ZUCKERBERG
SAN FRANCISCO GENERAL
Hospital and Trauma Center

Achieving Safe & Equitable Patient Care
A3SR Summary

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

San Francisco Department
of Public Health

Strategic A3

ZUCKERBERG SAN FRANCISCO GENERAL
Hospital and Trauma Center

Title: **Achieving Safe & Equitable Patient Care**
Owners: **Adrian Smith, Lisa Winston**
Team: ***Dana Freiser, Elaine Dekker, Tanvi Bhakta, Christina Bloom, Jhoyet Capacillo, Ossie Gabriel, Sandhya Kumar, Gabriel Ortiz***
Coaches: **Huen/Ross**

Version: 11	Date: 1/31/23

I. Background: What problem are you talking about and why focus on it now?

Why does this matter now?	History of Safe and Equitable Care Program:	Known Historical Data:
Current literature now estimates that as many as 1 in 4 admissions result in adverse events with nearly a quarter being preventable. At ZSFG patients are being harmed daily with a portion of those events being avoidable. CMS issued ZSFG the lowest star rating (1 star) which reflects the overall safety of care provided among other quality indicators. Patients at ZSFG remain at risk of unnecessary adverse events.	The patient safety program was dismantled at ZSFG in 2021 due to staff deployments and PSO re-designation. Historically this program worked closely with patient care units to ensure safe provision of care and promote a just culture. Currently, adverse event prevention continues through committee efforts and miscellaneous unit focused initiatives. With EPIC go live patient safety workflows were not part of stabilization efforts and leveraging safety surveillance features unexplored. Patient safety has not integrated equity and patient experience lenses into harm prevention strategies. The program does not assess for the impacts of bias or systemic racism or incorporate the patient voice.	ZSFG measures harm events through a combination of data extraction, EPIC reports, and adverse event reporting. Data is not stratified by REAL and disparities remain largely unknown. ZSFG historically drove efforts on 4 harm events based on star rating impacts and trends in outcomes: falls with injury, CLABSI, Colon SSI, and CAUTI. Currently 2 out of 4 metrics remain above goal levels of performance.

CMS Star Rating Safety Measure Group 4/2019-12/2019 & 7/2020-9/2020	%/#	Star Rating
Rate of CCs for hip and knee replacement patients	14.2%	★
Central-line associated bloodstream infection	17.4%	
Catheter-associated urinary tract infection	17.1%	
Surgical site infection from colon surgery	11.8%	
Surgical site infection from abdominal hysterectomy	na	
MRSA bloodstream infections	84%	
Clostridioides difficile infections	18.3%	
Patient Safety and Adverse Events Composite	6.7%	

II. Current Conditions: What is happening today and what is not working?

Processes to Achieve Safe and Equitable Care ⟷ **Outcomes on 2022 HARM Dashboard**

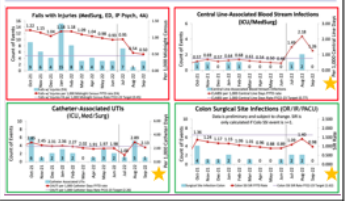
WHO:
- Decentralized effort to monitor harm events by existing committees or individual workflow owners
- Providers and clinical leaders operate in silos to ensure processes in place to prevent harm during patient care (traditionally collaborative with PS)

WHAT:
- Many patient harms at ZSFG are unmeasured with respect to frequency and severity
- Largely unknown health disparities in harm events
- Historic focus on falls w/injury, CLABSI, CAUTI, and Colon SSI, but no structure in place to pivot based on trends / goals

HOW (is harm measured and mitigated):
A) Measured:
- Data compilation through SAFE, EPIC, and manual collection with display lag time

B) Mitigated:
- PDSAs by departments unaligned with central efforts to monitor impact on outcomes
- Lean and DMS tools used for general communication not PS
- UBLT Teams largely dismantled
- Email announcements to staff regarding harm events have no measured efficacy
- Campus wide PS education and training materials are outdated
- EPIC Safety Surveillance software utilized variably
- Efforts to promote a culture of safety with limited effect to date

- Below Target: Colon SSI and CAUTI
- Above Target: Falls w/Injury and CLABSI
- HAPI (not on dashboard): Jumped from 6 in 2021 to 22 in 2022



PROBLEM STATEMENT: Many patient safety events at ZSFG are unmeasured with respect to frequency and severity and the presence of disparities. ZSFG lacks a central accountability structure and standardized workflows to prevent adverse outcomes, and patient harms persist at an unacceptable level as reflected in the 1 star CMS rating.

