Performance Improvement Annual Report

July 2012 - June 2013

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

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 2013 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 ranking rose to #7 in U.S. News & World Report)
- UCSF Medical Center Focus (e.g., Quality and Patient Safety goals for 2013 were achieved)
- Quality and Mortality Focus and Nursing Focus (CMI and HAPU improvements)
- Benioff Children's Hospital had 9 specialties nationally ranked in the U.S. News & World Report
- NSQIP rates for SSI and DVT/PE significantly reduced from FY2012

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.

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

Table of Contents

EXECUTIVE SUMMARY

Committees that report through the quality structure to Quality Improvement Executive Committee (QIEC) were asked to evaluate their work against defined indicators and targets. This focus on performance improvement has helped to drive efforts towards achieving excellence. A summary of the Fiscal Year 2013 organizational-wide quality and patient safety activities as defined in the UCSF Performance Improvement Plan is presented in this report; below is a high level assessment of key improvement efforts.

OUTSTANDING PERFORMANCE

NATIONAL AND CALIFORNIA STAGES

- U.S. News & World Report: America's Best Hospitals, UCSF Medical Center ranking rose to #7
- Accomplished all DSRIP milestones for FY 2013
- Achieved three year The Joint Commission (TJC) Accreditation for the Hospital and Home Care
- Achieved TJC disease specific certification for the Primary Stroke Center
- Leapfrog Hospital Safety Score "A" assigned to UCSF Medical Center - Mt Zion
- AHRQ Patient Safety Indicator performance rated as the 4th best among the UHC hospitals
- The American College of Surgery renewed the accreditation of the Helen Diller Family Comprehensive Cancer Center
- 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 FY 2013 were achieved
  - Increased sepsis resuscitation bundle of care from 39% to 71% on pilot units
  - Improved medication safety by achieving 90% compliance for: 1) bar coding medication, 2) scanning of patients, and 3) verification of orders within specified time frames
  - Achieved target level of performance in patient satisfaction
- **Quality and Mortality Focus**
  - CMI in Medicare patients increased to 2.23 with a corresponding fall in mortality observed: expected ratio to 0.88
  - Immediate CPR survival rates 76% compared to 44% national benchmark and hospital discharge rates after CPR 35%, also better than the national average of 15.4%
  - Sepsis mortality reduced to an average of 20%
  - Significantly reduced the use of deliriogenic and antipsychotic medications in ICU patients
  - SSI rates in eleven surgeries/procedures were better than the risk adjusted expected rates; hand hygiene compliance remained above 90% for entire year
  - Physicians adopted the Patient Advocacy Reporting System (PARS) developed at the Vanderbilt University Medical Center to promote patient and professional satisfaction
- **Nursing Focus**
  - HAPU prevalence rates reduced to 1.2% *(92% of all nursing units outperforming benchmarks)*
  - Reduced patient falls by ~42% since 2008; reduced restraint use by ~39% since 2008
- **Utilization and Throughput**
  - Length of stay in the PACU has declined for three consecutive years
  - The OR Committee's participation in a sustainability recycling program has resulted in almost $700, 000 savings.
  - Benioff Children's Hospital reduced readmissions on their hospital medicine service from 4.6% in FY12 to 3.0% in FY13

SIGNIFICANT ACCOMPLISHMENTS

- Benioff Children's Hospital had 9 specialties nationally ranked in the U.S. News & World Report
- NSQIP rates for SSI and DVT/PE significantly reduced from FY2012

STRIVING TO IMPROVE

NATIONAL AND CALIFORNIA STAGES

- Readmission rates for AMI, HF, PN, TKA-THA, COPD within national average rates
- Performance in CMS Value Based Purchasing metrics *(Core Measure, HCAHPS and 30-Day Mortality rates)*
- Leapfrog Hospital Safety Score "B" assigned to UCSF Medical Center – Parnassus
- Medication Reconciliation process needs monitoring and reporting to meet Leapfrog and TJC standards
- UHC rankings maintained at three stars level

UCSF MEDICAL CENTER FOCUS

- CLABSI rates only slightly reduced from last year
- CAUTI rates remained stable at 1.84/1000 catheter days though the SIR is below expected at .845
- SSI in hip arthroplasty patients is worse than risk adjusted expected rates
- Reported staff injuries increased by 5%

UCSF HOSPITAL-WIDE QUALITY PROJECTS

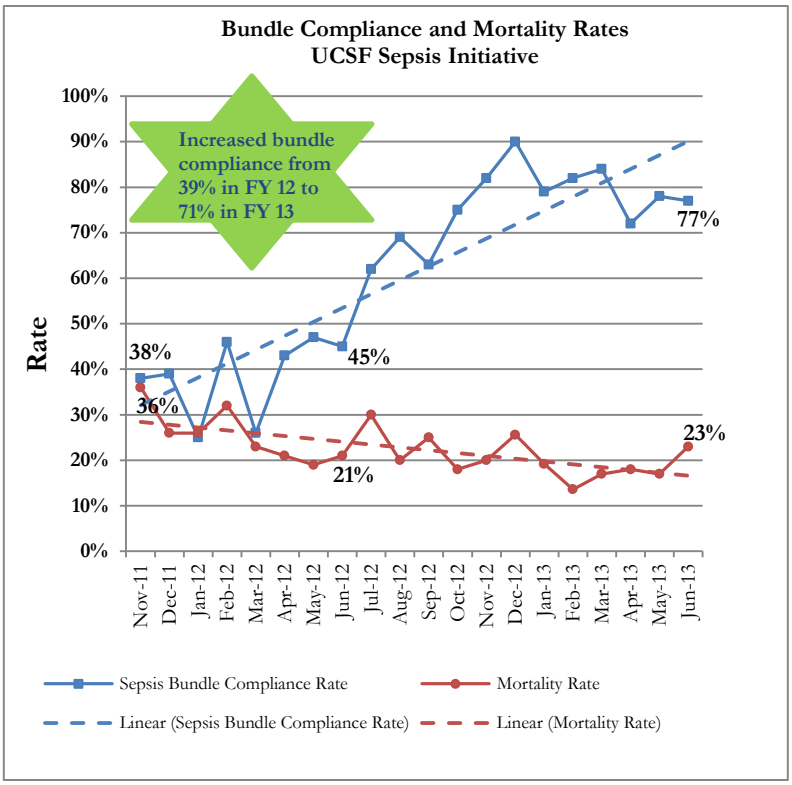
MEDICAL CENTER QUALITY GOALS

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

REDUCE SEPSIS MORTALITY BY INCREASING USE OF THE SEPSIS RESUSCITATION BUNDLE BY 30% FROM THE FY12 BASELINE IN THE EMERGENCY DEPARTMENT, 9/13 ICUS, AND 14TH FLOOR.

ACHIEVED

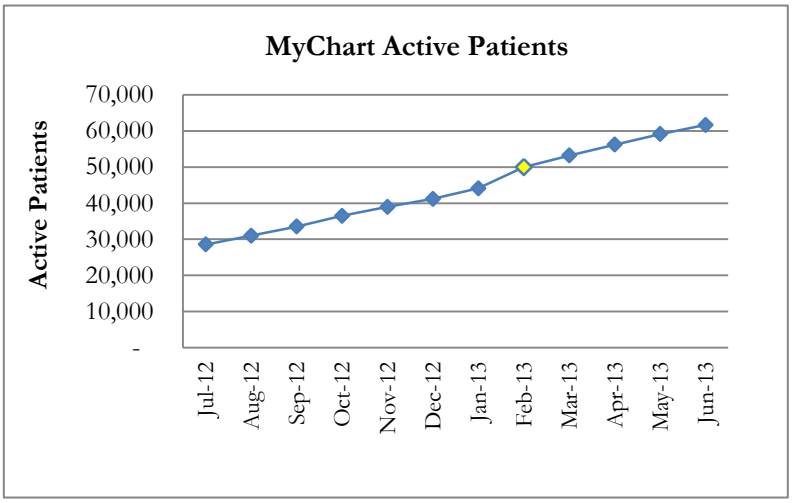
This year we have seen significant reform in the delivery of care to the patient with sepsis. Although there were several major activities and changes that took place during the year, three activities had the most impact on the delivery system; the use of the EMR in aiding the early identification of patients with severe sepsis/septic shock in the ED, timely feedback to treatment providers, and the formation of a Code Sepsis Team to assist with the implementation of the resuscitation bundle outside of the ED.



IMPROVE COMMUNICATION WITH PATIENTS BY INCREASING MYCHART ENROLLMENT TO 50,000 BY JUNE 30, 2013.

ACHIEVED

MyChart attained its target by achieving a final enrollment rate of 61,668 patients during the FY2013 period; 23% over the 50,000 target goal. Technology enhancements and strong Ambulatory Clinic support facilitated the patient enrollment increase.



Medical Center Quality Goals (continued from previous page)

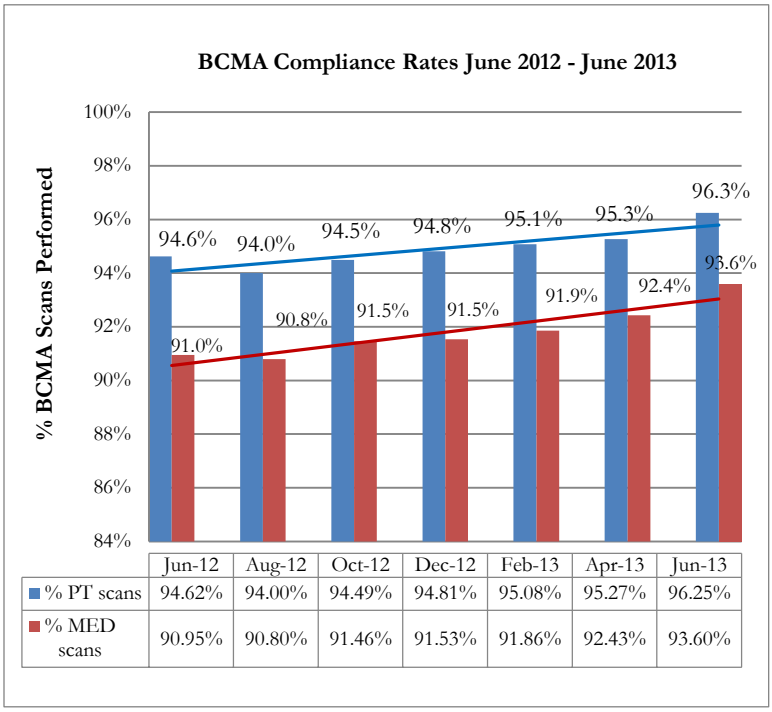
IMPROVE MEDICATION SAFETY (3-PART GOAL):

- ACHIEVE 90% COMPLIANCE WITH USE OF BAR CODE MEDICATION ADMINISTRATION (BCMA) FOR MEDICATIONS
- ACHIEVE 90% COMPLIANCE FOR SCANNING OF PATIENTS
- ACHIEVE 90% COMPLIANCE WITH PHARMACY VERIFICATION OF ORDERS WITHIN 15 MINUTES FOR STAT AND 30 MINUTES FOR ROUTINE ORDERS (EXCLUDING CHEMO AND TPN)

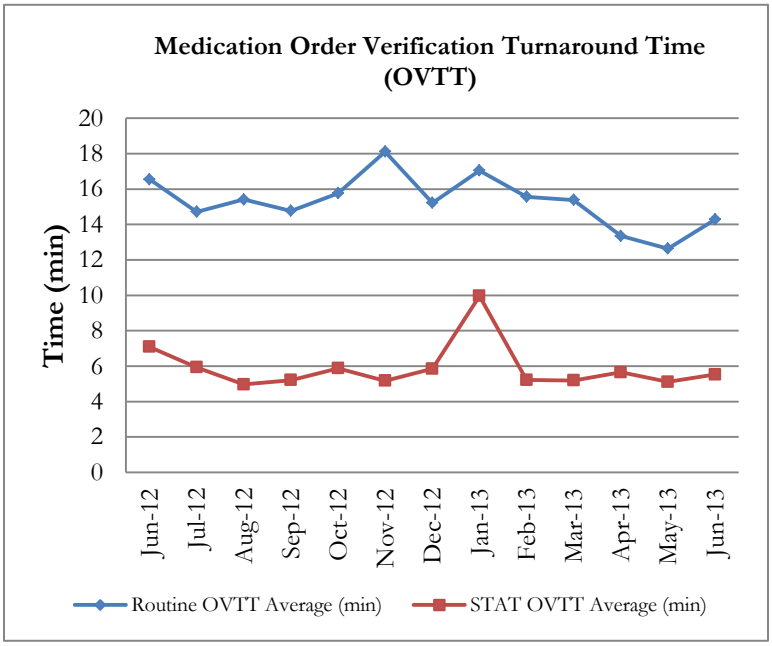
ACHIEVED

BCMA - Units/departments included in the FY13 IAP goal were Parnassus and Mt. Zion adult and pediatric inpatient units, Emergency Department, Perioperative areas, Radiology, and procedural areas. The BCMA Task Force, comprised of Nursing and Pharmacy, validated the APeX report that provided compliance data at the unit level. Nursing disseminated this data and provided training to nursing and Respiratory Therapy managers so they could identify opportunities for improvement. As a result, compliance rates for both scanning of patient and medication consistently improved and were sustained over the fiscal year.

In FY13 the Department of Pharmaceutical Services exceeded the IAP goal of verification time with routine and STAT orders. On average, routine orders were verified by pharmacy in 16.5 minutes and STAT orders verification averaged 6.4 minutes.



	Jun-12	Aug-12	Oct-12	Dec-12	Feb-13	Apr-13	Jun-13
% PT scans	94.62%	94.00%	94.49%	94.81%	95.08%	95.27%	96.25%
% MED scans	90.95%	90.80%	91.46%	91.53%	91.86%	92.43%	93.60%



THE QUALITY LANDSCAPE

CMS READMISSION MEASURES

Readmission measures are being followed in two programs, the CMS Hospital Readmissions Reduction Program, and the CMS Inpatient Quality Report (IQR); both programs focus on the same inpatient populations – AMI, HF, PN, THA/TKA. Readmissions for COPD are now included in FY2014. The CMS Hospital Readmissions Reduction Program determines penalties based on discharges of this population between July 1st, 2009 and June 30th, 2012 (January 2009-December 2011 for COPD) using Med PAR claims data. Penalties (up to 2% for FY2014) are applied to all DRG payments when readmission rates for targeted populations are greater than expected. This means that patients discharged from UCSF (index admission) who are then readmitted to UCSF or another hospital within a 30-day time frame are counted as UCSF's readmission case. Starting in FY2013, "planned" readmission (CMS definitions) will be excluded in the readmission rates.

Readmission Measures	AMI 30-day	HF 30-day	PN 30-day	THA/TKA 30-day	COPD 30-day
CMS Hospital Readmission Reduction Program					
UCSF Risk Stratified Readmission Rate (RSRR) (7/09-6/12) **Date range for COPD (01/09-12/11)*	18.6%	22.1%	17.5%	5.4%	22.0%*
Hospital Compare – IQR Program					
UCSF Actual (7/09-6/12)	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

Quality efforts around readmission have been led by the UCSF Transitions of Care Steering Committee, with focus work groups in Medicine/Primary Care, Cardiology, Orthopedics, Neurology and Neurovascular, and the Hospitalist's Service for Benioff Children's Hospital. A focus on improving the hospital discharge processes has been led by the UCSF Performance Improvement Department using LEAN methodology.

VALUE-BASED PURCHASING (VBP) – FY2014

- The VBP scores are calculated based on baseline period of 4/1 to 12/31/2010, and the performance period of 4/1 to 12/31/2012.
- The CMS FY2014 VBP program reflects performance on select clinical process of care measures (Core Measure, 45%), patient experience measures (Hospital Consumers Assessment of Healthcare Providers and Systems, HCAHPS, 30%), and outcome (mortality – AMI, HF, PN, 25%) scores. Performance put 1.25% of the UCSF base DRG payment at risk.
- UCSF received a VBP score of 39.86 point; this results in a negative 0.2056% in DRG base payment.

DSRIP PROGRAM

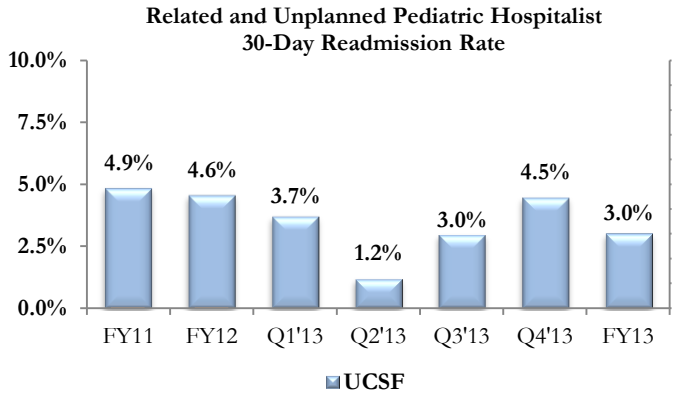
DSRIP refers to the CMS sponsored **D**elivery **S**ystem **R**eform **I**ncentive **P**ool in the demonstration waiver that provides federal matching funds up to $3.3 billion over five years (FY2011 – FY2015) to help support efforts by county and University of California hospitals to improve quality.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

Four focused intervention areas under DSRIP at UCSF are listed below, with quality of care at the center of many elements. The following section describes the achievements and activities in FY2013[1].

[1] FY 2013 = DY 8, Demonstration Year 8

The Quality Landscape (continued from previous page)

Category	Elements	Achievements and Activities
Category 1: Infrastructure Development	Expanded Primary Care Capacity (Access)	▪ Visit volume target was achieved with 102,647 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 53,000 requests for medical advice through the MyChart portal.
	Implement and Utilize Disease Management Registry Functionality (Quality)	▪ Diabetes, anticoagulation, pediatric asthma, colorectal and cervical cancer screening registries have been created and are in use in all primary care clinics. ▪ 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 (discussed in medical homes section).
	Enhance Performance Improvement and Reporting Capacity (Quality)	▪ Staff have been hired and trained in business intelligence reporting tools. ▪ Consultants were engaged to develop a standard approach to dashboards and advise on data governance. A dashboard reflecting key performance indicators in quality (e.g., follow up appointments, home care referrals, post discharge follow up, phone calls, 30 day readmissions) has been developed. Data are monitored and reported monthly to the UCSFMC Excellence in Transitions of care Committee. ▪ CareFx, a business objects tool, has been implemented. ▪ An operations dashboard was developed using QlikView. Tool is a prototype as a future analytic and data display tool.
Category 2: Innovation and Redesign	Expand Medical Homes (Access)	▪ The Grace Model of complex care was adopted and multidisciplinary teams have been formed to concentrate on intensive care management of high utilizer and complex patients. ▪ A primary care retreat was convened and consensus was reached on several metrics and goals in the areas of quality, access, utilization and patient experience. A new integrated dashboard was created to be in alignment with the CAPH Big Aims Initiative. ▪ A task force has been formed to apply for the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) recognition, first application slated for October 2013.
	Increase Specialty Care Access/ Redesign Referral Process (Access)	▪ E-referrals and smart phrase technology have been successfully implemented in eleven (11) specialty practices resulting in the redesign of the specialty referral process. ▪ Over 700 E-consults have occurred between PCP and specialty providers in FY2013. This enables primary care providers access to specialty care via a completely electronic interaction, thus eliminating an in person visit for the patient.
	Implement/Expand Care Transition Programs (Quality)	▪ Focus continues to be on Adult and Pediatric Hospital Medicine, CHF, AMI, Neurology and Orthopedic patients ▪ An Excellence in Transitions of Care Retreat was held in October with over 70 attendees, to understand and redesign discharge processes using Lean methodology. This was followed by a series of Lean Kaizen events to achieve this aim. ▪ APeX reports have been created to measure best practices including timely follow-up appointments, the use of "teach back methodology" for

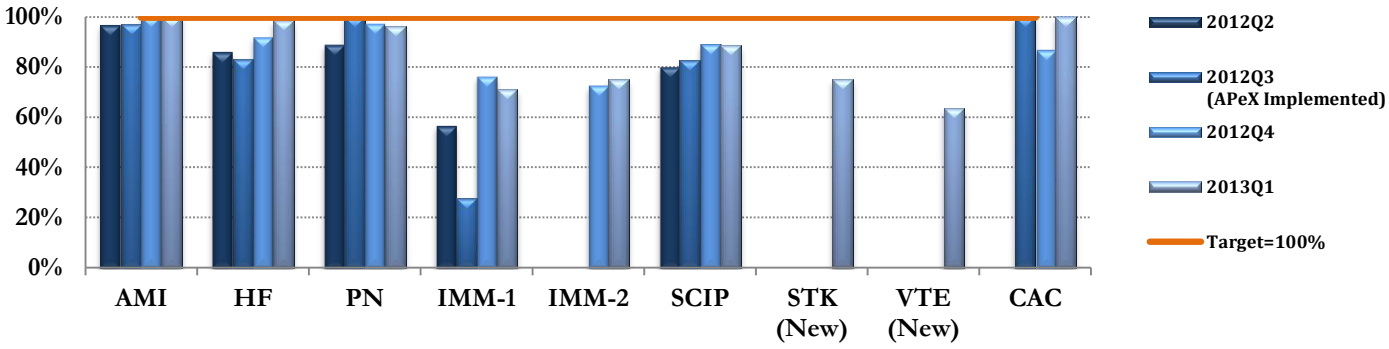
Category	Elements	Achievements and Activities
		patient instruction, ensuring communication with the patient's PCP and calling the patient within 72 hours via an RN led follow-up phone call program. ▪ The follow-up phone call program is in the process of changing to a model that leverages the efficiencies of centralization and automation. ▪ Children's hospital realized a reduction in readmissions due to refinement of discharge processes, such as "Tee-Time rounds", family centered rounding and a focus on teach back methodology for discharge teaching. 
Category 3: Population-Focused Improvement *UCSF reported new metrics reflecting population health*	Patient/Caregiver 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 CG-CAHPS scores.
	Care Coordination (Quality)	**Between July 1, 2012-June 30, 2013:** ▪ 0.2% of our primary care patients with diabetes were admitted to UCSF with a primary diagnosis of a short term complication from diabetes. ▪ 0.1% 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, 2012-June 30, 2013:** ▪ 70% of our primary care patients were screened for breast cancer. ▪ 34.7% of our primary care patients were immunized for influenza. ▪ 90.8% of our pediatric primary care patients were weight screened (BMI). ▪ 29.4% of our pediatric primary care patients had a BMI > 85th percentile. ▪ 41.5% of our primary care patients who smoke were given smoking cessation advice/counseling.
	At-Risk Populations (Quality)	**Between July 1, 2012-June 30, 2013:** ▪ 50.2% of our primary care patients with diabetes had an LDL level <100mg/dl. ▪ 67.6% of our primary care patients with diabetes had a Hemoglobin A1C level <8%. ▪ 11.3% of our primary care patients admitted for CHF were readmitted within 30 days.

