives impacting patients throughout Benioff Children's Hospital and pediatric patients elsewhere in UCSF Medical Center. The committee analyzes information and facilitates change to support continuous improvement, ensure patient safety, and improve patient outcomes.



BCH PATIENT SAFETY COMMITTEE – AREAS OF LONGITUDINAL FOCUS:

- TPN Safety
- Transitions and Handoffs
- Breast Milk Management
- Opiate Safety
- Insulin-Related Issues
- Early Identification and Intervention for Acute Decompensation

FY2014 ACTIVITIES AND ACCOMPLISHMENTS:

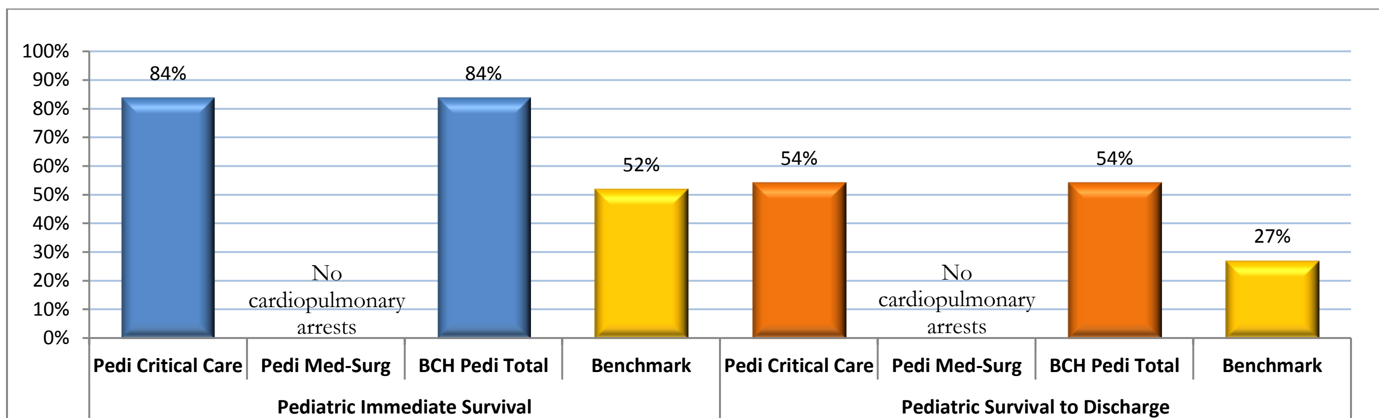
- Improved processes for TPN order verification and product checks.
- Developed guidelines for communication and accountability for care of diabetic patients admitted through the ED including a DKA protocol and insulin order sets.
- Developed an EMR based Pediatric Early Warning Scoring (PEWS) system with implementation scheduled for FY2015.
- Central lines: Participated in a study evaluating safety of reduced concentration heparin (10 units/ml vs. 100 units/ml) use in Port-a-caths; formally evaluated and recommended use of PICC line instead of midline catheters for patients receiving dihydroergotamine therapy resulting in improved efficacy and satisfaction; through collaborative efforts and sustained attention CLABSI rates in BCH decreased from 2.53 to 1.95/1000 line days – a 23% reduction.
- Collaboration between OHNS, Medicine and Case Management led to an organized process for care and discharge of the pediatric patient receiving a tracheostomy.
- Hospital-Acquired Pressure Ulcer rate was ***zero*** in FY2014.
- New processes and policies were developed in collaboration with Child Psychiatry, Nursing and Emergency Medicine for the disposition of and consultation for pediatric and adolescent patients with psychiatric or behavioral issues.
- Evaluated/adopted new standard of using a single aerobic bottle with blood cultures and reduced sample volumes.
- Process improvements were implemented to improve care of patients receiving spinal fusions including order set revisions, standardization of neuro assessments, and reliable handoffs between nursing and physicians.
- Process improvements were implemented for anesthesia consults, handoffs between Anesthesia and ICU and assuring Cardiac Anesthesia specialists for procedures done with patients with congenital heart disease.

BCH CODE WHITE AND RAPID RESPONSE TEAM

There are two teams at Benioff Children's Hospital that respond to acute changes in patients' conditions: Code White Team and Rapid Response Team (RRT). The Code White team responds to potentially life-threating medical emergencies such as cardiopulmonary arrest. It consists of a Pediatric Intensive Care (PICU) attending physician, a PICU Fellow, a PICU Charge RN, a pediatric respiratory care practitioner (RCP), a pediatric resident, the pediatric RN supervisor, and a pediatric pharmacist. The Rapid Response Team responds to acute changes, which are assessed as not immediately life-threatening, but warranting urgent assessment and treatment. The team consists of: Pediatric Critical Care Attending/Fellow MD, Critical Care Charge RN, and Critical Care RT. The BCH RRT is an additional safety net that provides immediate assistance to any family/staff member who is concerned that a patient is deteriorating. The RRT is an adjunct and not a substitute for the patient's primary attending or team.

ONGOING MONITORING AND QI:

- The Code White/RRT Committee oversees the policies, procedures and performances of the Code White Team and the Rapid Response Team (RRT).
- The Committee systematically tracks and evaluates performance on multiple quality metrics, including the number of code team activations by location and their outcomes, and the volume, reasons and outcomes of RRT events.
- All codes and RRT calls are reviewed to identify any opportunities to improve the care process and reduce the likelihood of codes.
- RRT calls are evaluated.
- In fiscal year 2014 there were no cardiopulmonary arrests in pediatric acute care units. Patient survival rates from cardiopulmonary arrest (CPA) at BCH exceed the National benchmarks both in the immediate success rate in returning spontaneous circulation in a patient who has suffered CPA and the survival rate at discharge.



