QUALITY COUNCIL
August 18, 2015

CO-CHAIRS: Will Huen, MD
ATTENDANCE:
Present: Terry Dentoni, Virginia Elizondo, William Huen (Co-Chair), Jay Kloo, Tina Lee, Todd May, Iman Nazeeri-Simmons, Kim Nguyen, Basil Price, Lann Wilder, Troy Williams, David Woods
QM/KPO Staff: Jenny Chacon, Valerie Chan, Jessica Morton, Jignasa Pancholy, Dennise Rosas, Leslie Safier, Sue Schwartz, Michael Zane
Excused: Thomas Holton, Shermineh Jafarieh, Aiyana Johnson, Anh Pham, Roland Pickens
Guests: Irin Blanco, Bev Cabellon, Greg Chase (for Max Bunuan), Dana Freiser, Nader Hammoud, Leslie Holpit, Yvonne Lowe, Roger Mohammed
Absent: Brent Andrew, Max Bunuan, Sue Carlisle, Margaret Damiano, Karen Hill, Valerie Inouye, Jim Marks, Anson Moon

AGENDA ITEM	DISCUSSION	DECISION/ACTION
I. Call To Order	Will Huen, MD called the meeting to order 10:05AM.	Informational.
II. Minutes	The minutes of the July 21, 2015 meeting were reviewed by the committee.	The minutes were approved.
III. Policies and Procedures	Cheryl Kalson presented the latest Administrative and Environment of Care (EOC) policies and procedures. **<u>Administrative Policies</u>** **Policy-1.14 Ambulatory Care Services' Follow-Up of Diagnostic Findings** Minor changes. **Policy-3.03: Clinic Charts** Clarifies permanent medical record process to include hybrid, electronic, and physical records in permanent medical record process. **Policy-3.06: Code Blue Response** Pharmacists and the accompanying responsibilities added to "Other Responders" list. **Policy-4.06: Trauma Diversion** No changes. **Policy-5.13: SFGH Staff Education Policy** No changes. **Policy-13.10: Health Information Services (HIS): Confidentiality, Security, Handling of Medical Records**	Policies and Procedures approved.

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	Information, and the Release & Use of Public Health Information No changes. **Policy-13.11: Medical Record Documentation** Further revision recommended to change reference to Health Care Financing Administration (HCFA) to Centers for Medicare and Medical (CMS). **Policy-16.15: Spiritual Care Services** Minor changes. **Policy-18.10: Radiation Oncology** No changes. **Policy-18.16: Patient Pre-Registration for Emergency Medical Care** No changes. **Policy-19.03: Stroke Program at San Francisco General Hospital and Trauma Center** Minor changes. **Policy-20.03: Management of Hospitalized Non-Acute Patients at SFGH** No changes. **Policy-21.06: Billing Requirements for Providers, including Medicare Billable Enrollment** Minor changes. **<u>EOC Policies</u>** **EOC Policy-14.01: Radiation Safety Subcommittee: Radiological Equipment Exposures** Outlines responsibilities of Biomedical Engineering, Radiology, and Department Managers.	Cheryl Kalson to make revision to Policy 13.11.
IV. Performance Measures	Will Huen, MD provided an overview of the new Quality Council report template. The revised template creates a standardized approach for departmental reporting to both Quality Council and PIPS. The group provided feedback on the new format and commended Will on the improved new template, which provides a comprehensive summary of performance gaps and solutions, in alignment with the SFGH True North strategic priorities. There was discussion of the support provided by the Co-Chairs and QM analysts to each	The roll out of the new template will continue with future reports. Co-Chairs and QM staff will schedule pre-

