Performance Improvement 
Annual Report 
July 2011 - June 2012 

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FY13 UCSF Organizational Goals
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 2012 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 FY2012 improvement efforts.

**Outstanding Performance**
- All organizational quality and patient satisfaction goals were achieved.
  - 85% compliance with hand hygiene
  - A 38% reduction in the prevalence of HAPUs, far exceeding the 10% target
  - Launched APeX: Clinical, Revenue Cycle and Provider Order Entry Applications
  - Likelihood of recommending performance reached a mean score of 91.3, exceeding the outstanding level of performance
- The Department of Nursing achieved Magnet status
- Observed expected mortality in the NSQIP patient population is better than expected. The same is true for risk adjusted mortality rates for our ICU patients using the UHC methodology.
- CMS Value Based Purchasing program recognized high performance and improvement in quality (Core Measure) and patient satisfaction (HCAHPS) with “earn back” funds amounting to approximately $250,000.
- DSRIP milestones were all met except for increasing primary care visit volume to expected levels.
- Sepsis mortality reduced to 18.8%
- Reduced patient falls by ~24% since 2008 with 85% of nursing units outperforming benchmarks
- Reduced restraint use by ~19% since 2008 with 83% of nursing units outperforming benchmarks
- AHRQ Patient Safety Indicator performance rated among the top 14 UHC hospitals
- The NIH recognized UCSF as a Center of Excellence Pain Education
- CPR survival rates (66%) and hospital discharge rates after CPR (33%) better than the nation
- Nine months of 100% compliance with glucose management following cardiac surgery
- The Operating Rooms have reduced medical waste by 910 pounds each month resulting in annual savings of ~$400,000
- Exceeds standards in providing breast feeding to neonates at discharge
- Consistently providing children and their parents with asthma home management plans
- Launched a web-based interactive system to help patients understand their medical conditions and planned procedures (EMMI)
- Readmission rates for heart failure patients continue to improve (June 2012 rate is 12%)

**Significant Improvements**
- Environment of Care compliance rates with safety indicators in patient care areas exceeds 90%
- Maintained CRBSI rate of 1.6% per 1000 device days
- Cancer Center improved patient satisfaction and “wait-time” satisfaction scores.
- SSI rates are at or below the national benchmarks for colorectal, adult cardiac, CABG, C-section, hip arthroplasty, knee arthroplasty, laminectomy, spinal fusion and spinal refusions

**Needs Improvement**
- NPSGs compliance is not at 100% (Medication Reconciliation needs an auditing program to determine compliance)
- U.S. News & World Report: America’s Best Hospitals, UCSF Medical Center ranking fell to #13
- U.S. News & World Report: Best Children’s Hospitals rankings decreased
- VAP rates rose slightly to 3.1 per 1000 device days
- UHC rankings maintained at three stars level
- Maintained performance on Leapfrog measures but received a grade of “B”
- Morbidity rates for DVT as reflected in our NSQIP patient populations
- Acute MI readmission scores are no different from the national rate, but higher than expected
- *Clostridium difficile* rate above the California state rate
UCSF HOSPITAL-WIDE QUALITY PROJECTS
MEDICAL CENTER QUALITY GOALS

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

ACHIEVE 85% HAND HYGIENE COMPLIANCE, WITH EXPANDED PARTICIPANT POOL FOR AT LEAST SIX OF TWELVE MONTHS

ACHIEVED

In FY2012, the hand hygiene improvement initiative expanded beyond its FY2011 scope to include 58 programs and all occupational groups. The program attained its FY2012 target by achieving 85% hand hygiene compliance for at least 6 of 12 months for this expanded participant pool. In FY2012, a total of 66,780 observations were collected with an average compliance rate of 88%.

REDUCE THE PREVALENCE OF HOSPITAL-ACQUIRED PRESSURE ULCERS (HAPU) IN PATIENTS BY 10%

ACHIEVED

HAPU prevalence rate of 1.22% was reached. This represents a reduction of 38% for FY12, far exceeding the goal. Since FY2005, the total prevalence of HAPUs for adult and pediatric patients has been reduced by 89%.

GO LIVE WITH APEX CLINICAL, REVENUE CYCLE, AND PROVIDER ORDER ENTRY APPLICATIONS

ACHIEVED

SCOPE OF FULL IMPLEMENTATION INCLUDED:

- Enterprise-wide scheduling/registration
- Research enrollment/Study Orders
- Physician Order Entry & documentation
- Nursing/Allied Health Provider Documentation
- All inpatient areas, ED, Obstetrics/L&D, Peri-Op & Anesthesia
- Hospital & Professional Fee Billing Systems
- Health Information Management Systems

ACCOMPLISHMENTS:

- Early implementation of Barcode Medication Administration, eMAR and APEX Pharmacy - February 2012.
- 134 of 164 ambulatory clinics “live” on APEX EMR
- Speech recognition for physician notes/consults introduced, reduced transcription costs by 50%.
- 26,360 patients enrolled in UCSF “MyChart”
- 30,000 Physician and staff learners trained on APEX
THE QUALITY LANDSCAPE

The internal and external quality landscape for quality reporting has broadened and the concept of value-based purchasing has intensified. The QI Department partners with physician champions and front line staff in committee and team settings to drive performance improvement. Oversight of performance lies within the Quality Committee infrastructure – respective quality committees, CPIC, QIEC, EMB and the GAC. The working committee and taskforce presents regular reports to the oversight committees and extends education/feedback to individual staff level.

INPATIENT CMS CORE MEASURES

UCSF participates in the CMS Inpatient Quality Reporting (IQR) Program and reports performance in seven focused population clusters: Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PN), Surgical Care Improvement Project (SCIP), Children’s Asthma Care (CAC); with ED Throughput Measures, and Global Prevention Measures as the latest addition beginning with Jan 2012 discharges. Reporting and performance of these measures are tied Medicare reimbursement update rate\(^1\) (funding), and national Value Based Purchasing Programs. Approximately 2% of Medicare funding is at risk.

Select inpatient core measures are pulled into a variety of reports and published in various scorecard settings, including:

- Non-Public: the TJC Oryx Report, the CMS IQR Report, the UHC Hospital Quality Management Report (HQMR), and some blue cross/shield accreditation application for Centers of Excellence.

Performance of most measures is at or above the 90-percent level. ED throughput and Global Prevention performance measures are not yet available. Stroke, VTE and Perinatal Care core measures sets will be required for FY 2015 payment in the CMS IQR program.

<table>
<thead>
<tr>
<th>Measure Set</th>
<th>Quarterly (UHC)</th>
<th>Analysis</th>
<th>Measure Set</th>
<th>Quarterly (UHC)</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>TJC Accountability Composite Rate (Rolling Year Q1 2011-Q1 2012)</td>
<td><img src="chart" alt="TJC Accountability Composite Rate" /></td>
<td>Consistently exceeds 85% TJC target.</td>
<td>PN Composite (Q1 2008-Q1 2012)</td>
<td><img src="chart" alt="PN Composite" /></td>
<td>Stable process in all areas except for PN-3b: ED Blood cultures before abs. APeX should alleviate documentation issues related to this measure.</td>
</tr>
<tr>
<td>AMI Composite (Q1 2008-Q1 2012)</td>
<td><img src="chart" alt="AMI Composite" /></td>
<td>Exceeds target; stable progress</td>
<td>SCIP Composite (Q1 2008-Q1 2012)</td>
<td><img src="chart" alt="SCIP Composite" /></td>
<td>Stable process in all areas except INF-9: Postop Urinary Catheter Removal. Collaborative efforts in progress to develop a nursing protocol and potential assistance from APeX.</td>
</tr>
<tr>
<td>HF Composite (Q1 2008-Q1 2012)</td>
<td><img src="chart" alt="HF Composite" /></td>
<td>Stable process in all areas except for HF-1: Discharge Instructions. Cardiology actively working on this.</td>
<td>CAC Composite (Q4 2008-Q1 2011)</td>
<td><img src="chart" alt="CAC Composite" /></td>
<td>No data displayed after CY Q4 2010; due to small n being reported.</td>
</tr>
</tbody>
</table>

\(^1\)Beginning with FY 2014, [CMS] may increase by ¼ of such applicable percentage increase \ldots\ specified by the CMS.
OUTPATIENT CMS CORE MEASURES
SCIP for outpatient (OP-6 & OP-7) and fee for service (claims based) Outpatient Imaging Efficiency indicators (OP-8 to OP-11) are now a focus of CMS attention. Imaging indicators are stable and as evaluated as “appropriate”. Outpatient SCIP data are shown below. Continuous attention has resulted in steady improvement.

<table>
<thead>
<tr>
<th>Measure Set</th>
<th>Quarterly (UHC)</th>
<th>Analysis</th>
<th>Measure Set</th>
<th>Quarterly (UHC)</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCIP OP-6</td>
<td></td>
<td>Steady improvement, last quarter 94.1%</td>
<td>SCIP OP-7</td>
<td></td>
<td>Steady improvement, last quarter 97%</td>
</tr>
<tr>
<td>Antibiotic Timing</td>
<td></td>
<td></td>
<td>Antibiotic Selection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Q1 2011-Q1 2012)</td>
<td></td>
<td></td>
<td>(Q1 2011-Q1 2012)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CMS READMISSION MEASURES
Readmission measures are being followed in 2 programs – the CMS Hospital Readmissions Reduction Program, and the CMS Inpatient Quality Report (IQR); both programs focus on the same inpatient core measures populations – AMI, HF, and PN. The CMS Hospital Readmissions Reduction Program determines payments (penalties) based on discharges of this population between July 1st, 2008 and June 30th, 2011 using Med PAR claims data. 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. The higher than expected AMI risk adjusted readmission rate may result in a < 1% reduction in all DRG payments for FY2013 (final determination not yet released by CMS). Hospital-wide all-cause unplanned readmission and 30-day risk standardized readmission following total hip/knee arthroplasty will be added to the CMS focus starting in FY2015.

<table>
<thead>
<tr>
<th>Readmission Measures</th>
<th>AMI 30-day</th>
<th>HF 30-day</th>
<th>PN 30-day</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Hospital Readmission Reduction Program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• UCSF Actual (7/08-6/11)</td>
<td>22.19%</td>
<td>24.1%</td>
<td>16.9%</td>
</tr>
<tr>
<td>• Expected</td>
<td>19.5%</td>
<td>24.6%</td>
<td>18.3%</td>
</tr>
<tr>
<td>• Excess Ratio</td>
<td>1.1353</td>
<td>0.9815</td>
<td>0.9233</td>
</tr>
<tr>
<td>Hospital Compare – IQR Program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• UCSF Actual (7/08-6/11) to be published</td>
<td>No Different than U.S. National Rate</td>
<td>No Different than U.S. National Rate</td>
<td>No Different than U.S. National Rate</td>
</tr>
</tbody>
</table>

Quality efforts around readmission have been led by the UCSF Transitions of Care Steering Committee, with focus work groups in Cardiology/Medicine/Primary Care, Neurology, and the Hospitalist’s Service for Benioff Children’s Hospital. Orthopaedic surgery has just the effort in FY13.

CMS MORTALITY MEASURES
Mortality measures are being followed in the CMS Inpatient Quality Report (IQR) and finalize for the CMS Value-Based Purchasing Program for FY 2014 (30% weight) – focus on the same inpatient core measures populations – AMI, HF, and PN.

<table>
<thead>
<tr>
<th>Mortality Measures</th>
<th>AMI 30-day</th>
<th>HF 30-day</th>
<th>PN 30-day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Compare – IQR Program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• UCSF Actual (7/08-6/11)</td>
<td>16.0%</td>
<td>10.7%</td>
<td>10.0%</td>
</tr>
<tr>
<td>• US National</td>
<td>15.5%</td>
<td>11.6%</td>
<td>12%</td>
</tr>
<tr>
<td>• UCSF Actual (7/08-6/11) to be published</td>
<td>No Different than U.S. National Rate</td>
<td>No Different than U.S. National Rate</td>
<td>No Different than U.S. National Rate</td>
</tr>
</tbody>
</table>
The Quality Landscape (continued from previous page)

Review of mortality cases is performed in departmental case reviews, QI committees, and the Surgical Case and Hospital Mortality Review Committee (SCHMRC) meetings.

CMS Value-Based Purchasing (VBP) Program

The CMS FY 2013 VBP program reflects performance on select clinical process of care measures (Core Measure) and patient experience measures (Hospital Consumers Assessment of Healthcare Providers and Systems, HCAHPS) scores. Values and improvement scores from July 2009 through March 2010 were compared to July 2011 through March 2012 for internal and national improvement scores. Clinical measures account for 70%, HCAHPS for 30% of the performance equation. Results were used to adjust payments for FY 2013 discharges. The VBP funding pool was 1% of the base-operating DRG payments to all hospitals, an estimated $950 million nationally.

FY 2013 Actual Percentage Payment Summary Report was published in Nov 2012. UCSF VBP performance score of 54.67272 exceeded the state and resulted in a VBP multiplier of greater than 1. This performance score includes:
- 61.81% in the Core Measures Domain (Clinical Process of Care) – weighted at 70% of total VBP score
- 30% in the Patient Satisfaction Domain (Patient Experience of Care) – weighted at 30% of total VBP score

For UCSF, this translated to an “earn back” of 1.0045331362% from the 1% Medicare base operating DRG payment at risk.

TJC Stroke Measures

UCSF has been designated the Joint Commission Accredited Advanced Primary Stroke Center for the past 9 years. This award is based on compliance with national standards, clinical guidelines and outcomes of care. Quality work around patients with stroke is led by the multi-disciplinary Stroke Team. Most measures (STK-1, 2, 3, 4, 5, 6, 10) have remained stable at 100% for the past 5 quarters; STK-8 (stroke education) reached 100% compliance by the end of FY 2012. CMS has confirmed Stroke measure set as part of the IQR for FY2015 payment. The specific measures vary slightly from those below.

