

ZSFG CHIEF OF STAFF REPORT
Presented to the JCC-ZSFG on February 25, 2020
02/10/20 Leadership MEC and 02/20/20 Business MEC

ADMINISTRATIVE/LEAN MANAGEMENT/IMPROVEMENT WORK/EPIC STATUS:

Improvement initiatives:

A. Ambulatory Patient Access A3

The migration to Epic created a series of challenges for Ambulatory patient scheduling and access to ambulatory visits. This occurred for a number of reasons:

- The effort to standardize the work of the eligibility worker patient access staff (category 2903) across the Network led to a shift of tasks, positions, and work locations for many frontline employees.
- Epic eligibility work introduced new workflows for the Patient Access staff, including new billing, scheduling, and registration practices as well as new supervisory structures.
- A higher intensity of focus on following the new Epic-recommended steps for registration and collecting revenue added tasks to the 2903's roles.
- The 2903 staff did not receive enough in-depth training on eligibility and registration content prior to Epic go-live, and many struggled with Epic uptake as well.
- The Patient Access team remains understaffed in the post go-live months, and additional HR processes unique to 2903's have slowed down hiring processes.
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Issues we have encountered post go-live include large workqueues for ambulatory patient appointments, delays in ambulatory patient access to visits, and poor phone access to the clinics. This has occurred in both primary care and specialty care clinics throughout the network. A Patient Access A3 Workgroup, including Patient Access managers and leaders as well as ambulatory clinical leaders and Epic leaders, formed to address this issue shortly after Epic went live and continues to meet.

Countermeasures undertaken and recommended by the Patient Access A3 Workgroup: These include countermeasures in 4 "buckets," including enhanced training for 2903 staff, close collaboration with HR to improve staffing, Epic build countermeasures to make scheduling work easier, and the creation of standard work for both front and back office in scheduling and registration.

Progress to date: In September, the combined workqueues for all clinics had climbed to contain 26,000 appointment requests and very few of these appointments were getting made. As of February, the total number of requests in the workqueues has been reduced by 55% (the histogram in the attached report includes performance by individual clinics). The goal has been set that no work queue should be more than thrice the average appointment requests coming in per week; originally no clinics were meeting this target, whereas now, 73% of the clinics are meeting that target. While continuing to focus on workqueues, the PAWG is now adding a focus on phone access, training, and hiring/supervision.

B. Clinical Documentation Integrity (CDI) Physician Advisors A3: Goals and Objectives – Aaron Harris, MD (ED) and Pallabi Sanyal-Dey, MD (Hospital Medicine):

Our two CDI champions, Drs. Harris and Sanyal-Day, explained why CDI is important, the basis of CDI, and the team's 2020 plan and goals. The True North pyramid was represented in a slide, pointing out that CDI touches on many of the true north goal categories. The team is only able to review charts of 20% of the patient load due to having only 2 reviewers. (to put it into perspective, UCSF has 20 CDI reviewers). Coding relies on diagnoses and procedures, and these are dependent on documentation in the medical record. The diagnoses must be documented by the attending's attestation or house staff's note. EPIC increases the ability of the organization to capture data accurately which should enhance the providers' ability to diagnose more accurately. Individual Provider metrics drive Hospital metrics and the better the organization codes, the more accurate billing is, and this impacts professional fee billing. Additionally, coding is an important way in which patient acuity is measured. The hospital star ratings are specifically tied to our Case Mix Index (CMI) which is directly determined by the way we code for inpatient billing; if our codes are too vague or underdescribe the severity of a patient's diagnosis, our overall acuity looks lower and thus our death rate looks higher than expected. Because of our coding, ZSFG is stuck at a one star rating.

ZSFG's CMI is 1.49 compared to 1.88 for America's Essential Hospitals and 2.00 Academic Medical Centers, so the acuity reflected in the coding is lower than like hospitals throughout the country. The presenters pointed out that the patients treated at ZSFG are as ill as those treated by other centers; our coding should reflect this. It is important for attendings and residents to pay attention to queries received so that modifications can be made to attestations appropriately. A list of the top 10 queries was included. Examples were provided of differences in reimbursement that the correct language can provide.