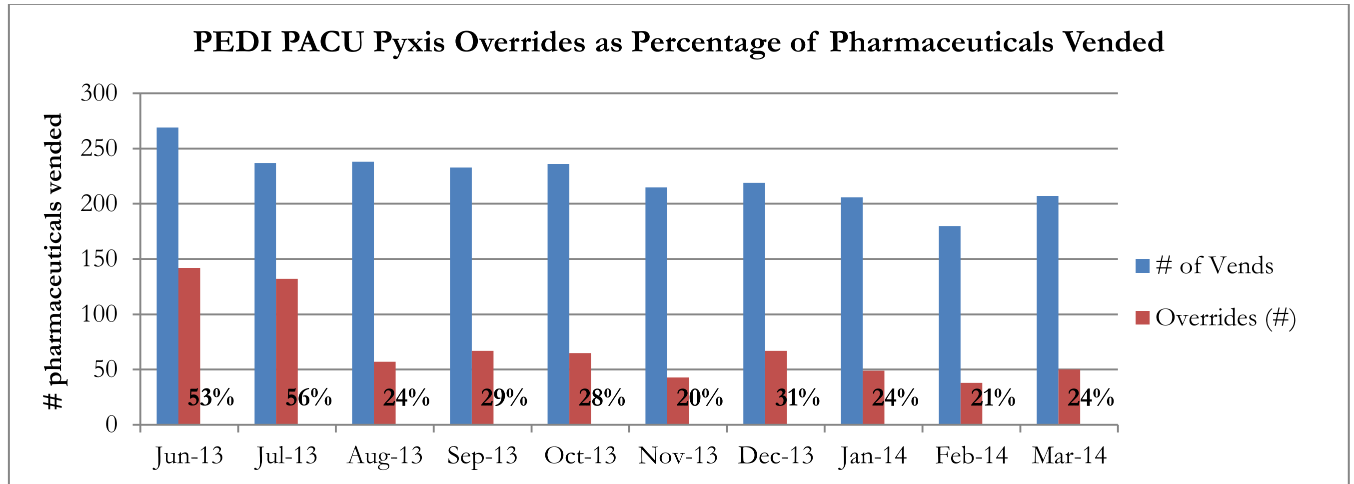
ACTIVITIES AND ACCOMPLISHMENTS:

- All codes are reviewed to identify any opportunities to improve the care process and reduce the likelihood of codes.
- Developing a family presence during codes policy for UCSF Benioff Children's Hospital to articulate that family may be present and specify the support they will receive from staff.
- Developed a RRT flowsheet to reduce the manual work of generating the RRT dashboard.
- Surveyed RRT customers to identify knowledge gaps in preparation for revisions of staff education modules.

BCH MEDICATION COMMITTEE

FY2014 ACTIVITIES AND ACCOMPLISHMENTS:

- Ensure safe and complete transition of all clinical and operational pharmacy services to Mission Bay
- Reduction in Pediatric PACU Override Rate



- Updated BCH Pyxis Override List
- TPN Ordering Process Reform:
  - Implemented HARD & SOFT limits for TPN additives and macro & micro nutrients
  - Developed new Medical Center approved TPN P&P and Ordering Guidelines (teamed with Nutrition & Food Services)
- Updated BCH Pediatric & Neonatal Weight Based Dose Policy and Procedures
- Developed Medical Center approved BCH Hypertonic Saline Guidelines
- Developed Medical Center approved BCH Ethanol Lock Guidelines
- Standardization of IV Intermittent Potassium Chloride (KCl) infusion rates and concentrations for peripheral and central catheter administration
- New BCH ECLS interdisciplinary workflow process for the PCICU & PICU
- Standardization of preparation and administration of Pedi Transport Medication in the field consistent with inpatient practices
- Remodeled 7th floor Pharmacy satellite

OTHER SAFETY INITIATIVES IN PROGRESS:

- PCICU Medication Drips for adult congenital heart patients (in progress)
  - Align and implement safer strategies to provide adult dosing options in APeX with acceptable standardized drug concentrations and Alaris SMART pump technology
- Increase Alaris® Guardrails SMART Pump Drug Library Compliance rate (in progress)
- Development of standardized procedures for the preparation and administration of low dose/low infusion rate Insulin in BCH (in progress)

INTEGRATED PEDIATRIC PAIN AND PALLIATIVE CARE: IP-3

IP-3 is a combined pain and palliative care service, staffed with pediatric anesthesiologists, integrative pain specialists, and palliative care specialists. There is a Nurse Practitioner who coordinates care and bridges services. The program has the support of Child Life and the Department of Pharmacy.

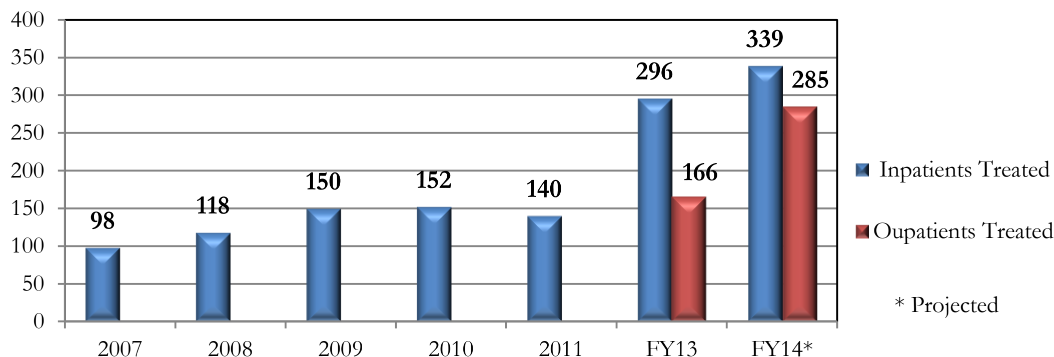
FIVE COMPONENTS OF IP-3:

- IP-3 Consult Service (inpatient pain and palliative care consults)
- Compass Care (longitudinal care coordination, bereavement, remembrance events, and staff education)
- Integrative symptom management (acupuncture, acupressure, biofeedback, canine therapy)
- Outpatient IP-3 Clinic (chronic pain and symptom management, complex care clinic)
- Sedation Service

The IP-3 program has seen steady growth in both volume and scope. It now offers comprehensive pain prevention and treatment, symptom management, care coordination, and bereavement services to pediatric and perinatal patients. Providing an innovative spectrum of services ranging from acute post-operative pain management to comprehensive care coordination services, IP-3 provides innovative multidisciplinary care across the continuum.