Category	Elements	Achievements and Activities
		▪ 30.5% of our primary care patients with hypertension had blood pressure control (< 140/90). ▪ 28.6% of our pediatric primary care patients with persistent asthma were prescribed at least one controller medication. ▪ 28.1% 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)	▪ Operationalized unit based and organizational dashboards with process and outcome goal compliance and a concurrent data abstraction process which includes secondary case reviews by physicians. Screening compliance reached >90% on pilot 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. ▪ APeX surveillance system in build phase for continuous surveillance of patients for signs of severe sepsis. Expected go-live December 2013. ▪ Current bundle compliance rate on required elements of care on all units is 71% and overall adult hospital mortality from sepsis was reduced to 16.6% in June 2013.
	Central Line-Associated Bloodstream Infection (CLABSI) Prevention (Infection Control)	▪ Ongoing education continues and re-education has been instituted within Nursing Annual Review. ▪ Patient care unit-specific and aggregate CLABSI rates for intensive care and acute care patients are calculated and reported monthly. ▪ 97% CLIP rate was achieved. ▪ CLABSI target (for DSRIP) for FY14 and FY15 is in progress.
	Surgical Site Infection (SSI) Prevention (Quality and Infection Control)	▪ UCSF has committed to SSI reduction via DSRIP in the following 6 procedures: colon, rectal, small bowel, C-section, knee arthroplasty, and appendectomy. ▪ A 25.6% reduction in SSI in these targeted populations was achieved with an aggregate SSI rate of 1.67%.
	Hospital Acquired Pressure Ulcer (HAPU) Prevention (Nursing Care)	▪ Over 300 nurses received pressure ulcer prevention intensive training. ▪ FY2013 HAPU rate was 1.35 %, significantly less than the DSRIP target of 1.7%.

The Quality Landscape (continued from previous page)

CORE MEASURES

THE CHART BELOW REFLECTS COMPOSITE PERFORMANCE FOR EACH CORE MEASURE



Acute Myocardial Infection (AMI) Measures

- Good performance, 100% compliance in composite score for 2 continuous quarters.

Heart Failure (HF) Measures

- Challenge with measure set is primarily with "HF discharge instructions" metric.
- Worked closely with APeX AVS group to distill appropriate HF discharge language into template: *(activity level, diet, discharge meds, F/U appointments, weight monitoring, worsened symptoms)*

Pneumonia (PN) and Immunization Measures (IMM)

- Working with APeX to institute 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.
- Global immunization measure severely impacted by APeX launch. The team worked actively with APeX builders to implement pre-checked box on adult and pediatric order set for appropriate immunization shifting non-compliance to administration challenges which are being addressed.
- Team worked closely with nursing staff and the APeX team to build CMS-acceptable vaccination contraindications language options into APeX.

Surgical Care Improvement Project (SCIP) Measures

- Challenge with measure set is primarily with "urinary catheter removal on post-op day 1 or 2" indicator.
- A progress note "Smartphrase" was developed to encourage appropriate documentation for urinary catheter removal. "Best Practice Alert" for catheter removal or documentation is being explored.
- The option of building a "Best Practice Alert" for catheter removal or documentation is being explored.

Stroke (STK) and Venous Thromboembolism (VTE) Measures

- These are new measures sets. Teams have been formed to manage these new initiatives.
- Poor compliance of the stroke measure set is linked to performance of the "stroke education" indicator; and the same for VTE set with "VTE warfarin discharge instructions". These indicators are similar to the "HF discharge instructions" and improvement activities have been collaborative. Appropriate language for stroke patient education/warfarin teaching has been built into APeX AVS templates.
- The VTE team is actively working with the APeX team to ensure that appropriate language and options are built into the core order set.

Children's Asthma Care (CAC)

- Measure tracked by Pediatric Medicine Division and provider feedback is sent when exceptions occur.

The Quality Landscape (continued from previous page)

UNIVERSITY HEALTHSYSTEM CONSORTIUM (UHC)
2005-2013 QUALITY & ACCOUNTABILITY STUDY RANKING

UHC Quality/Accountability Metric Rank	Ranking								
	2005	2006	2007	2008	2009	2010	2011	2012	2013
Overall Composite Rank[2]	2★ 61	3★ 39	5★ 10	3★ 34	4★ 18	4★ 30	3★ 57	3★ 63	3★ 67
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**
Mortality *O:E ratios of selected service lines*	58	29	13	20	36	55	62	**63**	**72**
Effectiveness *Core Measures and 30-day readmission rates*	12	56	18	21	51	23	41	**80**	**83**
Safety *Complications of Hospital Care : AHRQ PSIs*	22	26	16	22	5	11	6	**14**	**4**
Equity *No disparity of care based on race, gender, payor*	78	1	1	1	1	1	1	**86**	**1**
Patient Centeredness *Patient satisfaction scores; HCAHPS question + composite*	N/A	5	8	33	1	51	20	**31**	**41**
Efficiency	70	69	61	24	89	95	99	**97**	**96**

Key points regarding UCSF performance and the UHC methodology:

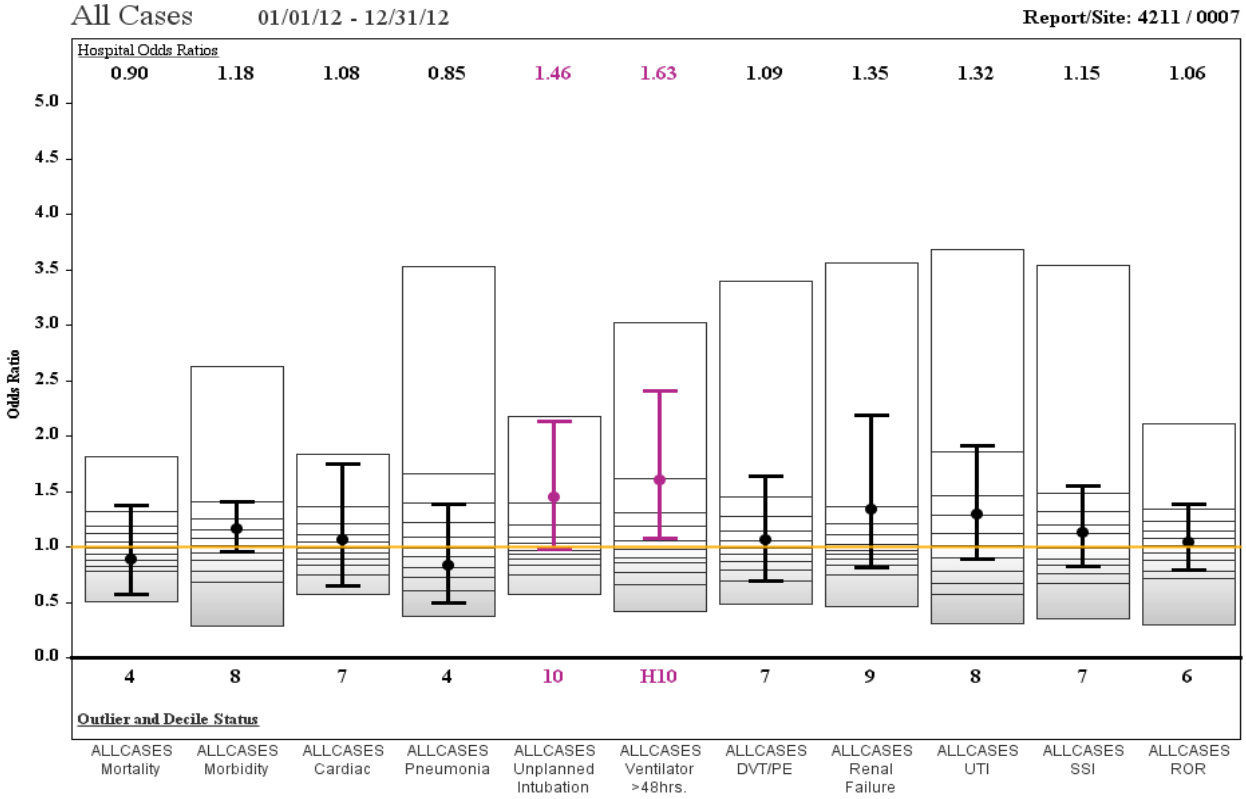
- Coding and documentation significantly influenced all of the observed to expected metrics. Some progress has been made in this area by the new Clinical Documentation Improvement program which began in October 2012.
- Mortality: This domain is scored using both system level and service-line level Observed: Expected (O: E) mortality ratios of MS-DRG codes in almost all patient service lines except pediatrics and neonatology.
- Effectiveness: The score of this measure was impacted by both readmissions and Core Measure performance. All-cause 30 day readmission rates (OB, newborns, neonatology and patients <18 years of age were excluded) were calculated. Core Measure performance for AMI, HF, PN, SCIP and Immunization were rated.
- Safety: The same five AHRQ Patient Safety Indicators were used (iatrogenic pneumothorax, CLABSI, post op hemorrhage/hematoma, post op respiratory failure, and post op PE/DVT).
- Equity: This reflects the composite scores for AMI, HF, PN, and SCIP testing for statistically significant differences in outcomes in 3 equity –based dimensions: gender, race and socioeconomic status (by payor class).
- 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. UCSF performance in these areas improved after the UHC abstraction time frame.
- 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.

[2] 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)

The ACS NSQIP Collaborative published its semi-annual report for period January 1st to December 31st 2012. This report is based on a total of 579,867 cases in the entire NSQIP comparative cohort, with 1,534 cases from UCSF Medical Center including select surgical subspecialties *(general surgery, vascular surgery, and subspecialties including: cardiac surgery, gynecologic surgery, neurosurgery, orthopedic surgery, otolaryngology, plastic surgery, thoracic surgery, and urology).* As the ACS NSQIP participation increased amongst hospitals, more risk adjusted reports have become available to reflect an overall view of the care of the surgical patient.

MULTISPECIALTY (GENERAL, VASCULAR, AND SUBSPECIALTY CASES)



High outliers in 2011, deep vein thrombosis/ pulmonary emboli (DVT/PE) and surgical site infections (SSI) have improved significantly in 2012. Interdisciplinary teams continue to focus on reducing these occurrences.

Several measures are performing better than expected. Surgical site infections (SSI) in Neurosurgery and Urology, the rate of return to OR among General Surgery patients, overall Thoracic Surgery morbidity and the incidence of pneumonia, are all performing better than expected compared to NSQIP benchmarks. In 2012, the measure, "Patients on Ventilator >48 hours" is a newly identified high outlier. The severely ill patients in this group are being reviewed by the department, along with the related category of Unplanned Intubation.

In 2013, UCSF has refined the NSQIP case selection focus from broad service line categories to specific procedures which should provide more useful outcomes data on selected high volume and high risk surgical procedures.

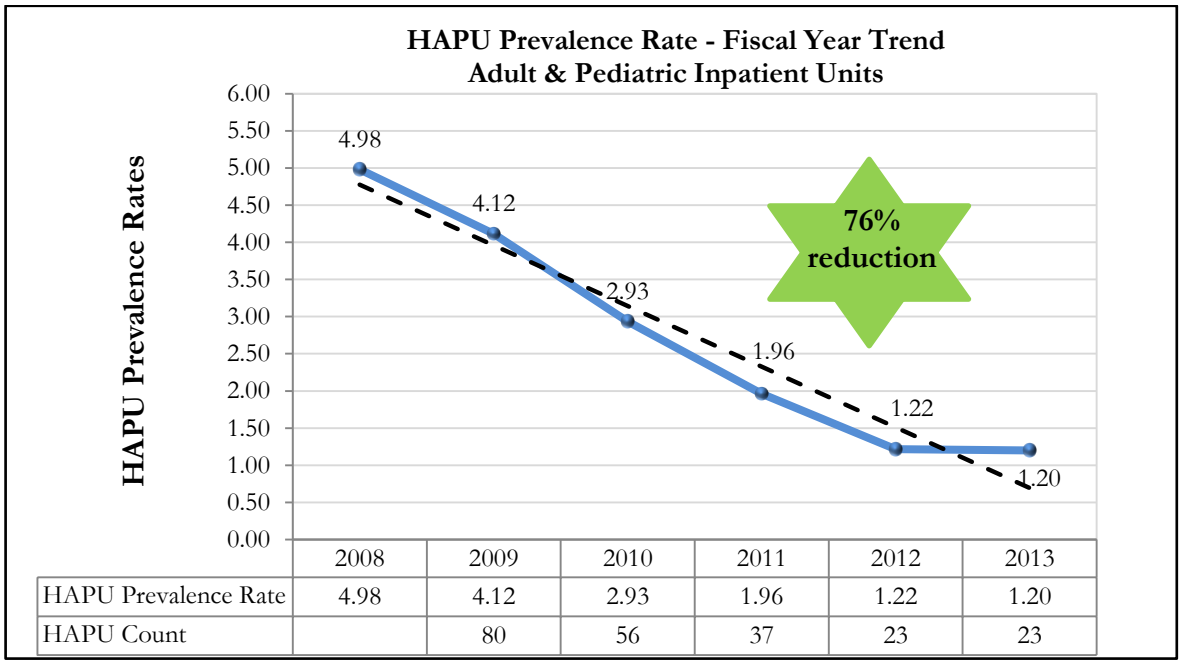
NURSING-SENSITIVE INDICATORS

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, restraints, catheter-associated urinary tract infections (CAUTI), ventilator associated pneumonia (VAP), and central line-associated blood stream infections (CLABSI).

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

HOSPITAL-ACQUIRED PRESSURE ULCERS

92% OF ALL NURSING INPATIENT UNITS OUTPERFORMED THE BENCHMARK



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

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 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 2013, 92% of inpatient units (22 of 24) outperformed the NDNQI mean at least 5 out of 8 rolling quarters.

The Department of Nursing also tracks and evaluates pressure ulcers reported through the incident reporting system. Pressure ulcer incidence is not benchmarked.

Nursing-Sensitive Indicators (continued from previous page)

ACCOMPLISHMENTS:

Adult Units

- Wound photography was implemented to support evaluation of wound progress
- Specialized positioning pads, to help alleviate occipital ulcers, were trialed for pediatric ECMO patients and expanded to the adult ECMO population
- The OR Department began a trial of Silastic naso-gastric tubes (softer and more pliable)
- Perioperative leadership began a process to review all possible OR-related pressure ulcers
- New beds with improved surfaces were purchased for all Adult Acute Care units

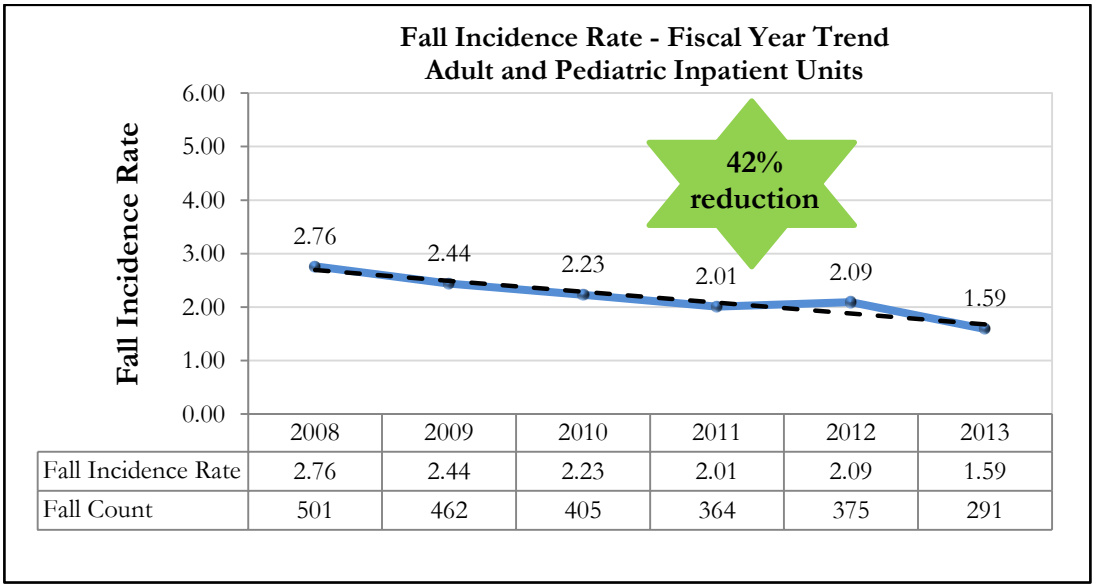
Pediatric Units

- Focus on PIV-related HAPUs resulted in a decreased from 11 in FY 2011 to 8 in FY 2013
- PU prevention educational classes were offered to all staff in FY 2013
- Initiated a process to evaluate incontinence-associated dermatitis products

FALLS

81% OF ALL NURSING INPATIENT UNITS OUTPERFORMED THE BENCHMARK

Since 2008, there has been a 42% reduction in fall rates for adult and pediatric units combined and a 44% reduction in Falls with Injury rates.



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

Inpatient falls data are collected via the incident reporting system and reported out by unit as the incidence of falls per 1000 patient days. By the end of Fiscal Year 2013, 81% of units (21 of 26) had outperformed the NDNQI mean for at least 5 of 8 rolling quarters.

ACCOMPLISHMENTS:

- Created criteria for use of bed exit alarm for patients at risk for falling and sustaining an injury
- Developed night-time guidelines for staff to follow for patients at risk for falling and sustaining an injury
- Revised the ABCS (age, bones, coagulopathy, surgery) screening elements per the Institute for Healthcare Improvement (IHI) 2012 recommendations
- Educated staff about preventing falls with injury
- *Your Health Matters* educational materials related to Falls updated in 2013

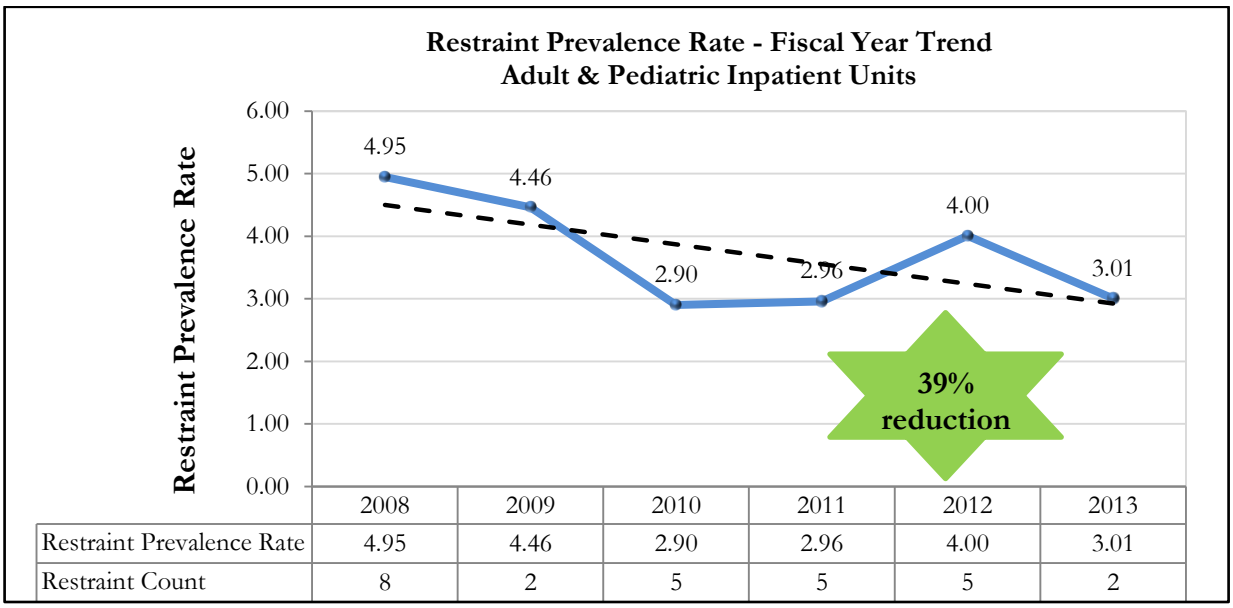
Nursing-Sensitive Indicators (continued from previous page)

RESTRAINTS

83% OF ALL NURSING INPATIENT UNITS OUTPERFORMED THE BENCHMARK

RESTRAINT USE PREVALENCE

Since 2008, there has been a 39% reduction in restraint prevalence rates for adult and pediatric units combined. Department of Nursing restraint data is obtained from quarterly prevalence studies in which patients are evaluated for restraint use.



	2008	2009	2010	2011	2012	2013
Restraint Prevalence Rate	4.95	4.46	2.90	2.96	4.00	3.01
Restraint Count	8	2	5	5	5	2

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. By the end of Fiscal Year 2013, 83% of units (20 of 24) outperformed the NDNQI mean benchmark for at least 5 out of 8 rolling quarters.