<table>
<thead>
<tr>
<th>Measure</th>
<th>STK-1</th>
<th>STK-2</th>
<th>STK-3</th>
<th>STK-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trends</td>
<td><img src="image1.png" alt="Bars" /></td>
<td><img src="image2.png" alt="Bars" /></td>
<td><img src="image3.png" alt="Bars" /></td>
<td><img src="image4.png" alt="Bars" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure</th>
<th>STK-5</th>
<th>STK-6</th>
<th>STK-8</th>
<th>STK-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trends</td>
<td><img src="image5.png" alt="Bars" /></td>
<td><img src="image6.png" alt="Bars" /></td>
<td><img src="image7.png" alt="Bars" /></td>
<td><img src="image8.png" alt="Bars" /></td>
</tr>
</tbody>
</table>

DSRIP Program

DSRIP refers to the CMS sponsored Delivery System Reform Incentive Pool in the demonstration waiver that provides federal matching funds up to $3.3 billion over five years (FY 2011 – FY 2015) 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 FY 2011\(^2\).

\(^2\) FY 2011 = DY 6, DSRIP year 6
<table>
<thead>
<tr>
<th>Category</th>
<th>Elements</th>
<th>Achievements and Activities</th>
</tr>
</thead>
</table>
| **Category 1: Infrastructure Development** | Expanded Primary Care Capacity (Access) | - A primary care strategic steering group was formed with representation from all academic departments involved in primary care.  
- UCSFMC’s Department of General Internal Medicine relocated to Osher Center.  
- Total square footage increased from 13,416 to 23,446, resulting in a capacity to increase visit volume by at least 10,000.  
- Visit volume increase was not achieved due to APeX implementation.  
- Alternative care delivery systems, such as My Chart encounters, are being analyzed to understand how care is delivered in an electronic environment. |
| | Implement and Utilize Disease Management Registry Functionality (Quality) | - The implementation of the APeX Electronic Health Record (EHR) occurred in April 2011.  
- Diabetes, anticoagulation, pediatric asthma, colorectal and cervical cancer screening registries have been created and many are in use.  
- These registries 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) | - Continuous quality improvement reporting methodologies have been established to report transition in care metrics for all transitions in care populations.  
- 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 Readmissions Taskforce.  
- CareFx, a business objects tool, has been purchased and is in the process of being implemented. |
| **Category 2: Innovation and Redesign** | Expand Medical Homes (Access) | - UCSF primary care clinics have begun to redesign the model of care to transform into high performing Patient Centered Medical Homes (PCMHs) with the key steps of population health panel management, and complex care nurse management.  
- All primary care teams have been trained in the “Share the Care Model” by the UCSF Center for Excellence in Primary Care (CEPC).  
- Work groups have been formed to address behavioral health integration, ACO integration, increasing capacity and access, and the examination of the scope and role of medical assistants at UCSF.  
- A task force has been formed to apply for the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) recognition. |
| | Increase Specialty Care Access/Redesign Referral Process (Access) | - E-referrals and smart phrase technology have been successfully implemented in many specialty practices resulting in the redesign of the specialty referral process.  
- E-consults have been implemented in nephrology and endocrinology, with more than 50 e-consults occurring in the first month of the pilot alone! 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 | - In order to ensure that hospitalized patients experience a safe transition to “home” and thus a reduced rate of readmissions, 5 pilot |
**PERFORMANCE IMPROVEMENT**  
**ANNUAL REPORT FY 2012**

<table>
<thead>
<tr>
<th>Category</th>
<th>Elements</th>
<th>Achievements and Activities</th>
</tr>
</thead>
</table>
| Programs (Quality) | units/patient populations (Cardiology, Neurology/Neurovascular, Orthopedic Surgery, Medicine and Pediatric Medicine) have implemented best practices in Transitions of Care.  
- Best practices include ensuring patient has a timely follow-up appointment, performing medication reconciliation, using the “teach back methodology” for 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.  
- An Excellence in Transitions of Care Retreat was held in October with over 70 attendees, to understand and redesign discharge processes using Lean methodology. |
| Patient/Caregiver Experience (Patient Experience) | The necessary planning, redesign, translation, training and contract negotiations in order to implement CG-CAHPS in DY8 have been achieved.  
- UCSF Medical Center has contracted with the survey firm Press Ganey Associates Inc. to conduct weekly surveying of a random sample of patients in all of the medical center’s adult primary care practices.  
- The survey has been developed in English and Spanish. We began mailing the survey to patients beginning with April 2, 2012 visits. |
| Care Coordination (Quality) | Between July 1, 2011-June 30, 2012 there were only 4 patients admitted out of 2290 patients in our primary care panel denominator (rate 0.2%) who were admitted to UCSF with a primary diagnosis of a short term complication from diabetes.  
- Between July 1, 2011-June 30, 2012 there were 0/2290 patients (rate 0.0%) who were admitted to UCSF with a primary diagnosis of uncontrolled diabetes. |
| Preventive Health (Quality) | Between July 1, 2011-June 30, 2012 there were 3101/4,654 patients (66.63%) screened for breast cancer.  
- Between July 1, 2011-June 30, 2012 there were 3567/11,149 patients (32%) were immunized for influenza. This influenza immunization rate is mostly reflective of the flu shots that patients received in our clinics. |
| At-Risk Populations (Quality) | July 1, 2011-June 30, 2012 there were 1114/2290 patients (48.6%) with diabetes that had LDL control <100mg/dl.  
- Between July 1, 2011-June 30, 2012 there were 1421/2290 patients (62.1%) with diabetes that had a Hemoglobin AlC level <8%. |
| Improve Severe Sepsis Detection and Management (Quality) | Implemented a nurse driven early sepsis screening tool on 4 pilot units, (including 2 ICUs, the ED and the medicine floors) as well as an RN procedure/protocol for ordering and drawing blood lactates based on a positive sepsis screen.  
- Developed unit based and organizational dashboards with process and outcome goal compliance and a concurrent data abstraction process which includes secondary case reviews by physicians.  
- Operationalized a multidisciplinary “code sepsis” team, comprised of a rapid response nurse, a critical care fellow (MD) and a pharmacist to respond to patients with severe sepsis or septic shock.  
- Enhanced APeX in the Emergency Department for continuous surveillance of patients for signs of severe sepsis.  
- Developed a UCSF sepsis intranet site. |

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<table>
<thead>
<tr>
<th>Category</th>
<th>Elements</th>
<th>Achievements and Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category Element</td>
<td>Current bundle compliance rate on required elements of care (pilot units) is 91% and overall adult hospital mortality from sepsis has been reduced to 18%.</td>
<td></td>
</tr>
<tr>
<td>Central Line-Associated Bloodstream Infection (CLABSI) Prevention (Infection Control)</td>
<td>As a method to reduce CLABSI, a neutral needleless connector device (infusion cap) was implemented in both inpatient &amp; outpatient settings in February 2011.</td>
<td>Training/education was completed over 8 consecutive days on all shifts, available to all inpatient and outpatient users. Approximately 700 nurses and providers were trained.</td>
</tr>
<tr>
<td>Surgical Site Infection (SSI) Prevention (Quality and Infection Control)</td>
<td>An institutional surgical site infection (SSI) and complication profile baseline was established for general surgery, vascular surgery and selected specialty surgical cases using the American College of Surgeons National Surgical Quality Improvement Program (NSQIP) and presented to UCSFMC quality committees. See previous “ACS NSQIP” section for details of work.</td>
<td>UCSF has committed to SSI reduction via DSRIP in the following 6 procedures: colon, rectal, small bowel, C-section, knee arthroplasty and appendectomy.</td>
</tr>
<tr>
<td>Hospital Acquired Pressure Ulcer (HAPU) Prevention (Nursing Care)</td>
<td>Over 100 nurses received pressure ulcer prevention intensive training. Education included a pre-test, review of successful strategies and challenges, identify populations of patients at risk, staging review, and risk assessment.</td>
<td>Ongoing education continues. See “Nursing-Sensitive Indicators” section for details of work.</td>
</tr>
</tbody>
</table>
The Quality Landscape (continued from previous page)

OTHER VIEWS OF QUALITY

Another important viewpoint of UCSF Quality is presented by the “University HealthSystem Consortium Quality and Accountability Study Ranking”. Data from 101 UHC members were used in constructing this scorecard with data from June 2011 – May 2012 with the exception of Core Measures (Q1 2011 – Q1 2012) and HCAHPS data (Q4 2010 through Q3 2011).

University HealthSystem Consortium (UHC) – 2005-2012 Quality & Accountability Study Ranking

<table>
<thead>
<tr>
<th>UHC Quality/Accountability Metric Rank</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Composite Rank</td>
<td>2★</td>
<td>3★</td>
<td>5★</td>
<td>3★</td>
<td>4★</td>
<td>4★</td>
<td>3★</td>
<td>3★</td>
</tr>
<tr>
<td>Overall Composite Score</td>
<td>61</td>
<td>39</td>
<td>10</td>
<td>34</td>
<td>18</td>
<td>30</td>
<td>57</td>
<td>63</td>
</tr>
<tr>
<td>(higher is better only in this row)</td>
<td>58.2</td>
<td>60.3</td>
<td>70.1</td>
<td>66.6</td>
<td>70.1</td>
<td>68.5</td>
<td>63.5</td>
<td>52.3</td>
</tr>
<tr>
<td>Mortality (O:E ratios of selected service lines)</td>
<td>58</td>
<td>29</td>
<td>13</td>
<td>20</td>
<td>36</td>
<td>55</td>
<td>62</td>
<td>63</td>
</tr>
<tr>
<td>Effectiveness (Core Measures and 30-day readmission rates)</td>
<td>12</td>
<td>56</td>
<td>18</td>
<td>21</td>
<td>51</td>
<td>23</td>
<td>41</td>
<td>80</td>
</tr>
<tr>
<td>Safety (Complications of Hospital Care ) AHRQ PSIs</td>
<td>22</td>
<td>26</td>
<td>16</td>
<td>22</td>
<td>5</td>
<td>11</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Equity (Racial, Gender, SES Outcomes in the Core Measures Population)</td>
<td>78</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>86</td>
</tr>
<tr>
<td>Patient Centeredness (Patient satisfaction score; HCAHPS question + composite)</td>
<td>N/A</td>
<td>5</td>
<td>8</td>
<td>33</td>
<td>1</td>
<td>51</td>
<td>20</td>
<td>31</td>
</tr>
<tr>
<td>Efficiency (Factored into Ranking for the first time 2011)</td>
<td>70</td>
<td>69</td>
<td>61</td>
<td>24</td>
<td>89</td>
<td>95</td>
<td>99</td>
<td>97</td>
</tr>
</tbody>
</table>

Key points regarding UCSF performance and the UHC methodology:

- Coding and documentation significantly influenced all of the observed to expected metrics. The new Clinical Documentation Improvement program will address this issue by working with both physicians to more accurately reflect the condition of patients, their diagnoses and treatments and coders to more accurately translate this information into codes. These codes are used to calculate many of the “expected” metrics.
- Mortality: This domain is scored using both system level and service-line level Observed: Expected (O: E) mortality ratios of MS-DRG codes. Eight service lines proved to be most predictive of performance and were used in the calculations: Cardiology, CT Surgery (both CT and Thoracic), Gastroenterology, Medical Oncology, General Medicine, Neurology, Neurosurgery, and General Surgery.
- Effectiveness: The score of this measure was impacted more by the readmission rates than the core measures performance this year. All cause readmission rates were used rather than related readmissions. OB, newborns, neonatology and patients <18 years of age were excluded.
- Safety: Five AHRQ Patient Safety Indicators were used (iatrogenic pneumothorax, CLABSI, post op hemorrhage/hematoma, post op respiratory failure and post op PE/DVT).
- Equity: One equity variance was observed in the core measure populations. Most (85) institutions had no disparities, resulting in a UCSF rank of 86.
- 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.
- Efficiency: LOS and direct cost O:E ratios were used for 8 service lines (same as the mortality domain). Performance on this measure is significantly influenced by the Bay Area wage index.

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

UCSF ratings resulted in a “B” grade on the Leapfrog Hospital Safety Score report card.

<table>
<thead>
<tr>
<th>Practice</th>
<th>Leapfrog Metric</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing Medication Errors</td>
<td>Computerized Physician Order Entry (CPOE) implemented (Validation of CPOE did not occur in time to meet reporting deadline and significantly impacted the progress rating and the assigned letter grade of “B”)</td>
<td></td>
</tr>
<tr>
<td>Appropriate ICU Staffing</td>
<td>24/7 attending coverage and 5 minute call backs</td>
<td></td>
</tr>
<tr>
<td>Steps to Avoid Harm</td>
<td>13 National Quality Forum (NQF) Safety Practices – internal analysis of adherence. (Medication reconciliation was not fully implemented prior to APeX implementation)</td>
<td></td>
</tr>
<tr>
<td>Managing Serious Errors</td>
<td>Disclosure Policy meets standard.</td>
<td></td>
</tr>
<tr>
<td>Reduce ICU infections</td>
<td>Based on 1000 central line days using the National Healthcare Safety Network (NHSN) standards (Care and maintenance audits show high compliance. CLABSI cases are reviewed in depth; cases occur in complex immunocompromised patients with multiple comorbidities in which CLABSI may not be preventable)</td>
<td></td>
</tr>
<tr>
<td>Maternity Care</td>
<td>Based on patient care with “normal deliveries”</td>
<td></td>
</tr>
<tr>
<td>Patient Experience of Care</td>
<td>HCAHPS Composite Measure. Credit awarded by quartile compared to other hospitals</td>
<td></td>
</tr>
<tr>
<td>Safety Focused Scheduling</td>
<td>Based on smooth patient scheduling in the Operating Room (Credit awarded based on improvement from baseline 85% or above)</td>
<td></td>
</tr>
</tbody>
</table>

Progress Towards Meeting Leapfrog Standards

- Willing to Report
- Some Progress
- Substantial Progress
- Fully Meets Standards
NATIONAL PATIENT SAFETY GOALS

Annually, The Joint Commission (TJC) publishes National Patient Safety Goals (NPSG) which focus on problematic areas in health care and describe solutions to these problems. The Patient Safety Committee (PSC) provides oversight for compliance with NPSGs. The data below reflects the compliance with the NPSGs as audited by the Department of Nursing, Ambulatory Practices and Ancillary Services staff.

Two Patient Identifiers 100%
Invasive Procedure – Pre-procedure Verification 95%
Invasive Procedure - Site Marking 99%
Invasive procedure –Time Out 96%
Critical Tests - Read Back and Confirm 93%
Critical Tests - MD Notified Within 60 minutes 89%

Compliance with the Medication Reconciliation process was not systematically measured during this year.