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	department as they prepare reports. Council members emphasized the need to ensure ongoing Quality Management staff capacity to provide coaching and assistance for each department.	QC meetings and continue providing support.
A. Biomedical Engineering	Nader Hammoud presented the Biomedical Engineering report. **Accomplishments:** • Major changes were made to the medical equipment tracking process which resulted in a better understanding of SFGH preventive maintenance needs and inventory. **Challenges:** • Biomedical Engineering's current equipment database has limited inventory tracking features, making sustaining the new preventive maintenance process challenging. **Highlights of Biomedical Engineering PI Indicators:** ***Safety*** Title: Preventive Maintenance (PM) of Medical Devices Target: By July 2015, develop baseline data for the rate of Preventive Maintenance completed for all medical devices. CURRENT STATUS: Goal met. • PM rates ranged between 92%-97%, of the 7,000 SFGH medical device inventory, which is within the industry standard of 95%. o Could Not Locate: Increased from 3% (Q1 2014) to 6% (Q4 2014). This increase was attributed to devices not located because they were moved across hospital locations, difficult to track because of small size (i.e. flowmeters, and oximeters), or lack of technology capacity to track devices (i.e. AeroScout). o Unavailable: 1%-2% of medical device inventory. Comprised of devices in use by patients or awaiting repair. Council members commended Biomed Services for the improvements made in tracking and maintaining	Biomedical Engineering to continue focusing on reducing number of medical devices unavailable or unable to locate to 3%. Virginia Elizondo, Deputy City Attorney, Iman Nazeeri-Simmons and Nader Hammoud to discuss contracting process for medical equipment.

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	equipment. There were questions about Biomed's role in communicating to departments about retired, failed or unavailable devices, as well as the process for managing leased equipment. • Leased Equipment: Biomedical Services tests all leased equipment for safe use and relies on staff to only use leased equipment procured through Biomed contracts. • Failed Equipment: Nader indicated that Biomed relies on self-reporting by end-users of failed equipment. ***Care Experience*** <u>Title: Response Time</u> <u>Target: To establish baseline data measuring the response time of service requests completed within 60 minutes by July 2015.</u> <u>CURRENT STATUS: Goal met.</u> • During June 2015, the average response time was 27.33 minutes. • Between March and June, the overall average response time was 32.05 minutes. Baseline data provided a better understanding of reasons for actual or perceived delays in response time. Reasons included staff delays due to longer completion time for previous repair requests and inconsistent notification of end users about delays.	2016 targets are: • Respond to Critical Care requests within 30 minutes. • Respond to non-critical requests within 60 minutes. Improvement efforts include continued training and coaching technicians in providing customer oriented services to ensure end-user are updated on the status of their work order.
B. Departmental Performance Measures Annual Review and Approval	Sue Schwartz, Director of Performance Improvement, reviewed the 2014-2105 grid of departmental performance measures. Changes to the grid's format made were: Inclusion of the True North Categories, adding reporting structure (PIPS or Quality Council), and EMTALA Plan of Correction measures. There was a discussion about the effectiveness and usefulness of the current performance improvement (PI) plan process and PI measure grid, which retrospectively documents measures and goals. Members agreed on the usefulness of the grid for regulatory reasons and providing an overview for leaders of all measures in their department's opportunities for improvement. Other recommendations included clearly defining the Executive Sponsor role in overseeing improvement work within their departments. It was suggested that a monthly check-in (i.e. 30 day cycle) between Executive Sponsors and managers to discuss progress towards achieving proposed targets would allow continuous assessment of progress toward goals. It was also recommended that proposed measures and targets for the upcoming year be submitted in the PIPS or Quality	Sue Schwartz to add IS performance measures to grid. Departmental measures were approved with suggested additions.

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	reports, on an ongoing basis instead of annually. Additional requests for revising the PI grid included: • Add Information Systems Dept. • Add designation of metrics as either Drivers or Watch.	Begin testing submission of 2016 performance metrics as part of Quality council reports.

V. Utilization Management Update	Ana Sampera and Irin Blanco presented the Utilization Management update.
	
	<u>Accomplishments</u>
	• Commitment and accountability of staff in identifying gaps and solutions, for LLOC and Admission Review within 24-hours which created a sense of ownership of the process.
	
	<u>Challenges:</u>
	• Staffing capacity and scheduling contributes to challenges with reviewing admissions with 24 hours. This includes limited weekend coverage for Psychiatry, case load assigned to individual staff, and the many points of entry into the hospital (e.g. clinics).
	• Decreasing LLOC is challenging since many identified barriers are outside the scope of the UM (i.e. no available placement), requiring a collaborative and multidisciplinary approach.
	