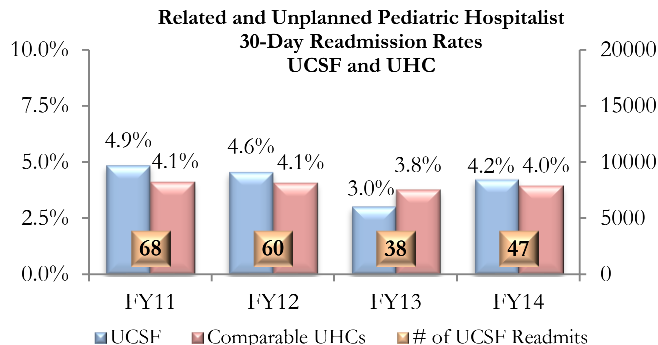
SCOPE OF SERVICES:

- Pain management
- Procedural sedation
- Palliative Care consultation
- Complex Care (outpatient)
- Family support
- Bereavement services
- Clinical guideline & policy development
- Education & training
- Community collaboration
- Integrative symptom management: acupuncture, acupressure, biofeedback, canine therapy, and other non-pharmacologic modalities



PEDIATRIC TRANSITIONS OF CARE TASK FORCE

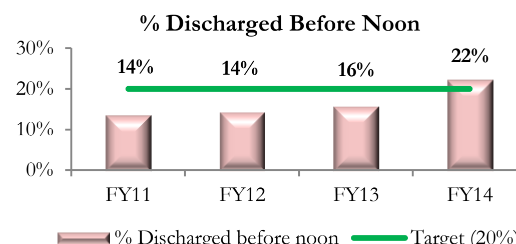
The Pediatric Transitions of Care Task Force was created to improve care transitions at UCSF Benioff Children's Hospital. Safe care transitions require effective communication about a patient's hospital stay and healthcare needs between the hospital team and those caring for that patient after they leave the hospital - both the patient's family and the outpatient medical providers. Since inception, the task force has focused on piloting interventions to improve care for the Pediatric Hospital Medicine service patient population. These interventions have positively impacted pediatric readmission rates.



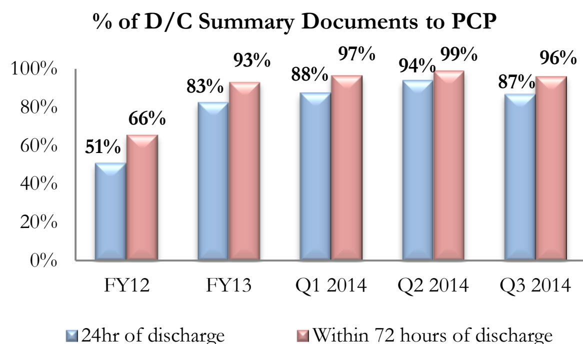
TASK FORCE INTERVENTIONS:

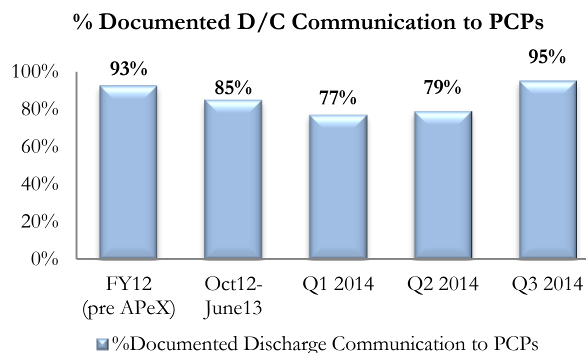
- **Family-Centered Rounds** – Family Centered Rounding (FCR) was implemented to enable families and caregivers of pediatric patients to participate actively in multidisciplinary discussions about the care of their child, involving hospitalists, specialists, nurses, pharmacists, and other key team members. Patients are responding positively and report that they "feel more involved in the care plan" and "have better access to complete information."

- **Discharge Planning** – Internally, the Pediatric Hospital Medicine service has made efforts to expedite discharges so that there is less wait-time for patients and families at UCSF Benioff Children's Hospital. Care teams have set aside two times during the day: the "morning huddle" and "afternoon tee time," to meet and plan the present and following day's discharges. The care team reviews which patients are ready to be discharged, and makes sure all necessary orders and paperwork are completed.



- **PCP Follow-up Phone Calls and Auto-Faxing of Discharge Summaries** – One of the task force goals was to increase the reliability and timeliness of verbal and written Primary Care Physician (PCP) handoffs. This is how the hospital relays information about a patient's progress to his or her PCP. Residents complete follow-up phone calls to PCPs after discharge, which are documented in our electronic medical record. In addition, there has been a targeted effort to have discharge summaries completed as soon after discharge as possible and get them in the hands of PCPs before the patient's first follow-up appointment. Automated faxing of discharge summaries was initiated in the 3rd quarter of 2012, eliminating delays based on manual transmittal or mailing. Percent of summaries transmitted has continued to improve.

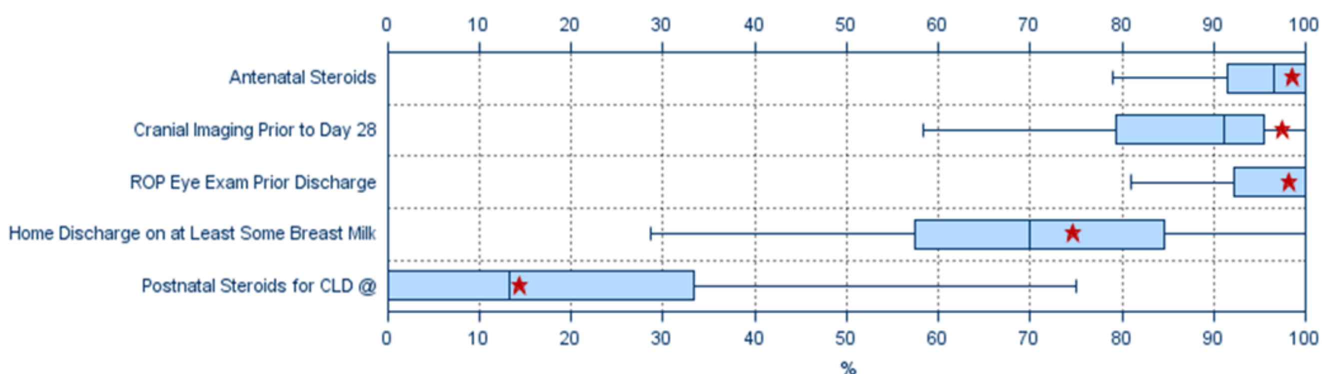




- **Family/Caregiver Follow-up Phone Calls –** Patient case managers make an attempt to reach all patients by phone after they are discharged (preferably within 72 hours). This provides patients with the opportunity to answer questions, and set follow-up appointments. At the same time, the case manager can connect patients to resources and assess the caregiver's understanding of discharge instructions. UCSF uses this feedback to continuously improve provider communication with patients.