FAILURE MODE AND EFFECT ANALYSIS (FMEA)

A Failure Mode and Effect Analysis (FMEA) is a proactive methodology used to evaluate a high risk process with the aim to identify and reduce risk. The UCSF CY2012 FMEA is an evaluation of our telemetry central monitoring processes.

In anticipation of implementation of a centralized telemetry monitoring system for the adult inpatient nursing units, the processes related to centralized telemetry monitoring underwent a comprehensive, multidisciplinary review to analyze systems and to detect possible failures. Methodologies to enhance and strengthen these systems have been identified and implementation is ongoing. The Patient Safety Committee provided oversight for this analysis.

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 (32.5%), Survival (32.5%), Patient Safety (5%) and Other Care Measures such as Magnet designation (30%). Performance measures on 16 specialties are considered. This year the method for scoring these measures and calculating the rank was changed. Although UCSF Medical Center was ranked as the highest hospital in Northern California, UCSF fell from the Top Ten list to a rank of #13. Ranking in all specialties dropped suggesting the methodology was central to the change. Additional factors impacting the score include the lack of Magnet designation and our risk adjusted mortality ratio which represents documentation and coding opportunities.
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 2011. This report is based on a total of 443,861 cases in the entire NSQIP comparative cohort, with 2,170 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)

Risk adjusted mortality is better than expected. However, the overall morbidity for UCSF is high outlier driven by deep vein thrombosis/pulmonary embolus (DVT/PE) and surgical site infection (SSI).

- Urinary tract infections (UTI) which were noted on the last report as a high outlier have improved based on education effects for early urinary catheter removal. Continuing this year are efforts by nursing to implement the Care of Urinary Catheter bundle.

- An SSI Reduction Task Force was formed in July 2012 to bring together HEIC, NSQIP, SCIP and Surgical Quality Improvement leadership to share and coordinate information and develop an interdisciplinary approach to SSI risk reduction and best practice implementation.

- DVT/PE is a newly identified outlier and is now a focus of attention. Departments are aware and are reviewing the individual cases. A few departments have participated in DVT/PE reduction initiatives.

ACS NSQIP has changed their focus to the highest risk surgeries as identified by ACS NSQIP members. UCSF will select areas of focus for future analysis. The new data will provide more information and outcomes specific to these high risk surgeries.
MAGNET RECOGNITION 2012

UCSF Medical Center received Magnet designation for nursing care excellence from the American Nurses Credentialing Center for the first time on September 17, 2012.

“The Magnet Recognition Program® recognizes healthcare organizations both nationally and internationally for their outstanding quality patient care, nursing excellence and innovations in professional practice. Achieving Magnet status underscores the fact that UCSF is a world-class organization as only five percent of hospitals in the United States and abroad have received this designation to date. Although much of the July validation survey focused on nursing, Magnet designation speaks to the great work performed by all staff, management, residents and physician colleagues.”

Sheila Antrum, Chief Nursing Officer

CRITICAL ELEMENTS TO ACHIEVE MAGNET STATUS:

- Must outperform national benchmarks for key nursing-sensitive quality indicators for more than 50% of units, more than 50% of the time over 8 rolling quarters
- Must demonstrate professional engagement and participation of direct-care nurses in organizational decision-making
- Must demonstrate achievement in advancement of nursing education and practice, specialty nursing certification, evidence-based practice and nursing research
- Must provide detailed examples that exemplify excellence in the following areas:
  - Transformational Leadership
  - Structural Empowerment
  - Professional Nursing Practice
  - New Knowledge, Innovation and Quality Improvement

FISCAL YEAR 2012 ACCOMPLISHMENTS:
The rigorous Magnet application process required the combined efforts over the past five years of nursing leaders, direct-care nurses, and medical center staff from the inpatient, outpatient and home care settings at UCSF Medical Center. The 3,600 page application was submitted on January 31, 2012 and the Magnet appraisers completed their onsite evaluation during the week of July 23, 2012.

FISCAL YEAR 2013 PLANNED ACTIVITIES:
UCSF Medical Center will submit an interim status report to the ANCC Magnet Recognition Program® in 2014 and participate in a full re-designation application in 2016. The Magnet Recognition Program® requires not only sustaining excellence, but continually improving outcomes in nursing and quality of patient care.
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!

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. As of Fiscal Year 2012, 92% of inpatient units (22 of 24) outperformed the NDNQI mean at least 5 out of 8 rolling quarters.

The Department of Nursing Performance Improvement also distributes a monthly incidence report, based on number of filed incident reports by unit. Pressure ulcers are attributed to the unit/department where they initiated. For example, if a patient is transferred to the critical care unit from the operating room and a hospital-acquired pressure ulcer is discovered on the admission skin assessment, the pressure ulcer will be attributed to the operating room. Pressure ulcer incidence is not benchmarked to date.

ACCOMPLISHMENTS:

- The Wound Care Team was established to conduct wound care rounds; approximately 700 patients were evaluated.
- Patient ceiling lifts were installed in ICUs to help move patients.
- Hover Mats were implemented to facilitate transfer of bariatric patients.
- Wound care photography was implemented on units to support evaluation of wound progress.
- Under the Gordon and Betty Moore Foundation Grant, high-risk units implemented strategies to reduce HAPU rates.
- A program to improve management of moisture was initiated with new skin care products and staff nurse education.
Nursing-Sensitive Indicators (continued from previous page)

FALLS

85% of all nursing inpatient units outperformed the benchmark!

Since 2008, there has been a 24% reduction in fall rates for adult and pediatric units combined and a 33% reduction in Falls with Injury rates.

Inpatient falls data is collected via the incident reporting system and is reported out by unit as the incidence of falls per 1000 patient days. As of Fiscal Year 2012, 85% of units (22 of 26) outperformed the NDNQI mean for at least 5 of 8 rolling quarters.

ACCOMPLISHMENTS:

- Implemented Post-Fall Huddles on adult units for immediate analysis of circumstances leading to the fall in order to identify preventative measures going forward.
- 12 Long initiated a patient-contract with their arthroplasty patients to support fall prevention education.
- APeX reports were developed to identify and manage patients at risk for falls.
- Type of fall was added to monthly unit level analysis to target interventions based on fall type.
RESTRAINTS

83% OF ALL NURSING INPATIENT UNITS OUTPERFORMED THE BENCHMARK!

RESTRAINT USE PREVALENCE
Since 2008, there has been a 19% 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.

![Restraint Prevalence Rate - Fiscal Year Trend](image)

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 has been historically low. As of Fiscal Year 2012, 83% of units (20 of 24) outperformed the NDNQI mean benchmark for at least 5 out of 8 rolling quarters.

RESTRAINT WORKGROUP
The Restraint Workgroup was reconvened in Fiscal Year 2011 to identify opportunities for reductions in restraint use, as appropriate, and to increase awareness with restraint use in general. The purpose of the workgroup is to ensure 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.

ACCOMPLISHMENTS:
- Researched the use of restraint protocols in the immediate post-op recovery phase
- Networked with like-units and like-hospitals with low restraints to identify opportunities for decreased restraint use
- Established a process to conduct case reviews on patients with prolonged restraint use
- Developed staff education to accurately assess for appropriate restraint use
- Laid the foundation for improved patient and family education, including a debriefing process
- Created APeX reports to identify and monitor documentation of patients on restraints
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
PATIENT SAFETY COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:
- Conducted 25 Root Cause Analyses (RCAs) with 104 action plans developed
- Analyzed and disseminated the results of a Culture of Patient Safety Survey in the Benioff Children’s Hospital
- Facilitated the first UCSF celebration of National Patient Safety Week which included the first Patient Safety Grand Rounds
- Enhanced the sustainability monitoring process to evaluate the long term effectiveness of RCA action plans
- Improved the report functionality of the Patient Safety Database to track RCA data
- Continued oversight of the TJC Sentinel Event Alerts
- Continued oversight for the Incident Reporting System

INCIDENT REPORTING: Over 9,885 incident reports were filed in FY12 reflecting a robust culture of reporting. All events ranked as serious were reviewed weekly by the committee.

<table>
<thead>
<tr>
<th>Event Types FY 2012</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Error</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
<tr>
<td>Procedural Complication</td>
<td>3</td>
</tr>
<tr>
<td>Radiation Event</td>
<td>2</td>
</tr>
<tr>
<td>Self-Harm Attempt</td>
<td>1</td>
</tr>
<tr>
<td>Treatment Delay</td>
<td>2</td>
</tr>
<tr>
<td>Air Embolism</td>
<td>1</td>
</tr>
<tr>
<td>Serious Injury due to Nosocomial Infection</td>
<td>1</td>
</tr>
<tr>
<td>Elopement - Significant Issue</td>
<td>1</td>
</tr>
<tr>
<td>Specimen Issue</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Focus of Corrective Action Plans FY 2012</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication management</td>
<td>23</td>
</tr>
<tr>
<td>Availability of information</td>
<td>17</td>
</tr>
<tr>
<td>Orientation and training of staff</td>
<td>15</td>
</tr>
<tr>
<td>Policies</td>
<td>8</td>
</tr>
<tr>
<td>Care planning process</td>
<td>7</td>
</tr>
<tr>
<td>Adequacy of technological support</td>
<td>5</td>
</tr>
<tr>
<td>Continuum of care</td>
<td>5</td>
</tr>
<tr>
<td>Security systems and processes</td>
<td>5</td>
</tr>
<tr>
<td>Staffing levels</td>
<td>5</td>
</tr>
<tr>
<td>Communication among staff members</td>
<td>4</td>
</tr>
<tr>
<td>Physical environment</td>
<td>4</td>
</tr>
<tr>
<td>Equipment maintenance / management</td>
<td>3</td>
</tr>
<tr>
<td>Competency assessment / credentialing</td>
<td>2</td>
</tr>
<tr>
<td>Supervision of staff</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Actions</strong></td>
<td><strong>104</strong></td>
</tr>
</tbody>
</table>
ENVIRONMENT OF CARE (EOC) COMMITTEE

EOC SAFETY PROGRAM: The Medical Center Safety Program concentrated the majority of its efforts in developing policies and plans for reducing patient handling injuries; authorizing and distributing safety updates covering topics that include: Waste Management, Respirator Protection Guidance, developing Physicians training on-line EOC module, continuing to build and improve a multi-disciplinary EOC Safety Rounds Program that engages staff and department managers; and ways to proactively identify risks to the organization.

INJURY AND ILLNESS REDUCTION PROGRAM: The Medical Center had an increase in reported injuries of 12.3%. The majority of these were injuries requiring some medical treatment and in some cases, a period of modified duty, but did not result in lost time. Serious injuries requiring significant medical treatment and lost time from work were down 17.5%. UCSF Medical Center won two Workers Compensation awards for performance in fiscal year 2011 from the UC Office of the President: Best Reduction in Workers Compensation Rate and Lowest Workers Compensation among the UC Medical Centers. Although an increase in injuries in FY12, these awards truly acknowledge a significant reduction in expenses associated with the Workers Compensation program, and resulted in a rebate of $8.5 million to the Medical Center.

EMERGENCY MANAGEMENT (EM): In addition to continuing to provide Hospital Incident Command System (HICS) training to staff this past year, EM successfully finalized its Code Dry plan and conducted one functional water failure/disruption drill at Mt. Zion that disrupted the environment of care in the night shift. Drills and training prepared the Medical Center to respond to two HICS activations (i.e., Parnassus Power Outages and the China Basin Network Disruption).

SECURITY: In response to the Sentinel Event Alert 45 “Preventing violence in the health care setting” the Security Program continued to focus on providing staff training in management of assaultive behavior techniques through new hire, Annual Safety, and staff in-service sessions. Security worked with the Departments of Nursing, Risk Management, and Campus Police to increase monitoring, notifications and follow up measures to decrease the number of incidents, lessen the severity of disruptive incidents as well as continue to improve the REG ALERT system for rapid notification to various departments for known patients with prior history of violence, drugs or behavioral issues.

HAZARDOUS MATERIALS: Use of the SaniPak waste treatment showed a significant reduction in the weight of regulated medical waste being disposed offsite. There was a total of ~ 680,000 lbs. of regulated medical waste for the period between Q2-Q4 of which 310,000 pounds of red bag waste was treated using the SaniPak system. This resulted in savings of approximately $50,000.
Environment of Care (EOC) Committee (continued from previous page)

**FIRE, LIFE, AND SAFETY:** In a continued effort to respond to Sentinel Event Alert 29 “Preventing Surgical Fires” and all other codes governing fire prevention; the Fire Safety program increased fire/life safety awareness by continuing to expand a floor warden program, continuing its training program for personnel in oxygen-enriched locations, measuring fire drill effectiveness through participation numbers and failed drill frequencies, and began hands-on fire extinguisher training using the Bullex simulated training system that was funded through the Be Smart About Safety. The program also continues to monitor, fund, and complete Plans For Improvement projects creating a safer environment for providing patient care.

<table>
<thead>
<tr>
<th>Qtr. AVG 2010/2011</th>
<th>Qtr. AVG 2011/2012</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>334</td>
<td>393</td>
<td>18%</td>
</tr>
</tbody>
</table>

**Building Life Safety Code Deficiencies: Plan for Improvement Projects**

<table>
<thead>
<tr>
<th>Location</th>
<th>Qtr. AVG 2010/2011</th>
<th>Qtr. AVG 2011/2012</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mt. Zion</td>
<td>2%</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>Parnassus</td>
<td>9%</td>
<td>5%</td>
<td>4%</td>
</tr>
</tbody>
</table>

**MÉDICAL EQUIPMENT:** The Medical Equipment Program made efforts to improve the medical equipment inventory process, develop QA reporting systems, and began developing a cross-training program with nursing that increased preventative maintenance (PM) rates for non-life support equipment and reduced the number of total unscheduled work orders.