	Highlights of Utilization Management Report:
	<u>Title: Admission Reviewed Within 24 Hours</u>
	Financial Stewardship and Developing People
	<u>Target: By December 2015, UM will review 90% of MedSurg and Psychiatry cases within 24 hours of admission.</u>
	<u>Current Status: Goal met in MedSurg but not Psychiatry (61%).</u>
	• From April 2015 to July 2015, MedSurg admissions reviewed within 24 hours increased from 79% to 90%.
	• In July 2015, the Psych admission review rate was 61%.
	• SFGH has a daily average of 41 admissions.
	  o 28% of all Psych patients and 22% of MedSurg patients are admitted on the weekends.
	  o On weekends, there is only one MedSurg UM coordinator working and no coverage for Psych.
		Provide weekend UM Psych coverage by December 2015.

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	Improvements in July resulted from critical review of data sources and cleanup of reporting systems, such as inclusion of OB Package accounts in data. This requires completion of both admission and discharge reviews upon discharge. Title: Percent of Patient Days at Lower Level of Care (LLOC) ***Financial Stewardship*** Target: By December 2015, Decrease LLOC days to 5% of patient days in MedSurg and 30% of patient days in Psychiatry. CURRENT STATUS: Goal not met. • During Quarter Two, Med Surg LLOC patient days was 21.20% which was an increase from the previous quarter's rate of 14.45%. • Barriers for LLOC placement were identified. o Psych: 78% of all LLOC patient days are due to awaiting decision by placement facility (3099 days). Despite not meeting goals, improvements were seen patients in LLOC patient days with a 51% rate in Quarter Two. This was a decline from Quarter 1 of 59.07%. o MedSurg: -18% LLOC patient days due to complex discharge coordination, such as registered sex offenders, who are challenging to place. -14% LLOC patient days are a result of non-acute upon admission. The council recommended analyzing reasons for these admissions in more detail, using and A3 tool. Council members discussed needs for multidisciplinary accountability for addressing placement barriers. Todd May, MD expressed concern about the increase of MedSurg's LLOC from the the fourth quarter of 2014, from 13.37% to 21.20%, during the second quarter of 2015. UM staff responded that there is a growing elderly population that lives alone, and requires a specialized level of discharge placement that does not exist. A network solution for placing elderly is needed. Council members recommended further analysis of current conditions and development of countermeasures through UM participation in upcoming A3 trainings.	UM to develop plan for addressing identified placement barriers in collaboration with the Placement Team and community services by the fourth quarter of 2015. As part of the Patient Flow A3, Ana Sampera and Terry Dentoni will be developing counter measures to address LLOC.
VI. 2014 FMEA Proactive Risk Assessment Summary - AWOL at Risk	Sue Schwartz presented the 2014 Proactive Risk Assessment, a Joint Commission requirement to identify and analyze an organizational risk, which focused on AWOL At-risk patients. The assessment focused on identifying weaknesses or potential failures in the AWOL-At-Risk process which was led by the Code Green Committee Co-chairs, Lann Wilder and Basil Price.	Troy Williams and Sue Schwartz will follow up with Joint Commission regarding publishing FMEA Analysis in

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	Results: • Three key potential failures identified: o Alarm Fatigue due to overuse of Emergency Exits. o No clear definition for identifying At-Risk patients who may go AWOL o Unclear process and roles for SFSD in assistance with AWOL reporting and searches. • Improvement efforts to address vulnerabilities included: o Stairwell exit alarms improvement. o Clear definitions of AWOL-At-Risk patients requiring Close Observation were developed. o Security measures were implemented through AeroScout and Policies and Procedures (i.e. Code Green Policy). o The role of SFSD in responding to AWOL patients was clarified. Lann Wilder indicated that two areas of vulnerability remained for AWOL At-Risk patients: o Residents need education, on the definition of At-Risk patients, to ensure they are put on Close observation or Code Green is launched if they go AWOL. o In general, delays in launching Code Green drills by staff remain a challenge. The Code Green Committee is currently evaluating strategies for ensuring staff prioritize implementation of drills. Dr. Todd May commended the group on the FMEA analysis and efforts made to ensure the safety of At-Risk patients. Members recommended publishing the FMEA findings in the Joint Commission's "Innovations" publication or in the" Sentinel Event Alert."	"Innovations" or in the "Sentinel Event Alert." The 2014 Proactive Risk Assessment was approved by council members.
VI. AWOL/ Close Obs Update	Leslie Holpit and Dana Freiser presented the AWOL/Close Obs update which primarily focused on the results of a recent Close Observation Order Form audit. ***Close Observations Order Form Audit*** In July, 17 charts were audited for required Close Observation Order documentation. **Results:** • Three errors were found: o Two orders were missing provider assessments. o One order was not signed or dated. • Monthly audits of Close Observation orders to continue to ensure proper dating and signature.	Continue monthly updates on AWOL/Close Obs Process.