THE CALIFORNIA PERINATAL QUALITY CARE COLLABORATIVE (CPQCC)

UCSF participates in the California Perinatal Quality Care Collaborative (CPQCC) which is an outgrowth of a 1997 initiative proposed by the California Association of Neonatologists (CAN). The initial focus of the Collaborative was the development of perinatal and neonatal outcomes and information, which allowed for data driven performance improvement and benchmarking throughout California. The Collaborative has expanded to include process metrics important to understand hospitals' performances in the care of infants with very low birth weights (400-1500 grams) and or extreme prematurity (22-29 weeks gestational age).



This graph shows the percentage of infants who received the listed interventions/experienced the listed outcome. The distribution of the percentage across the CPQCC network is displayed as a horizontal box plot for each outcome. The box plot displays the lower and upper quartile of the percentage across the CPQCC network as the left and right boundary of the blue box. This means that 25% of CPQCC NICUs have a percentage that is lower than the lower quartile (left box boundary), and 25% of CPQCC NICUs have a percentage that is higher than the upper quartile (right box boundary). The median percentage across CPQCC NICUs is displayed as a vertical bar. The box plot also shows the minimum and maximum outcome percentage across the comparison group that is within the lower and upper fence. The red star represents the percentage of infants receiving the listed intervention/experienced the listed outcome at UCSF. Higher percentages indicate better performance for compliance in antenatal steroids, cranial imaging prior to day 28, retinopathy of prematurity (ROP) eye exam prior to discharge, and home discharge on at least some breast milk. UCSF Benioff Children's Hospital performs better than most CPQCC hospitals in these measures. Conversely, a lower rate indicates better performance for use of postnatal steroids for chronic lung disease. UCSF is similar to peer hospitals on this measure.

PATIENT EXPERIENCE

MEDICAL CENTER PATIENT EXPERIENCE GOAL

The UCSF patient experience incentive award program goal for FY2014 had two components equally weighted: achievement on the Press Ganey Likelihood of Recommending question (50%) and on the HCAHPS survey domains (50%). For Press Ganey, UCSF achieved a combined mean score of 92.4 for 4th quarter of fiscal year 2014, exceeding the outstanding level. For HCAHPS, UCSF achieved an average of the 60th percentile for all HCAHPS domains in the 4th quarter, achieving the target level of the goal. Details of the results are outlined below:

Press Ganey LIKELIHOOD OF RECOMMENDING Dashboard

Press Ganey Survey	Quarterly							
	Jul-Sep13 (n=5771)		Oct-Dec13 (n=5786)		Jan-Mar14 (n=6346)		Apr-Jun14 (n=19227)	
	Mean FINAL	%ile	Mean FINAL	%ile	Mean FINAL	%ile	Mean FINAL	%ile
Outpatient Medical Practices	92.4	28	92.6	29	93.0	36	92.6	31
Adult Inpatient	92.8	83	93.1	84	93.4	86	93.0	83
Pediatric Inpatient	90.9	38	95.4	92	93.2	67	90.9	37
Emergency Department	84.8	50	86.5	64	83.9	45	85.3	51
Combined Mean/%ile	92.3	41	92.4	43	92.7	47	**92.4**	36

HCAHPS Domain Dashboard

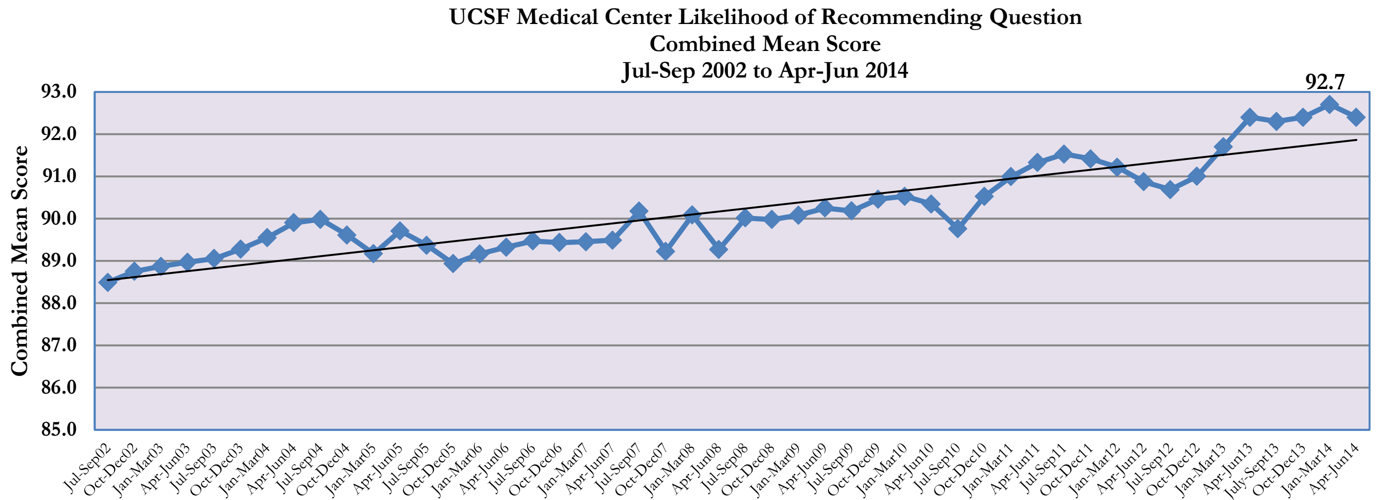
HCAHPS Survey Domain	Quarterly							
	Jul-Sep13 (n=1246)		Oct-Dec13 (n=1251)		Jan-Mar14 (n=1308)		Apr-Jun14 (n=931)	
	Top Box FINAL	%ile	Top Box FINAL	%ile	Top Box FINAL	%ile	Top Box FINAL	%ile
Rate hospital 0-10	77	78	75	70	75	70	76	73
Communication w/ Nurses	79	53	78	42	80	55	81	66
Responsiveness of Hospital Staff	0	26	62	30	63	37	67	55
Communication w/ Doctors	82	63	82	55	83	66	82	61
Hospital Environment	61	22	60	22	59	19	63	34
Pain Management	71	28	69	31	73	60	72	55
Communication About Medicines	66	66	67	72	65	59	66	64
Discharge Information	89	78	90	83	90	85	89	74
Average %tile of all Domains		53		51		59		**60**