<table>
<thead>
<tr>
<th>Number of unscheduled work orders</th>
<th>Qtr. AVG 2010/2011</th>
<th>Qtr. AVG 2011/2012</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Total, % from No Problem Found, % from Operator Error -- Goal &lt;5%)</td>
<td>2510, 11%, 3%</td>
<td>2617, 8%, 3%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Equipment: Risk Level 2 &amp; 3 PM rates</th>
<th>Qtr. AVG 2010/2011</th>
<th>Qtr. AVG 2011/2012</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>87%</td>
<td>89%</td>
<td>2%</td>
<td></td>
</tr>
</tbody>
</table>

**UTILITIES MANAGEMENT:** The PM program for fan units at Parnassus and Mt. Zion is an on-going project; there was a slight increase in the number of unscheduled maintenance events since FY11 for supply and exhaust fans located at MZ due to higher ventilation demands that require fans to operate at higher working ranges. FM will work with the infrastructure program to evaluate PM program effectiveness at MZ and evaluate equipment improvement opportunities. A reduction in unscheduled maintenance events for fan units is a key performance indicator for an effective Preventative Maintenance program for all medical center critical utility equipment.

<table>
<thead>
<tr>
<th>Location</th>
<th>Qtr. AVG 2010/2011</th>
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<td>5%</td>
<td>4%</td>
</tr>
</tbody>
</table>

**ETHICS COMMITTEE**

**ACTIVITIES AND ACCOMPLISHMENTS:**
- Continued educational series both at ethics meetings and with staff and physician groups
- Revised multiple policies including brain death (focusing on pediatric brain death determination) and withdrawal of life sustaining treatment
- Continued to work with CTDN on organ donation policies and procedures including DCD
- Ethics Consultations:
  - 27 formal ad-hoc consults July 2010-June 2011
  - 21 adults, 6 children/newborns
  - 24 Parnassus, 3 Mt. Zion
  - Consults: Medicine 8, CRI 4, Peds 3, ICN 3, other services 9

**THEMES AND CHALLENGES:**
- Limitation of life-sustaining therapies interpretation and education including current policies
- Longitudinal complex outpatient issues
- The effects of health care reform and new pressures from insurers on patient care
**RISK MANAGEMENT**

**ACTIVITIES AND ACCOMPLISHMENTS:**

- Reviewed 19 cases in litigation and coordinated risk reduction strategies in the following areas:
  - Medication management
  - Reporting of test results to avoid delay in diagnosis
  - Mitigation risk related to faulty equipment design/use resulting in patient harm
  - Transition of care between procedural area, Surgery and Anesthesia following procedural complication
  - Communication and Coordination of care between non-UCSF and UCSF providers
  - Research protocol requirements
  - Documentation related to treatment recommendations
  - Care management of pediatric nephrology patient with improvement of clinic systems for follow-up and management
  - Indications for and management of cardiac catheterization and related complications
  - Risk issues related to use of e-mail vs medical record to document treatment recommendations
  - Adequacy of informed consent
  - Risk issues related to patient conditions/contraindications for administration of live vaccines

- **EARLY RESOLUTION PROGRAM:** Risk Management Committee oversaw early resolution of an admitted liability case involving significant damages. The case was reviewed, including internal and external expert review and case was mediated by an independent third party.

- **CONSENT PROCESS:** Reviewed electronic consent options for future implementation. Revised the Consent Form for Surgery and Procedures to enhance clarity for patients and providers. Reviewed *Escalation for Nurses Policy*. Reviewed and approved *Safe Patient Handling Policy*.

- **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 the chronic conditions, hospitalization and surgical or invasive procedure 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 meant to augment, not substitute for, the informed consent process. Areas implemented:
  - Gastroenterology
  - Cardiac Electrophysiology
  - Heart Failure
  - Interventional Cardiology
  - Cardiothoracic Surgery
  - Orthopedics
  - Bariatric Surgery
  - Gyn Surgery
  - OB
  - Neurosurgery/spine

- **LAUNCHED THE 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 planned work includes broader educational initiative related to risk reduction programs raised by claims and issuance of guidelines related to use of e-mail as a means of communication between patients and providers.
INFECTION CONTROL COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:

- Directed organizational performance improvement in hand hygiene compliance to meet the UCSF Medical Center Quality IAP goal with 12 months of 85% or greater compliance in all inpatient locations for all occupational groups
- Oversaw prevention efforts by the Device Related Committee for Central Line-Associated Bloodstream Infections (CLABSI), Ventilator-Associated Pneumonia (VAP) and Catheter-Associated Urinary Tract Infections (CAUTI) surveillance and data dissemination
- Tested and approved new checklist for outbreak management in response to FY11 outbreaks
- 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
  - Exposure management: TB, Scabies, Parvovirus
- Provided oversight of the infection prevention programs in the following department:
  - Nutrition and Food Services: refrigerator temperature management, cooling food holding, labeling and discarding food
  - Sterile Processing: Sterilizer cleaning, high-level disinfection process management in outpatient clinics
  - Facilities Management: Reporting for sewage spills, preventive maintenance governance, pigeon abatement
  - Pharmacy: Hood testing, facility maintenance
  - Hemodialysis: Dialysis water testing, hand hygiene, surface disinfection
  - Hospitality: QA for room cleaning, surface disinfectant changes and management, migration of PSAs to Hospitality oversight, San-I-Pak installation for on-site medical waste management
  - Nursing: enteral tube feeding management and documentation
- Sponsored Clostridium difficile prevention “bundle” response to first statewide data showing UCSF rate (13.8) higher than the California mean (7.0)
- Implemented a patient preparation program (chlorhexidine bathing and intranasal mupirocin for 5 days preoperatively) targeted at reducing SSI rates following revision knee arthroplasty
- Awarded the “Certificate for Outstanding Contribution in Promoting Patient Safety with Medical Devices” by the FDA Center for Devices and Radiological Health MedSun Patient Safety Staff for reporting performance issues with the MicroClave Neutral Displacement IV Access Connector
- Re-established the Construction Subcommittee to enhance communications among the departments of Hospital Epidemiology and Infection Control, Facilities Management and Design and Construction
- Endorsed HEIC surveillance methods; CDPH validated Specificity, Sensitivity and Positive Predictive Value at 92% for MRSA and VRE bloodstream infection, C. difficile infection and CLABSI. Reviewers recognized UCSF for having the highest case volumes and most complex patients, noting UCSF to be among the top scoring facilities in the state-wide validation study
- Oversaw development of Learning Management System (LMS) compliance reporting for infection control training/education
- Responded to findings from the Medication Error Reduction Program survey
- Responded to CDPH state-wide reports
- Supported UCSF in DSRIP reporting for CLABSI, CLIP, and SSI
- Reviewed surgical procedure observations with recommendations to OR Committee for practice improvement
- Approved Aerosol-Transmissible Diseases Exposure Control Plan
- Approved increased number of portable HEPA air filtration units for 11L anticipated influx of vulnerable patients; reviewed report of air sampling after HEPA units in place
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). CLABSI and CAUTI are no different than expected when compared to National Healthcare Safety Network’s Standardized Infection Ratio (SIR). 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 DRI. Adherence to “bundled” care elements are audited and reported both internally and to external agencies. Significant reduction strategies implemented in FY12 include: use of continuous disinfecting caps on IV tubing of patients with central lines, antimicrobial agent for oral care of ventilated patients, and standardized basic urinary catheter care.

UCSF Medical Center and Benioff Children Hospital Critical Care
Central Line Associated Bloodstream Infection (CLABSI) Rate per 1000 Line Days
July 2008 - June 2012

VAP/1000 Ventilator Days

CAUTI/1000 Indwelling Catheter Days

FY12 TD Rate=1.8 (Jan-Jun 2012)
Infection Control Committee (continued from previous page)

SURGICAL SITE INFECTIONS (SSI) PER 100 SURGERIES FY 2009-2012

Surgical Site Infection (SSI) surveillance is performed for 29 surgical categories and reported publicly by the California Department of Healthcare Services. A three-trigger method is used to identify SSI: positive culture, readmission or code for “incision and drainage” in a patient who has undergone surgery in the last 12 months.

Baseline Surgical Site Infection (SSI) Rates vs. FY12
Includes Wound Class 1 and 2 Surgeries and Resulting SSIs

SSIs REPORTED TO DELIVERY SYSTEM REFORM INCENTIVE POOL (DSRIP) PROGRAM
## SSI MANDATORY REPORTING FY12

SSI performance is significantly better (fewer than expected SSI) in 9 categories\(^*\) for FY12, and is as expected in all other categories. No category is significantly worse than expected. Standardized Infection Ratio (SIR) is calculated based upon national data from 2006-2008.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>Overall</th>
<th>Adult</th>
<th>Pediatric (Age &lt; 18)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># Procedures</td>
<td># SSI</td>
<td>Rate</td>
</tr>
<tr>
<td>Abdominal Aortic Aneurysm</td>
<td>27</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Appendectomy</td>
<td>222</td>
<td>3</td>
<td>1.35</td>
</tr>
<tr>
<td>Biliary Surgery(^^)</td>
<td>397</td>
<td>23</td>
<td>5.79</td>
</tr>
<tr>
<td>Cardiac Surgery</td>
<td>296</td>
<td>4</td>
<td>1.35</td>
</tr>
<tr>
<td>CABG, 2 Incisions</td>
<td>81</td>
<td>3</td>
<td>3.70</td>
</tr>
<tr>
<td>CABG, 1 Incision</td>
<td>3</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Gallbladder Surgery</td>
<td>343</td>
<td>4</td>
<td>1.17</td>
</tr>
<tr>
<td>Colon Surgery(^^)</td>
<td>293</td>
<td>9</td>
<td>3.07</td>
</tr>
<tr>
<td>C-Section</td>
<td>429</td>
<td>15</td>
<td>3.50</td>
</tr>
<tr>
<td>Spinal Fusion</td>
<td>920</td>
<td>15</td>
<td>1.63</td>
</tr>
<tr>
<td>Fracture Reduction</td>
<td>242</td>
<td>2</td>
<td>0.83</td>
</tr>
<tr>
<td>Gastric Surgery</td>
<td>261</td>
<td>5</td>
<td>1.92</td>
</tr>
<tr>
<td>Hip Prosthesis</td>
<td>430</td>
<td>6</td>
<td>1.40</td>
</tr>
<tr>
<td>Heart Transplant</td>
<td>5</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Abdominal Hysterectomy</td>
<td>298</td>
<td>6</td>
<td>2.01</td>
</tr>
<tr>
<td>Knee Prosthesis</td>
<td>417</td>
<td>7</td>
<td>1.68</td>
</tr>
<tr>
<td>Kidney Transplant</td>
<td>339</td>
<td>5</td>
<td>1.47</td>
</tr>
<tr>
<td>Luminectionotomy(^)</td>
<td>1111</td>
<td>4</td>
<td>0.36</td>
</tr>
<tr>
<td>Liver Transplant(^)</td>
<td>128</td>
<td>7</td>
<td>5.47</td>
</tr>
<tr>
<td>Kidney Surgery</td>
<td>384</td>
<td>1</td>
<td>0.26</td>
</tr>
<tr>
<td>Ovarian Surgery</td>
<td>813</td>
<td>3</td>
<td>0.37</td>
</tr>
<tr>
<td>Pacemaker Surgery</td>
<td>185</td>
<td>0</td>
<td>0.00</td>
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<tr>
<td>Rectal Surgery(^)</td>
<td>153</td>
<td>7</td>
<td>4.58</td>
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<tr>
<td>Refusion of Spine(^)</td>
<td>184</td>
<td>1</td>
<td>0.54</td>
</tr>
<tr>
<td>Small Bowel Surgery(^)</td>
<td>441</td>
<td>23</td>
<td>5.22</td>
</tr>
<tr>
<td>Spleen</td>
<td>59</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Thoracic Surgery(^)</td>
<td>362</td>
<td>1</td>
<td>0.28</td>
</tr>
<tr>
<td>Vaginal Hysterectomy</td>
<td>118</td>
<td>2</td>
<td>1.69</td>
</tr>
<tr>
<td>Abdominal Surgery(^)</td>
<td>1061</td>
<td>11</td>
<td>1.04</td>
</tr>
</tbody>
</table>

1) SIR (Standardized Infection Ratio) = Number "expected" SSI / number "observed" SSI;
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 requirement.
**Medical Records Committee**

**Activities and Accomplishments:**

**AHRQ Patient Safety Indicators**
- UHC top performer – Ranked 14 of the UHC hospitals based on Patient Safety given low rates of AHRQ Patient Safety Indicators.
- Sustained high physician engagement with an average response rate at 75%.
- Stable rates of disagreement at 32%.
- Stable rate of Patient Safety Indicators requiring recoding at 39%.
- Created query specific protocols for escalation in collaboration with service stakeholders.

**Medical Records Compliance**
- Maintained excellent compliance with required documentation: Informed Consent, Operative Procedures, History and Physical, and Discharge Summary.
- Ensured that completion of documentation and of required elements would be measurable in APeX.
- Provided feedback of service level performance quarterly to Service Directors.

**New Policies and Initiatives**

**Allied Health Professionals Documentation**
- Collaborated with Risk, Compliance, HIMS, and Quality Improvement to create coding guidelines for nurse practitioners and physician assistants to allow their documentation to contribute to diagnoses and severity of illness.

**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.
- Engaged an outside consultant to begin an initiative to ensure 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.

### Documentation Performance

<table>
<thead>
<tr>
<th>Documentation</th>
<th>Metric</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operative Reports</td>
<td>Timely (post-procedure)</td>
<td>99%</td>
</tr>
<tr>
<td></td>
<td>Findings</td>
<td>74%</td>
</tr>
<tr>
<td></td>
<td>Post-Operative Diagnosis</td>
<td>94%</td>
</tr>
<tr>
<td></td>
<td>Estimated Blood Loss</td>
<td>95%</td>
</tr>
<tr>
<td>History and Physical</td>
<td>Performed before Surgery</td>
<td>99%</td>
</tr>
<tr>
<td></td>
<td>History of Present Illness</td>
<td>99%</td>
</tr>
<tr>
<td></td>
<td>Past Medical History</td>
<td>99%</td>
</tr>
<tr>
<td></td>
<td>Review of Systems</td>
<td>99%</td>
</tr>
<tr>
<td></td>
<td>Provisional Diagnosis</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td>Plan of Care</td>
<td>86%</td>
</tr>
<tr>
<td>Discharge Summary</td>
<td>14-day Completion</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Hospital course</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Disposition</td>
<td>88%</td>
</tr>
<tr>
<td></td>
<td>Diet/Activity</td>
<td>74%</td>
</tr>
<tr>
<td></td>
<td>Discharge medications</td>
<td>98%</td>
</tr>
<tr>
<td></td>
<td>Follow up plans</td>
<td>93%</td>
</tr>
<tr>
<td></td>
<td>Discharge Diagnosis</td>
<td>86%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disagreement</th>
<th>Referral</th>
<th>Code Unchanged</th>
<th>Agency Review – Change Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>64%</td>
<td>4%</td>
<td>62%</td>
<td>13%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Internal Coding Review</th>
<th>Change Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>13%</td>
<td>26%</td>
</tr>
</tbody>
</table>
UTILIZATION MANAGEMENT COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:
The primary focuses for UM committee in FY2012 were to provide 1) oversight for patient throughput efforts, 2) to support efforts to correctly identify appropriate patients for Observation Status and 3) to provide oversight and guidance in the development of community partnerships. The committee performed ongoing analysis of the Utilization Management Scorecard particularly with respect to length of stay.

