QUALITY COUNCIL
May 17, 2016

CO-CHAIRS: Will Huen, Susan Ehrlich
ATTENDANCE:
Present: Susan Brajkovic, Jeff Critchfield, Terry Dentoni, Susan Ehrlich, Virginia Elizondo, Thomas Holton, Will Huen, Shermineh Jafarieh, Jay Kloo, Tina Lee, Jim Marks, Todd May, Iman Nazeeri-Simmons, Lann Wilder (For Max Bunuan), Troy Williams
QM/KPO Staff: Jenny Chacon**,** Valerie Chan, Stephanie Chigos, Emma Moore, Jessica Morton, Jignasa Pancholy, Leslie Safier, Justin Weber
Excused: Margaret Damiano
Guests: Irin Blanco**,** Beverly Cabello**,** Brandi Frazier (For Aiyana Johnson), Julie Haslam, Yvonne Lowe, Roger Mohamed (for Margaret Damiano), Michelle Tom, Trevor Towne
Absent: Brent Andrew, Jenna Bilinski, Max Bunuan, Sue Carlisle, Karen Hill, Valerie Inouye, Aiyana Johnson, Kim Nguyen, Basil Price, David Woods

AGENDA ITEM	DISCUSSION	DECISION/ACTION
I. Call To Order	Will Huen and Susan Ehrlich called the meeting to order at 10:05AM.	Informational.
II. Minutes	The minutes of the April 19, 2016 meeting were reviewed by the committee.	The minutes were approved.
III. Policies and Procedures	Cheryl Kalson presented the Policies and Procedures for approval. **<u>Administrative Policies</u>** **Policy-7.03: SFGH Compliance Program** Revisions included new reporting relationships of the Compliance Officer and updated compliance hotline number. **Policy-16.31: Safe Medication Management-Patient-Specific Medication Ordering** Minor revisions.	Administrative Policies and Procedures approved.
IV. Performance Measures **a. Utilization Management (UM)**	Irin Blanco and Beverly Cabellon presented the department report. **<u>Accomplishments:</u>** • Implementation of staff satisfaction survey. Results were used to develop staff satisfaction performance improvement measures and implement process changes.	

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	Challenges: • Utilization Management is currently in a transitional period of reevaluating appropriate staff roles and responsibilities as it redesigns the department. **Highlights of Utilization Management PI Indicators:** ***Financial Stewardship*** TITLE: Discharges Reviewed Within 24 Hours AIM: Increase review of all discharges within 24 hours from 72% to 80% by June 30, 2016 and to 80% by December 31, 2016. STATUS: In progress • Current average is 70% for all discharges reviewed within 24 hours. This is a significant improvement from 24% in March 2015. • Barriers to achieving a higher completion rate include: lack of weekend staffing, reporting limitations, and IS systems limitaitons. TITLE: Admissions Reviewed Within 24 Hours AIM: UM will increase admissions reviewed in 24 hours in MedSurg from 63% and 53% in Psych to 92%. STATUS: Goal not met. • Admission reviews within 24 hours averaged 85% for MedSurg and 61% for Psych. • Approximately 28% of Psych and 22% of MedSurg admissions occur on weekends. There is no UM Psych coverage on the weekend and only one UM case worker for Med-Surg. Todd May inquired about the status of addressing weekend staff coverage to ensure timely discharges and admission reviews. UM staff reported that they are currently evaluating staff coverage, roles, and staff who can be cross-trained to provide weekend coverage. UM is also in the process of hiring additional staff to work weekends. ***Developing People*** TITLE: Employee Satisfaction	UM to conduct time study to evaluate where current staffing can be shifted to meet weekend coverage needs by the end of summer.