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 2013 was to ensure documentation compliance in APeX which involved 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 restraint in the immediate post-op recovery phase
- Developed APeX reports that track and trend data for all patients on 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
- Reviewed and updated the restraint policy and procedure to reflect changes in regulatory standards

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 FY 2013, 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.

2013 GOLD SEAL OF APPROVAL

THE JOINT COMMISSION (TJC)

In April of 2013, UCSF Medical Center underwent a successful triennial survey by the Joint Commission. The survey included a team of surveyors here for five days. Surveyors visited inpatient and outpatient locations and also surveyed UCSF Home Health. The Medical Center remains fully accredited for the next three years. In addition to the Hospital survey, UCSF also successfully completed a disease specific certification survey for Primary Stroke Services.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

CMS completed three separate certification surveys at UCSF during FY 2013. These included:

- Children's' Dialysis Center at UCSF in April of 2013
- Adult Dialysis Program in May 2013
- Transplant Program in July of 2012. The Transplant survey included re-certification for all solid organ transplant programs.

All surveys were successfully completed and each program remains re-certified for another three years.

MISSION BAY

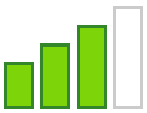
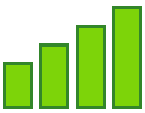
The Medical Center has begun laying the groundwork for licensing of the new hospital at Mission Bay. Preliminary meetings with the California Department of Public Health have been held to discuss licensing plans and timelines. The new hospital licensing survey is anticipated to occur in December of 2014.

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). Metrics are reported below in the following areas with the UCSF achievement ratings. 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.	
	Safety Focused Scheduling	Based on smooth patient scheduling in the Operating Room (Credit awarded based on usage of 85% or above during prime time).	
Maternity Care	Rate of Early Elective Deliveries	Normal newborn deliveries performed between 37 & 39 completed weeks gestation.	
	Rate of Episiotomy	Incision made in the perineum during childbirth.	
	Maternity Care Standard Precautions	Screening newborns for jaundice before discharge and preventing blood clots in women undergoing cesarean section.	
	High-Risk Deliveries	Births in which infants are predicted to weigh less than 1500 grams at birth.	
High-Risk Surgeries	Aortic Valve Replacement	Quality of Care- Outcomes Rank	
	Abdominal Aortic Aneurism Repair	Quality of Care- Outcomes Rank	

	Practice	Leapfrog Metric	Rating
	Pancreatic Resection	Quality of Care – Survival Odds	
	Esophageal Resection	Quality of Care – Survival Odds	
Hospital-Acquired Conditions	Reduce ICU infections	Based on 1000 central line days using the National Healthcare Safety Network (NHSN) standards	
	Reduce UTI infections	In ICUs	
	Reduce Hospital-Acquired pressure ulcers	Stage III and IV pressure ulcers	
	Reduce Hospital-Acquired Injuries	Refers to falls and other traumatic injuries.	
Resource Use	Length of Stay	Based on Common Conditions - AMI, HF, PN	
	Readmissions	Readmissions for Common Acute Conditions - AMI, HF, PN	
Safety Score	Hospital Safety Score	UCSF rating on the April 2013 Leapfrog Hospital Safety Score report card.	**B for M/L** **A for MZ**

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 2013-14 were published in July of 2013. UCSF Medical Center was ranked[3]:

- **#7** in the National Top Ten List
- **#2** in California out of 430 hospitals
- **#1** in the San Francisco Metro Area of all 47 hospitals

13 specialties were listed in the National Top 50 List	
#7	Cancer
#5	Diabetes & Endocrinology
#12	Ear, Nose & Throat
#27	Gastroenterology & GI Surgery
#8	Geriatrics
#8	Gynecology
#7	Nephrology
#5	Neurology & Neurosurgery
#14	Ophthalmology
#14	Orthopedics
#24	Pulmonology
#10	Rheumatology
#7	Urology

2 specialties were ranked "High-Performing"
Cardiology & Heart Surgery
Psychiatry

UCSF is also the highest ranking hospital in Northern California.

UCSF rose from #13 in the last ranking (2012-2013) to a rank of #7 in the Top Ten List. Important factors impacting the score include the lack of Magnet designation and our risk adjusted mortality ratio which represents documentation and coding opportunities.

[3] http://health.usnews.com/best-hospitals/area/ca/ucsf-medical-center-6930043

U.S. NEWS & WORLD REPORT "BEST CHILDREN'S HOSPITALS"

SUMMARY OF U.S. NEWS SURVEY

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.

In the 2013-14 rankings, UCSF Benioff Children's Hospital had nine nationally ranked specialties: Cancer, Cardiology & Heart Surgery, Diabetes & Endocrinology, Gastroenterology & GI surgery, Neonatology, Nephrology, Neurology & Neurosurgery, Pulmonology, and Urology. 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 2013. As a result, overall rankings have increased markedly, with five programs now ranked among the top 20 of their specialties nationwide. US News results are significantly influenced by patient volumes. Despite our small size, UCSF BCH continues to advance in rankings.

Nationally Ranked Specialties	
#14	Diabetes & Endocrinology
#15	Nephrology
#17	Cancer
#18	Cardiology & Heart Surgery
#19	Gastroenterology & GI Surgery
#22	Neurology & Neurosurgery
#26	Neonatology
#28	Urology
#35	Pulmonology

COMPLETED & ONGOING IMPROVEMENT INITIATIVES FOR FUTURE SURVEYS

Key contributors to the improved rankings have been the implementation of a new electronic health record (EHR) and achieving Nurse Magnet designation, an award granted by the American Nurses Credentialing Center recognizing hospitals for quality patient care, nursing excellence and innovations in professional nursing practice.

UCSF BCH is actively refining the EHR to track more effectively specific patient populations, procedures performed, and patient outcomes. The EHR will assist caregivers by monitoring changes in patient status and providing early warnings and promote timely recognition and treatment. These advances in the EHR will enable higher quality care.

UCSF BCH continues to recruit the best pediatric specialists from around the Nation and the world. Pediatric cardio-thoracic surgery is actively developing a heart failure/transplant program that will enhance measured quality in the Cardiology and Heart Surgery program.

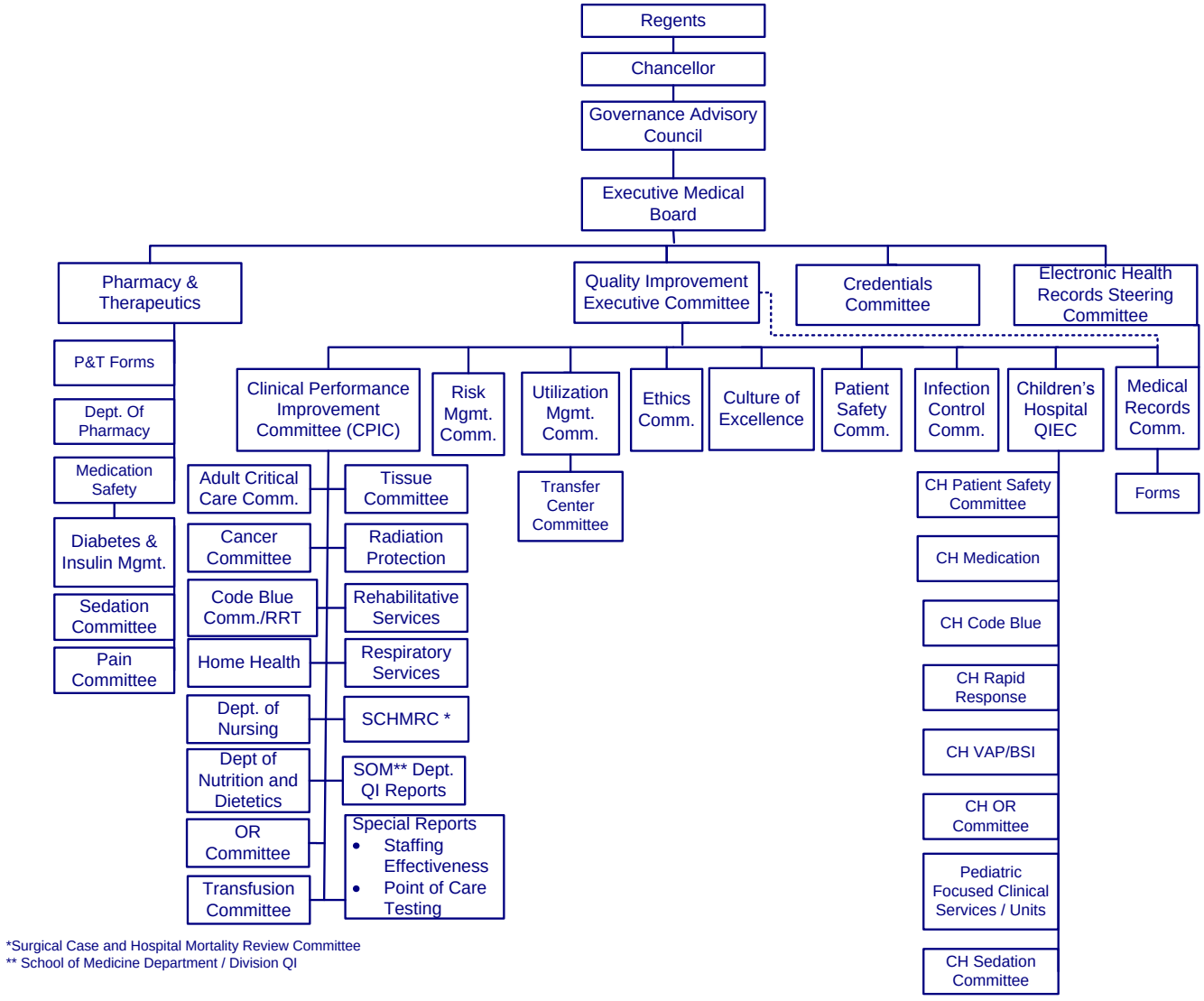
Infection control and quality improvement opportunities identified in the survey are being addressed by the BCH Quality Program through committee work, task forces and targeted interventions guided by systematic performance monitoring and evaluation.

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 measures.



*Surgical Case and Hospital Mortality Review Committee
** School of Medicine Department / Division QI

ENVIRONMENT OF CARE COMMITTEE

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."

EOC SAFETY PROGRAM FOCUS:

- Authorization and distribution of the updated EOC Manual.
- Development of a committee structure and written policy.
- Establishment of resources so that the organization can be compliant with AB 1136 and the proposed Cal-OSHA Title 8 5120: Health Care Worker Back & Musculoskeletal Injury Prevention Standard.

EMERGENCY MANAGEMENT (EM):

- EM finalized the Medical Center's Disaster Privileges Policy and activated the Hospital Incident Command System (HICS) four times in response to varying Medical Center emergency events.
- The EM program conducted one power failure functional drill at Mt. Zion in conjunction with the State Health & Medical Exercise.
- UCSF MC participated in the annual state-wide California "Shake-Out" Event promoting earthquake preparedness with staff.
- The EM program also created a Be Aware, Get Prepared Personal Preparedness Campaign that was considered a best practice by The Joint Commission (TJC) and was selected as a Best Practice for the 2013 California Hospital Association annual Disaster Planning Conference in Sacramento.

INJURY AND ILLNESS REDUCTION PROGRAM: Reported injuries in the Medical Center increased by 5%. The majority of these were injuries requiring some medical treatment and in some cases, a period of modified duty, but which did not result in lost time. Serious injuries requiring significant medical treatment and lost time from work were down 12%. UCSF Medical Center Workers Compensation program received all four UCOP WC awards (lowest WC rate, best reduction in WC rate, best overall program improvement, and lowest cost of risk). This was the first time in the summit's history that an institution merited this honor. Although there was an increase in injuries in FY13, these awards truly acknowledge a significant reduction in expenses associated with the Workers Compensation program.

Incident Type	FY 2012	FY 2013	% change
Bloodborne Pathogen Exposures	126	137	9%
Slips and Falls	61	58	-5%
Incidents Related Patient Handling	78	54	- 31%
Workstation Related Repetitive Stress	79	88	11%

MEDICAL EQUIPMENT:

- The Clinical Engineering (CE) program was critical to the implementation of Phases 2 and 3 of the Centralized Telemetry Project. CE participated in the Centralized Telemetry Failure Mode and Effects Analysis thereby enabling a safer and a more reliable enterprise wide monitoring system.
- CE also implemented an On-Line Service Requester program that has allowed customers to place service requests directly to Clinical Engineering. This has resulted in improved CE response times and customer satisfaction.
- The Medical Equipment program has also established a new Clinical Engineering Training Center/Team that is focused on developing device training programs for medical equipment technicians on both existing and new technology.

SECURITY:

- The Security Program implemented and expanded TJC's Sentinel Event Alert 45, "Prevention of Violence in the Healthcare Setting."
- In FY13, the security program focused on the development of Code Silver policies and overhead pages.

Environment of Care Committee (continued from previous page)

UTILITIES MANAGEMENT: The Facilities Management Program replaced over 400 beds in the Parnassus and Mount Zion Campuses. A key to this success was the Real Time Location System (Awarepoint) that allowed tracking and inventorying of all beds as they entered the Medical Center. Using mobile devices, Facilities developed a system of integrating the barcode, serial number, purchase order, manufacturer information and service warranty, which allowed the Facilities team to track and perform preventive maintenance on the beds in the unit.

Below is an update on key infrastructure-related projects:

- A secondary campus fire water system connection project is being jointly funded by Medical Center and Campus. The project will provide an emergency connection and pump house and will bring the entire Campus and Medical Center in compliance with current NFPA code requiring a secondary water source for fire sprinklers.
- Moffitt hospital fire sprinkler project is in pre-construction phase with selected contractor. It will be coordinated with back-fill projects and completed in phases through 2017.
- Funding has been approved for a new ACC Emergency Generator and contractor bidding will begin in FY14.
- The campus has accelerated a project to replace transfer switch and electrical cables identified as root cause during a major electrical outage affecting the entire campus.
- The Moffitt and Long Domestic Hot Water Project is fully funded to replace aged infrastructure, work will begin in FY14.

ETHICS COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:

- Continued educational series both at ethics meetings and with staff and physician groups.
- Focused on work related to ethics of caring for prisoners, neonatal ethics and organ donation/donation after cardiac death (DCD).
- Ethics Consultations:
  - 33 formal *ad-hoc* consults July 2012-June 2013
  - 27 adults, 6 children/newborns
  - Consults: Medicine 9, Surgery 4, Neurosurgery 4, Neurosurgery 3, ICN 3, Cardiology 3, other services 7

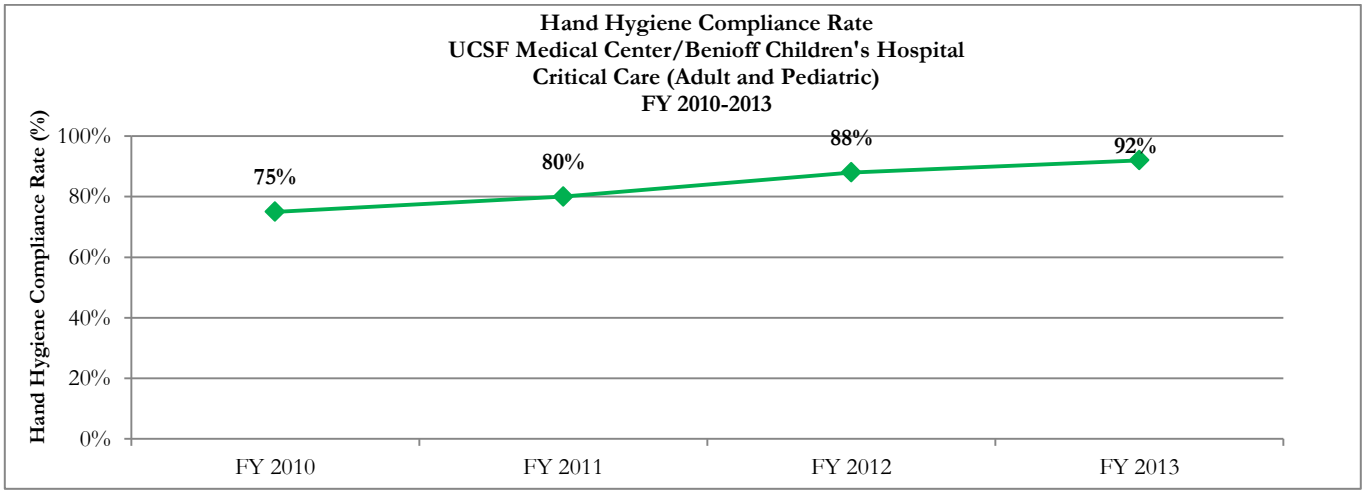
THEMES AND CHALLENGES:

- Limitation of life-sustaining therapies interpretation and education including current policies.
- Increased "group consults" regarding systems of care.
- Increased consults from outside UCSF.
- Increased questions regarding utilization of resources.
- Rotating team structure and application to patients with ethical concerns.

INFECTION CONTROL COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:

- Directed organizational performance improvement in hand hygiene compliance to meet the UCSF Medical Center Workplan goal of 12 months of 90% or greater compliance in all inpatient locations and occupations
- Performed surveillance for and oversaw data dissemination and prevention efforts by the Device Related Infections Committee for Central Line-Associated Bloodstream Infections (CLABSI), Ventilator-Associated Pneumonia (VAP) and Catheter-Associated Urinary Tract Infections (CAUTI)
- Worked with and supported Occupational Health Services activities related to infection prevention:
  - Influenza immunization/declination: Employees=94%; Faculty=51%; Residents=52%
  - TB Screening: 74% employee compliance; 100% physician and student compliance
- Oversaw infection prevention programmatic elements in Nutrition and Food Services, Sterile Processing, Facilities Management, Pharmacy, Hemodialysis, Hospitality, and Nursing
- Sponsored *Clostridium difficile* infection prevention "bundle" application in all units
- Expanded a surgical patient preparation program (chlorhexidine bathing and intranasal mupirocin for 5 days preoperatively) targeted at reducing Surgical Site Infections following revision knee and now hip arthroplasty
- Gained CDPH endorsement for HEIC surveillance methods; CDPH validated UCSF's surveillance strategy for surgical site infection (SSI) identification and reporting. CDPH requested to pilot the validation tool for SSIs at UCSF
- Reviewed surgical procedure observations with recommendations to OR Committee for practice improvement
- Revised Aerosol-Transmissible Diseases Exposure Control Plan; prevailed in CalOSHA citation reduction
- Approved increased portable HEPA units to meet air changes per hour (ACH) requirements in AIIR
- Granted $1.35M from UCOP Healthcare Epidemiology Collaborative to develop and implement SSI reduction "bundles" for patients undergoing arthroplasty, spine and colorectal surgery



DEVICE RELATED INFECTION SURVEILLANCE

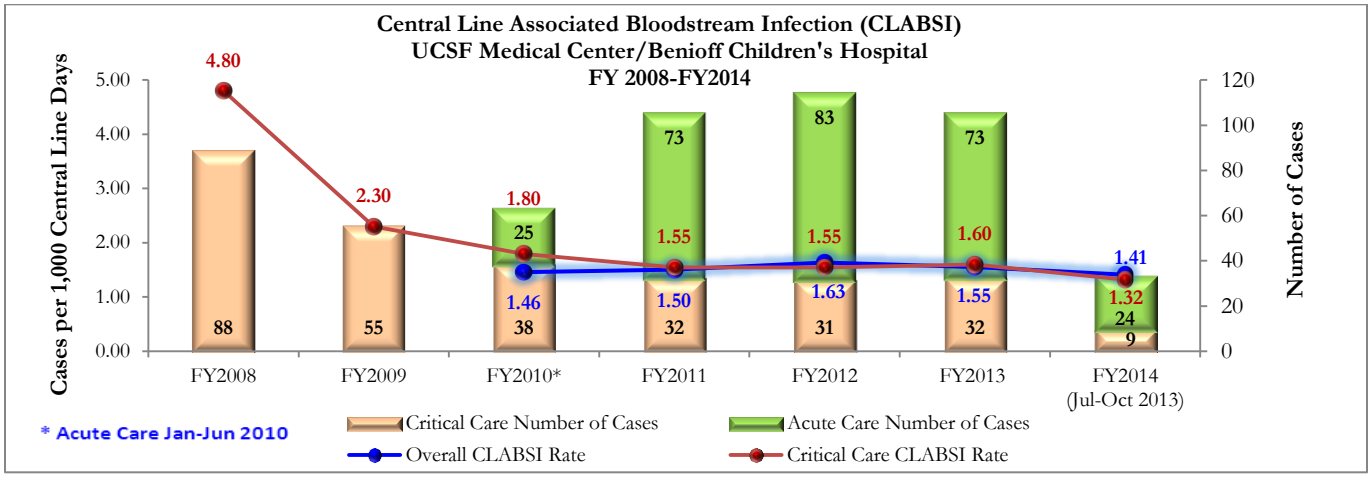
Device-related infections (DRI) include Central Line Associated Bloodstream Infection (CLABSI), Ventilator-Associated Pneumonia (VAP), and Catheter-Associated Urinary Tract Infection (CAUTI). The numbers of CLABSI and CAUTI at UCSF are statistically significantly lower than expected according to the 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

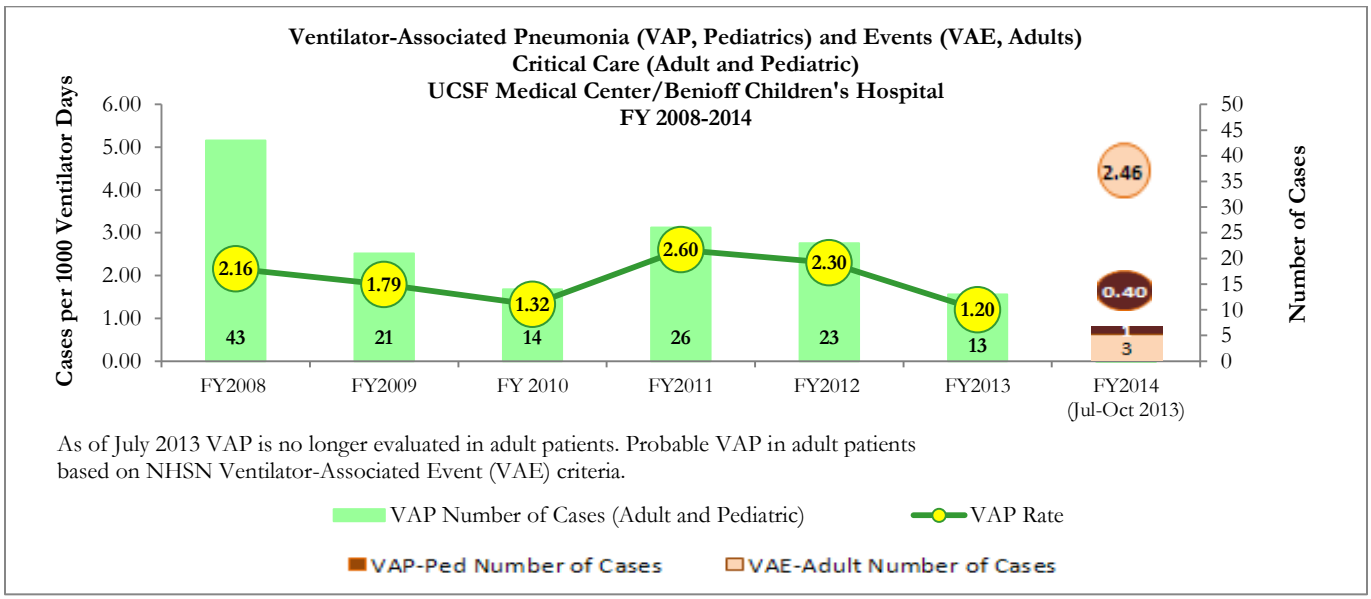
Infection Control Committee (continued from previous page)

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 FY13 include: pilot test of chlorhexidine bathing (CHG bathing) for CLABSI reduction in adult and pediatric critical care units; implementation of Culture of Unit-Based Safety (CUSP) case review; joint RT-RN implementation of oral care for ventilated patients; and improved daily assessment of need for urinary catheter.