PATIENT THROUGHPUT AND LENGTH OF STAY
- Door to Floor efforts included many interventions but no overall improvement in Door to Floor time. Notably, efforts by the Medicine Service led to decreased time from notification of admission to the completion of admission orders.
- In depth analysis of high census days demonstrated consistent mismatch in admitting and discharge patterns.
- Reviewed LOS and explored interventions with services in which the observed length of stay exceeded the expected or in which there appeared to be an upward trend.

OBSERVATION AND 1 DAY STAYS
- The incorrect assignment of patients to Inpatient Status rather than Observation for low acuity conditions remains challenging. Processes developed for Case Manager-MD communication and for provider feedback regarding incorrect admission status.

COMMUNITY RELATIONSHIPS
- Committee provided oversight and guidance for the development of a partnership and contract with Kindred in response to an analysis identifying opportunities to enhance utilization of skilled nursing facilities.
- Committee provided oversight and guidance for the development of a new collaboration, the SF Care Transitions Program, through the Department of Aging and Adult Services with many other SF hospitals and community agencies.
TRANSITIONS IN CARE – HEART FAILURE READMISSIONS PROGRAM

The UCSF Heart Failure Program was started in November 2008 through a grant from the Gordon and Betty Moore Foundation. The aim of the grant was to decrease 30 and 90 day readmissions for patients 65 years and older by 30%. The program has achieved its goals. Essentials of the program in the first two years included:

- Two Heart Failure Program Coordinators (now 1 FTE with expanded responsibilities)
- Support from the Institute of Healthcare Improvement
- Creating a multidisciplinary team, revising educational materials, incorporating the Teach Back method of patient education, discharge phone calls, developing a data collection system, increasing communication and referrals to UC Home Care, and working to improve the overall discharge process
- Developing the outpatient program by utilizing the Nurse Practitioners in the heart failure clinic for high risk patients
- Starting the GeriTRACCC program with home visits
- Developing a program with several skilled nursing facilities in the community

The third year of the program, 2011, the focus was on expanding some of the successful interventions to services within the hospital through the Readmission Task Force as well as extensive mentoring to numerous hospitals in the state and nation. In 2012, the program reached all adults with primary and secondary heart failure regardless of age or unit location and has become a national model for reducing hospital readmissions in this population.

---

**30-Day Readmission for UCSF Heart Failure Program: Primary and Secondary HF Diagnosis**

- Average for 2009 = 24%
- Average for 2010 = 19%
- Average for 2011 = 13%
- Average for 2012 = 10%

**Goal Line:** 16% (30% reduction)

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~ Page 32 of 63 ~
QUALITY COMMITTEES REPORTING TO CLINICAL PERFORMANCE IMPROVEMENT COMMITTEE (CPIC)
ADULT CRITICAL CARE COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:

- Maintained the incidence of central line-associated blood stream infections (CLABSI) at 1.1 per 1000 line days, same as FY11, and down from 1.8 in FY10.
- The incidence of ventilator-associated pneumonia (VAP) has increased modestly to 3.1 per 1000 ventilator days, up from 3.0 in FY11, despite increased efforts to prevent this complication of care.
- Expanded the practice of early-mobilization of ICU patients to 13ICU to decrease morbidity and complications, and hasten recovery.

<table>
<thead>
<tr>
<th>ICU Mortality FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>MS-DRG Severity of Illness Grouping</td>
</tr>
<tr>
<td>Minor</td>
</tr>
<tr>
<td>Moderate</td>
</tr>
<tr>
<td>Major</td>
</tr>
<tr>
<td>Extreme</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICU Length of Stay FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>MS-DRG Severity of Illness Grouping</td>
</tr>
<tr>
<td>Minor</td>
</tr>
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</tr>
<tr>
<td>Major</td>
</tr>
<tr>
<td>Extreme</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Central Line-Associated Blood Stream Infections FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit</td>
</tr>
<tr>
<td>9 and 13 ICU</td>
</tr>
<tr>
<td>10 ICC</td>
</tr>
<tr>
<td>8 and 11 NICU</td>
</tr>
<tr>
<td>Mt. Zion ICU</td>
</tr>
<tr>
<td>Adult Composite</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ventilator-Associated Pneumonia FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit</td>
</tr>
<tr>
<td>9 and 13 ICU</td>
</tr>
<tr>
<td>10 ICC</td>
</tr>
<tr>
<td>8 and 11 NICU</td>
</tr>
<tr>
<td>Mt. Zion ICU</td>
</tr>
<tr>
<td>Adult Composite</td>
</tr>
</tbody>
</table>

UCSF ICU mortality index (observed rate/expected rate) in all patients with an ICU stay has increased and is higher than the mean rates of the AAMC Teaching hospitals. Mortality is less than the expected (UHC mortality probability model) in minor, moderate and major severity of illness (SOI) groups and greater than expected in the extreme SOI group. Mean ICU length of stay is similar to the UHC AAMC Teaching hospitals.

Central line-associated bloodstream infections which had fallen steadily from 2.0 per 1000 device days in FY09 to 1.4 in FY10 and 1.1 in FY11, have remained constant at 1.1 in FY12. The rate of ventilator-associated pneumonia has risen modestly from 3.0 per 1000 ventilator days in FY11 to 3.1 in FY12.

The pilot program of Early Mobilization of ICU Patients previously demonstrated to be effective in reducing length of stay in 9ICU with a higher percentage of patients discharged to home versus extended care facilities has been expanded to 13ICU.
CANCER COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:
Oversight of Cancer Program accreditation by the American College of Surgeons, Commission on Cancer.
Committee activity has focused on:
- Palliative Care program for Mount Zion inpatients
- Wave 3 ApEx roll-out to the Cancer Center practices and preparation for the upcoming April 2013 re-accreditation survey
- Psychosocial Distress Screening
- Survivorship Care Planning
- Patient Navigation/New Patient Orientation (to be phased in by 2015)

Oversight of the Cancer Center Quality Initiative
The Cancer Center and Cancer Committee continues to monitor bi-annual quality scorecards. Data are collected and reported on Patient Satisfaction, 3rd Available Appointments, and Bump Rates as depicted in the graph below. Improvement in scores for wait time questions resulted from targeted interventions.

For the last 3 years, the Committee has also monitored the annual Cancer Center practice-specific quality metrics for 22 Mount Zion practices. This component of the quality initiative program was postponed in 2012. Cancer Committee continues to prioritize review of current NCDB breast and colorectal metric compliance as required by accreditation. UCSF continues to evaluate compliance with established treatment guidelines and ranks over 90% compliant for 5 of the 6 quality metrics for the last complete accession year, 2010.

<table>
<thead>
<tr>
<th>National Cancer Database (NCDB) Quality Metric Performance</th>
<th>Estimated Performance Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast and Colorectal cancer cases diagnosed and/or receiving all or part of first course treatment at UCSF between 2007-2011</td>
<td>2007</td>
</tr>
<tr>
<td>BREAST</td>
<td>Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer. [BCS/RT]</td>
</tr>
<tr>
<td></td>
<td>Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC TNM T1c N0 M0, or Stage II or III ERA- and PRA-negative breast cancer. [MAC]</td>
</tr>
<tr>
<td></td>
<td>Tamoxifen or third generation aromatase inhibitor is considered or administered within 1 year (365 days) of diagnosis for women with AJCC T1c N0 M0, or Stage II or III ERA and/or PRA positive breast cancer. [HT]</td>
</tr>
<tr>
<td>COLON</td>
<td>Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC Stage III [lymph node positive] colon cancer. [ACT]</td>
</tr>
<tr>
<td></td>
<td>At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer. [12RLN]</td>
</tr>
<tr>
<td>RECTUM</td>
<td>Radiation therapy is considered or administered within 6 months (180 days) of diagnosis for patients under the age of 80 with clinical or pathologic AJCC T4N0M0 or Stage III receiving surgical resection for rectal cancer. [AdjRT]</td>
</tr>
</tbody>
</table>
CODE BLUE COMMITTEE AND RAPID RESPONSE TEAM

ACTIVITIES AND ACCOMPLISHMENTS:

- Conducted clinical debriefing and review of all Codes Blue in the medical-surgical units of M-L Hospital. Eight of thirty-three (24%) codes reviewed in FY12 were referred for further M&M/QI Committee review.
- Deployed new code carts throughout the Medical Center standardized for adult, pediatric and neonatal rescue and resuscitation. Improved efficiency by converting from discrete item inventory and restocking to a module replacement process.
- Reviewed and modified emergency medications on the code carts and emergencies backpacks.
- Initiated a device evaluation process to plan for the replacement of all end-of-life defibrillators.
- Added a Spiritual Care provider to the Code Blue Team.
- Continued oversight of the pediatric emergency team, “Code White”
- Developed and tested a Code Blue Narrator in APeX. Testing in mock codes determined that real-time documentation in the electronic medical record is not feasible.
- Updated the Code Blue policy.

UCSF cardiopulmonary arrest (CPA) outcomes exceed the National benchmark[^4]. Immediate CPR success rate was 66%, compared with the benchmark of 44%, and 33% of these patients survived to hospital discharge, significantly better than the national benchmark of 17%.

RAPID RESPONSE TEAM

A monthly dashboard is produced for the Moffitt-Long adult Rapid Response Team (RRT). Data elements reported are call volume, reason for call, outcome of call, calls by nursing unit, calls by shift (AM or PM) and code team activations.

FY12 RRT call volume averaged 183 calls per month (increased from 138/month in FY11), not including vascular access related calls which averaged 149 calls per month. The high volume units were: 14M (21%), 10CVT (15%), 12L (11%), 9L (9%), 13L (8%), 14L (7%) 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 cardiac concerns and altered mental status. Calls for BiPAP/CPAP evaluations, required under a new policy, accounted for 11% of the calls. RRT began participating in screens for sepsis during the last part of the fiscal year. These accounted for only 1% of the calls, but are expected to increase significantly as the sepsis initiative expands beyond the pilot units.

Figure 2 shows the outcomes of the RRT calls in FY12. Fifty-eight percent of the patients were stabilized in place and did not require transfer. Thirty-one percent were transferred to a higher level of care.
**DIABETES AND INSULIN MANAGEMENT COMMITTEE**

This committee is responsible for setting direction and evaluating care provided to patients with diabetes in the Medical Center with the goal of providing quality and safe care. The committee recommends strategies and priorities for improving clinical outcomes; and provides oversight to clinical initiatives around care of diabetic patients with focus of, but not limited to, insulin management. Additionally, policies/procedures and related tools that guide clinical practice for this patient population are reviewed and updated. This committee also provides recommendations on staff educational programs and competencies.

**DM-RELATED ORDERS AND GUIDELINES**

Committee members worked with the APeX Team to move all Adult, Pediatric, and Obstetric insulin order sets online. The goal was met to have all sets adapted for “ease of use,” and improve over paper sets where possible.

**EDUCATION AND TRAINING**

Online educational modules to teach physicians and pharmacists how to write insulin orders in APeX were completed. Online training modules were updated for all nurses, NPs, PAs, and pharmacists. These modules include a new section on insulin pumps, as well as analyses covering most commonly occurring errors and instructions to prevent these errors.

**AUDITS AND MONITORING**

**Adult Blood Glucose (BG):**

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Units</th>
<th>FY12 Goal</th>
<th>FY12 Performance</th>
<th>Improvement Activities / Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Glucose Data for Adult ICU IV Insulin</td>
<td>% BG mg/dL &lt; 40</td>
<td>&lt;1%</td>
<td>0.08%</td>
<td>The rates of hypoglycemia in our ICUs are extremely low. Other centers have reported severe hypoglycemia (&lt; 40mg/dL) in the range of 4.8% (Crit Care med 38:1430, 2010).</td>
</tr>
<tr>
<td></td>
<td>% BG mg/dL &lt;70</td>
<td>&lt;2%</td>
<td>0.92%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>mean BG mg/dL</td>
<td>&lt;160mg/dL</td>
<td>162mg/dL</td>
<td></td>
</tr>
<tr>
<td>Blood Glucose Data for Adult ICU SQ Insulin</td>
<td>% BG mg/dL &lt; 40</td>
<td>&lt;1%</td>
<td>0.10%</td>
<td>**The NICE-Sugar study showed that mortality in the ICU is increased when targeting BG levels between 80 to 110mg/dL compared to less strict control of BG less than 180mg/dL. For this reason, our ICU BG target is less than 180mg/dL.</td>
</tr>
<tr>
<td></td>
<td>% BG mg/dL &lt;70</td>
<td>&lt;2%</td>
<td>0.74%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% in range 80-180 mg/dL</td>
<td>**</td>
<td>66%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>mean BG mg/dL</td>
<td>&lt;180mg/dL</td>
<td>166mg/dL</td>
<td></td>
</tr>
<tr>
<td>Blood Glucose Data for Adult Med/Surg</td>
<td>% BG mg/dL &lt; 40</td>
<td>&lt;1%</td>
<td>0.07%</td>
<td>Hypoglycemia rates remain very low. Our goal of 80% within target remains that, a goal. There is not a standard to meet, but rather something to strive for. New daily outlier BG reports have been created in APeX. These reports are enabling us to intervene and more rapidly assist in bringing BG levels under control.</td>
</tr>
<tr>
<td></td>
<td>% BG mg/dL &lt;70</td>
<td>&lt;2%</td>
<td>0.61%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% in range 80-180 mg/dL</td>
<td>80%</td>
<td>59%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>mean BG mg/dL</td>
<td>&lt;160mg/dL</td>
<td>179mg/dL</td>
<td></td>
</tr>
</tbody>
</table>
Severe Hypoglycemia Audit: A 4 month audit of adult inpatients was completed to determine cause and possible morbidity/mortality for BG levels <40 mg/dl. Only 3 instances of actual low blood glucose were identified.