PRESS GANEY PATIENT EXPERIENCE SURVEY RESULTS

UCSF Medical Center and UCSF Benioff Children's Hospital have been actively eliciting feedback from patients since the early 1980's and before it was commonplace. Today, UCSF sends approximately 350,000 patient experience surveys a year. The survey information is used to evaluate the patient's experience, track progress, and identify areas for improvement. The medical center partners with the survey firm, Press Ganey Associates, Inc. to conduct weekly surveys of all hospital and Home Health patients and to a sampling of clinic patients. Surveys are sent via email or mail by Press Ganey to patients within a few days after being discharged from the hospital or after a clinic visit.

UCSF's quarterly score has improved from 88.5 in 2002 to a high of 92.7 in the third quarter of 2014 based on patient responses to the survey question "Likelihood of your recommending this hospital to others?" as outlined on the graph below. Our staff works diligently to ensure each and every patient's experience is a positive one, and we welcome and encourage any feedback from patients to assist us in identifying areas where we might improve. UCSF staff's dedication to the patient experience has helped us achieve and maintain our standing as one of the Top 10 hospitals in the country.

Medical Center Patient Experience Goal (continued from previous page)



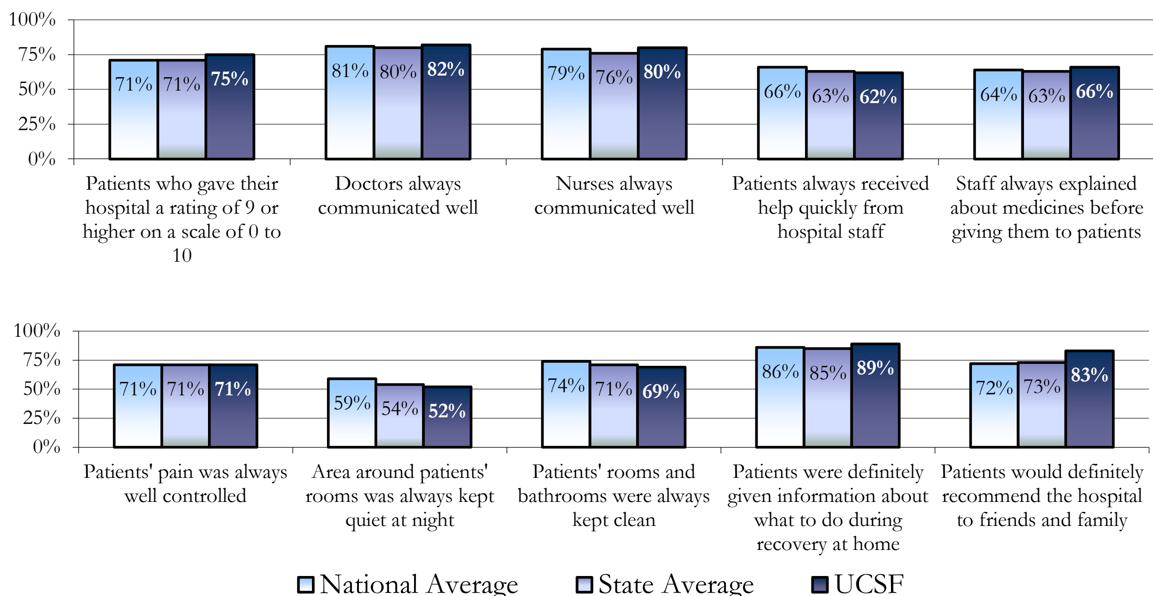
HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS & SYSTEM (HCAHPS)

UCSF Medical Center participates in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, sponsored by the Centers for Medicare and Medicaid Services (CMS).

The HCAHPS Survey is composed of 18 patient rating and patient perspectives on care items that encompass seven key topics: communication with doctors, communication with nurses, responsiveness of hospital staff, cleanliness and quietness of hospital environment, pain management, communication about medicines, and discharge information. Two overall rating questions are also captured: recommend the hospital and overall hospital rating. Effective July 2011, performance on the HCAHPS survey impacts Medicare reimbursement via CMS' Value Based Purchasing program.

HCAHPS JULY 2013 – JUNE 2014 DATA COLLECTION SUMMARY OF PERFORMANCE

UCSF Medical Center has consistently scored above average on the Overall Hospital Rating and the Recommend Hospital questions as compared to State and National hospitals. Results are reported as a "top box" score – percent of patients who rated UCSF at the highest level.



COMPLAINTS AND GRIEVANCES

Complaints and grievance trends are based on patient feedback reported to the Patient Relations department directly from patients or their representatives or from patients who wish to discuss concerns after they have received a discharge call. They are tracked and reported to the Culture of Excellence Committee, QIEC, and used for the Committee on Professionalism and Physician Advocacy Program (PARS), the physician ongoing professional performance evaluation, and other venues on a regular basis.

- **Compliance Rate FY2014:** Our policy goal is to close complaints and grievances within 30 days.
  - **(171) Grievances** **72%** closed in 30 days or less
  - **(1,985) Complaints** **97%** closed in 30 days or less
- Average number of days to close a grievance = 23 Days
- Average number of days to close a complaint = 8 days