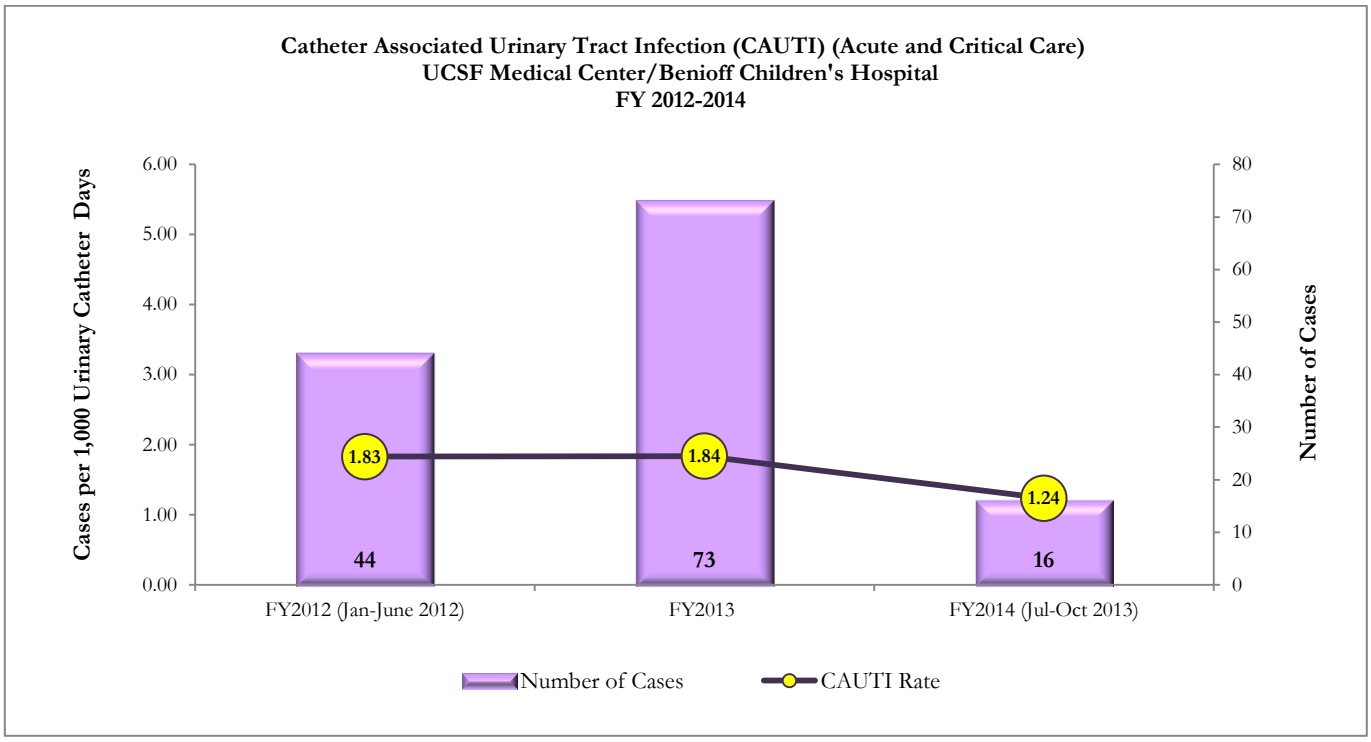
The aggregate CLABSI rate declined slightly from the baseline.

- Standardized Infection Ratio (SIR) (observed to expected ratio) was statistically significantly lower than expected or 0.742.
- The critical care and acute care CLABSI rates, which include both adult and pediatric patients, increased slightly.
- The Neonatal Intensive Care (ICN) achieved an overall decrease of 44.4% for the year.
- The Central Line Insertion Practice (CLIP) milestone to maintain the 97% compliance target was achieved.
- Procedure note template which includes the CL insertion practice elements was created in Apex to support CLIP compliance.



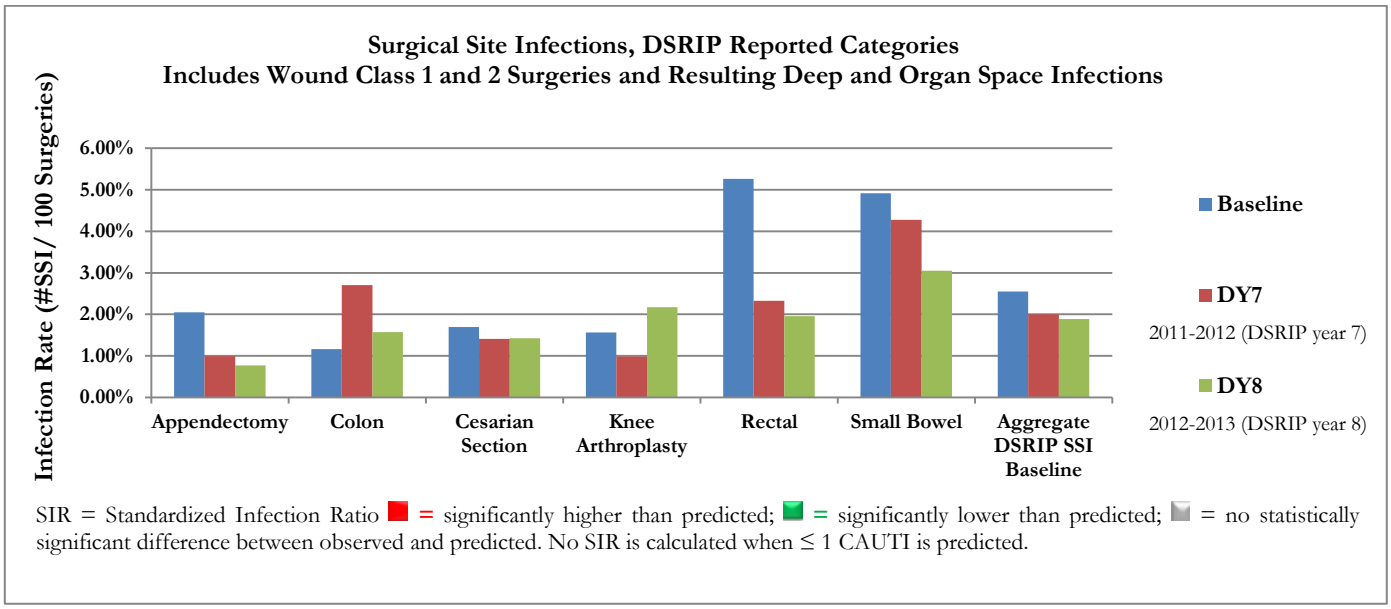


Infection Control Committee (continued from previous page)



SURGICAL SITE INFECTIONS (SSI) PER 100 SURGERIES FY 2013

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 is significantly better (fewer SSI than expected) in eleven categories for FY13, and is significantly worse (more SSI than expected) in one category. A three-trigger method is used to identify cases to review for SSI: post-operative wound, tissue or body fluid culture, readmission or operation for "incision and drainage" in a patient who has undergone surgery at UCSF.



SIR = Standardized Infection Ratio = significantly higher than predicted; = significantly lower than predicted; = no statistically significant difference between observed and predicted. No SIR is calculated when ≤ 1 CAUTI is predicted.

SSI MANDATORY REPORTING FY13 WITH STANDARDIZED INFECTION RATIO (SIR)*

	Overall						Adult			Pediatric (Age < 18)		
CATEGORY	# Procedures	# SSI	Rate	SIR	P-Value	95% CI	# Procedures	# SSI	Rate	# Procedures	# SSI	Rate
Abdominal Aortic Aneurysm	36	0	0.0	0.000	0.156	,1.983	18	0	0.0	18	0	0.0
Appendectomy	171	2	1.2	0.455	0.186	0.055, 1.644	139	2	1.4	32	0	0.0
Biliary Surgery	371	24	6.5	0.589 (-)	0.003	0.377, 0.877	357	24	6.7	14	0	0.0
Cardiac Surgery	373	2	0.5	0.322	0.053	0.093, 1.162	203	2	1.0	170	0	0.0
CABG, 2 Incisions	90	1	1.1	0.455	0.355	0.012, 2.536	90	1	1.1	0	0	--
CABG, 1 Incision	2	0	0.0	--	--	--	2	0	0.0	0	0	--
Gallbladder Surgery	430	3	0.7	0.690	0.368	0.142, 2.015	407	3	0.7	23	0	0.0
Colon Surgery	349	16	4.6	0.480 (-)	0.001	0.268, 0.791	319	16	5.0	30	0	0.0
Craniotomy*	1130	13	1.2	0.355 (-)	0.000	0.189, 0.606	1038	12	1.2	92	1	1.1
C-Section	493	14	2.8	1.137	0.359	0.606, 1.945	493	14	2.8	0	0	--
Spinal Fusion	1015	17	1.7	0.608 (-)	0.022	0.347, 0.987	973	16	1.6	42	1	2.4
Fracture Reduction	263	0	0.0	0.000 (-)	0.017	,0.900	232	0	0.0	31	0	0.0
Gastric Surgery	241	3	1.2	0.337 (-)	0.023	0.069, 0.984	219	3	1.4	22	0	0.0
Hip Prosthesis	482	16	3.3	2.198 (+)	0.004	1.255, 3.569	481	16	3.3	0	0	--
Heart Transplant	13	0	0.0	--	--	--	13	0	0.0	0	0	0.0
Abdominal Hysterectomy	377	7	1.9	0.700	0.249	0.257, 1.524	377	7	1.9	0	0	--
Knee Prosthesis	355	4	1.1	0.927	0.567	0.252, 2.372	350	4	1.1	0	0	--
Kidney Transplant	354	3	0.8	0.306 (-)	0.012	0.063, 0.896	340	3	0.9	14	0	0.0
Laminectomy	1043	7	0.7	0.585	0.091	0.235, 1.205	1026	7	0.7	17	0	0.0
Liver Transplant	147	5	3.4	0.185 (-)	0.000	0.060, 0.431	137	5	3.6	10	0	0.0
Kidney Surgery	399	1	0.3	0.179 (-)	0.025	0.005, 0.998	383	1	0.3	16	0	0.0
Ovarian Surgery	650	1	0.2	0.316	0.176	0.008, 1.761	637	1	0.2	0	0	--
Pacemaker Surgery	269	4	1.5	--	--	--	242	2	0.8	27	2	7.4
Rectal Surgery	138	3	2.2	0.171 (-)	0.000	0.035, 0.499	129	3	2.3	9	0	0.0
Refusion of Spine	191	3	1.6	0.348	0.028	0.072, 1.018	190	3	1.6	1	0	0.0
Small Bowel Surgery	429	22	5.1	0.569 (-)	0.003	0.352, 0.869	380	22	5.8	49	0	0.0
Spleen Surgery	52	0	0.0	0.000	0.298	,3.044	49	0	0.0	3	0	0.0
Thoracic Surgery	399	3	0.8	0.342 (-)	0.025	0.070, 0.998	323	2	0.6	76	1	1.3
Vaginal Hysterectomy	70	1	1.4	--	--	--	70	1	1.4	0	0	--
Ventricular Shunt*	370	2	0.5	0.118 (-)	0.000	0.014, 0.425	304	2	0.7	66	0	0.0
Abdominal Surgery	1163	12	1.0	0.357 (-)	0.000	0.185, 0.624	1075	11	1.0	88	1	1.1

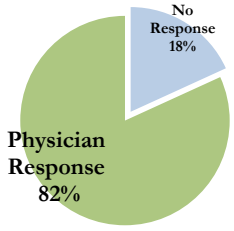
1) SIR (Standardized Infection Ratio) = # expected SSI/# observed SSIs. **SIR OF =/<1 IS DESIRABLE**
2) No SIR is calculated when the number of expected SSI is less than one
3) Data shown are reported to the National Healthcare Safety Network (NHSN) database per California Health & Safety Code.
**** Voluntarily reported to NHSN.***

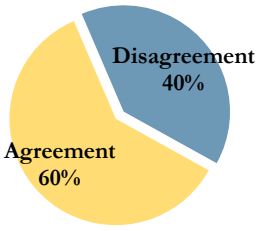
MEDICAL RECORDS COMMITTEE

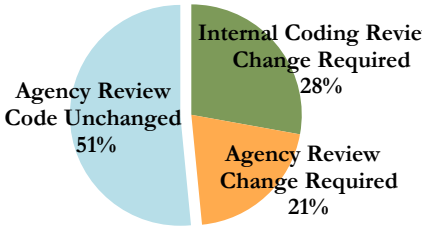
ACTIVITIES AND ACCOMPLISHMENTS:

AHRQ Patient Safety Indicators

- UHC top performer – Ranked 16 of the UHC hospitals based on Patient Safety given low rates of AHRQ Patient Safety Indicators
- Increased physician engagement with a cumulative response rate of 82%
- Stable rates of physician disagreement at 40%
- Increased rate of Patient Safety Indicators requiring recoding to 49%
- Created query specific protocols for escalation in collaboration with service stakeholders







MEDICAL RECORD COMPLIANCE:

Documentation	Metric	Performance
Operative Reports	Timely (30 min post-procedure)	88%
	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	90%
	Diet/Activity	95%
	Discharge medications	95%
	Follow up plans	99%
	Discharge Diagnosis	98%

- Maintained excellent compliance with required documentation: Informed Consent, Operative Procedures, History and Physical, and Discharge Summary
- Transitioned manual audit to automated audit for many of documentation requirements
- Provided feedback of service level performance quarterly to Service Directors

NEW POLICIES AND INITIATIVES:

Clinical Documentation Integrity

- Ensuring that all diagnoses, complications and comorbidities are documented in the medical record; with the goal of capturing the severity of illness of our patients and the extra resources used on their behalf
- Physician response rate to queries regarding documentation specificity >80% for the year
- Increase in Medicare CMI from a baseline of 2.09 to 2.23, with a corresponding fall in Mortality O/E from 1.09 to 0.88

PATIENT SAFETY COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:

- Conducted 19 Root Cause Analyses (RCAs) with 82 action plans developed
- Enhanced the process for disseminating key learnings and improvements from RCAs. Eight RCAs from CY12 were selected for dissemination of learnings/improvements. Methodology for dissemination was tailored to the improvement activity and included a variety of educational activities and multidisciplinary, coordinated efforts to implement new processes across services and units
- Collaborated with Office of Graduate Medical Education to disseminate patient safety lessons to residents and fellows through a new Patient Safety Bulletin. Four bulletins developed and disseminated
- Benioff Children's Hospital Patient Safety Committee re-structured with focused efforts on key pediatric safety issues
- Coordinated educational events to celebrate National Patient Safety Week including Patient Safety Grand Rounds and poster presentations
- Conducted organizational review of Joint Commission Sentinel Event Alert on practices associated with opioid ordering and administration

INCIDENT REPORTING: A total of 9730 incident reports were filed in FY13 a number of which resulted in practice and system review for clinical improvement. Serious events are reviewed weekly by the patient safety committee. Began organizational preparation for a new Incident Reporting system to be launched November 2013.

RCA Event Types FY 2013	Count
Death/Serious Injury from Burn	1
Fall Death/ Serious Injury	1
Medication Error	6
Other	5
Procedural Complication	3
Retained Foreign Body	1
Transfusion Issue	1
Treatment Delay	1
Total	**19**

Focus Areas of RCA Actions Plans FY 2013	Count
Adequacy of technological support	4
Availability of information	10
Care planning process	11
Communication among staff members	6
Communication with patient / family	1
Competency assessment / credentialing	5
Continuum of care	3
Equipment maintenance / management	11
Medication management	15
Orientation and training of staff	6
Policies	8
Staffing levels	2
Total	**82**

RISK MANAGEMENT

ACTIVITIES AND ACCOMPLISHMENTS:

- Reviewed 19 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
  - Consent, lab processing, storage and maintenance of sperm samples, labeling and management of pathology specimens
  - Pre-operative planning and consent process for surgery
  - Coordination of care between endoscopy and surgery
  - Informed consent related to surgery and recognition of complications
  - Communication and coordination of care between non-UCSF and UCSF providers
  - ED and Radiology detection of foreign bodies
  - Requirements to report patient with condition characterized by lapses of consciousness
  - Informed consent related to use of Zometa (based on changing FDA and known risks over time)
- **REVIEW OF 2 MEDICAL MALPRACTICE TRIALS:** Risk Management Committee reviewed 2 cases prior to decision to take the cases to trial. Cases involved allegations of 1) failure to diagnose lung cancer, and 2) negligence related to cardiac catheterization procedure.
- **CONSENT PROCESS:** Reviewed educational in-service material for new consent form.
- **POLICY REVIEW:** Reviewed and approved the following policies: Elder/Dependent Adult Abuse Reporting, Patient's Right to Refuse Treatment, Alcohol and Drug Usage and Possession, Transfer of Patients to Other Hospitals, Admission and Transfer of Patient, and Death of a Patient.
- **OVERSIGHT OF EMMI IMPLEMENTATION**: The program, "EMMI Solutions" (Expectation Management and Medical Information) is a web-based, interactive educational product used by physicians to educate patients about chronic conditions, hospitalization and surgical or invasive procedures they are about to undergo. It uses a multi-media approach to clarify complex information to further the informed consent process. The patient and his or her family are provided the opportunity to view the educational session at home and EMMI tracks the time spent by the patient reviewing the material. It is designed to augment the informed consent process. Areas implemented: Anti-coagulation, DGIM, inpatient Hospitalist service, Neurovascular and Stroke, Hill ACO, and Neuro-Crani.
- **REVIEW OF CERTIFICATE OF INSURANCE DISTRIBUTION AT NON-UCSF LOCATIONS:** Reviewed the distribution of insurance certificates as an indication of the level of institution wide risk for the professional liability program.
- **OVERSIGHT OF TRAINING RELATED TO PATIENT ADVOCACY REPORTING SYSTEM (PARS)**, a reliable tool to identify unnecessary variations in safety and quality outcomes, and intervene to promote professional accountability among all health care professionals.
- Reviewed Category Manager Incident Report data related to Consent and Patient Property loss.
- Future work includes improvement of informed consent process to increase the frequency of consent form completion prior to the day of surgery.

UTILIZATION MANAGEMENT COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:

The primary areas of focus for UM committee in FY2013 were to provide 1) guidance regarding the appropriate utilization of inpatient status, 2) review of denial trends and 3) oversight for patient throughput efforts and transfer center activities. The committee performed ongoing analysis of the Utilization Management Scorecard and outlier length of stay review.

MEDICARE CLASSIFICATION OF PATIENTS: INPATIENT VS OUTPATIENT

The correct assignment of patients to Inpatient Status rather than Observation or ONB (outpatient needing a bed) is a challenge. The UM committee supported the engagement of an external physician advising service, Accretive PAS, to assist. As of January 1, 2013 Accretive PAS has provided an external opinion and justification for the appropriate status of cases referred to them. From January-August 2013, 1,058 cases were referred to Accretive with 82% agreement and 18% suggestions to change status. The use of Accretive has led to improvement in reimbursement, as well as greater compliance with correct patient status as outpatient or inpatient under Medicare's definition. Physicians are educated both proactively and through case by case notification when a patient is deemed to be more appropriate for a different status than initially ordered.

DENIAL TRENDS:

The UM committee analyzes denial trends to identify possible sources of improvement in utilization and the stewardship of resources. The most common sources of denial remain patients with an unsafe discharge plan who require placement or conservatorship. Denials vary significantly by payer. No significant trends in the processes of care have been identified.

