

ZSFG CHIEF OF STAFF REPORT
Presented to the JCC-ZSFG on March 28, 2017
(03/13/17 Leadership MEC and 03/16/17 Business MEC)

ADMINISTRATIVE/LEAN MANAGEMENT/A3 REVIEW:

SFHN Budget – Greg Wagner, DPH CFO/Alice Chen, MD, CMO SFHN shared the current state of DPH finances in the context of the overall City budget:

Most of “the City’s” budget and therefore most of DPH’s budget decisions are dependent and centered on general fund (GF) dollars. The City has a requirement that there be a balanced budget each year. The financial planning of the City and DPH are synchronized on a yearly basis. The budget has grown in both expenditures and general fund subsidy over time. The rate at which DPH’s GF subsidy has grown is faster than the GF as a whole, and continuation of this trend is not a sustainable track. There has been extraordinary growth since 2010/11 with over 1,000 FTEs having been added, the largest being that required for the electronic health record project. City wide, revenues are growing at 11% and expenditures at 29% according to projections based simply on continuation of past trends.

There is not a lot of room for economic growth of the City - it has reached its capacity, having grown at a rate of 8-10% growth in revenues over the last several years, and that growth is projected to decrease. The projected City 5-year expenditure growth is 50% in Salaries & Benefits, and 32% Citywide Operating Costs, with 3% in departmental costs and 15% in baselines and reserves.

The City and DPH are in a period where they are having to be more constrained, and are spending more of their energy thinking of the midterm financial picture and how they prepare themselves to survive in a period where they are not going to be able to grow at the rate experienced over the past several years, requiring restraint and frugality to whatever extent possible.

A large amount of money is received by San Francisco DPH for insuring about 100,000 people under ACA, which includes Medicaid expansion (> \$100,000,000 revenue DPH gets for people insured under Medicaid Expansion). A substantial risk to the City exists with threats to withhold federal dollars from sanctuary cities. Voters have increased the set-asides, which reduces the amount of GF available for SFDPH.

Going forward, DPH has to focus on maximizing revenue generation to pay for its own services, and focus on how to provide better services within the existing costs versus adding them. DPH has already met a couple of the growth reduction targets, no new FTEs proposed and reduction of growth and GF subsidy.

SERVICE REPORT:

Ophthalmology Service Report – Jay Stewart, MD, Chair:

Dr. Stewart reviewed the scope of clinical services, technical services, and coverage:

-Regarding clinical productivity, they had 28,445 OP visits last year, 615 surgery cases, and 1,310 minor procedures, seeing an upward trend.

-The Eye Van service, which has been around for some years, goes to different health care centers performing various examinations, especially beneficial for those patients with transportation barriers.

-There was an upward trend in OR cases, but a decline in cataract cases due to the loss of a very busy corneal surgeon who had been one of the main drivers behind the fast-track cataract services, (which is being reconstituted). Also, there was some reduced efficiency when first having moved to the new hospital. There have been upward trends in the types of OR cases, in particular retinal, due to efficiencies gained by improved equipment. The minor procedures have almost doubled over the past year. Diagnostic testing has increased to the point where additional machines have been purchased to keep up.

- True North Metrics for eye care:

* Equity: Patient education has been a focus, creating a dedicated staff position. Translation services are accessed as needed. Data is collected and data bases have been created so that trends can be identified better. The Department is trying to further improve waiting times for patients. Also, multi-lingual signs have been posted to provide directionality for the patients.

* Safety: Laser Safety Committee was re-established, with certification of two ophthalmic techs as laser safety officers. Policies and Procedures have been updated

* Patient Satisfaction: Capacity has increased, as well as referrals due to teleretinopathy screening services. Cameras have been installed in the clinics as well as the Eye Van, which required special considerations, waivers, etc. The van can be sent out with the tech only with capability of sending images to the server centrally and be remotely read by optometrists, thus increasing number of patients that they can screen. Care experience statistics were provided. Access to diabetic retinal screening was improved. Cataract surgery wait times improved. There is MD oversight of optometrist readings. Now that the minor procedure rooms are operative and providing more OR time for cataracts, the pterygium removal cases can get more attention and be done in a more timely manner. Wait times have been reduced for both optometry and ophthalmology.

* Developing People: The Department funds certification of tech staff and supports the staff.

* Financial Stewardship: There are some issues with statistical encounters that need to be solved. A Financial Summary was provided.

Residency: UCSF has one of the top Ophthalmology Programs in the country, about one third at ZSFG, and the residents are appreciative of this opportunity. The increased workload has given the residents more to do.

Research : There will probably be more growth.

Future goals: Includes attending engagement with the house staff's care and continuing to provide better care as the volumes grow.

COMMITTEE REPORT:

Critical Care Committee– Antonio Gomez, MD, Chair:

Dr. Gomez' highlighted a couple of areas CC has been working on, one being working across disciplines to improve operations. One is "target temperature management" (TTM) also known as the *Cooling Protocol* following cardiac arrest. A multi-disciplinary committee has been convened to take a new look at it, there being several different order sets and protocols throughout the facility. The other project is the electronic medical record, or the transition to SALAR (TeamNotes) rolled out in the MICU August/September of 2016. This should enhance communication and improve billing.

The census is up in the ICU, including patients waiting for med-surg beds, and due to the crunch on med-surg, ICU has been discharging more patients to home or their destination facility, which places strain on the already limited social work in the ICU. The VAP bundle was discussed briefly.