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	• A list of draft of metrics are being developed for measuring patient outcomes. ***Close Observation Process Electronic Protocol*** • The development of an electronic Close Observation Protocol, based on a doctor's order and nurse assessment on the level of patient observation required, is still in process. • Nursing Practice Council to review the protocol after draft completion. Leslie Holpit and Dana Freiser discussed the challenges in identifying and defining At-Risk and Close Observation Patients. Some patients are considered "At-Risk", because of fragile health conditions, but are not in danger of going AWOL or needing Close Observation. Troy Williams also reported that AeroScout will be tested on the Skilled Nursing Facility (4A) this month.	
VIII. Regulatory /POC Update	Jay Kloo, Director of Regulatory Affairs, provided the regulatory update. ***CDPH Privacy Breach-MD Student Imposter*** <u>Current Status: Goal met.</u> • UCSF's Dean's Office successfully implemented new standard practices, for confirming identification of student observers, from UC Medical Center and completed its three-month reporting obligation. • The Dean's office will continue Emergency Dept. audits with other School of Medicine Departments to ensure appropriate identification of visitors. ***Emergency Department (ED)t CDPH/CMS/EMTALA and Patient's Rights Plan of Corrections (POCs)*** <u>Current Status: Goal not met (100%):</u> • Nursing Triage Documentation Audit: In July, 180 charts were audited, and had compliance rates of 82% to 93%, on required documentation components. Improvement work will focus on emphasizing documentation requirements • RN Screening Documentation: 99% accuracy for Doctor/Nurse Practitioner Documentation and Nursing Documentation. ***CMS EMTALA POC Disposition Log Audit***	Monthly POC update at next Quality Council meeting. ED to continue monitoring documentation compliance for CDPH/CMS/EMTALA and Patient's Rights POC.

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	Current Status: Goal not met in all departments (100%).
	• Labor and Delivery: For July 2015, 24 out of 30 charts audited had all required elements for documentation.
	  o Improvement efforts to focus on improving communication, with all clinical staff, about completing log disposition documentation requirements.
	• Pediatrics Inpatient: 100% compliance for June and July.
	• Urgent Care Center (UCC): In July, 28 out of 30 audits were completed for discharge disposition documentation.
	
	Department of Training and Education (DET)-Halogen "Treating Patients with Dignity and Respect"
	Current Status: Goal not met (100%):
	• In July, staff course completion rate increased to 90%.
	• The Emergency Department staff completion rate is 98%.
	
	CMS EMTALA Plan of Correction Validation Survey
	• No deficiencies noted.
	
	CDPH Quality of Care
	• Med/Surg and 4B: July had 100% compliance for all affected units for CSMT Capillary and Notification documentation.
	
	Joint Commission-Triennial Survey Infection Control (IC) Update
	Title: Environmental Rounds
	Current Status: Goal not met (90%):
	• ED/EVS Rounds: Current compliance (July 2015) 82%- improvement from 72% (June 2015):
	  o Ongoing vulnerabilities include high and low dusting, over-filled sharps containers, and medication room clutter, open food/beverage containers in patient areas.
	  o Improved compliance was attributed to scheduled joint EOC rounds between ED and EVS staff.
	• In July, Infection Control led EOC rounds showed 100% compliance.
		Labor and Delivery to continue ongoing audits for Disposition log documentation.

X. Announcements	No announcements.	

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Next Meeting	**The next meeting will be held September 15, 2015 in 7M30 10:00am-11:30am**	