LOS AND OUTLIER REVIEW:

The committee reviews the utilization dashboard for length of stay outliers, overall trends, and areas of focused opportunity. Follow up with the appropriate services is performed on an ad hoc basis.

ACCOUNTABLE CARE ORGANIZATIONS (ACO)

UCSF has established 2 commercial ACOs. One for City and County of SF (CCSF) employees insured through Blue Shield of CA, and one for University of CA employees insured through HealthNet Blue and Gold. ACO partners include UCSF Medical Center, Hill Physicians Medical Group, Dignity Health, and other health plans. Highlights of initial focus areas include:

- LOS and transitions management via coordination across all ACO partners and implementation of a Care Transitions Manager
- Increased PCP, urgent care and behavioral health access
- Data sharing and EHR integration

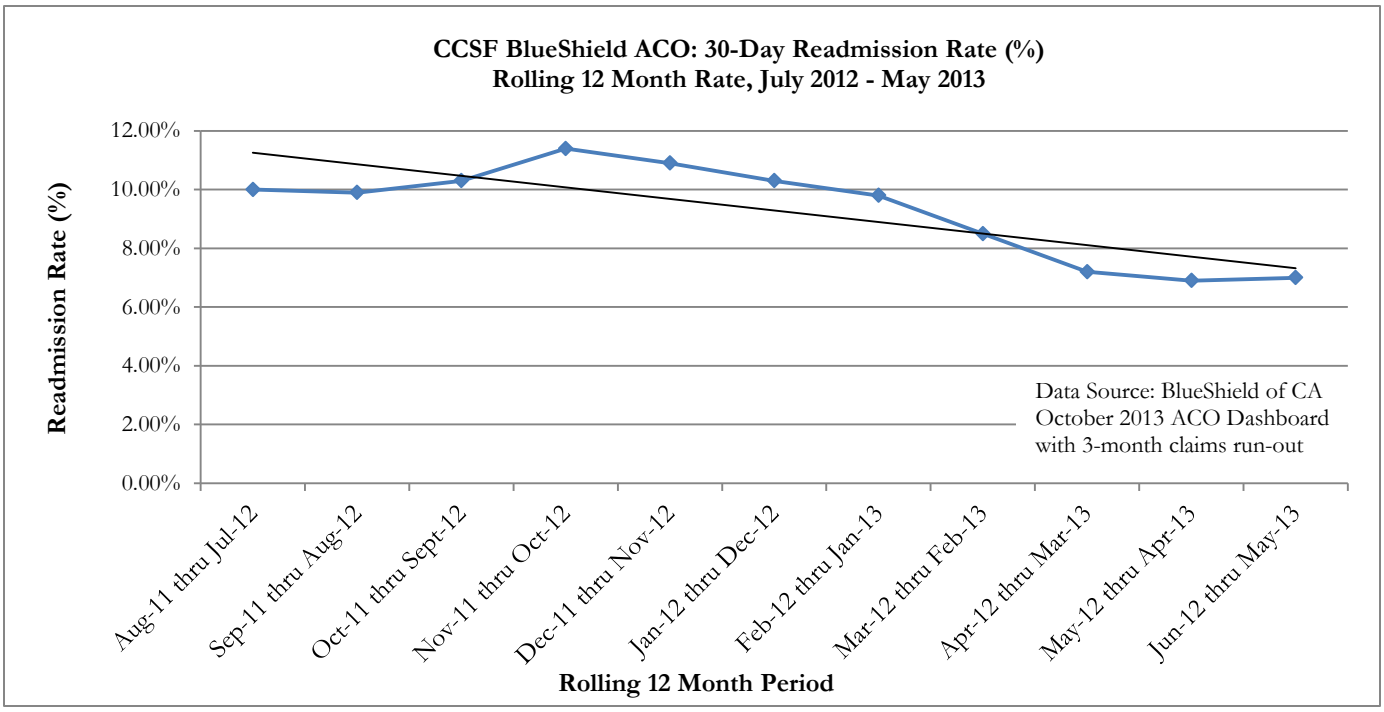
City and County of SF - BlueShield ACO

During the first performance year, the BlueShield CCSF ACO population demonstrated improvements across several key utilization measures, shown in the table below.

Measure (Source)	Baseline Rate (Jul 2010 – Jun 2011)	Year 1 Rate (Jul 2011 to Jun 2012)
Admits Per 1000 (BlueShield)	63.8	56.5 (-7%)
Days Per 1000 (BlueShield)	327.1	258.2 (-21%)
ALOS (BlueShield)	5.13	4.57 (-11%)

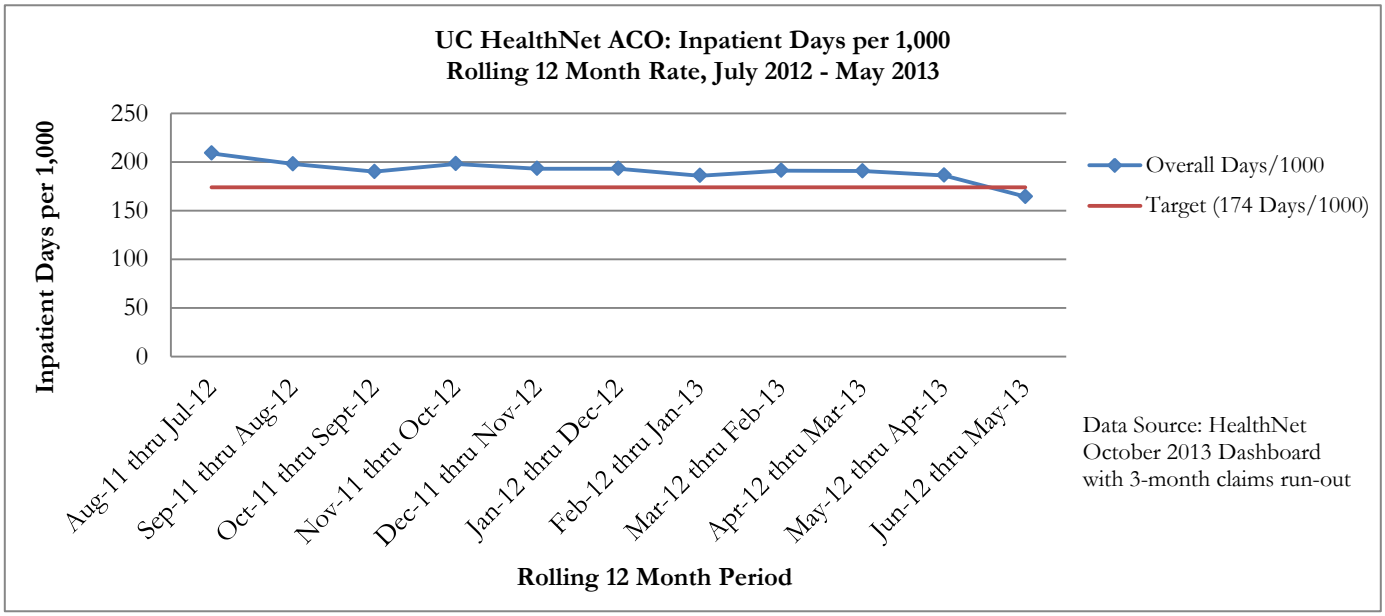
Utilization Management Committee - ACO (continued from previous page)

In addition, the rolling 12 month rate of 30-day readmissions improved from 10% in July 2012 to 7% as of May 2013 (CCSF BlueShield graph shown below).



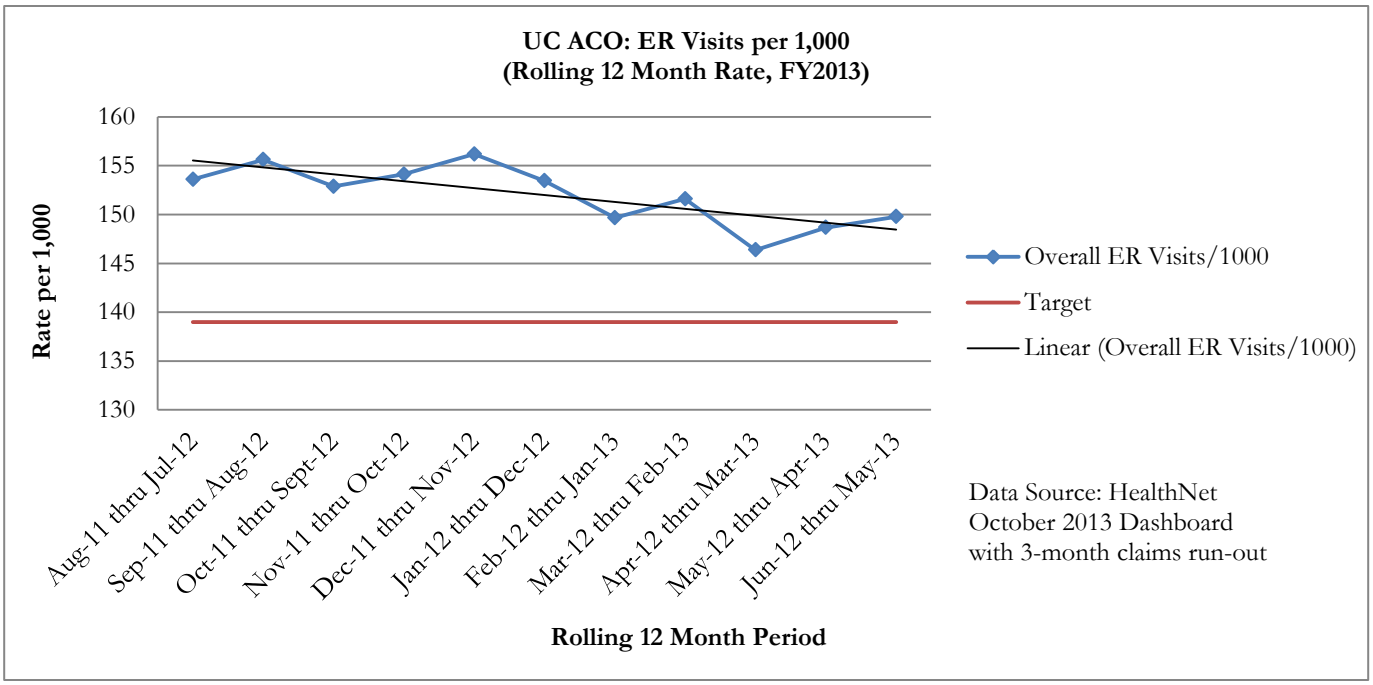
UC - HealthNet Blue & Gold ACO

The UC HealthNet accountable care arrangement began in January of 2013, and improvements in utilization have been seen in this population as well. The graph below shows the rolling 12 month rate of inpatient days per 1,000, which beat the clinical target in May 2013 with a rate of 165 days per 1,000.



Utilization Management Committee - ACO (continued from previous page)

Several ACO interventions have focused on improving patient access to primary care, urgent care, and behavioral health services, with the goal of reducing preventable ED visits and improving continuity of care. Between July 2012 and May 2013, the rolling 12 month rate of ER visits per 1,000 declined from 154 to 150 for the UC ACO population.



QUALITY COMMITTEES REPORTING TO CLINICAL PERFORMANCE IMPROVEMENT COMMITTEE (CPIC)

ADULT CRITICAL CARE COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:

- **The ICU Early Mobilization Program**
  - Expanded from 5 days/week physical therapy in 9 and 13 ICU to 6 days/week coverage
  - Physical therapy orders are now written and responded to within 48 hours of admission to the ICU
  - Increased physical therapy staff for ICU patient
  - Program offers continuing education for early mobility to other critical care areas around the country

- **The Medication Overuse Committee**
  - A study was conducted to look at the appropriateness of ICU Stress Ulcer Prophylaxis (SUP) in 9 & 13 ICUs
  - Results: 1) reduction in inappropriate use of SUP in the ICU (from 19% to 6%, p=0.002).
    2) reduction in inappropriate SUP use at hospital discharge (from 11% to 0%, p=0.04)

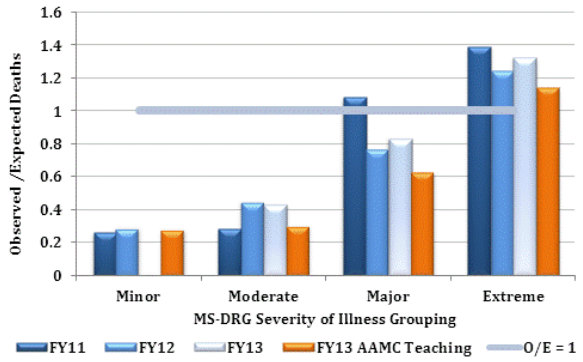
- **ICU Delirium QI Project**
  - Led by the ICU pharmacists with multidisciplinary team on delirium screening, prevention and treatment
  - Results: 1) increase in Confusion Assessment Method[4] (CAM-ICU) screenings in the cardiac and med-surg ICUs (62% vs 70%, p=0.005)
    2) reduction in deliriogenic medication exposure (71% v 44%, p<0.001)
    3) antipsychotic medication use (12% v 4%, p < 0.001) in med-surg ICU patients

ONGOING MONITORING AND QI:

- The incidence of CLABSI increased slightly to 1.2 per 1000 line days, up 1.1 in FY12 and FY11; incidence of VAP has decreased to 1.4 per 1000 ventilator days 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 severity of illness groups, but has increased for major and extreme SOI groups. Mean ICU length of stay is similar to that of the AAMC Teaching hospitals.

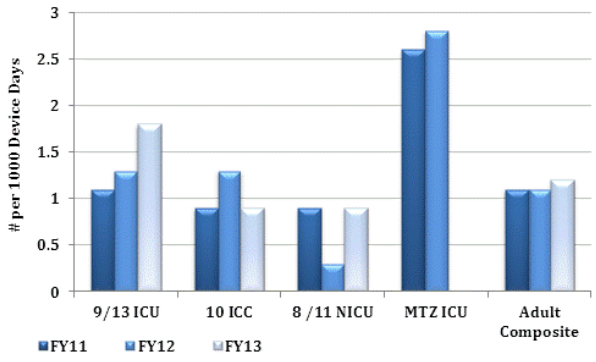
QI Metrics

ICU Mortality

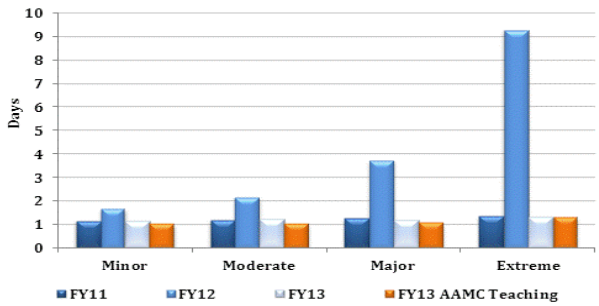


Infection Metrics

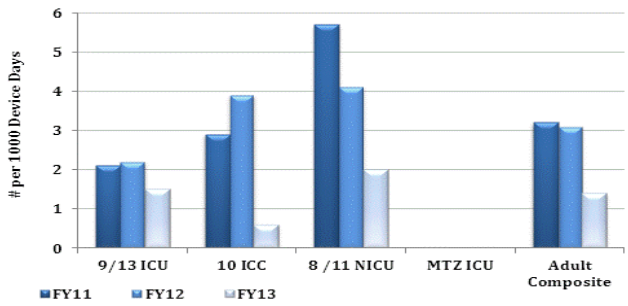
Central Line-Associated Blood Stream Infections



ICU Length of Stay



Ventilator-Associated Pneumonia[5]



[4] *A delirium monitoring instrument*
[5] *For FY 14 the criteria will change and Ventilator Associated Event (VAE) will be reported instead of Ventilator Associated Pneumonia (VAP).*

CANCER COMMITTEE

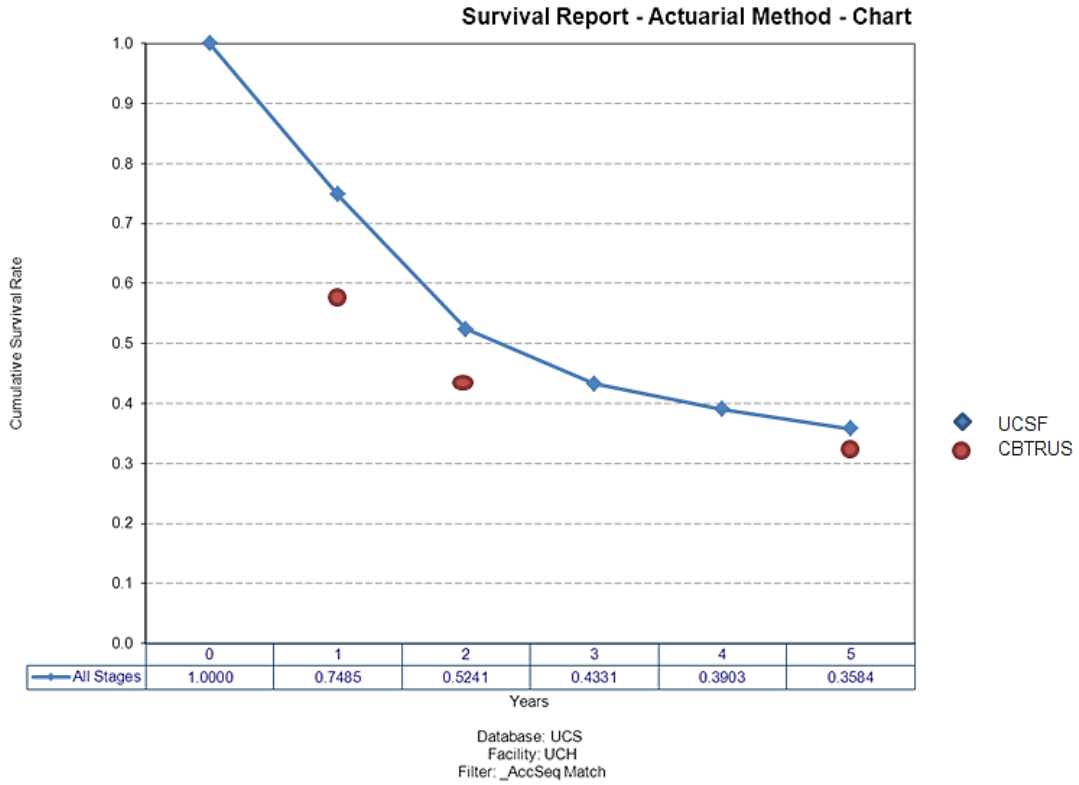
OVERVIEW:

- Cancer Committee facilitated participation in the American Cancer Society's *Cancer Prevention Study-3* using the Helen Diller Family Comprehensive Cancer Center (HDFCCC) as a host enrollment site.
- The HDFCCC Cancer Program was surveyed for re-accreditation by the American College of Surgeons, Commission on Cancer on April 15, 2013. Accreditation has been extended another 3 years.
- Cancer Committee oversees compliance with accreditation standards and has focused on the following:
  - Implementation of American Joint Committee on Cancer (AJCC) TNM cancer staging in APeX
  - Implementation of Survivorship Care Planning, Patient Navigation, and Distress Screening for cancer patients

NOTABLE HIGHLIGHTS:

10-Year Malignant Glioma Study

- 2,535 malignant gliomas diagnosed and treated at UCSF 2002-2011 (average 253/year)
- Median Age at Diagnosis: 50-59 year age range (pediatric cases excluded); Gender Distribution: Male = 59% vs. Female 41%
- Race/Ethnicity: Caucasian = 81.4%, Hispanic = 7.6%, Asian/PI = 6.3%, African American = 2.3%
- Catchment Area: 38% GSFBA*, 42% Northern California counties other than GSFBA, 18% out of state, 2% foreign
- Clinical Trial Enrollment: 35% enrolled on therapeutic clinical trials
- Survival: 76% at 1 year (vs. 58% CBTRUS**); 37% at 5 years vs. 34% CBTRUS)

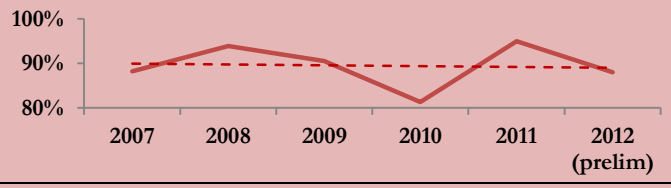
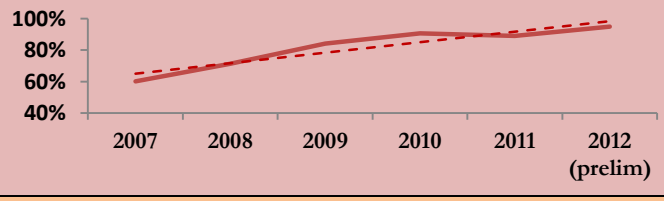
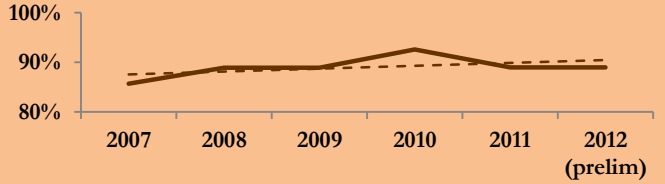
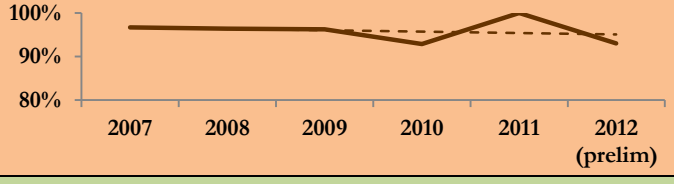
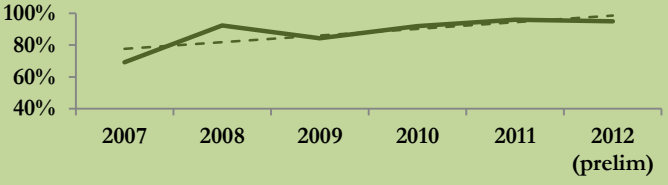


**Greater San Francisco Bay Area (GSFBA) = Alameda, Contra Costa, Marin, Monterey, San Benito, San Mateo, San Francisco, Santa Clara, Santa Cruz*
***CBTRUS = Central Brain Tumor Registry of United States*

Cancer Committee (continued from previous page)

NATIONAL CANCER DATABASE (NCDB) QUALITY METRIC PERFORMANCE

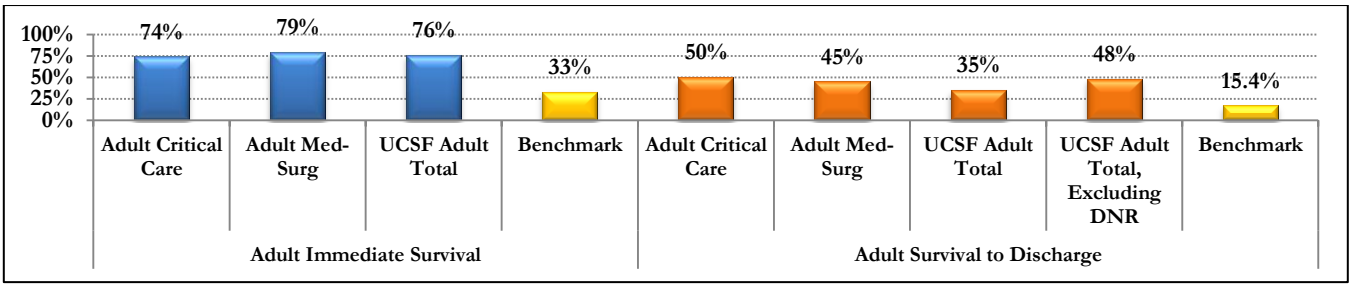
The National Quality Forum (NQF) brought public and private payers together with consumers, researchers, and clinicians to broaden consensus on performance measures for breast and colorectal cancer. The performance rates shown in the Cancer Program Practice Profile Reports (CP3R) match the specifications of the breast, colon and rectal cancer care measures endorsed by the NQF in April, 2007. The Commission on Cancer has been actively engaged in this process. The CoC has instituted the CP3R 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.