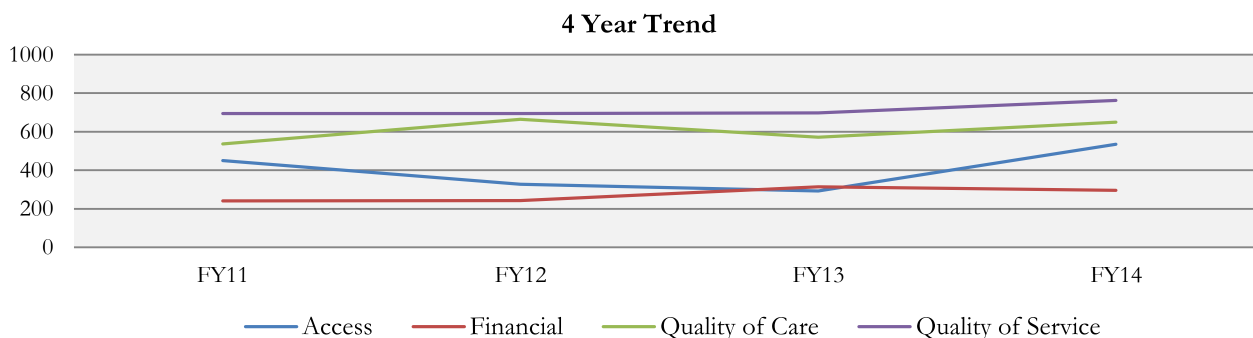
COMPLAINT/GRIEVANCE TRENDS

Grievances have trended down slightly and complaints up slightly. Complaints resolved at the time of service remain complaints, whereas complaints not resolved at the time of service can turn into to grievances. Consultations have leveled off. Staff is comfortable implementing service recovery they have learned. Amendments have increased due to MyChart access.

Classification	FY2013	FY2014	Difference +/-	% Change Trend
Grievance	197	171	26↘	13%↘
Complaints	1713	1985	272↗	16%↗
Compliments	203	149	54↘	27%↘
Consults/Assistance	534	530	4↘	0
Amendment Request	29	45	16↗	55%↗
Total:	2676	2880	204	7.5%

In summary, communication breakdowns remain at the root of most complaints and grievances. Patient Relations acting in a consultative role is showing positive results as reflected in a downward trend in Grievance volume and consultations, demonstrating staff consistently reaching out for coaching through difficult situations. Downward trends illustrate that proactive measures such as partnerships with discharge phone call programs, coaching staff prior to difficult conversations, rounding and Every Day Pride classes has impacted the severity of issues reported. Greater patient satisfaction can be achieved early in the process with patient centered care and the right service recovery techniques across the continuum.

A. TREND BY TYPE



Complaints and Grievances (continued from previous page)

The graph above reflects the majority of patient concerns are related to Quality of Service, (attitude/courtesy) Quality of Care and Access (ability to get an appointment or reach someone on the telephone), and financial (incorrect insurance billing, longs waits on the phone, attitude and courtesy of staff).

- Quality of Service is trending upward, and Quality of Care dipped in FY2013 and however began trending back up Q2 FY2014.
- Finance complaints show a steady decrease over the last 4 quarters. Single Billing Office (SBO) worked hard to reduce the abandonment rate of calls from 15.8% (1,404 calls) in December 2013 to a current 0.8% (57 calls) in September 2014. SBO improved phone systems to efficiently route callers and provide information, eliminating the need to wait in the phone queue to speak to a representative. Improved the on-line access for routine inquiries (PFS e-mail) and bill payment (Patient Compass). SBO analyzed their department complaint data and conducted RCA, in partnership with the IT APeX team. Increased targeted training in partnership with Ambulatory Services Administrators for front-end users. Finalizing new design of new patient statement.
- Access spiked Q2FY2014 due to a one-time Radiology need for Patient Relations to assist with phone access, and plateaued slightly higher than it had been prior to the peak FY2011.

B. TRENDS BY STAFF TYPE

AIDET classes, bedside handoffs, hourly rounding all contribute to communication skills which reduced issues for the Department of Nursing. Physician category shows a small increase partially due to PARS coding requirement to identify each physician by name; mostly due to RL 6 data base now including all providers, (Physicians, NP, PA and Residents) in the same category. Support staff increased due to issues related to courtesy and responsiveness.

	Q3-Q4 2013	Q1-Q2 2014	Difference +/-	%Change
Physicians, NPs, PAs & Residents	271	286	15	5%↗
Nursing	32	26	6	18%↘
Support Staff	43	62	19	44%↗

Actions:

Trend data is evaluated with patient satisfaction data and used to identify improvement opportunities. Individual complaints and grievances are thoroughly reviewed by the staff involved in the care and their superiors as needed, and responded to in real time. Escalation to the multi-disciplinary Grievance Oversight Team (GOT) weekly meeting assures a higher level review and response to complex grievances. Individualized and automated reports are regularly distributed to departments. Patient Relations provides improvement coaching based on low performing areas.

CULTURE OF EXCELLENCE COMMITTEE

The goal of the committee is to create an environment and culture at UCSF Medical Center and UCSF Benioff Children's Hospital where all employees feel valued and inspired, healthcare providers believe their patients are receiving the best care possible, and patients feel the quality of their care and service is excellent.

Living PRIDE is our organizational drive towards a Culture of Excellence focusing on patient, provider and employee experience.

ACTIVITIES AND ACCOMPLISHMENTS:

- Completed 21 AIDET Supersessions, providing training to over 450 staff
- Completed 134 AIDET Simulation Labs, offering individualized coaching to over 400 staff
- Nursing Hourly Rounding rolled out to inpatient units
- Nurse Leader Rounding for Outcomes on Patients: Pilot of iRounding Tool
- Patient Passport piloted on Medicine unit
- Roll out of Automated Post Discharge Phone Call Program
- Upgraded and standardized database for benchmarking complaint and grievance trends system wide at the 5 UC Health campuses
- Roll out of online performance management tool, ePerformance
- Employee Engagement survey conducted in Spring, follow-up training on action planning in Summer 2014
- Revision of NEO onboarding with emphasis on culture development, E-learning modules for required regulatory courses completed
- Continued roll-out of LEAN Reach for Excellence Training
- Produced Living PRIDE-related training videos for physicians and staff
- Provided over 200 consultations and presentations/training to departments on the patient experience
- Co-produced four Living PRIDE Institutes (LPI's)
- Continued Ambulatory Services New and Existing Employee Customer Care class
- Expansion of sound masking device program to improve quietness for patients
- "Have a Seat" program expansion in progress on nursing units to encourage providers to sit while talking with patients
- Patient Relations and Volunteer Rounding program expansion to additional nursing units and some medical practices.
- Increased number of Physician Champions from 20 to 76
- Held first Physician Living PRIDE Retreat bringing over 40 providers together
- AIDET SMiLe for physicians ***(2600 Completions)***
- New Medical Director of Patient and Provider Experience, role expanded to .5 FTE to continue to drive improvement efforts starting FY 15
- Launched Living PRIDE newsletter for providers (2 issues)
- Streamlined Patient Satisfaction Reporting at Continuous Performance Improvement Committee (CPIC) for all departments
- Improved provider communication scores in all clinical service areas (adult inpatient 53rd to 61st %ile, inpatient pediatrics 72nd to 73rd %ile, ED 60th to 68th %ile, outpatient 18th to 25th%ile)
- Living PRIDE presentations to 20 Clinical Service areas via Grand Rounds, faculty meetings, individualized leader meetings
- Analyzed and shared Press Ganey Patient Satisfaction comment summary reviews with adult inpatient service leaders and Living PRIDE champions
- Created process to share patient feedback from volunteer rounding directly with providers
- Won Press Ganey Success Story Award for National Conference 2014