<table>
<thead>
<tr>
<th>Unit</th>
<th>Total Glucose Checks</th>
<th># of Actual Low (% low)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICU (IV)</td>
<td>3,378</td>
<td>1 (0.03%)</td>
</tr>
<tr>
<td>ICU (SQ)</td>
<td>5,241</td>
<td>1 (0.02%)</td>
</tr>
<tr>
<td>Med/Surg</td>
<td>15,661</td>
<td>1 (&lt;0.01%)</td>
</tr>
</tbody>
</table>

SCIP Core Measure INF-4: This chronically underperforming measure was stabilized through collaboration between the Diabetes and Insulin Management Committee and the Diabetes Resource Nurses' Group and has been 100% for the past 9 consecutive months. Updated IV insulin protocols were implemented; IV Insulin is now continued through 0600 on POD #2 and measure compliance is concurrently monitored by the Nursing staff.

Inf-4 Cardiac Surgery Patients with Controlled 6 a.m.
Postoperative Serum Glucose

![Graph showing percentage of controlled postoperative serum glucose levels from July 2011 to June 2012. The percentage values range from 50% to 100%.

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PERFORMANCE IMPROVEMENT
ANNUAL REPORT FY 2012

OPERATING ROOM (OR) COMMITTEE

PRESSURE ULCER REDUCTION INITIATIVES FOR CARDIAC SURGERY PATIENTS: 31% DECREASE IN INCIDENCE

In response to an alarming increase of incidence of hospital-acquired pressure ulcers among patients who had undergone long cardiac surgical procedures, several action plans were instituted, including use of pressure relieving OR bed surfaces. This population is at increased risk of pressure ulcer due to the unique demands of temperature and circulation regulation during cardiac surgery.

In Oct. 2010, the Berchtold Tablegard Patient Care System went into service for adult cardiac surgical cases including transplants and ECMO. This system combines warming and true pressure relief to combat hypothermia and pressure related tissue trauma. As a result, in FY2011 HAPU incidence in 10 ICCU was reduced by 31%. Another bed surface has been acquired and deployed with Vascular Surgery.

OR utilization has continued to rise through FY2012

Compliance with the perioperative timeout (Universal Protocol) is 99% or greater at all surgical locations.

Surgical Care Improvement Project

Eight of ten inpatient SCIP measures exceeded the UHC target of 95% throughout CY 2011. Inf-4 (Glucose Control) is on track to exceed targets in 2012.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>CY 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inf-1</td>
<td>Timely prophylactic antibiotics</td>
<td>95.3%</td>
</tr>
<tr>
<td>Inf-2</td>
<td>Appropriate antibiotic selection</td>
<td>96.7%</td>
</tr>
<tr>
<td>Inf-3</td>
<td>Timely discontinuation of antibiotics</td>
<td>98.2%</td>
</tr>
<tr>
<td>Inf-4</td>
<td>Glucose control after cardiac surgery</td>
<td>93.5%</td>
</tr>
<tr>
<td>Inf-6</td>
<td>Appropriate hair removal</td>
<td>100%</td>
</tr>
<tr>
<td>Inf-9</td>
<td>Timely removal of urinary catheter</td>
<td>94.6%</td>
</tr>
<tr>
<td>Inf-10</td>
<td>Perioperative temperature management</td>
<td>98.3%</td>
</tr>
<tr>
<td>VTE-1</td>
<td>Appropriate venous thromboembolism prophylaxis orders</td>
<td>98.9%</td>
</tr>
<tr>
<td>VTE-2</td>
<td>Appropriate venous thromboembolism prophylaxis orders</td>
<td>98.4%</td>
</tr>
<tr>
<td>Card-2</td>
<td>Surgery patients on beta blocker therapy who received beta blocker in the periop period.</td>
<td>100%</td>
</tr>
</tbody>
</table>

MEDICAL DEVICE RECYCLING PROGRAM

Participation in the Stryker Sustainability Solutions medical device recycling program is producing cost and medical waste reductions.

Average monthly savings in CY 2011:
- $33,825
- 910 pounds medical waste
PAIN COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:

- Developed procedure to enable low-dose ketamine analgesia, formerly restricted to use in the ICU, to be used in select adult and pediatric medical-surgical units in a pilot program for palliative care patients.
- The NIH recognized UCSF as a Center of Excellence Pain Education. The award petition includes a planned follow-up to last year’s successful pain summit, multi-disciplinary mock team training and inter-professional assessment of pain management, transforming lectures to be more interactive, publication of a pain newsletter and other initiatives to promote pain education.
- Extended the Patient Controlled Analgesia (PCA) lockout period from 6 minutes to 10 minutes for patient safety.
- Conducted pre and post implementation audit to confirm that the change did not reduce the effectiveness of PCA care.
- Implemented new order sets for analgesics.
- Conducted a pilot of IV acetaminophen, under Pain Service review, to offer a non-opioid alternative to provide for greater patient safety. Conducted a medication use evaluation.

SEDATION COMMITTEE

ACTIVITIES AND ACCOMPLISHMENTS:

- Revised the policy, Sedation Administration by Non-Anesthesiologists, to include a qualification of all providers of moderate sedation to maintain ACLS and/or PALS, as appropriate for the patient age. The certification must be achieved and maintained by February 2013.
- Developed policy and a curriculum for non-anesthesiologist providers in select circumstances to petition for deep sedation privileges and undergo training and competency verification by the Department of Anesthesia.
- Developed the Sedation Narrator in APeX for real-time documentation during procedural sedation.

<table>
<thead>
<tr>
<th>FYI2 Sedation Process Measures Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-procedure Assessment</td>
</tr>
<tr>
<td>Medications Documented</td>
</tr>
<tr>
<td>Consent Form</td>
</tr>
<tr>
<td>Recovery Criteria Met Before D/C</td>
</tr>
<tr>
<td>ASA Assigned</td>
</tr>
<tr>
<td>Pre-procedure Verification</td>
</tr>
<tr>
<td>Discharge Instruction</td>
</tr>
<tr>
<td>Transport</td>
</tr>
<tr>
<td>Monitoring Post-procedure</td>
</tr>
<tr>
<td>Teaching</td>
</tr>
<tr>
<td>Aldrete Score</td>
</tr>
<tr>
<td>NPO</td>
</tr>
<tr>
<td>H&amp;P</td>
</tr>
<tr>
<td>Monitoring Intraoperative</td>
</tr>
<tr>
<td>90% 92% 94% 96% 98% 100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FYI2 Adverse Sedation Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Arrest</td>
</tr>
<tr>
<td>Cardiac Arrest</td>
</tr>
<tr>
<td>Unplanned Sedation</td>
</tr>
<tr>
<td>Decreased SpO2</td>
</tr>
<tr>
<td>Increased Level of Care</td>
</tr>
<tr>
<td>Hemodynamic Instability</td>
</tr>
<tr>
<td>New Assisted Ventilation</td>
</tr>
<tr>
<td>Reversal Agent Used</td>
</tr>
<tr>
<td>Unplanned Progression to Deep Sedation</td>
</tr>
<tr>
<td>Failed Sedation</td>
</tr>
<tr>
<td>Patient Left AMA</td>
</tr>
<tr>
<td>0.00% 0.04% 0.08% 0.12%</td>
</tr>
</tbody>
</table>
SURGICAL CASE AND HOSPITAL MORTALITY REVIEW COMMITTEE (SCHMRC)

SCHMRC CASE REVIEW ACTIVITIES:
- 100% of all deaths (652) were reviewed.
- 90% of all deaths are reviewed within 3 months.
  - New target for FY13: 75% within 2 months
- Systems issues identified through the committee review process are reported below.

PLANNED FOR OCTOBER 2012:
- Committee members will begin to use the QI on-line case review database to capture ratings and systems issues.
- The Committee will track and report systems issues twice yearly.

SYSTEMS ISSUES IDENTIFIED AND ACTIONS TAKEN – SCHMRC RECOMMENDATIONS

<table>
<thead>
<tr>
<th>Areas</th>
<th>Focus</th>
<th>Improvements</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED/ECG</td>
<td>Test results follow-through and resident oversight</td>
<td>Synopsis of systems issues distributed to all ED Program Directors and trainees about necessity of follow-up on test results, particularly related to handoffs. Multidisciplinary task force developed guidelines and comprehensive plan to increase housestaff competency for safe and effective handoffs.</td>
</tr>
<tr>
<td>Neurology/Pharmacy</td>
<td>Warfarin reversal</td>
<td>The Neurovascular Service and the Department of Pharmacy developed standardized heparin protocol for warfarin reversal for intracranial hemorrhage.</td>
</tr>
<tr>
<td>Medicine</td>
<td>Anticoagulation for Internal Jugular (IJ) thrombus</td>
<td>Addressing standard of care for IJ thrombus, Medical QI service disseminated guidelines relating to conditions that require anticoagulation. Medical QI service reinforced need to document even informal consults.</td>
</tr>
<tr>
<td>Surgery/LTU</td>
<td>Inadequate pre-op studies review</td>
<td>Surgery QI Committee to develop a Preoperative Checklist to ensure that the most recent diagnostic studies have been reviewed. Liver Transplant Service discussed need to do further imaging prior to all transplants.</td>
</tr>
<tr>
<td>Peds Cardiology</td>
<td>Cath Lab procedure for transfer patients</td>
<td>Intervention cases are now presented at a joint Pediatric Cardiology and CT Surgery conference.</td>
</tr>
<tr>
<td>Critical Care</td>
<td>Line sepsis</td>
<td>Changes in procedure, with emphasis on the importance of documentation and patient follow-up by Critical Care after discharge from the unit.</td>
</tr>
</tbody>
</table>
Tissue Committee

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

FY 2012 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.

- **Surgical Site Infections:**
  The Department of Hospital Epidemiology and Infection Control reported that there were no surgical site infections related to tissue transplantation occurred for this reporting period.

- **Sterility of Hematopoietic Stem Cell Products:**
  Adult Blood and Marrow Transplant Laboratory reported positive cultures of 1.22% (5 out of 411). Pediatric Blood and Marrow Transplant Laboratory reported positive cultures of 0.9% (2 out of 213). This is below the target threshold of <5%. Aliquots of positive cultures are re-tested for verification. No patient harm reported.

- **ICN Storage of Donor Breast Milk:**
  The Intensive Care Nursery obtained a Tissue Bank License on January 9, 2012. Relative policies and procedures, including continuous temperature monitoring, received CDPH approval.

Joint Commission Survey Preparedness

- **Tissue Product Vendors:**
  A review of FDA registration and California licensure of all vendors providing tissue products to UCSF was conducted. Several vendors were removed from the approved vendor list due to a lack of appropriate licensure. Ongoing tracking has been turned over to Materiel Management.

- **Compliance Inspections**
  Site visits to all of the primary tissue license sites were conducted. Documentation of processes, standard operating procedures, and compliance with Joint Commission standards were evaluated.

Improving Patient Safety: Solid Organ Transplant Working Group

In collaboration with Transplant Surgery, the Perioperative Division and the Blood Bank, the Tissue Committee provides oversight to the patient safety initiative that is reengineering the identification and flow of solid organs and vessels for transplantation under the supervision of the Blood Bank.

**Phase I:** The Working Group has developed a process for the delivery of boxed kidneys directly to the Moffitt-Long Blood Bank, entry of the organ into the Blood Bank inventory, verification of ABO compatibility and issue of organ along with Blood Bank Transplant Record to OR. Phase 1 was successfully implemented in September 2011. The turnaround time (~15 minutes) has been acceptable and the process has worked very well.

**Phase II (implementation targeted for FY 2013):** Revision of organ verifications forms and design of downtime procedures and protocols for revised workflow have been completed. The new process is designed for fast-track processing of deceased donor livers. The fast-track process involved a major revision of the Organ Verification Form and creation of a Proxy card in lieu of the organ container. ABO verification and issue of the BB Transplant Record will follow procedures established for Phase I.

**Phase III:** The Working Group is currently discussing workflow revisions and changes to forms required to develop a process for handling organs recovered at UCSF from living donors.

Next Steps for FY 2013-2014:

- **Phase IV:** Design and implementation of process for handling heart and lungs.
- **Phase V:** Design and implementation of processes for handling vessels.
- Explore an APeX-driven workflow to further support Tissue and Solid Organ activities.
TRANSMUSION COMMITTEE

MASSIVE TRANSFUSION PROTOCOL AND AVAILABILITY OF THAWED PLASMA

On March 27, 2012, Moffitt-Long Blood Bank implemented a blood product order and issue protocol to support massively bleeding patients. Key elements of MTP are provided on the Laboratory Medicine Online Manual website. Modified processes for emergency release of blood products were also implemented at this time. Mt Zion Blood Bank also implemented this protocol in September 2012.

IMPROVING PLATELET TRANSFUSION SAFETY: DECREASING RISK OF BACTERIAL CONTAMINATION

Increased sample volumes will be obtained from UCSF Donor Center plateletpheresis products when culture testing is performed for bacterial contamination. This new sampling strategy has been adopted by BSI to further enhance the sensitivity of detection using BacT culture methods. Larger sampling volumes from both single apheresis collections as well as multi-unit collections are predicted to increase sensitivity by 15-20%.

SOLID ORGAN TRANSPLANTATION PROCESS IMPROVEMENT

Blood Bank and Transplant Working Group developed a process for the delivery of boxed kidneys from CTDN directly to the Moffitt-Long Blood Bank, entry of the organ into the 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 and by May 2012, 162 kidneys, 6 enbloc kidneys, 9 kidney/pancreas and 3 pancreas transplants have been performed under the new process. With an average turnaround time of about 15 minutes, the new process is working very well. Phase II included a major revision to the organ verification forms and workflow for handling organs in the OR along with design of computer downtime protocols for ensuring ABO compatibility of organs.

PROCESS IMPROVEMENT ACTIVITIES RELATED TO APeX

- ABO/Rh reconfirmation specimen:
  The workflow for the collection and acceptance criteria for this specimen were redesigned and further tightened to decrease risk of mistransfusion from specimen collection errors.