	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.	
BREAST	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.	
BREAST	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.	
COLON	Adjuvant chemotherapy is **considered or administered** within 120 days of diagnosis for patients < 80 with AJCC Stage III (lymph node positive) colon cancer.	
COLON	At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.	
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.	

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).
- A Code Blue workgroup met to plan Mission Bay Code Blue response.
- The Committee closely monitors relevant QI metrics: UCSF adult cardiopulmonary arrest (CPA) outcomes exceed the national benchmark. Immediate CPR success rate was 76%, compared with the benchmark of 44%. UCSF adult CPA survival to hospital discharge rate is 35% when all adult cardiopulmonary arrest patients are included and 48% when adult CPA patients who were made DNR are excluded, significantly better than the national benchmark of 15.4%.

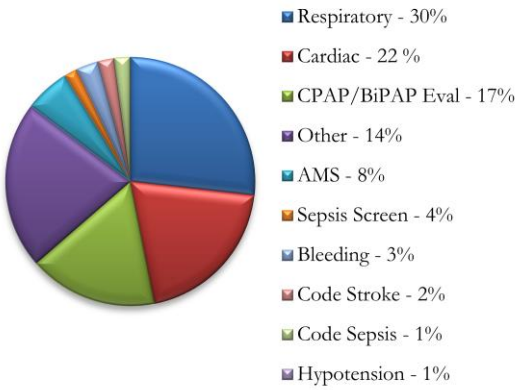


ACTIVITIES AND ACCOMPLISHMENTS:

- Majority of the 28 code blue events in the medical-surgical units of M-L hospital were reviewed and debriefed. Cases were referred for further M&M/QI Committee review as appropriate.
- The Committee continues to review and evaluate devices with a plan for defibrillator replacement.
- Evaluated the 10 ICC charge nurses role in attending other ICU codes. A 3-month pilot demonstrated the benefits of local ICU charge nurse coverage. This change went into effect permanently at the end of FY13.
- **Advanced Resuscitation Training (ART):** UCSF committed to joining the other UC campuses in creating an ART infrastructure.

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.
- FY13 RRT call volume averaged 192 calls per month (increased from 183/month in FY12), not including vascular access related calls which averaged 103 calls per month. The high volume units were: 14M (24%), 10CVT (14%), 12L (11%), 9L (11%), 13L (11%), 14L (9%), and 11L (7%).



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

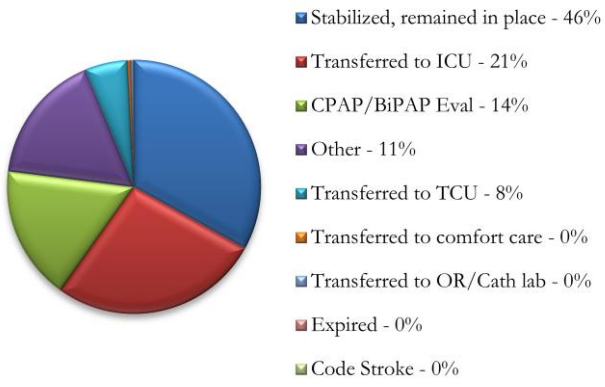


Figure 2 shows the outcomes of the RRT calls in FY13 Forty-six percent of the patients were stabilized in place and did not require transfer. 29% percent were transferred to a higher level of care.

DIABETES AND INSULIN MANAGEMENT COMMITTEE

DM-RELATED ORDERS AND GUIDELINES:

- Sixteen unique APeX insulin order sets for inpatient adults, pediatrics, and obstetrics were developed.
- The "Daily Blood Glucose Report" was developed to improve diabetes management. It captures all adult acute care and critical care patients in the previous 24 hour period with hyperglycemic and hypoglycemic excursions.
- The report triggers a virtual Glucose Management Service Note providing standardized patient-specific recommendations to assist primary service providers in management of their patient's blood sugars.

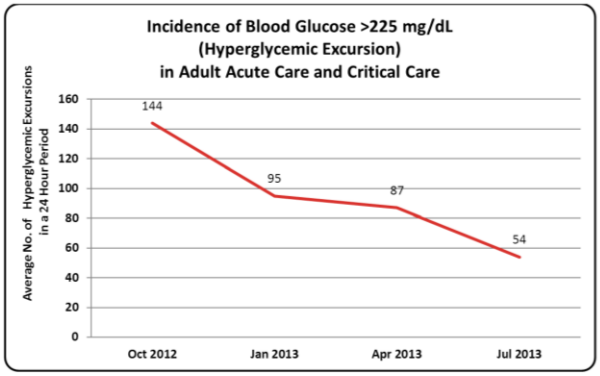
EDUCATION AND TRAINING:

- Instructor-led training was conducted for both physicians and RNs, offering an opportunity to ask questions and interact with clinical experts to problem solve case scenarios.
- Education for all new inpatient Adult and Pediatric RNs was included in FY 13 Department of Nursing Orientation, and education for all new Adult Services' residents and hospitalists continued.
- Updated interactive online education modules, teaching physicians and pharmacists how to write insulin orders in APeX, were developed and implemented, as were online education modules addressing correct use of the new insulin order sets for RNs.

AUDITS AND MONITORING:

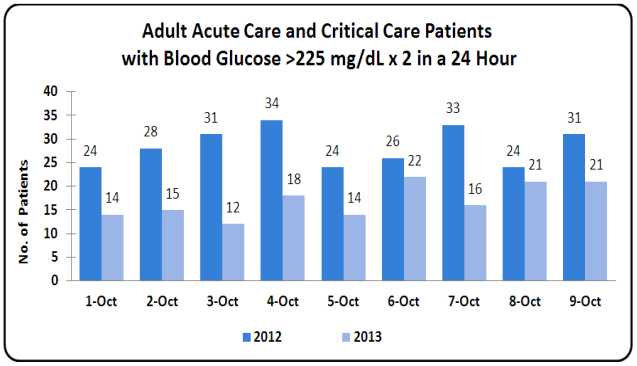
Daily Blood Glucose Report

Below are graphic representations showing the steady decline in out of range blood sugars for adult acute care and critical care patients receiving subcutaneous insulin for FY 2013. Largely attributed to the daily "APeX Glucose Management Service Note", both overall incidence of hyperglycemic excursion and the number of patients experiencing hyperglycemic excursion were markedly reduced. With the lower glucoses, there was no increase in our already low rate of hypoglycemia.



Graph-1 ➡

A 62% reduction in the incidence of hyperglycemic excursions in adult acute and critical care occurred in the nine months following implementation of the "APeX Glucose Management Service Note". Hyperglycemic excursions are defined as blood glucose level > 225 mg/dL.



⬅ Graph-2

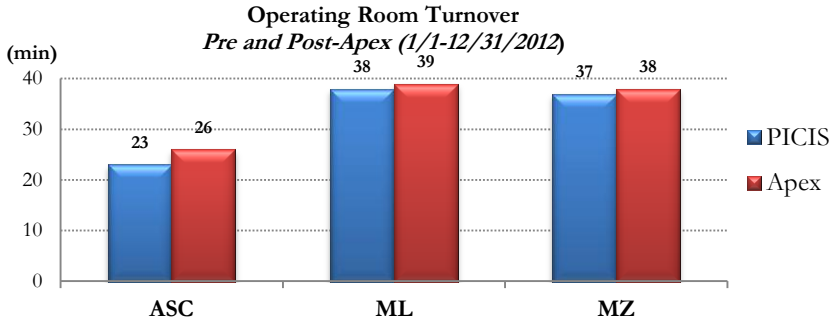
The total number of adult acute care and critical care patients receiving subcutaneous insulin experiencing a hyperglycemic excursion **decreased by 12% to 62% per day for the same nine day period in October 2013 as compared to 2012,** with a median reduction of 44%.

OPERATING ROOM COMMITTEE

PERFORMANCE IMPROVEMENT ACTIVITIES AND ACCOMPLISHMENTS:

- Zero retained sponges in CY 2012. Compliance with sponge counts and medication labeling audits was 100%
- 24% reduction in workplace injuries from 2011-2012 in the Parnassus Operating Rooms
- $697,000 in cost savings from participation in the Stryker Sustainability medical device recycling program. This is an increase in savings of more than $291,000 compared to FY2011
- New surgical consent form implemented
- New protocol implemented for the management of unretrieved device fragments
- Improved laser surgery per-procedure time out and airway fire management procedure implemented
- Cancellation rates of the Parnassus Operating Rooms achieved a 29% decrease from September 2012 through June 2013

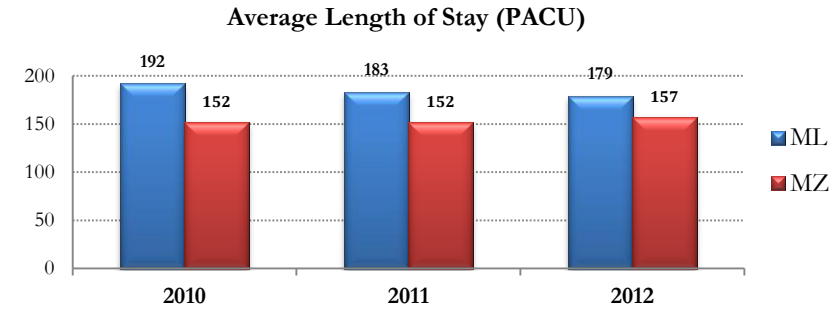
IMPLEMENTATION OF APEX OPTIME IN THE PERIOPERATIVE AREAS



The implementation of an electronic health record is known to be disruptive and to adversely impact care process time.

With good planning, education, and communication, the impact of the transition from PICIS to APeX in the perioperative areas was minimized.

LENGTH OF STAY IN POST ANESTHESIA CARE UNITS



Continuous improvements in centralized patient management have decreased the length of stay in the Post Anesthesia Care Unit of the Parnassus Operating Rooms for three consecutive years.

There was a 2% reduction in the PACU ALOS from 2011 to 2012 while the surgery volume increased by 1% during the same period.

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	**FY13**	**Target**	
Immediate Use Steam Sterilization (IUSS)	12%	15%	
IUSS Loads with Implants	0%	0%	
# of Failed Biologic Tests Resulting in Recall	0%	0%	
Sterilizer Cleaning 1x/month	99%*	100%	
OR Accuracy	96%	93%	
Case Cart QA	99%	93%	

PAIN COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:

- The second Pain Summit was held on May 16, 2013. The Summit will be planned as an annual event
- A new physician has been appointed as the new Medical Director for the UCSF Chronic Pain Consult Service and the UCSF Pain Management Center
- The first "Pain Newsletter" was disseminated campus wide and posted on the NIH Portal as a part of the NIH Pain Consortium Center of Excellence in Pain Education Program
- "Multimodal analgesia" had been tested in a pilot projected on 12 L. The project had been successful and is currently implemented for all hip and knee arthroplasty patients as part of their analgesic program
- The Chronic Pain Consult Service was developed and endorsed by the Pain Committee
- Developed and published guidelines for Neuraxial Anesthesia and Antithrombic Management
- Developed a response to The Joint Commission Sentinel Event Alert, "Safe Use of Opiods in Hospitals" issue 49, August 8, 2012. The top recommendations identified by the Pain Committee for remediation are:
  1. Add a dedicated NP/CNS for comprehensive pain education and management
  2. Recruit a CNS in pain and/or establish a plan to hire a NP with dual roles that include participation on the pain service plus an educational mission to help sustain and embed best practices on the safe use of opioids in the medical center
  3. Enable a mechanism to order non-pharmacologic options
  4. Provide real time feedback to nursing in regards to pain assessments

  These recommendations were presented to the Patient Safety Committee for consideration of implementation.

SEDATION COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:

- A new Chair for the Medical Staff Sedation Committee was appointed
- The Committee continues to work with the UCSF APeX team on modifying the Sedation Narrator for real-time documentation during procedural sedation
- The Committee developed an automated sedation audit within APeX. This tool will be implemented after the Sedation Narrator revision has been completed and optimized
- The Committee continues to monitor quarterly sedation process and outcomes for all non-operating room areas performing procedural sedation. No system issues or trends had been observed

SURGICAL CASE AND HOSPITAL MORTALITY REVIEW COMMITTEE (SCHMRC)

ACTIVITIES AND HIGHLIGHTS:

- 100% of all deaths (737) were reviewed and rated
- 95% of all deaths were reviewed within 3 months
  - Target for FY14: 75% of cases reviewed within 2 months of event date
- In March 2013 committee members began to use an on-line case review database to capture ratings and systems issues
- Systems issues identified by the committee are summarized below:

HIGHLIGHT OF SYSTEMS ISSUES IDENTIFIED AND ACTIONS TAKEN

Areas	Focus	Improvements
Medicine, General Surgery, CTS, Cardiology, Pediatrics	**Co-management / communication between teams**	Four cases were brought to committee with potential issues. All cases were referred for action to appropriate leaders, including CMO, CNO, division chiefs, and Patient Safety. Committee Recommendation: • Clinical teams should co-manage patients with serious conditions that bridge both (or all) areas • Rounding should be done jointly, so everyone knows the plan • Formulate guidelines for optimizing procedures such as IABP removal • Defined criteria for success and failure of major changes in treatment
Cardiology, Radiology	**Resident and fellow supervision and oversight**	Three cases were brought to Committee with potential issues around oversight of trainees: • Two were referred to Cardiology and one to Radiology QI • Both services took steps to create and strengthen oversight practices and policies

PLANNED PROCESS CHANGES FOR FY2014:

- A proposal from the CMO to increase the focus on systems or interventions that could have prevented certain deaths, and revise the peer review component to strengthen the link back to the department chair and the re-credentialing process
- Revise and streamline rating system to include additional systems-related categories
- Set up formal process to track and refer cases to the Patient Safety Committee, NPIEC/CIDP or other appropriate M&M forums for action and follow-up

TISSUE COMMITTEE

The charge of the Tissue Committee is to develop policies and practices, and to act as an oversight body for procurement, issuance, and handling of tissues.

FY2013 TISSUE SAFETY HIGHLIGHTS:

- **Recalled Tissue Products:**
  The Department of Materiel 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 Blood and Marrow Transplant Laboratory reported positive cultures of 1.70% (8 out of 481) in FY2012. Pediatric Blood and Marrow Transplant Laboratory reported positive cultures of 3.4% (7 out of 204). This is below the target threshold of <5%.
- **Milk Bank:**
  The donor milk bank obtained a tissue license in 2012 and remains in active use in compliance with Joint Commission standards. The milk is tested for the presence of bacteria and viruses, and the donors are healthy mothers who are nursing their own babies and have an abundant milk supply. Donors do not receive any financial compensation, and are screened both by blood tests every six months and by recommendation from their providers. The screening follows the American Association of Blood Bank Guidelines wherever applicable to human milk.
- **Blood Bank Oversight of Solid Organs and Vessels for Transplantation: Phases I and II:**
  In CY 2012, the blood bank brought into inventory, verified ABO compatibility, and issued organ and transplant records for 294 organs (238 kidneys, 15 pancreas, and 41 livers).
- Livers began to be issued by the blood bank in September 2012 via a proxy card process to expedite deliver in lieu of delivering the organ box to the Blood Bank. The turnaround time for kidneys is 13.8 minutes, and 10.8 minutes for livers.

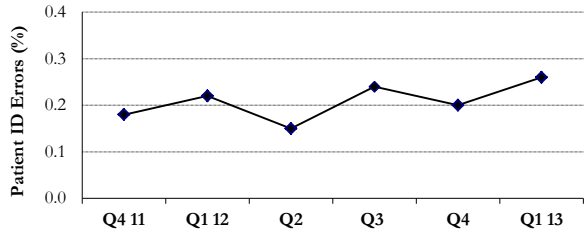
NEXT STEPS FOR FY 2013-2014:

- **Donor Tissue Infection Management:** The Tissue Committee will devise a reporting process with Hospital Epidemiology and Infection Control to cross check existing reports with patients who had a recent implant/transplant at UCSF. This process is to improve capture of adverse events related to tissue or donor infections.
- **Solid Organs and Vessels for Transplantation:**
  - Phases III and IV: Working Group completed workflow revisions and changes to forms required to develop a process for handling organs harvested at UCSF from living donors and for paired exchange organs received from living donors at OSH. Successfully implemented in September 2013.
  - Phase V: Design and implementation of process for handling heart and lungs with a TAT < 5 minutes. Successfully implemented in September 2013.
  - Phase VI: Design and implementation of processes for handling vessels. Working Group has completed workflow design and created forms to develop a process for storing, issuing and tracking disposition of vessels, to meet CMMS/UNOS requirements. Implementation is scheduled for October 2013.

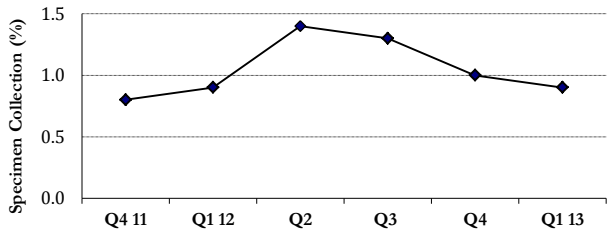
TRANSFUSION COMMITTEE

SPECIMEN ERRORS

Mislabeled Blood Bank samples can lead to an ABO incompatible transfusion. Blood Bank monitors specimen errors including near misses. Despite significant retraining, education, and other interventions, overall specimen collection and labeling errors were showing no decline. The Transfusion Committee is collaborating with the Clinical Performance Improvement Committee, Department of Nursing, and the Patient Safety Committee to identify and implement solutions and monitor progress.



Error with potentially serious adverse impact to recipient was discovered prior to testing and blood product selection/issue.



The Blood Bank Supervisor and Assistant Medical Director are working with patient care managers to identify root causes of errors and possible solutions.

SPECIAL PRODUCT REQUESTS: PROCESS IMPROVEMENTS

A review found two variances in 2012 where products lacking special requirements (e.g. irradiation) were allocated for patients. Although no patient harm occurred, the Blood Bank made significant changes to procedures, work flows and protocols to ensure special requirements are always captured at the time of receipt of the order, and also verified at the time of product issue. To date, audits indicate that the correct products have been issued in 100% of all cases and no incidents have occurred since implementation.