PATIENT SATISFACTION SURVEYS

- E-surveying of patients in Ambulatory Services and Emergency Department initiated

Culture of Excellence Committee (continued from previous page)

DIVERSITY AND INCLUSION

- UCSF Medical Center achieved National Leader status for the 7th year in a row on the Annual LGBT Health Equity Index
- Collaboration with campus LGBT and Diversity manager to enhance climate of diversity and inclusion for patients, families, and staff
- Created Diversity website on UCSFhealth.org
- Partnered with UCSF stakeholders/external best practice resources to outline plan for APeX documentation related to LGBT needs
- Co-sponsored LGBT Health Awareness Day with campus
- Evaluated patient satisfaction among special needs patients: LGBT, Culture and Race, Disabilities
- Linguistic & Cultural Competency Certification Program for Providers begun
- Video Medical Interpreting roll out launched

OTHER

- UC system-wide collaboration: Neurosurgical Focus Group to standardize care to improve outcomes and the patient experience
- Patient Education: 3,000 UCSF internal materials uploaded into APeX
- EMMI (Expectant Management and Medical Information) has been implemented in over 20 areas, including an automated BATCH issuance of EMMI
- Rolled out Patient Advocacy Reporting System (PARS), a peer mentoring and messengering program that assists physicians who are at risk for malpractice claims based on patient complaint data
- Outpatient Hepatology Practice: 360 degree evaluation with results of increased patient and staff engagement and decreased wait times
- The annual Voice of the Patient Awards recognized the following areas for their patient experience efforts in FY14:
  - Highest performing units/practices:

Inpatient	***Outpatient***
11 Long	Neuro-Oncology
5 North Mount Zion	Pediatric Heart Center
9 Long	Urologic Medicine – Cancer Center
7 North	Head & Neck Surgery – Cancer Center

  - Most improved units/practices:

Inpatient	***Outpatient***
15 ICN	Occupational Health at Mount Zion
7 Long	Pediatric Orthopedics
12 Long	Pediatric Surgery

CONTACT INFORMATION AND ACKNOWLEDGEMENTS

This annual report was compiled from information presented at the Clinical Performance Improvement Committee (CPIC), Quality Improvement Executive Committee (QIEC), Patient Safety Committee, and the BCH Quality Improvement Executive Committee (BCHQIEC) meetings between July 2013 and June 2014.

For questions regarding report content, contact:
- QIEC: Patient Safety and Quality, Brigid Ide, brigid.ide@ucsf.edu
- CPIC: Quality Improvement Department, Joy Pao, joy.pao@ucsf.edu
- Benioff Children's Hospital (BCH) QIEC: CH Quality, Paul Monsees, Stephen.Monsees@ucsf.edu
- Delivery System Reform Incentive Pool Program: Gina Intinarelli, Gina.Intinarelli@ucsf.edu

Referenced information within this report can be obtained from:
- California Nursing Outcomes Coalition (subscription required) www.calnoc.org
- Centers for Medicare and Medicaid Services www.cms.gov
- CMS Hospital Compare www.hospitalcompare.hhs.gov
- The Joint Commission www.jointcommission.org
- The Leapfrog Group www.leapfroggroup.org
- The Office of Statewide Health Planning and Development www.oshpd.cahwnet.gov
- Press Ganey Associates (subscription required) www.pressganey.com
- The University HealthSystem Consortium (subscription required) www.uhc.edu
- U.S. News & World Report www.usnews.com

The following committee chairs and staff contributed to this report:
- Accountable Care Organizations: Ami Parekh MD, JD, Adrienne Green, MD and Sara Coleman
- Adult Critical Care Committee: Matt Aldrich MD and Jenifer Twiford
- Benioff Children's Hospital Code Blue Committee: Maurice Zwass MD and Shelley Diane
- Benioff Children's Hospital Medication Committee: Julie Wilson-Ganz PharmD, Steve Wilson MD, PhD and Kim Scurr
- Benioff Children's Hospital Patient Safety Committee: Steve Wilson MD, PhD and Jim Stotts
- Benioff Children's Hospital QIEC: Steve Wilson MD, PhD and Paul Monsees
- Benioff Children's Hospital Rapid Response Committee: Steve Wilson MD, PhD and Shelley Diane
- Cancer Committee: Lee-May Chen MD, Gerrie Shields, Ann Griffin and My Nguy
- Clinical Performance Improvement Committee (CPIC): Ryutaro Hirose MD, Paul Brakeman, MD, PhD and Joy Pao
- Code Blue Committee/Rapid Response: Matt Aldrich MD and Jenifer Twiford
- Complaints and Grievances: Deborah Avakian, Christine Diamond, Susan Alves-Rankin, and Susan Ritter
- Culture of Excellence Committee: Mark Laret, Josh Adler MD, Diane Sliwka MD, Kathleen Balestreri, Deborah Avakian, Susan Ritter, Rachael Moore, and Frances Flannery
- Diabetes and Insulin Management Committee: Robert Rushakoff MD, Umesh Masharani MD, and Janice Hull
- Environment of Care Committee: Matthew Carlson
- Ethics Committee: Scott Andy Josephson MD
- Failure Mode and Effect Analysis (FMEA): Jim Stotts
- Infection Control Committee: Peggy Weintrub MD, Catherine Liu MD and Amy Nichols
- Leapfrog Group Survey: Brigid Ide and Ivy Kolvan
- Medical Records Committee: Michelle Mourad MD, Seth Bokser MD and SheRee Garcia
- MyChart: Pam Hudson and Brian Cosgrove
- National Surgical Quality Improvement Program (NSQIP): Mary McGrath MD, Tennille Parsons, and Yanina Stanislavskaya
- Nursing-Sensitive Indicators: Maureen Buick, Wendy Abbott, Carrie Meer, Mary Moore, and Tricia Ochoa
- Operating Room Committee: Nancy Ascher MD, PhD, Errol Lobo MD, PhD, Joann Rickley, Erika Grace and Julio Barba