- Blood Management Tools: APeX Transfusion Orders were designed to include a hard stop for patient consent and fields for ‘indications’. Creating ‘hard stops’ for product orders, requiring providers to state indications and thresholds for transfusion promote appropriate blood product usage. BB has approached APeX for building Clinical Decision Support tools and creating reports for data capture & analysis for use in blood product utilization initiatives.

SPECIMEN ERRORS

Background: Mislabeled Blood Bank samples can lead to an ABO incompatible transfusion. Blood Bank monitors specimen errors and classifies them as a “Near Miss Error” or a “Specimen Collection Problem”.

- ABO/Rh samples for kidney transplant candidates
  Per UNOS requirement, 2 ABO/Rh types drawn on “two separate occasions” are required prior to listing a patient for transplant. During 1st quarter of 2012, Blood Bank noticed an increase in two ABO/Rh samples being drawn at the same time. Blood Staff are trained to reject the second ABO/Rh sample if drawn at the same time as the first sample. BB met with the Pre-Kidney Transplant nursing and suggested that revised instructions be sent with the collection kits to the outpatient dialysis centers.

- Communications/interventions addressing specimen errors from nursing floors.
  Report cards summarizing Blood Bank Near Miss Specimen Errors and Specimen Collection Errors were sent to Patient Care Managers of OR, ED, and each inpatient unit. A summary of Blood Bank Specimen Errors and a letter from CPIC, requesting corrective actions and system-wide approaches/training interventions, was sent to Senior Nursing Management in June 2012. The Blood Bank will continue to monitor progress and recommend process improvements as needed.
QUALITY COMMITTEES REPORTING TO THE BENIOFF CHILDREN’S HOSPITAL QUALITY IMPROVEMENT EXECUTIVE COMMITTEE (BCH QIEC)
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.

CPQCC advocates not only for superior patient care, but also efficiency in resource allocation and utilization. Quality improvement activities are aimed at identifying desired outcomes and promoting best practices. Both the patient and the payer are considered when formulating best practices. Health care providers and academic researchers benefit from this demographically and biologically rich database, which offers nearly real time data management. Sound data are critical for generating new hypotheses to be tested in the field, and for developing new analytical approaches to understanding health risks and public health in general.

Infants 401 to 1,500 grams or 22 to 29 weeks gestation received interventions associated with optimal care greater than 90% of the time. Although difficult to achieve in this population, almost 80% of these tiny babies were discharged home on at least some breast milk. (Data for 2011)

VERMONT OXFORD NETWORK (VON)

The Vermont Oxford Network (VON) is a non-profit voluntary collaboration of health care professionals dedicated to improving the quality and safety of medical care for newborn infants and their families. Established in 1988, the Network is today comprised of over 850 Neonatal Intensive Care Units around the world.

UCSF Benioff Children’s Hospital is a member of VON and joins other health care professionals from member institutions to collect and share data. The sharing of data enables NICUs around the world to work together to identify and implement better practices aimed at achieving measurable improvements in quality and safety.

Research shows that very low birth weight infants who are breast feeding at discharge is associated with less medical complications. The graph below demonstrates that UCSF Benioff Children’s Hospital exceeds VON’s standards in this measure.
BCH CODE BLUE AND RAPID RESPONSE TEAM

The Benioff Children’s Hospital Rapid Response team was implemented in January of 2008. The team consists of: Pediatric Critical Care Attending/Fellow MD, Critical Care Charge RN, and Critical Care RT. The BCH RRT is an additional safety net that provides immediate assistance to any family/staff member who is concerned that a patient is deteriorating. RRT is an adjunct and not a substitute for the patient’s primary attending or team.

ACTIVITIES AND ACCOMPLISHMENTS:
Committee presently focusing on:
- Increasing unit’s charge RN participation in committee
- Analysis of qualitative feedback from staff/families
- Weekly review of RRTs with analysis of how many were multiples for one patient within 24 hours; how many are readmitted to ICN within 24 hours; how many were the primary attending MD notified of activation as well as identifying any other issues
- Monitoring the percentage of activations resulting in a transfer to higher level of care
- The Hospitalist division also reviews Acute Care service RRTs monthly, looking for opportunities for earlier intervention

SPOTLIGHT ON FY2012

ANALYSIS
The CH RRT had approximately 158 activations in FY 2012, consistent with 160 activations last year, on average 13 per month. The top two reasons for activations are respiratory related (35%) and neurology related/altered mental status (20%). In the previous fiscal year, hemodynamic instability was the number two leading reason for activation. Over half of the activations resulted in a transfer to a higher level of care, indicating both the need for a Pediatric RRT as well as staff recognition of early deterioration signs. There were 93 codes in the pediatric inpatient units, 7 of which were outside the ICU. While the total codes increased, fewer were outside the ICU; In FY 2011 there were 67 total codes, 18 outside the ICU. The increase of Acute Care codes in 2011 was likely due to aberrant periodic increase in 7-Long acuity. The increase in ED calls was likely due to clarification of the need for RRT in the ED as means for tracking of resource usage.
BCH Medication Committee

Key Areas of Focus:
- Dose Standardization Initiative
- Discharge Medication Process “Reform”
- TPN Ordering Process “Reform”
- Continue to bring disciplines together to address medication issues in the Benioff Children’s Hospital

Activities and Accomplishments:
- APeX Implementation
  - Creation of countless APeX order sets and therapy plans improved for safety and validated by interdisciplinary subject matter experts.
- Medication Standardization Initiative for Neonatal and Pediatric Patients
  - Standardized 206 drug concentrations.
  - Implemented ‘new’ lower controlled substance concentrations to avoid dilution for 3 IV injection products (Fentanyl, Midazolam, Methadone).
  - Updated online references for critical care continuous infusion dosing guidelines.
  - Updated Oral Extemporaneous Compounded Recipes & standardized online format.
- SMART Pumps: Optimized and updated safety features for Neonatal/Pediatric Drug Libraries
- Successful implementation and education of standardized improved language and formatting into five new Insulin order sets initially on paper and then transitioned into APeX
- As part of the ‘Opiate Safety Plan’ approved the use of the updated “Guide to Initial Pain management of new-Onset Pain”
- Updated the BCH Pyxis Override List
- Provided “Free” Tdap & Flu Vaccine program to parents & caregivers of BCH neonatal and pediatric patients
- Conducted joint UCSF BCH Nursing and School of Pharmacy BCMA observational audit for critical care and acute care BCH patient care units
- Completion of 48 month study (24 months–‘PRE’ & 24 months–‘POST’) to evaluate the use of tPA post implementation of lowered standardized concentrations of Heparin flush in patients with implanted Ports
- Completion of IV Acetaminophen pilot
BCH PATIENT SAFETY COMMITTEE

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

In 2012, the BCH PSC updated its mission statement to more clearly define the committee’s purpose. A new reporting structure was developed to provide a more robust oversight of patient safety activities in BCH. Four main subcommittees were identified and will report twice a year. The committee identified six areas of longitudinal focus that it will use to focus the reporting of incidents and areas of concern on a rotating basis. Any acute issues will be discussed as they arise.

BCH PATIENT SAFETY COMMITTEE – SUBCOMMITTEES

- Code White
- Device Related Infections
- Transitions of Care
- Medication Committee

BCH PATIENT SAFETY COMMITTEE – AREAS OF LONGITUDINAL FOCUS

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

PLANNED MEETING STRUCTURE

- Subcommittee Reports (Code White, DRI, Transitions, Medication)
- Longitudinal Task Force reports
- Acute issues (RCAs, etc.)
HEMATOLOGY/ONCOLOGY (HEME/ONC)

The Heme/Onc Collaborative was launched in October of 2009 and has systematically implemented standard and new interventions and improvements to reduce the central line associated blood stream infections (CLABSI) in the Heme/Onc and bone marrow transplant (BMT) pediatric populations. The collaborative achieved this goal by:

- Identifying trends in co-morbidities, diagnoses, treatment, and central access type as they relate to CLABSI
- Identifying potential practice and line maintenance issues which may contribute to CLABSI
- Providing clinicians with essential knowledge and tools to implement CLABSI prevention strategies
- Implementing additional best practices as they relate to line preparation and set-up, central line access, and site care, and monitor for compliance with these measures

ACCOMPLISHMENTS AS REFLECTED IN THE NACHRI REPORT:

- 52 Infections prevented, 6 deaths prevented, $1,835,465 cost savings
- Decrease in CLABSI rate from 2.8 for 6 months of FY 2010 to rate of 2.4 for 6 months of FY 2011 (down from over 5 pre-collaborative)
- Increased awareness of central venous catheter best care and CLABSI prevention strategies
- Increased physician and pharmacy engagement

6 LONG (6L)

The 6L NACHRI Collaborative was engaged in 3 process-improvement projects during the 2012 fiscal year:

- Family-centered rounds
- Transitions of care
- Discharge Process Improvement

FAMILY-CENTERED ROUNDS (PFCR):

The team launched a process change that is expected to increase nurse participation during morning rounds and improve communication and reduce delays in care. Updated rounding protocols increase communication with the caregivers and family and bedside nurse. A rounds facilitator is tasked with inviting the bedside nurse to rounds, asking targeted questions, and conducting teach-backs. (See PFCR report for more details.)

TRANSITIONS OF CARE:

A Transitions taskforce was established to decrease the anxiety of patients and families and increase staff satisfaction and communication during transition of care from a higher to a lower level of care. The taskforce began changing the transitions process to include:

- Transfer Letter to family while in PICU
- Tour of the Acute Care Unit, intro to Charge RN
- Welcome to Acute Care Unit, review by admit RN
- Use of a sticker on hard chart to record process

DISCHARGE PROCESS:

This project was designed to improve barriers to timely discharge and optimize inpatient throughput. The first intervention as part of this project was to establish the Family admit/discharge lounge which opened in January 2012.
UCSF PATIENT & FAMILY-CENTERED ROUNDS (PFCR)

UCSF Patient & Family Centered Rounding was implemented on 6 Long of UCSF Benioff Children’s Hospital in May 2012. This is a multidisciplinary effort that includes pediatric hospitalists, subspecialists, nurses, pharmacists, case management, social work and Child Life. It recognizes the family as the focus of care and involves the family in the decision making process by including them in bedside rounds. Goals of PFCR include improved transparency, communication, and efficiency; increased patient and family satisfaction; and enhancement of resident education/teaching.

UCSF PFCR ROLL-OUT

Longitudinal, multidisciplinary collaboration:

- Committee formed in October 2011
- Approximately 50 participants including physicians, nurses, pharmacy, case management, social work and child life
- Divided into 3 teams with unique focus: 1) Education, 2) Interdisciplinary collaboration, 3) Patient focus
- Implemented rounding coordinator to schedule appointments for each patient; notify team members of schedule and facilitate nursing and subspecialist participation on rounds

FY12 PROCESS IMPROVEMENT ACTIVITIES

UCSF PFCR Committee presently focusing on:

- Increasing RN participation in rounds
- Analysis of qualitative feedback from staff/families
- Monthly multidisciplinary review of UCSF PFCR with inclusion of all stakeholders
- Resident initiated survey of impact of UCSF PFCR on house staff education

Qualitative data from surveys of families

- "Good for staff and very important that everyone does it."
- “[We] like to be included in morning rounds because it provides [us] with more information.”
- Can be "intimidating for a lot of parents."

UCSF PFCR NEXT STEPS

- Hire dedicated rounding coordinator
- RNs to have defined role during patient presentation (“SPOC” mnemonic: Safety, Pain, Orders, Concerns)
- Incorporate suggestions from resident survey
- Enhanced training of students, Residents and Attendings in PFCR
BCH MORTALITY REVIEW

The Children’s Quality Improvement Executive Committee conducted a careful review of pediatric mortality rates and trends in FY 2012. It was found that the majority of deaths were neonates and 49% of the deaths were in patients born elsewhere or transferred to UCSF, usually due to rapidly deteriorating clinical conditions. Two thirds of the patients had a severity of illness defined as “extreme.” More than half (61%) were patients receiving comfort or palliative care.

When focusing on neonates (the largest population of mortalities in the hospital) it was found that our observed to expected (O/E) ratio was greater than expected and higher than other academic hospitals in our benchmark group. However, UCSF’s observed mortality rate was comparable. Clinical case review showed no issues or irregularities with the standard of care provided to these patients. It was determined that our diagnosis coding of our patients, underrepresented the severity of illness of our patients. This was leading to a lower than average expected mortality rate and was the cause of our high O/E ratio. The hospital strives to reflect its patient population more accurately by improving clinical documentation and diagnosis coding within our systems.

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5 BCH Compare Group: Duke, Hopkins, Lucille Packard, Mass General, Michigan, Oregon, UC Davis, UCLA, Vanderbilt
**PEDiATRiC PAiN ANd PALLiATIVE CARe PrOGRAM: IP-3**

IP-3 is a combined pain and palliative care service, staffed with pediatric anesthesiologists, integrative pain specialists, and palliative care specialists. The program also receives support from Child Life Services and the Department of Pharmacy. A Nurse Practitioner coordinates care and bridges disciplines. During FY12, the program was broadened to include an ambulatory complex care and chronic pain clinic, laser acupuncture, inpatient canine therapy, and neonatal pain management consultation.

**FIVE COMPONENTS OF IP-3**

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

**COMPASS CARE**

Compass Care is an important component of the IP-3 program. Since 2007, the program has seen steady growth (see graph below) and is viewed by staff as an important element to: Clinical Case Support, Provision of Resources, Family Support Programs, Bereavement Programs, Staff Support, Education & Training. It offers services to children and the perinatal population. Compass care helps children with medically complex conditions, life-threatening or limiting conditions, those who suffer due to trauma, and children who are dying.