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	AIM: By August 2016, staff who responded: • Strongly Agree for question "Being Rewarded for My Efforts." Increase response rate from 18.18% to 25%. • For question "Volume of Tasks Too Many." Decrease response rate from 64.7% to 50%.- • Strongly agree for question "Maintaining Work/Life Balance:" Maintain 40% baseline. Status: In progress. • Current response rates for staff who answered: Strongly Agree for question "Being Rewarded for My Efforts" is 11.7%; "Volume of Tasks Too Many" is 54.55%; and Strongly Agree for question "Maintaining Work/Life Balance" is 23.50%. • Countermeasures included: Staff involvement in the development and revision of work processes; staff huddles to increase communication; and standardization of hand-off processes. **Proposed 12 Month Performance Measures:** **DRIVER METRICS** ***Financial Stewardship*** TITLE: Discharges reviewed within 24 hours. AIM: Increase discharges reviewed within 24 hours from 70% in MedSurg and Psych to 85% by May 2017. ***Financial Stewardship*** TITLE: Admissions reviewed within 24 hours. AIM: Increase admissions reviewed within 24 hours from 85% of MedSurg Admissions and 61% of Psych Admission to 90% by May 2017. ***Developing People*** TITLE: Improving Employee Satisfaction Survey AIM: By August 2016, staff who responded: • Strongly Agree for question "Being Rewarded for My efforts." Increase response rate from 11.7% to 25%. • "Volume of Tasks Too Many": Decrease response rate of from 64% to 50%.	

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	• Strongly Agree for question "Maintaining Work/Life Balance:" Maintain 40% baseline. **WATCH METRICS** ***Safety*** TITLE: Workers Compensation Claims AIM: Maintain the zero workers compensation claims. ***Financial Stewardship*** TITLE: Patient Days at Lower Level of Care (LLOC) AIM: Reduce the Percent Patients of LLOC in MedSurg from 12.5% to 11% and in Psych from 61.5% to 54%. Jim Marks discussed the need to ensure metric alignment with the ZSFG-wide Flow A3 given their focus on decreasing LLOC. Iman Nazeeri-Simmons indicated that the Social Services along with Utilization Management are undergoing a LEAN process to redesign workflow, roles and responsibilities of both clinical and non-clinical staff. Metrics will result from this LEAN process and will be monitored on a more frequent basis through Tier One as well as annual reporting. ***Contract Measures:*** Contractor: UCSF Tertiary Care Contract AIM: Services will not exceed $2.1M annually. Status: Goal met. Contractor: PRN Data Service, Inc. AIM: 100% of all LLOC patients are place on a broadcast email advising the need for placement. Status: Goal met.	UM Proposed Performance metrics approved. UM to submit revised 12 month performance metrics resulting from departmental redesign process (summer), and update Quality Council leadership. Continue contract monitoring for compliance.

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b. Social Services	Trevor Towne and Irin Blanco presented the department report. **Accomplishments:** • Proud of organizational changes implemented in Social Services, which resulted in a stronger collaborative relationship between Social Services and Utilization Management. **Challenges:** • The department is in a transitional period with recent leadership changes, staff capacity challenges, and lack of clarity of staff roles and responsibilities. **Highlights of Social Services PI Indicators:** ***Care Experience*** TITLE: Completion of Transfer Packet AIM: Increase the number of transfer packets for acute and Skilled Nursing Facility (SNF) transfers from <20% to 100% by April 2016. STATUS: Goal met. • Increase in transfer pack completion was attributed to staff retraining in documentation requirements through standard work development. ***Developing People*** TITLE: Restructuring the Social Services Department AIM: By the end of 3rd quarter 2016, create standard work instructions and metrics based on expected social services work activities and regulatory requirements. STATUS: In process. • A staff perception of having a heavy case workload averageing 25-30 patients was contributing to staff disastisfation. Further analysis revealed that Social Workers had an average case load of 16 to 18 patients to cover the average 160-185 daily census of MedSurg patients. • Additional assessments will be conducted to better understand all concerns related to employee dissatisfaction and turnover rate. These results will be used to create meaningful training targets and standard work to decrease turnover rate of 16%.	Review all clerical positions to determine appropriate allocation of work activities to decrease Social Worker administrative tasks. Implement staff satisfaction survey to establish baseline by August 2016.