Contact Information and Acknowledgements (continued from previous page)

- Pain Committee: Mark Schumacher MD, PhD and Jenifer Twiford
- Patient Safety Committee: Adrienne Green MD and Jim Stotts
- Pediatric Pain and Palliative Care Program: IP-3: Karen Sun MD
- Patient Experience: Deborah Avakian, Susan Alves-Rankin, Jason Phillips, and Susan Ritter
- Quality Improvement Executive Committee: Mari-Paule Thiet MD and Brigid Ide
- Quality Landscape: Brigid Ide, Joy Pao, Carla Graf, and Gina Intinarelli
- Risk Management Committee: Neal Cohen MD and Susan Penney
- Sedation Committee: Gail Shibata MD and Jenifer Twiford
- Surgical Case and Hospital Mortality Review Committee (SCHMRC): Philip Ursell MD and Rosanne Rappazini
- Transfusion Committee: Ashok Nambiar MD, John Feiner MD and Julio Barba
- Tissue Committee: Mort Cowan MD, Delene Johnson, and Julio Barba
- UCSF Patient & Family-Centered Rounds (PFCR): Arpi Bekmezian MD
- Utilization Management Committee: Adrienne Green MD and Elizabeth Polek
- U.S. News & World Report: "America's Best Hospitals": Joy Pao
- U.S. News & World Report : "Best Children's Hospitals": Paul Monsees and Kim Scurr
- Technical Work/Report Production: Dhemy Padilla

FY15 ORGANIZATIONAL GOALS

Quality and Safety (25%)

During the FY15 influenza season, improve overall compliance with influenza vaccination at UCSF:

Tactics

1) Increase inpatient vaccinations to 90% (3 of 6 months)
2) Increase Primary Care vaccinations to 51%
3) Maintain Faculty, Staff and Residents vaccinations at >95%

Measurement:

- Threshold: Achieve one of three tactics
- Target: Achieve two of three tactics
- Outstanding: Achieve three of three tactics

Patient Experience (25%)

On the HCAHPS and CGCAHPS survey question; "would you recommend to your family & friends" achieve the following average result for the last quarter (50%):

- Threshold: 87% of patients rated "yes definitely"
- Target: 88% of patients rated "yes definitely"
- Outstanding: 89% of patients rated "yes definitely"

Increase the percentage of practices for which 75% of new patients are seen within 14 days of requesting an appointment (baseline 18% of practices) (50%):

- Threshold: 57%
- Target: 59%
- Outstanding: 61%

Finance and Operations (25%)

1. Outpatient adjusted discharges (50%):
   - Threshold : Budget
   - Target: Budget plus .5%
   - Outstanding: Budget plus 1%
2. Operating Income (50%) (exclusive of pension changes):
   - Threshold : Reach budget
   - Target: Better than budget by $ 7,000,000
   - Outstanding: Better than budget by $14,000,000

- Department Goal: 25%

FY15 OPERATIONS WORKPLAN

Quality and Safety: Continuously pursuing actions that support safe care and quality outcomes

Decrease sepsis mortality by 10% from FY14 baseline of 12.63% to 11.37%

Reduce hospital- acquired infections:

- Decrease CAUTI by 10% from 1.63 to a rate of 1.47
- Decrease CLABSI by 5% from 1.13 to a rate of 1.07

Reduce Readmission by 1.5% in FY15

Decrease HAPU rate to an average of <1.1 for the rate for DSRIP population

Full implementation of Discharge Phone Calls across the organization

Improve patient flow with 20% of patients Discharged Before Noon for 6 of 12 months

Implement Unit-Based Leadership Groups on 5 inpatient units and 5 clinics

Develop and implement wave 1 of CPI training plan

Improve patient safety through dissemination of a monthly summary of recent errors

Service: Improve the patient experience

Plan and execute Annual Living PRIDE Institute focused on accountability for performance (High/Middle/Low) *and* hardwire Living PRIDE initiatives

- Rounding & Monthly Meeting Model
- Physician Engagement/Survey
- Implement QlikView dashboard

Develop a model for alignment of patient/staff/provider experience with Continuous Process Improvement (CPI) Unit-Based Leadership Groups

People: Improving employee engagement and staff development

Ensure competency and timely staffing of Mission Bay by having 90% of staff trained and 50% of net new staff on-boarded by December 2014 in preparation for opening of Mission Bay

20 additional leaders will complete Lean Leader certification. Value stream improvement along 8 value streams, initial 5 carrying over from FY14

5% reduction in workplace injuries over the next two years

Engagement survey with .15 target improvement in the Accountability Index

Operations: Increase efficiencies and reduce costs

Open Mission Bay Hospitals on time – February 1, 2015

New Health System organization structure will be implemented

Secure OSHPD building permits by December 2014 for Nursing units on Moffitt/Long: 7, 11, 12, 15 and begin construction on Moffitt/Long 7 and 15 by February 2015

Integrate 1st phase of operations across pediatric enterprise - UCSF Benioff Children's Hospitals to achieve maximum efficiencies and alignment

Complete integration of Langley Porter Hospital and Clinics into the Health System by June 30, 2015

Growth: Grow services and Patient volume

ACO:

- Implement care management program for ACO patients
- Establish ACO joint venture with regional ACO partners

Network Development:

- Sign agreements for clinical services provision with 2 hospital organizations
- Finalize definitive agreement for East Bay Health System collaboration
- Complete business plan and legal structure for Adult Medical Foundation

Destination Programs:

- Implement 4-5 Destination Program Action Plans and associated dashboards

Post-acute:

- Develop and implement one post-acute contractual agreement

Implement Funds Flow:

- Remove financial barriers that have created disincentives for growing patient volume. Increase outpatient visits 5% by increasing faculty practice capacity and decreasing patient wait times for appointments.