ABO DISCREPANCY ERROR: PROCESS IMPROVEMENTS

One case review resulted in the following process improvements:

- LIS and testing algorithm enhancements: Changes to computer entry of forward and back type results, display and interpretation of ABO discrepant results, and additional tables to help trigger QA alerts
- Blood Bank procedures revised to simplify blood product selection algorithm for all patients (transplant and non-transplant related) with ABO discrepancy
- Training exercises to resolve ABO discrepancy problems added to annual competency tasks

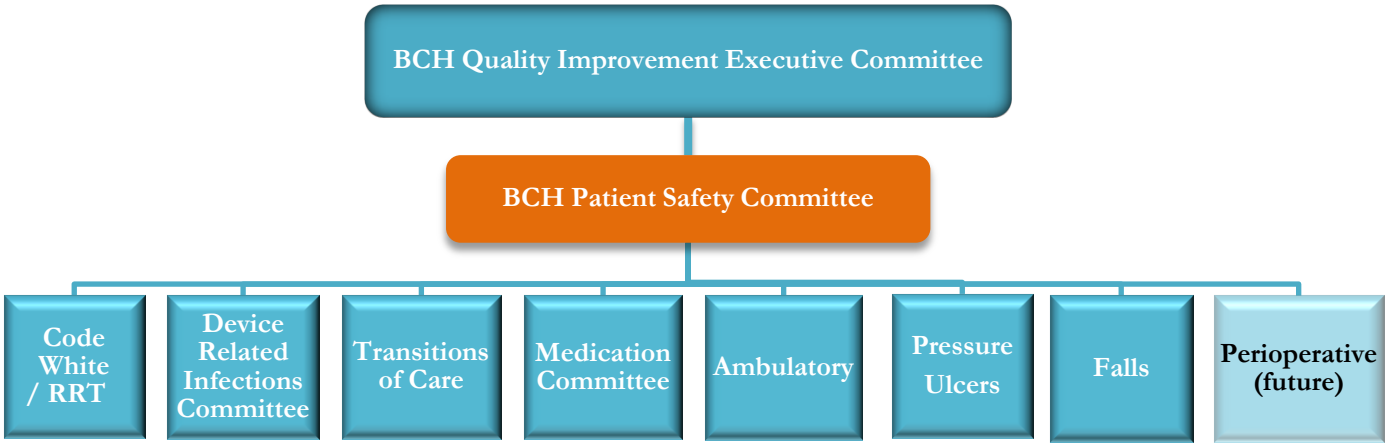
SOLID ORGAN TRANSPLANTATION PROCESS IMPROVEMENT

- *Phase I:* Solid Organ Transplant Working Group developed a process for delivery of boxed kidneys from CTDN directly to the Blood Bank, entry of organ into Blood Bank inventory, verification of ABO compatibility and issue of organ along with Blood Bank Transplant Record to OR. Phase I was successfully implemented in September 2011. The turnaround time (~ 13.8 minutes) has been acceptable.
- *Phase II:* Revision of organ verification forms and design of downtime procedures & protocols for revised workflow completed. The new process is designed for fast track processing of deceased livers received from CTDN or harvested at UCSF. Implemented in August 2012. The turnaround time (10.75 minutes) has been acceptable.
- *Phases III and IV:* Working Group completed workflow revisions and changes to forms required to develop a process for handling organs harvested at UCSF from living donors and for paired exchange organs received from living donors at OSH. Successfully implemented in September 2013.
- *Phase V:* Design and implementation of process for handling heart and lungs with a TAT < 5 minutes. Successfully implemented in September 2013.
- *Phase VI:* Design and implementation of processes for handling vessels. Working Group has completed workflow design and created forms to develop a process for storing, issuing and tracking disposition of vessels, to meet CMMS/UNOS requirements. Implementation is scheduled for October 2013.

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 (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

FY13 ACTIVITIES AND ACCOMPLISHMENTS:

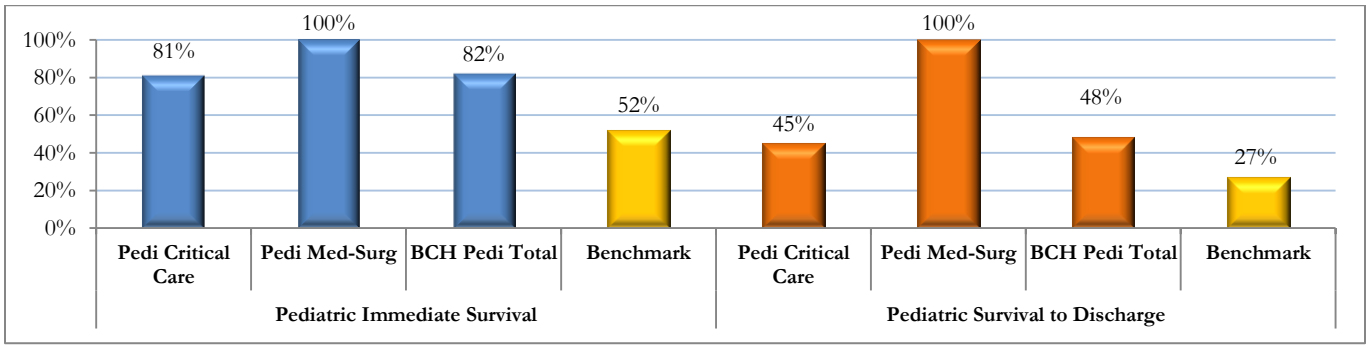
- I-PASS handoff communication was implemented in a pilot in the Pediatric Treatment Center
- TPN Safety improved through redesign of the electronic health record
- Insulin ordering/documentation procedures revised to enable single-dose ordering and timely administration
- NG tube placement policies and procedures were modified to promote safety, including color-coding, tracing lines from source to patient, and prohibiting modifications
- Bar-coding was implemented to ensure right breast milk is administered to right baby
- Worked with the product manufacturer to promote redesign of a closed drug transfer device to reduce inadvertent patient and staff exposures to chemotherapeutic agents
- Reduced the incidence of related and unplanned readmissions
- Implemented Family-Centered rounding for improved communication, care coordination, and discharge planning

BCH CODE WHITE AND RAPID RESPONSE TEAM

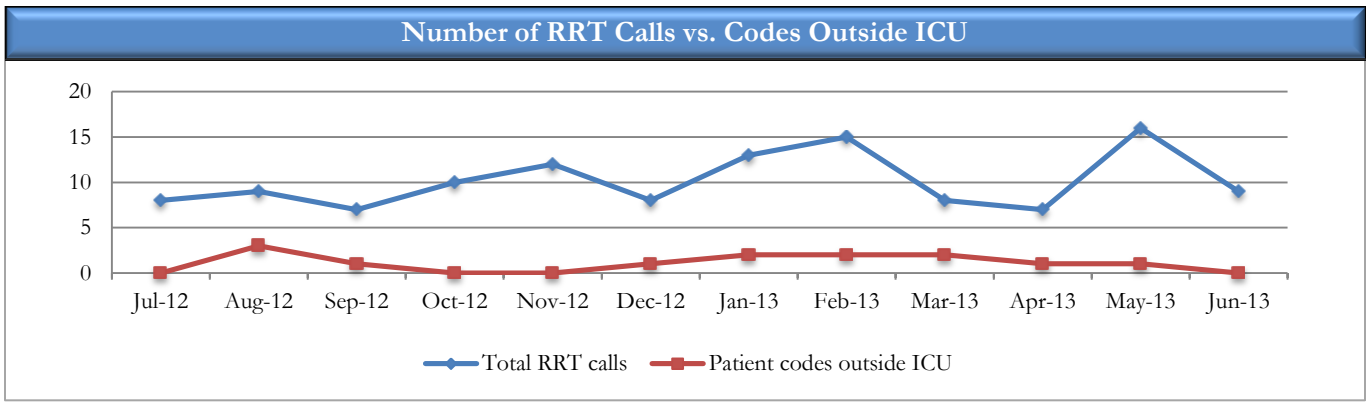
There are two teams at UCSF Benioff Children's Hospital (BCH) that respond to calls about acute changes in patient conditions: Code White Team and Rapid Response Team. The Code White team responds to potentially life-threatening medical emergencies such as cardiopulmonary arrest. The Rapid Response Team responds to acute changes, which are assessed as not immediately life-threatening, but warranting urgent assessment and treatment. The BCH RRT is an additional safety net that provides for 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.

ACTIVITIES AND ACCOMPLISHMENTS:

- 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 are reviewed to identify any opportunities to improve the care processes and reduce the likelihood of codes. The committee explored pediatric early warning scores (PEWS) as a means to systematically monitor for clinical deterioration and alert providers. A new system for PEWS will be developed in FY14.
- Patient survival rates from cardiopulmonary arrest (CPA) at BCH (shown below) 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.
- The committee evaluated defibrillators to replace those presently in use to add new quality monitoring functions.
- Reviewed policy on family presence during codes. Families may elect to remain with the patient during a code.



- The use of a rapid response team to address emergent patient care issues has enabled UCSF Benioff Children's Hospital to minimize the number of Code White calls as demonstrated in the graph below.



BCH MEDICATION COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:

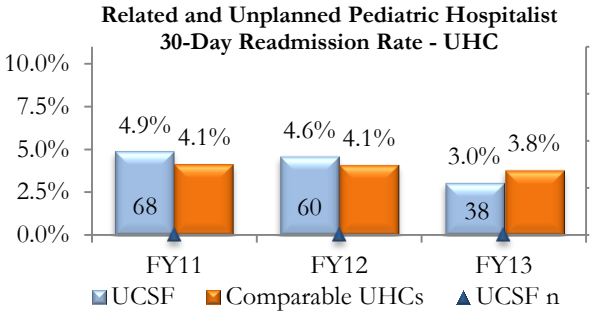
- Mission Bay Readiness: Ensure safe and complete transition of all medication clinical and operational services, and select most effective equipment for medication delivery
- Pulmonary Hypertension Program - introduced 3 new parenteral therapies for patients:
  - IV Remodulin® (Treprostinil Sodium)
  - SQ Remodulin® (Treprostinil Sodium)
  - IV Flolan® (Epoprostenol Sodium)
- Implemented IV/PO conversion per pharmacy protocol as approved by P&T Committee
- Removed Codeine & Codeine containing products from the BCH formulary, including OB/L&D patient care areas (implementation pending)
- Reformed the TPN Ordering Process:
  - Implemented independent two-RN checks prior to TPN administration
  - In Progress: Revise HARD & SOFT limits for TPN electrolytes and macro & micro nutrients
- Multidisciplinary team collaborated with national company to decrease disconnections between CSTD and administration sets
- UCSF and Walgreen's partnered to provide flu vaccine vouchers for patient family members

OTHER SAFETY INITIATIVES IN PROGRESS:

- Weight-Based Dose Policy (in progress)
  - Goal: update to ensure clinical decision support within the CPOE environment
- PACU Override Initiative (in progress)
  - Goal: reduce the number of overrides in the Pediatric PACU Pyxis from 54% to 15%
- Medication Dose Standardization (in progress)
  - Goal: to increase the number of patient specific doses
- Pyxis Override List (in progress)
  - Comprehensive, interdisciplinary review of urgent/emergency medications for all patient care areas
- 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
- Alaris® Guardrails SMART Pump Compliance (in progress)
  - Increase compliance rate for pediatrics profile </= 40 kg to 70% (from 52%)

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 and patient satisfaction.

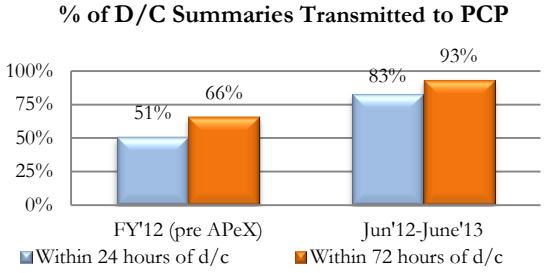


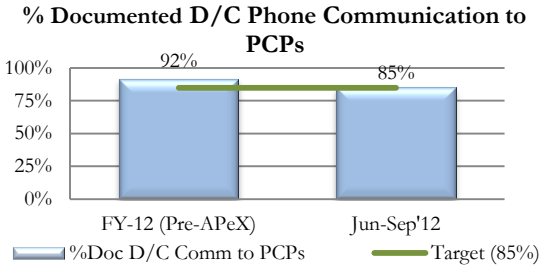
TASK FORCE INTERVENTIONS

- **Family-Centered Rounds** – Family Centered Rounds (FCR) was implemented in May 2012. These rounds allow 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."[6]

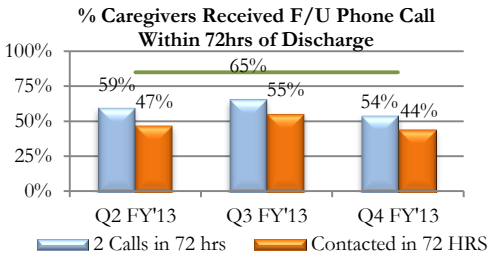
- **Discharge planning** – Internally, the Pediatric Hospital Medicine service has made efforts to expedite discharges so that there is less wait-time for patients and families at UCSF Benioff Children's Hospital. Care teams have set aside two times during the day: the "morning huddle" and "afternoon 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.





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



[6] UCSF Patient Relations survey results (November-December, 2012)

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.

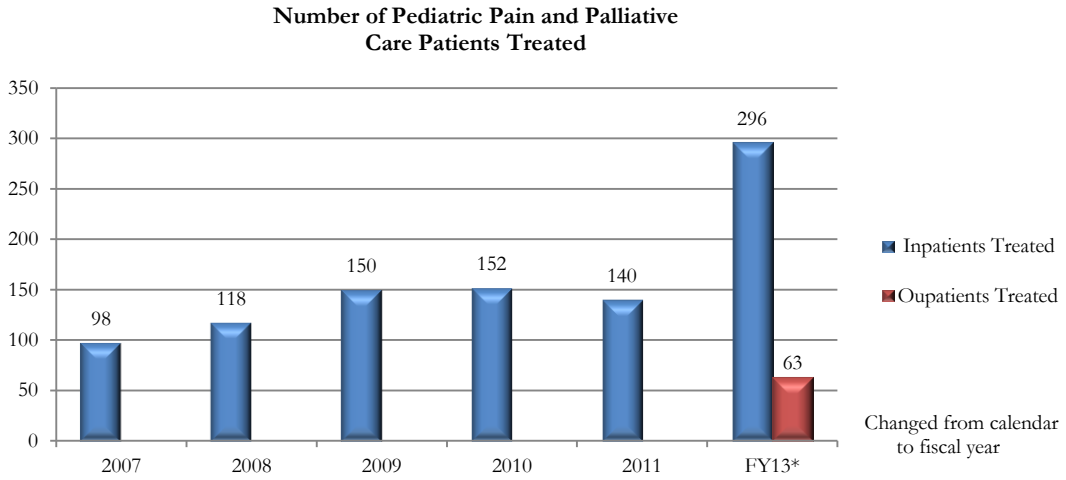
FIVE COMPONENTS OF IP-3

1. IP-3 Consult Service (inpatient pain and palliative care consults)
2. Compass Care (longitudinal care coordination, bereavement, remembrance events, and staff education)
3. Integrative symptom management (acupuncture, acupressure, biofeedback, canine therapy)
4. Outpatient IP-3 Clinic (chronic pain and symptom management, complex care clinic)
5. 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
- Sedation
- Palliative Care consultation
- Complex Care (outpatient)
- Family support
- Bereavement services
- Clinical guideline & policy development
- Education & training
- Community collaboration

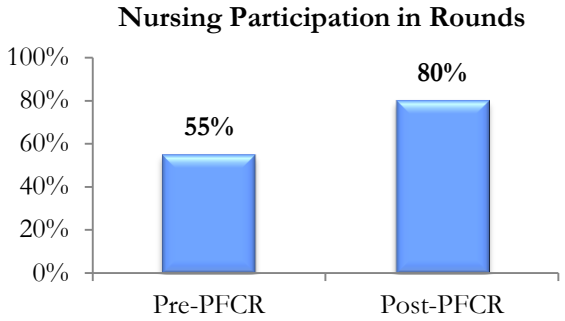


CHILDREN'S HOSPITAL ASSOCIATION (CHA) COLLABORATIVE PROJECT

ACUTE CARE FOCUS GROUP

The CHA Acute Care Focus Group (13 CHA hospitals) has targeted 5 areas for improvement in the recent year: nurse attendance in rounds, patient transfer communication (intensive care to acute care), infant safe sleep environment, discharge process, and isolation procedures.

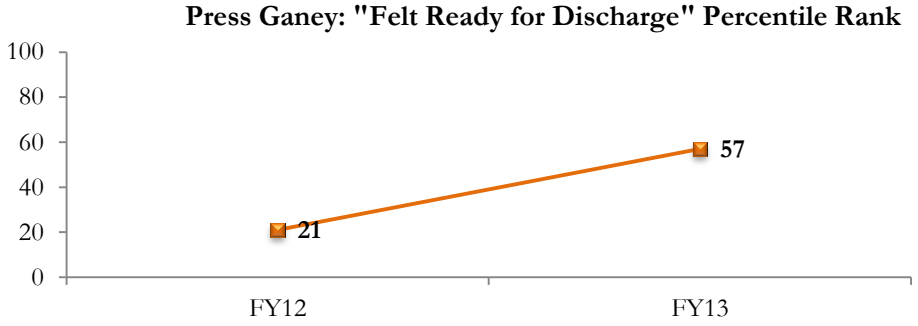
- **Nurse Attendance in Rounds** – Nurse attendance in clinical rounds improved from 55% in the pre-interventions period to 80% following the interventions. Patients and families report that they feel "more involved in the care plan," have the "opportunity to ask questions," and "have better access to complete information."



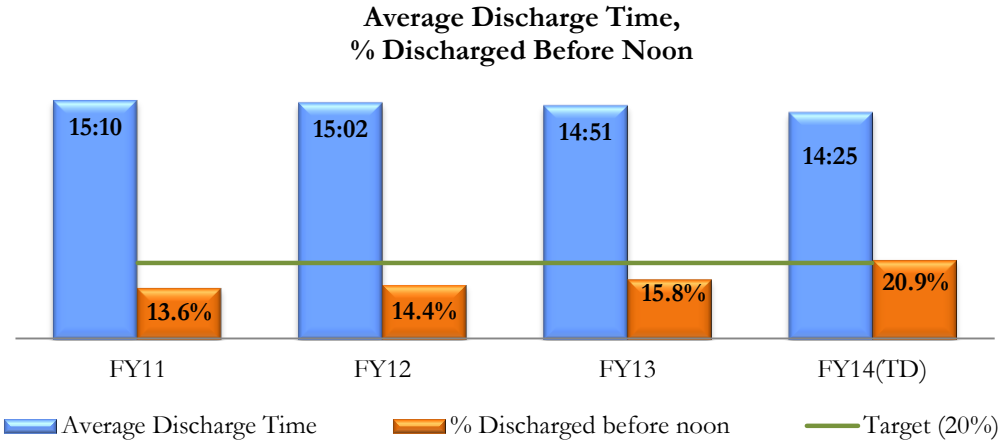
- **Patient Transfer Communication (Intensive Care to Acute Care)** – The interventions included a brochure to families while the patient was in intensive care, a tour of the acute care unit and introduction to the Charge RN prior to transfer, a formal welcome to the unit upon transfer, and a tracking process to ensure all steps were done. Post implementation data is being collected and analyzed including Press Ganey patient satisfaction scores.

- **Infant Safe Sleep Environment** – Interventions include staff education; use of the American Association of Pediatrics suggested sleeping practices: no bundling of infants, back-positioned sleeping, flat head-of-bed, eliminating items from the crib, use of sleep sacks, and no co-sleeping.

- **Discharge Process** – A new pharmacy education plan and a patient discharge lounge were implemented. The percent of discharges within one hour of written order improved from 42% to 66%.



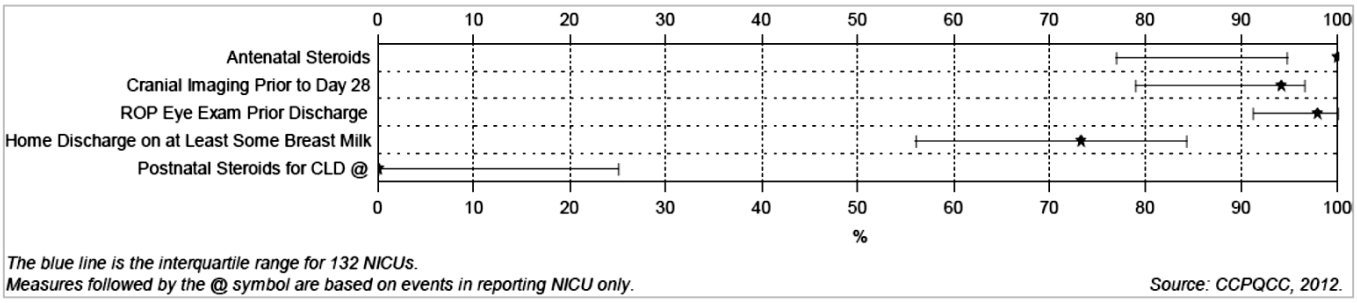
Children's Hospital Association (CHA) Collaborative Project (continued from previous page)



- **Isolation Procedures** – Patients may be placed into or remain in protective infectious isolation (contact precautions, respiratory precautions) unnecessarily. The collaborative will gather and compare institutional policies and current standards.

THE CALIFORNIA PERINATAL QUALITY CARE COLLABORATIVE (CPQCC)

The California Perinatal Quality Care Collaborative (CPQCC) 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.



Higher percentages indicate better performance for compliance in antenatal steroids, cranial imaging prior to day 28, 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 all measures, except home discharge on at least some breast milk, in which the performance is similar to peer hospitals. Conversely, a lower rate indicates better performance for use of postnatal steroids for chronic lung disease.