Pro-fee Billing

In response to a concern raised by MEC at its last meeting regarding billing and the supervisory requirements for ZSFG's trainees, it was reported that a workgroup has and will continue to meet. It was suggested by the workgroup that the pro-fee billing piece of it has been suspended until the staff figures out what the supervisory requirements are and what it will take for ZSFG to meet them. More to come on this subject.

Hospital Census

There have been challenges around discharge of patients regarding lower level of care and social needs so there is approval for six new as-needed social worker FTEs. HR is working on filling these positions to help the IP teams. The FTEs will be distributed amongst the IP teams according to need.

EPIC

The chiefs were encouraged to invite the EPIC Thrive trainers to their Faculty meetings. EPIC has initiated, the voice recognition software within EPIC, which they have been piloting for the last couple of months. The residents have been part, but there are 50 extra licenses should any faculty be interested in taking part.

CLINICAL SERVICE REPORT:

- A. Urology Report – Benjamin Breyer, MD, Chief:** A PowerPoint slide presentation was attached to the 2/10/20 MEC minutes. The following was highlighted by Dr. Breyer.
1. The Department has 4 clinics, one of which is Pediatric (with a voiding dysfunction clinic on Thursday afternoon), seeing about 200 children per year. All the surgical problems have been rolled into the adult practice, hosting about 4,000 patients per year. Clinic wait times are very good.
 2. Volume: The Department is seeing about 1,000 new patients per year.
 3. Urology is in the OR three days a week, and has a procedure clinic that is currently housed in the operating room, which will move when the renovation of the old ORs is completed. They are very excited about getting a new Cysto suite.
 4. Urology has block time on Monday, Wednesday, and Thursday, which they feel is the right fit for now, and the wait time to get in for surgery is about two to four weeks, depending upon the amount of specialty care needed. They are always able to accommodate 'urgent' surgeries.
 5. Work chart: Peter Carroll, MD, Ben Breyer's mentor and boss, stepped down after 24 years as chair and Raj Pruthi, MD, from the University of No. Carolina has accepted the position and began January 1, 2020.
 6. Org Chart: Ben Breyer assumed the Associate Director of Education, Residency Program director. Dr. Chi will be replaced this coming academic year, kidney stone expert. He has increasingly become more involved with administrative duties across the university and will be replaced by a resident who has done a urology fellowship with UC (his expertise is stone disease), David Bayne, MD, with 50% appointment at ZSFG, this being his primary site.
 7. Equity: The residency program is 50% female. Urology as a whole is 9% women, under age 40 years is 25% women, 44% underrepresented in Medicine.
 8. Education: There are conferences that augment residents' training.
 9. UroLean: Residents have a team Huddle Tuesday morning 7 am in front of the board, and a MWedThurs 7:10 am at patient bedside. They also do Huddle with anesthesia and nursing prior to cases, which has been helpful.
 10. Epic: Working on their templates - the Epic workflow in the clinic has been great.
 11. PI: Projects were listed, particularly understanding and limiting opioid usage prescribed after common urologic procedures. The overall satisfaction average in clinic was highest with English speaking, then Spanish, then Chinese speaking residents. The Department is looking at ways to improve this, including improving its translator services. Performance with un-reviewed lab counts has improved.
 12. The residents go through RCC training.
 13. Strengths: Very dedicated attendings and the program was ranked #3 by Department, US World News Reports. It is #1 in NIH funding and ZSFG is an important part of that. One quarter of the educational work is done at ZSFG, and this is always a highlight for the residents.

14. Challenges: There is a little more leg work required at ZSFG for residents to schedule patients and conduct follow up. Resident work space is a challenge—it is being worked on. There are challenges for attendings covering across all sites. Urology is a small service and is always seeking to align with DPH and hospital goals.
15. Future: Revenue capture, needs to improve. Patient/provider satisfaction, needs to improve.