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	Irin Blanco added that Social Services and Utilization Management have collaborated in identifying areas of overlap to decrease redundancy. Iman Nazeeri-Simmons indicated that challenges related to staff capacity were being addressed through the hiring of additional supervisors, leadership and case workers to assist with the distribution of work. Trevor Towne also mentioned that efforts are in process to assess case manager assignments and composition (i.e. number of complex patients being handled) to ensure adequate patient caseload distribution. **Proposed 12 Month Performance Measures:** **DRIVER METRICS** ***Developing People*** TITLE: Hiring Process for Social Workers AIM: Decrease Social Worker vacancy rate from 15% to 0% by May 2017. ***Developing People*** TITLE: Motivational Interview Competency Checklist AIM: Develop a baseline for motivational interview competency checklist completion. **WATCH METRICS** ***Care Experience*** TITLE: eDP/Transfer Packet Completion AIM: Maintain 100% documentation compliance for eDP/Transfer Packet completion. ***Contract Measures:*** Contractor: BayMed Express AIM: 90% of patients will report satisfaction with wheelchair van transportation. Status: Goal met. Contractor: Semax Enterprises AIM: 90% of patients will report satisfaction with wheelchair van transportation. Status: Goal met.	Social Services to submit revised 12 month performance metrics resulting from departmental redesign process, and update Quality Council leadership after completion by end of Quarter 3 2016. The eDP Transfer packet completion metric was adjusted from a Driver to Watch metric.

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	Contractor: Transmetro Inc. AIM: 90% of patients will report satisfaction with wheelchair van transportation. Status: Goal met. Contractor: Protransport AIM: 90% of patients will report satisfaction with ambulance transportation. Status: Goal met. Contractor: King American AIM: 90% of patients will report satisfaction with ambulance van transportation. Status: Goal met. Contractor: Jack Snow AIM: 90% of patients will report satisfaction with eye glasses provided. Status: Goal met. Contractor: Sincere Care Medical AIM: 90% of patients will report satisfaction with respiratory or durable medical equipment (DME) provided. Status: Goal met. Contractor: Regents of the University of California AIM: 90% of patients will report satisfaction with orthotics and prosthetics equipment provided. Status: Goal met.	Continue contract monitoring for compliance.
V. Annual Patient Safety Report	Thomas Holton presented the Annual Patient Safety Plan. **Accomplishments:** • Centralized Associated Bloodstream infections (CLABSI) were zero for six out of the last 12 months.	

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	Challenges: • There has been a steady increase in patient falls with injury. Some challenges identified were inconsistent deployment of falls prevention across the hospital (i.e. multiple interventions). **Highlights from Patient Safety Report:** TITLE: Falls with Injury. AIM: Zero patient harm. STATUS: In progress • From June 2015 to May 2016 there were 86 falls with injuries. • Fall preventions efforts included use of a Falling Star (a visual identification for patients at-risk of falling) and utilization of bed and chair alarms. • In response to the increase of Falls with Harm, Patient Safety leadership began daily tracking of falls from the Unusual Occurrence (UO) database and launched Falls Rounding on Med-Surg. The effectiveness of falls prevention efforts are being evaluated on a weekly basis. TITLE: Venous Thrombosis (VTE) Prevention AIM: Zero patient harm. STATUS: In progress. • From July 2015 to March 2016 there were 17 VTE cases. This is a downward trend, from the previous fiscal year 14-15, of 33. • Countermeasures included patient screening upon admission for VTE. This enabled differentiation between community and hospital acquired VTEs which contributing to a decrease in the number of cases. TITLE: Report Critical Results AIM: Report critical results within time frame and ensure complete form in associated chart 90% of time. STATUS: In progress.	