PATIENT SATISFACTION

MEDICAL CENTER PATIENT SATISFACTION GOAL

The UCSF patient satisfaction incentive award program goal for FY13 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 2013, exceeding the outstanding level of performance goal of 91.7. For HCAHPS, UCSF achieved 5 of 8 domains at the 60th percentile for the 4th quarter, achieving the threshold level of the goal. Combined performance of each resulted in the target level of achievement of the goal. Details of the results are outlined below:

Press Ganey LIKELIHOOD OF RECOMMENDING Dashboard

Press Ganey Survey	Quarterly							
	Jul-Sep12 (n=6476)		Oct-Dec12 (n=5487)		Jan-Mar13 (n=5168)		Apr-Jun13 (n=5019)	
	Mean	%ile	Mean	%ile	Mean	%ile	Mean	%ile
	FINAL		FINAL		FINAL		TO-DATE 83% of surveys	
Outpatient Medical Practices	90.3	15	91.0	18	92.0	27	92.3	31
Adult Inpatient	92.5	80	91.4	70	92.2	77	93.4	86
Pediatric Inpatient	93.0	61	93.8	71	94.1	75	94.2	75
Emergency Department	85.0	58	84.7	55	83.3	44	88.0	77
Combined Mean/%ile	90.6	34	90.9	34	91.7	41	**92.4**	42

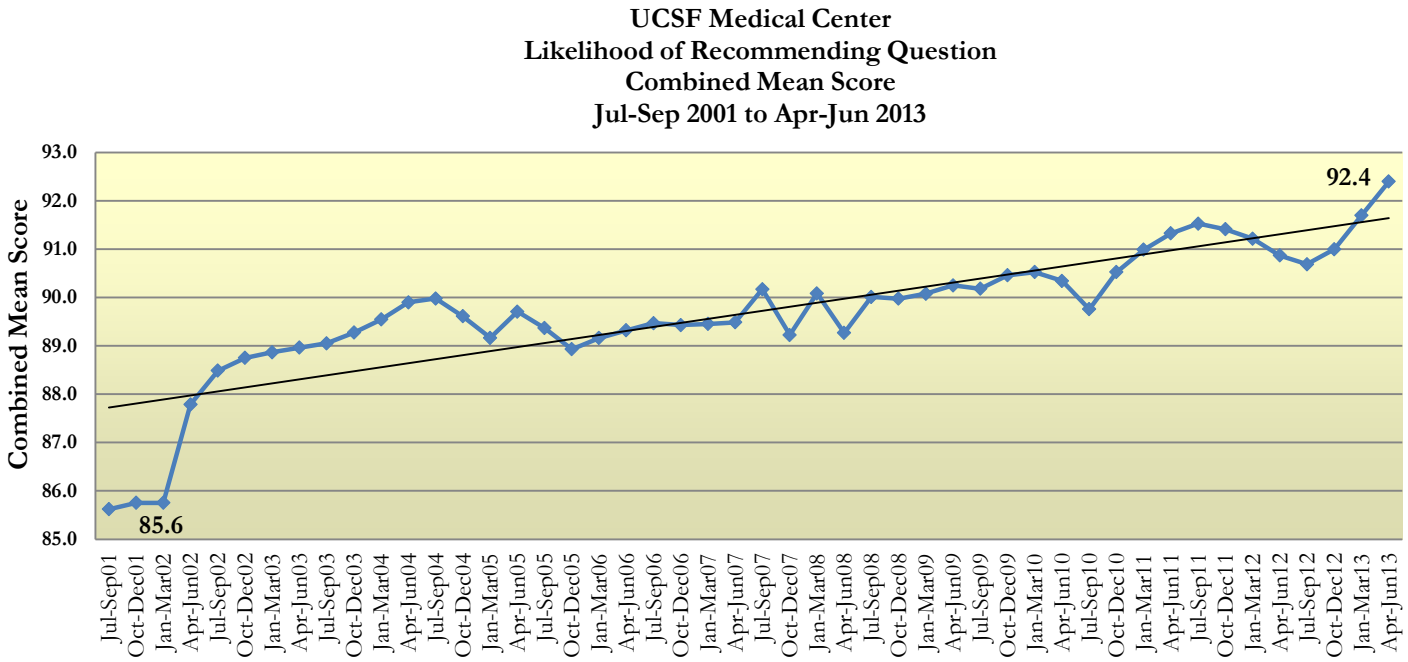
HCAHPS Domain Dashboard

HCAHPS Survey Domain	Quarterly							
	Jul-Sep12 (n=1562)		Oct-Dec12 (n=1466)		Jan-Mar13 (n=1289)		Apr-Jun13 (n=921)	
	Top Box	%ile	Top Box	%ile	Top Box	%ile	Top Box	%ile
	FINAL		FINAL		FINAL		TO-DATE 70% of surveys	
Rate hospital 0-10	75	74	72	59	75	71	78	81
Communication w/ Nurses	78	46	77	35	77	34	81	60
Response of Hospital Staff	58	20	62	33	60	23	62	30
Communication w/ Doctors	81	59	80	44	80	46	83	67
Hospital Environment	60	24	61	27	57	12	62	29
Pain Management	69	36	71	45	71	45	70	41
Communication About Medicines	63	49	64	60	62	41	65	65
Discharge Information	87	67	88	70	88	73	90	88
# of Domains at 60% or higher		2		2		2		**5**

PRESS GANEY PATIENT SATISFACTION 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 mails out 87,000 patient satisfaction surveys a year, or almost 17,000 a week. 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 a random sampling of clinic patients. Surveys are mailed by Press Ganey to patients within a few days after being discharged from the hospital or after a clinic visit.

Over the past ten years, UCSF's quarterly score has improved from 84.1 in 2001 to a high of 92.4 in 2013 based on patient responses to the survey question "Likelihood of your recommending this hospital to others?" as outlined on the graph below. Our staff work 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.



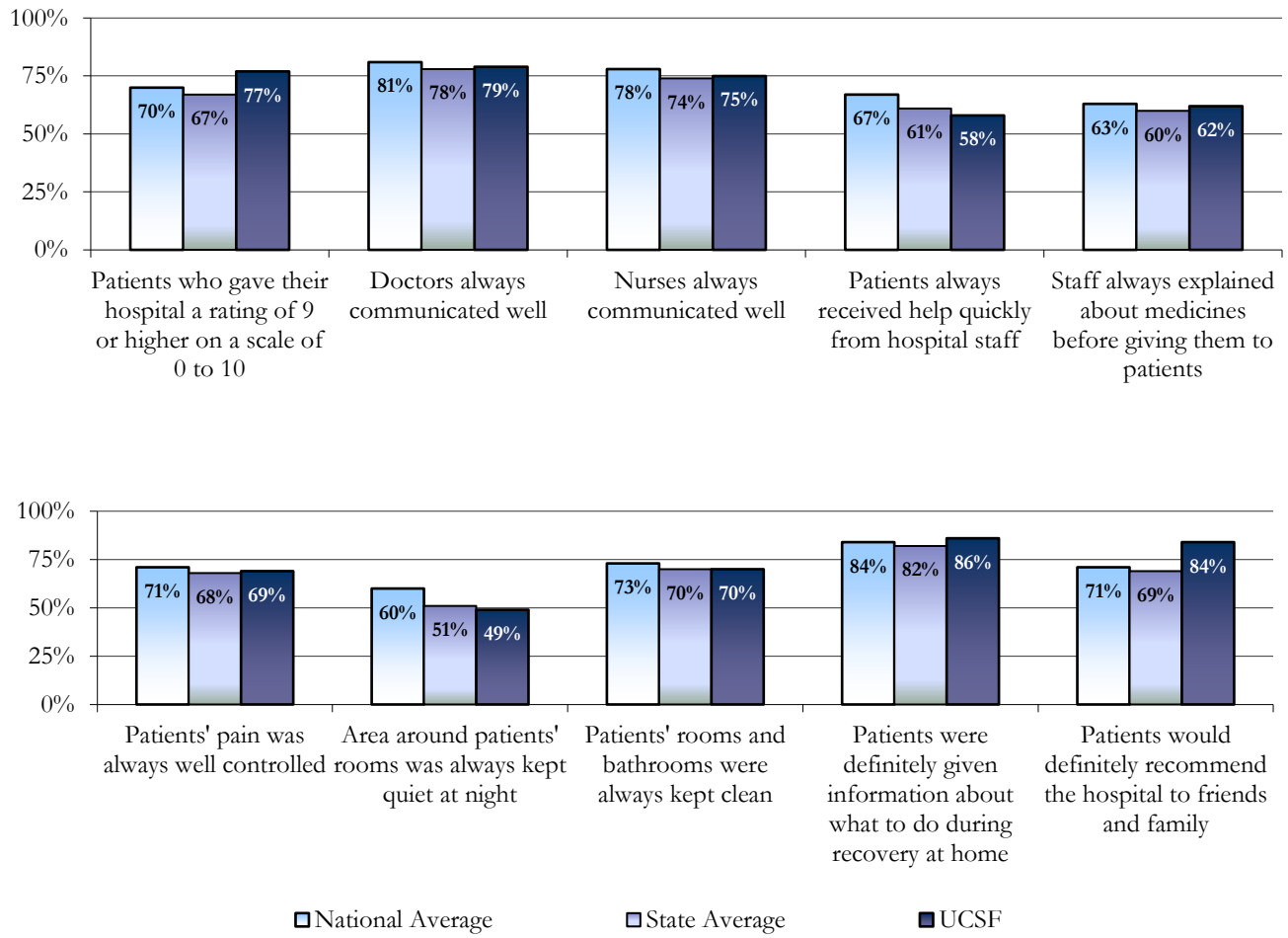
HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS & SYSTEMS (HCAPHS)

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 OCTOBER 2011-SEPTEMBER 2012 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.

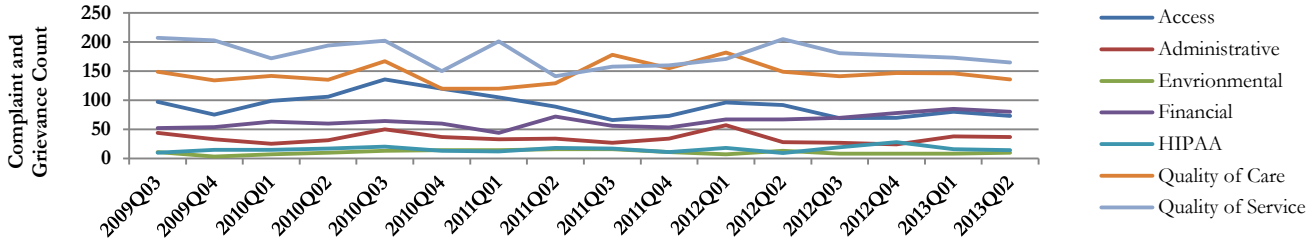


COMPLAINTS AND GRIEVANCES

Complaints and grievance trends are based on unsolicited patient feedback reported to the Patient Relations department directly from patients or their representatives. They are tracked and reported to the Culture of Excellence Committee, Committee on Professionalism, used for the Physician Advocacy Reporting Program (PARS) the physician ongoing professional performance evaluation and other venues on a regular basis. Trend data is evaluated with patient satisfaction data and used to identify improvement opportunities Individual complaints and grievances are thoroughly reviewed 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.

- **30-Day Review and Response Compliance Rate:**
  - Grievance: 72%
  - Complaints: 96%
- **Average number of days to respond to a grievance is 24 Days**
- **Average number of days to respond to a complaint is 11 days**

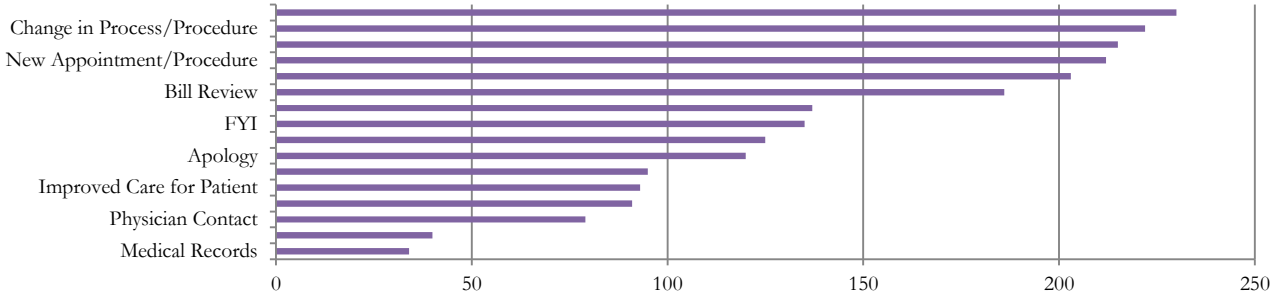
COMPLAINT/GRIEVANCE TRENDS BY CATEGORY:



The graph above reflects:

- The majority of patient concerns are related to Quality of Service, Quality of Care and Access (ability to get an appointment or reach someone on the telephone).
- Quality of Service and Quality of Care have steadily declined from a peak in FY 2012 Quarter 2.
- Finance complaints show a steady increase since 2011 Quarter 4.
- Access complaints continued to trend downward in the last 2 Quarters FY 2013.

COMPLAINT/GRIEVANCE TRENDS "WHAT OUR PATIENTS WANT":



The above graph reflects that patients want (1) corrective action, (2) change in our processes or procedures, (3) a review of their care, (4) a new appointment and (5) clarification or explanations.

In summary, almost all complaints stem from perceived or actual breakdowns in communication at a touch point in the patient's experience. Proactive measures such as staff education and rounding on patients is working to address concerns at the point of service and improve the patient experience. Focused trainings continue in all venues from Living Pride trainings to classes to assisting staff in customer service techniques on a daily basis.

CULTURE OF EXCELLENCE COMMITTEE

The goal of the Culture of Excellence 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, health care 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 outcomes based performance management program to move the organization towards a Culture of Excellence focusing on communications, physician and staff engagement, accountability, organizational development, and performance improvement.

ACTIVITIES AND ACCOMPLISHMENTS:

- Engaged Physician and Resident Champions, and AIDET training for staff and AIDET SMiLe for physicians
- Implemented Leader Rounding on Direct Reports
- Provided over 200 consultations and 30 formal presentations/training to departments on the patient experience
- Completed pilot on use of sound masking device to improve quietness for patients; expansion currently in process
- Completed pilot for "Have a Seat" program to encourage providers to sit while talking with patients
- Expanded Patient Relations and Volunteer Rounding program to six new nursing units
- Received funding for partial nurse resource to mentor clinical volunteer programs

PATIENT SATISFACTION SURVEYS

- E-survey go-live scheduled for FY14 Q1

CAHPS EXPANSION

- CGCAHPS – inclusion for all practices began July 1, 2012
- PCMH (patient centered medical home – annual CGCAHPS survey)
- Peds-CAHPS (pilot in BCH)
- ICH-CAHPS (dialysis center)
- UHC Pilot (specialty practices using CGCAHPS)

CULTURAL COMPETENCY AND LGBTQ

- Maintained a perfect score on Annual LGBT Health Equity Index highlighting the medical center as a national leader
- Evaluated patient satisfaction among special needs patients: LGBT, Culture and Race, Disabilities
- Revised policies and APeX documentation for improved communications

OTHER

- Lean Reach for Excellence launched by Operations Improvement team
- Employee Engagement Survey and follow-up training on action planning completed Employee Apparel Program; implementation complete for all patient care staff - Not completed until late Spring 2013 so is still accurate
- New Advanced Healthcare Directive Toolkit roll out across the organization
- Expectant Management and Medical Information (EMMI™) now available in approximately 15 locations.
- Phase II of employee ID drop-down safety/title cards expanded to include more working titles
- Coordination and planning for pilot of automating discharge phone calls, and roll-out to all adult inpatient units
- Spiritual Care Services – continue with Music is Good Medicine on units, and Annual Holiday concert Patient Visitor Services cards translated into Chinese and Spanish

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 2012 and June 2013.

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

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
- 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

The following committee chairs and staff contributed to this report:
- Accreditation and Survey Activity: Cathy Dietzen
- Adult Code Blue Committee/Rapid Response: Matt Aldrich MD and Jennifer Twiford
- Adult Critical Care Committee: Michael Gropper MD, PhD and Jennifer Twiford
- Cancer Committee: Lee-May Chen MD, Gerrie Shields, Ann Griffin, and My Nguy
- Children's Hospital Code White Committee: Maurice Zwass MD and Shelley Diane
- Children's Hospital Medication Committee: Julie Wilson-Ganz PharmD, Steve Wilson MD, PhD, and Kim Scurr
- Children's Hospital Patient Safety Committee: Steve Wilson MD, PhD and Paul Monsees
- Children's Hospital QIEC: Steve Wilson MD, PhD and Paul Monsees
- Children's Hospital Rapid Response Committee: Steve Wilson MD, PhD and Shelley Diane
- Clinical Performance Improvement Committee (CPIC): Ryutaro Hirose MD, Paul Brakeman MD, PhD, and Joy Pao
- Complaints & Grievances: Deborah Avakian, Christine Diamond, and Susan Alves-Rankin
- Culture of Excellence Committee: Mark Laret, Josh Adler MD, Kathleen Balestreri, Deborah Avakian, Frances Flannery, Susan Alves-Rankin, and Jason Phillips
- Diabetes and Insulin Management Committee: Robert Rushakoff MD, Umesh Masharani MD, Mary Sullivan, and My Nguy
- Environment of Care Committee: Matthew Carlson
- Ethics Committee: Scott Andy Josephson MD and Cindy Byrd
- 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, Michael Blum MD, and SheRee Garcia
- MyChart: Pam Hudson and Brian Cosgrove
- Children's Hospitals Association (CHA) Collaborative Project: Lisa Tsang and Arpi Bekmezian MD
- National Surgical Quality Improvement Program (NSQIP): Mary McGrath MD, Tenille 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, and Julio Barba
- Pain Committee: Mark Schumacher MD, PhD and Jennifer Twiford
- Patient Safety Committee: Adrienne Green MD and Jim Stotts
- Pediatric Pain and Palliative Care Program: IP-3: Robin Kramer

- Pediatric Transitions of Care: Steve Wilson MD, PhD, Arpi Bekmezian MD, and Paul Monsees
- Pharmacy: Daniel Wandres, PharmD and Kethen So
- Patient Satisfaction: Deborah Avakian, Susan Alves-Rankin, and Jason Phillips
- Quality Improvement Executive Committee: Mari-Paule Thiet MD and Brigid Ide
- Quality Landscape: Brigid Ide, Joy Pao, and Gina Intinarelli
- Risk Management Committee: Neal Cohen MD and Susan Penney
- Sedation Committee: Sandra Jeker-Annaheim MD and Jennifer 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, Cynthia Ishizaki, and Julio Barba
- Utilization Management Committee and Accountable Care Organizations: Adrienne Green MD, Elizabeth Polek, and Sara Coleman
- 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

FY14 ORGANIZATIONAL GOALS

Quality and Safety (25%)

- Reduce hospital-wide central line associated blood stream infections (CLABSI) by 15% to 1.36/1000 line days
- Increase percent of patients discharged before noon by 12% from 17.6% to 20% for 3 of 12 months
- Increase MyChart enrollment by 25,000 to a total of 85,000
  - Threshold: Achieve One Goal
  - Target: Achieve Two Goals
  - Outstanding: Achieve Three Goals

Patient Satisfaction (25%)

1) Press Ganey Likelihood of Recommending patient survey question (50%).
   - Threshold: Maintain an average Press Ganey mean score of 92.1
   - Target: Maintain an average Press Ganey mean score of 92.2
   - Outstanding: Maintain an average Press Ganey mean score of 92.3
2) The average of all HCAHPS survey domains for the last quarter (50%). Improve from 46th percentile to;
   - Threshold: Achieve a national percentile ranking of 55th
   - Target: Achieve a national percentile ranking of 60th
   - Outstanding: Achieve a national percentile ranking of 65th

Finance and Operations (25%)

1) Operating Margin (50%)
   - Threshold: Operating Margin $123M
   - Target: Operating Margin $128M
   - Outstanding: Operating Margin $133M
2) Cost per discharge (50%)
   - Threshold: Achieve budgeted cost per discharge
   - Target: Achieve a 0.5% reduction in cost per discharge
   - Outstanding: Achieve a 1% reduction in cost per discharge

Note: Department Goal (25%)

FY14 OPERATIONS WORKPLAN

Quality and Safety: Continuously pursuing actions that support safe care and quality outcomes	Service: Improve the patient experience	People: Improving employee engagement and staff development	Operations: Increase efficiencies and reduce costs	Growth: Grow services and Patient Volume
• Define a pediatric early identification and intervention process for sepsis. • Reduce sepsis mortality by implementing and achieving 70% compliance with the Sepsis Bundle of Care on *all* Adult Units and in the ED • Reduce catheter associated urinary tract infection rates by 30% • Reduce hospital acquired pressure ulcers to 1.1% by 2015 • Achieve 100% compliance on all Adult and Children's Core Measures • Implement 5 new dashboards • Improve transitions and decrease readmission through a centralized post-discharge phone call program.	• Hardwire Living PRIDE initiatives by June 30, 2014 • Increase access to UCSF Medical Group Specialties such that 75% of new patients are seen within 14 days • Increase access to Pediatric Specialty practices - 75% of new patient appointments within 14 days of referral by 4th quarter • Develop plan and metrics to reduce patient wait times in practices: 80% of patients seen within 15 minutes of scheduled appointment time • Complete Comcast TV installation • Implement pricing transparency plans under Single Billing Office reducing patient billing complaints by 25%	• Develop training for staff development and succession planning. • Increase the diversity of our talent pool; hire and retain diverse, top-tier talent. • Launch new electronic evaluation tool for Managers and Directors by October 2013 • Develop Lean capabilities to demonstrate respect for people, reduce waste and increase value across all dimensions • Develop and implement departmental action plans to respond to the employee engagement survey	• Continue ICD-10 preparedness. • Complete integration plan for Children's Hospital and Research Center Oakland (CHRCO) and UCSF • Implement Advanced Beneficiary Notice process across all ambulatory practices • Develop a plan for faculty practice funds flow to establish a singular Clinical Enterprise • Optimize outpatient Apex process • Develop an outpatient space utilization criteria • Create an Enterprise Data Warehouse • Implement Phase 1 of Enterprise Content Management System • Complete Mission Bay Construction substantial by June 30, 2014 • Complete Integration of Langley Porter Hospital and Clinics into the Medical Center • Develop a Mission Bay staffing plan with 300 FTE, net • Begin Implementation of a new Payroll System	• Develop infrastructure to support population health management • Close the Pacific Partner Management Services Incorporated (PPMSI) transaction; complete a Bay Area Knox Keene license feasibility study • Complete children's and adult media campaigns • Complete the Clinical Enterprise Strategic Plan and Implementation Plan by December 31, 2013 • Launch a second UCSF Primary Care Practice location • Design an evaluation process and capital allocation methodology to support strategic investment opportunities

Workplan in **blue font** indicates a multi-year project.