**COMPASS CARE SCOPE OF SERVICE:**

- Clinical support
- Clinical mentorship
- Sedation
- Family support
- Staff support
- Bereavement services
- Clinical guideline & policy development
- Education & training
- Community collaboration

![Compass Care Referral Summary](image)
**BCH Quality Dashboard**

The Benioff Children’s Hospital Quality Improvement Executive Committee reviews comprehensive quality data regularly as a part of its Quality Improvement process. The BCH QIEC dashboard results for FY12 are included in tables below.
U.S. NEWS & WORLD REPORT
“BEST CHILDREN’S HOSPITALS”

SUMMARY OF U.S. NEWS SURVEY:
The U.S. News & World Report survey for “Best Children’s Hospitals” attempts to rank children’s hospitals across the nation based on 10 pediatric sub 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 publically reported data, and a reputational survey sent to 1,500 board-certified pediatric specialists. In the 2012 survey, children’s hospitals that had at least 3 programs ranked in the top 10% of their sub specialty area were awarded “Honor Roll” status.

UCSF Benioff Children’s Hospital has made steady progress in increasing the number of calculable survey points (68.3% in 2011 to 72.3% in 2012), but overall rankings have decreased. This has been due to a combination of factors that impacted all program rankings such as lack of an Electronic Medical Record, Nurse Magnet Designation, and pediatric trauma. Patient volume in some UCSF BCH programs also impacts the ranking.

COMPLETED & ONGOING IMPROVEMENT INITIATIVES FOR FUTURE SURVEYS:
Implementation of the EMR (APeX) and achieving Nurse Magnet designation will immediately add 90 points and reduce the points deficit in the Structure category by 20%

Through use of the new EMR, UCSF BCH can more effectively track specific patient populations, procedures performed, and outcomes in order to increase potential points. The U.S. News has survey has grown in complexity over the years and some survey questions have required manual records search which inherently increases the potential for error.

Pediatric trauma can potentially be included in the 2013 survey since UCSF BCH physicians primarily support the pediatric trauma program at San Francisco General. UCSF Medical Center was awarded trauma program points in the 2012 adult survey using similar reasoning with U.S. News. Regardless, UCSF BCH will be able to claim pediatric trauma through the affiliation with Children’s Hospital Oakland, though in the 2014 survey.

UCSF BCH continues to recruit the best pediatric sub specialists from around the nation and the world. Recruitment of a nationally known pediatric heart surgeon in August 2012 will launch efforts to establish a pediatric heart transplant program and initiate external reporting for outcomes (both areas are awarded points in the survey).

Quality and Infection Control activities identified in the survey continue to be a focus for the BCH Quality Program.
PATIENT SATISFACTION
MEDICAL CENTER PATIENT SATISFACTION GOAL

UCSF achieved a combined mean score of 91.3 in fiscal year 2012, exceeding the outstanding level of the incentive award goal. This placed the medical center at a combined percentile ranking of 62nd. The chart below shows our performance for each survey area.

<table>
<thead>
<tr>
<th>Survey Area</th>
<th>FY12 Mean Score</th>
<th>FY12 Percentile Ranking</th>
<th>Peer Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Medical Practice</td>
<td>91.5</td>
<td>36th</td>
<td>UHC</td>
</tr>
<tr>
<td>Adult Inpatient</td>
<td>92.2</td>
<td>80th</td>
<td>UHC</td>
</tr>
<tr>
<td>Pediatric Inpatient</td>
<td>92.4</td>
<td>69th</td>
<td>Children’s Hospital within a Hospital</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>83.6</td>
<td>61st</td>
<td>UHC</td>
</tr>
<tr>
<td>COMBINED TOTAL</td>
<td>91.3</td>
<td>62nd</td>
<td></td>
</tr>
</tbody>
</table>

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 1980s 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 91.5 in 2011 based on patient responses to the survey question "Likelihood of your recommending this hospital to others?” as outlined on the graph below. Our staff works diligently to ensure each and every patient’s experience is a positive one, and we welcome and encourage any feedback from patients to assist us in identifying areas where we might improve.
HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS & SYSTEMS (HCAHPS)

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

HCAHPS

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. As previously described, the HCAHPS survey impacts Medicare reimbursement via CMS’ Value Based Purchasing program.

HCAHPS JAN-DEC 2011 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, based on unsolicited patient feedback reported to the Patient Relations department directly from patients or their representatives, are tracked and reported to the Culture of Excellence Committee, Nursing Quality Council, and other venues on a regular basis. Trend data is used to identify improvement opportunities in concert with patient satisfaction data, as part of the physician periodic performance evaluation and Medical Staff reappointment process, and for committee activities. Individual complaints and grievances are thoroughly reviewed and responded to in real time at the time of receipt. The multi-disciplinary Grievance Oversight Team (GOT) meets weekly to assure a thorough review and response to complex grievances. Individualized and automated reports are available and sent out weekly, monthly, and at various intervals to departments as requested and needed.

The 7 day response time for sending grievance acknowledgement letters was 100%. Although the average days to respond to a grievance was less than 30 days, meeting the Medical Center 30 day grievance response time goal is particularly challenging given multi-disciplinary care grievances which involve extensive reviews and continues to be a priority.

- **7-Day Grievance Acknowledgment Letters Compliance Rate:** 100%
- **30-Day Review and Response Compliance Rate:**
  - Grievance: 73%
  - Complaints: 96%
- **Average Days to Respond to a Grievance:** 21 Days
- **Average Days to Respond to a Complaint:** 10 Days

**COMPLAINT/GRIEVANCE TRENDS BY CATEGORY:**

The graph below reflects that 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). For FY 12, **Quality of Service, Quality of Care** and **Access** complaints continued to be the top categories and each reflected a slightly increased trend.

![Graph of Complaints & Grievances by Category (July 2009 - June 2012)](image)
Complaints and Grievances (continued from previous page)

**Complaint/Grievance Trends by Patient Type:**
The majority of patient concerns involved Outpatient Medical Practice areas, which related largely to service, access, and appointment issues and the high visit volume. The majority of grievances related to inpatient quality of care allegations although care related complaints in outpatient areas are increasing. Service and communication issues also comprised a majority of inpatient concerns.

In summary, patient complaints, especially service related increased slightly in both the 3rd and 4th quarters. Through the Culture of Excellence Committee and other venues, some strategies to address identified trends included Living PRIDE, My Chart, a proactive patient rounding program, and staff education.
CULTURE OF EXCELLENCE COMMITTEE (CEC)

The goal of the culture of excellence committee is to create an environment and culture at UCSF Medical Center and UCSF 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.

ACTIVITIES AND ACCOMPLISHMENTS:
- Engaged the Studer Group and launched Living PRIDE – including Leadership Rounding, Rounding on Direct Reports, Rounding on Patients, thank-you notes and Everyday PRIDE Standards of Behavior.
- Expanded CMS-sponsored patient satisfaction surveys to outpatients and pediatrics.
- Expanded Patient Relation Rounding Program.
- Further involved patients in the feedback and improvement process with the Patient/Family Advisory Councils.
- Implemented several new initiatives including: patient focus groups; post-discharge phone calls; and hourly rounding and standardized white board programs for inpatients.
- Launched Ambulatory Customer Care Training and New Hire Orientation for all employees.
- Continued to expand discharge phone calls to all Medicine patients to improve communication and continuity of care, as well as other services - Neurology/Neurovascular, and Cardiology.
- Continued to support Lab/Test Results task force to improve provider follow-up with patients and referring physicians.
- Expanded Apparel Program (uniforms) for all clinical employees (final phase in Fall 2012).

EMPLOYEE APPAREL PROGRAM

Project Scope:
All employees having direct contact with patients throughout all locations of the Medical Center will be dressed in apparel assigned and issued under the direction of the Medical Center.

The primary goals of the project included:
- **Patient Safety:** Improve role identification for patients and families.
- **Professional Image:** Conform and color code apparel to standardize professional consistency.
- **Patient Satisfaction:** Evidence in the literature indicates a correlation between uniformed personnel and increased patient satisfaction by improving patient confidence, communication, trust, credibility, and quality of services.
- **Employee Satisfaction:** Employees receive support for complying with organizational goals. Professional appearance is one way to demonstrate our PRIDE values.

![UCSF Medical Center Employee Apparel Program](image)

<table>
<thead>
<tr>
<th>Benioff Children's Hospital Registered Nurses</th>
<th>Ancillary Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Assistants (MA, MA, MA)</td>
<td>Rehabilitation Services</td>
</tr>
<tr>
<td>APEX</td>
<td>Adult Services Registered Nurses</td>
</tr>
</tbody>
</table>

The following depicts uniforms rolled out to date and it is anticipated that additional outpatient and other ancillary departments will be incorporated into the apparel program in the future.
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 2011 and June 2012, with select updates to October 2012.

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, Veronica Cox, Veronica.Cox@ucsfmedctr.org

Referenced information within this report can be obtained from:
- The California Healthcare Assessment and Reporting Taskforce, www.calhospitalcompare.org
- California Nursing Outcomes Coalition (subscription required), www.calnoc.org
- The Joint Commission, www.jointcommission.org
- The Leapfrog Group, www.leapfroggroup.org
- The Office of Statewide Health Planning and Development, www.oshpd.ca.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:
- Adult Code Blue Committee/Rapid Response: Matt Aldrich MD and Paul Monsees
- Adult Critical Care Committee: Michael Gropper MD, PhD and Paul Monsees
- Cancer Committee: Lee-May Chen MD, Gerrie Shields, Ann Griffin and My Nguy
- Children’s Hospital Code Blue Committee: Maurice Zwass MD and Shelley Diane
- Children’s Hospital Medication Committee: Julie Wilson-Ganz, Steve Wilson MD and Kim Scurr
- Children’s Hospital Patient Safety Committee: Scott Soifer MD, Steve Wilson MD, and Veronica Cox
- Children’s Hospital QIEC: Steve Wilson MD, PhD and Veronica Cox
- Children’s Hospital Rapid Response Committee: Steve Wilson MD, PhD and Shelley Diane
- Clinical Performance Improvement Committee (CPIC): Ryutaro Hirose MD and Joy Pao
- Complaints & Grievances: Deborah Avakian and Susan Alves-Rankin
- Culture of Excellence Committee: Mark Larer, Josh Adler MD, Kathleen Balestrieri, Deborah Avakian, and Frances Flannery
- Diabetes and Insulin Management Committee: Robert Rushakoff MD, Umesh Masharani MD, Mary Sullivan, My Nguy and Jennifer Pacholuk
- Delivery System Reform Incentive Pool Program: Gina Intinarelli
- Environment of Care Committee: Matthew Carlson
- Ethics Committee: Scott Andy Josephson MD and Cindy Byrd
- Failure Mode and Effect Analysis (FMEA): Kathy Radics
- 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
- National Association of Children’s Hospitals and Related Institutions (NACHRI) Collaborative: Lisa Tsang and Arpi Bekmezian MD
- National Surgical Quality Improvement Program (NSQIP): Mary McGrath MD, Rochelle Szuba and Jordan Stout
- Nursing-Sensitive Indicator: 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 Paul Monsees
Patient Safety Committee: Adrienne Green MD and Kathy Radics
Pediatric Pain and Palliative Care Program: IP-3: Robin Kramer
Press Ganey Patient Satisfaction: Susan Alves-Rankin and Jason Phillips
Quality Improvement Executive Committee: Mari-Paul Thiet MD and Brigid Ide
Quality Landscape: Brigid Ide and Joy Pao
Risk Management Committee: Neal Cohen MD and Susan Penney
Sedation Committee: Sandra Jeker-Annaheim MD and Paul Monsees
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
Transitions in Care – Heart Failure Readmission Program: Maureen Carroll and Teresa De Marco MD
Tissue Committee: Mort Cowan MD, Cynthia Ishizaki, and Julio Barba
UCSF Patient & Family-Centered Rounds (PFCR): Karen Sun MD
Utilization Management Committee: Adrienne Green MD and Elizabeth Polek
U.S. News & World Report: “America’s Best Hospitals”: Brigid Ide

A special acknowledgement and thanks goes to Dhemy Padilla from Hospital Epidemiology and Infection Control for the technical work involved in producing this report.
<table>
<thead>
<tr>
<th>Departmental Goal/Individual Goal(s)</th>
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<tbody>
<tr>
<td>Patient Satisfaction</td>
</tr>
<tr>
<td>Financial Performance</td>
</tr>
<tr>
<td>Threshold Performance</td>
</tr>
<tr>
<td>Maintain an average Press Ganey mean score of 91.5 on the likelihood of recommending.</td>
</tr>
<tr>
<td>Achieve a percentile ranking of 60 or greater on at least 5 of 8 HCAHPS domains.</td>
</tr>
<tr>
<td>Maintain an average Press Ganey mean score of 91.6 on the likelihood of recommending.</td>
</tr>
<tr>
<td>Achieve a percentile ranking of 65 or greater on at least 5 of 8 HCAHPS domains.</td>
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<tr>
<td>Maintain an average Press Ganey mean score of 91.7 on the likelihood of recommending.</td>
</tr>
<tr>
<td>Achieve a percentile ranking of 70 or greater on at least 5 of 8 HCAHPS domains.</td>
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<thead>
<tr>
<th>Operating Margin at $102M</th>
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<tbody>
<tr>
<td>Outstanding Performance</td>
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<tr>
<td>Target Performance</td>
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<tr>
<td>Threshold Performance</td>
</tr>
<tr>
<td>Meet All Three Goals</td>
</tr>
<tr>
<td>Improve communication with patients by increasing MyChart enrollment to 50,000 by June 30, 2013.</td>
</tr>
<tr>
<td>For routine orders (excluding Chem and TPY)</td>
</tr>
<tr>
<td>Improvement of scanning of medications and 90% of orders within 15 minutes for STAT and 30 minutes for routine orders.</td>
</tr>
<tr>
<td>Improvement of medication safety by achieving 90% compliance with use of bar code medication administration for medications and 90% compliance for scanning of medications.</td>
</tr>
<tr>
<td>Reduce steps monthly by increasing use of the steps resuscitation bundle by 30% from the FY12 baseline in the Emergency Department.</td>
</tr>
</tbody>
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<thead>
<tr>
<th>Patient Safety &amp; Quality</th>
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<tbody>
<tr>
<td>QUALITY &amp; SAFETY</td>
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<tr>
<td>FY13</td>
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<tr>
<td>SERVICE &amp; PEOPLE</td>
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<tr>
<td>OPERATIONS &amp; GROWTH</td>
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<tr>
<td>Organizational Goals</td>
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<tr>
<th>Goals</th>
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<tr>
<td>Threshold Performance</td>
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<td>Target Performance</td>
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<tr>
<td>Outstanding Performance</td>
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