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	• An 88% (822/926) baseline of Critical Results was documented for paper records, within the correct time frame, in Med/Surg, Intensive Care Unit (ICU), Emergency Department, and Operating Room. • Of the 104 that did not meeting the documentation requirements, 77 were from electronic documentation. To increase electronic documentation compliance, Patient Safety worked with the clinical leads of affected units on developing standard work for Critical Values in eCW. <u>TITLE: Clinical Alarms</u> <u>AIM: Follow established processes to reduce harm from clinical alarms (90%).</u> <u>STATUS: In progress.</u> • 88% (113/129) of individuals were able to verbalize the process for clinical alarms. Existence of several unit specific clinical alarms policy was seen as a barrier for not meeting a proposed 90% goal. • Patient Safety created a standardized hospital-wide Clinical Alarms Policy, which consolidated six department policies, prior to the move to the new building (B25). Susan Ehrlich, CEO, recommended Patient Safety develop a countermeasure summary of one to two measures illustrating the patient safety plans drivers. Other discussion items included the appropriate role of Patient Safety and clinical units in the oversite of specific patient safety metrics.	Terry Dentoni and Troy Williams to collaborate with Patient Safety and Falls Taskforce to develop a countermeasure summary report of falls with injuries and present at June Quality Council.
VI. Quality Measures Update	Leslie Safier presented the CMS Quality Core Measures Update for Quarter 4 2015. Updated core quality measure data for Q1 2016 will be will be presented at the Joint Conference Committee (JCC) May meeting. **<u>Highlights from Quality and Safety Measures Update:</u>** **Venous Thromboembolism (VTE)** • ICU Prophylaxis increased to 98% from 82% which was attributed to audits with feedback, and inclusion of Sequential Compression Devices (SCD).	Leslie Safier to work with Flow Team on addition and format of updated quality data for May JCC meeting.

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	• Overall Prophylaxis: There was a decrease to 83% from 91% with lack of SCD machine use after ordering cited as a contributing factor. • Current performance improvement efforts include collaborating with medical surgical nursing leadership to evaluate the SCD process and use of smaller SCD machines in Building 25. **Psychiatry Measures:** • The rate for Tobacco Use Treatment/Practical Counseling Provided or Offered stayed at 0%. • Improvement efforts to increase compliance included meeting with Psych leadership to discuss documentation and adjustments to workflow. New options are being added to Psychiatry's electronic documentation system to assist with ensuring this metric is being followed. Susan Ehrlich asked for further clarification about why VTE measures were being retired since ZSFG still had areas of improvement in this area. Leslie Safier indicated that ZSFG will continue to proactively monitor VTE outcome measures.	
VII. CMS Hospital Star Rating Update	Leslie Safier presented a CMS Star Rating update. **<u>Highlights from CMS Hospital Star Rating Update:</u>** • CMS is introducing a new hospital quality star rating system (from one to five stars) to provide consumers with an overall hospital quality rating. • The release of the star rating from CMS was delayed, from April to tentatively July, due to ongoing advocacy to risk adjust scores for hospitals that serve low Socio-Economic Status (SES) populations. • Areas measured in the new CMS system are Mortality, Safety of Care, Readmissions, Patient Experience, Effectiveness of Care, Timelines of Care and Efficient Use of Imagining. • ZSFG's overall score is 1 star. Top contributors to this score included patient experience, safety, readmissions and mortality.	Present updated CMS Star Rating once released.

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VIII. Regulatory Update	Jay Kloo presented the Regulatory update. **<u>Highlights of Regulatory Report:</u>** • The California Department of Public Health (CDPH) hospital licensing survey for the new facility was a huge accomplishment in May. The survey was completed in four hours and had no findings. • CMS/Joint Commission Conditions of Participation Survey: Anticipate full validation survey within 3-6 months post move to Bldg. 25.	Continue monthly regulatory updates.
VIII. Announcements	• Iman Nazeeri-Simmons announced that Aiyana Johnson and Jeff Critchfield were presenting at Grand Rounds 5/17 on ZSFG Patient Experience.	
Next Meeting	**The next meeting will be held June 21, 2016 in 7M30 10:00am-11:30am**	