III. Targets and Goals: What specific measurable outcomes are desired and by when?

Selected Metrics	Baseline	Target by [When]
Harm Dashboard Metrics (* = Top Contributors to One-Star Safety Rating) • CAUTI*, CLABSI*, Colon SSI*, Falls with Injury, HAPI	See Separate Chart	See Separate Chart
Timely availability of patient harm data to frontline unit staff • Long term goal – will develop dashboards using New Safety System	60 days	30 days
Selected Harm Dashboard metrics stratified by REAL	0	100% of selected metrics by 6/1/23
% departments that are actively driving or watching patient safety metrics aligned with the ZSFG Patient Safety Program/Strategic Team as presented in their PIPS reports	TBD	TBD Not 100%, (critical units)

IV. Analysis: Why does the problem exist, in terms of causes, constraints, barriers?

People	Method
P1. No designated PS leaders: department dismantled P2. PSO merged with CQO position P3. RN dept with record high vacancies and ongoing staffing crisis P4. No PS education lead: each dept expected to design systems for training P5. Interdisciplinary collaboration limited and unexplored P6. Equity training is not an existing competency for those driving PS work P7. Unknown competencies for PS workflows across all disciplines P8. Partnership between QM and RN department siloed in driving PS changes P9. Inconsistent A3 and other LEAN training for staff engaged in the work P10. Night staff not incorporated into change management efforts	M1. Dedicated workflow owners doing the daily work are also responsible for the improvement work and training M2. Methodology for determining PS department drivers not transparent M3. UBLT/DMS systems used to leverage change not maintained M4. SAFE(UO) system data / sentinel event RCA largely unincorporated into PS strategy M6. Multi-modal aggregate data collection methodologies with lag times in delivery (Harm Dashboard) M7. No stratification of harm events based on REAL M8. Time for dedicated staff to conduct PS work competes with frontline urgencies M9. EPIC stabilization for workflows pertaining to PS not addressed M10. Outpatient not scoped into patient safety work
Materials/Supplies	**Environment**
S1. Space for in person training limited S2. PS training materials for the campus not maintained S3. Programing for SAFE system in progress S4. EPIC quality / safety dashboards not validated	E1. Culture of safety concepts not widely adopted across SFDPH E2. PS not aligned with industry standards/best practices E3. Strained staff morale post pandemic E4. Limited bandwidth of CQO to prioritize PSO

V. Possible Countermeasures: What countermeasures do you propose and why?

Cause	*Countermeasure*	*Description ("If-Then")*	*Impact*	*Effort*
P1,P2, P4, P8	Re-establish Patient Safety team within QM 1. Determine what evidence-based tools to use 2. Complete needs assessment. 3. Design structure for patient safety team 4. Partner with unit-based teams in Periop, Med-Surg, ICU, ED, 4A 5. Invite patients to contribute to better address their needs and increase accountability	A team of staff that can lead and coordinate the work being done throughout the organization can standardize improvement processes and allow outcomes to be more transparent Patient involvement will enable a more holistic approach to patient safety initiatives	H	H
M6, M7	Increase value of harm dashboard and include 4 current goals + HAPI 1. Publish dashboard in timely manner, redesigned for users 2. Driver and broad watch metrics aligned with goal to increase Star Rating 3. Stratification of harm data by REAL and units/areas	Data being available to staff doing the work will inform and engender ownership at unit level, closing the loop in the Performance Improvement cycle	M	M
S3, M4	Implement new safety software 1. Meet major milestones to achieve proposed go live date 2. Continue with optimization in Q1 & 2 post go live	Will provide reporting, feedback and loop closure for culture of safety in daily operations	H	H
M1, M3, P9, P5	1. QM/KPO to train and partner w/ED, Periop, Med-Surg, ICU, to deploy goals and reinvigorate huddles, standard work, PDSA, drivers, UBLT to engage staff in improving patient safety 2. Develop tiered reporting and cross-functional problem solving through the Safety Strategy Team and PIPS and incorporate metrics into DMS, UBLTs, etc.	Will enable us to provide the necessary resources, encouragement and coaching to ensure that DMS implementation returns to pre-pandemic status and then expand to other areas	H	H

VI. Plan: What, where, how will you implement, and by whom and when?

Countermeasure	*Owner*	*When*
Re-establish Patient Safety Team aligned with departments/units	Smith/Freiser	1/23-6/23
Revise Patient Harm Dashboard with new KPIs, REAL data	To/Freiser	2/23-6/23
Implement and optimize Safety Software	Brajkovic	5/22-6/23
Assess, train, implement via ZSFG Way DMS Teams	Huen	1/23- 12/23
Strategic Team to Charter Teams and A3s, Begin Tiered Reports aligned with Units, Teams, PIPS	Smith/Freiser	1/23-12/23

VII. Follow-Up: How will you assure ongoing PDSA?

Tier 1: Unit huddles
Tier 2: UBLTs and task forces (e.g. in ED, Periop, Med-Surg, ICU, ED, 4A)
Tier 3: Safety Strategic Team monthly meeting
Tier 4: Review information reported at Tier IV
Tier 5: Executive Score Card – Tiered Reporting Monthly: PIPS/Exec Team/ICC Annually

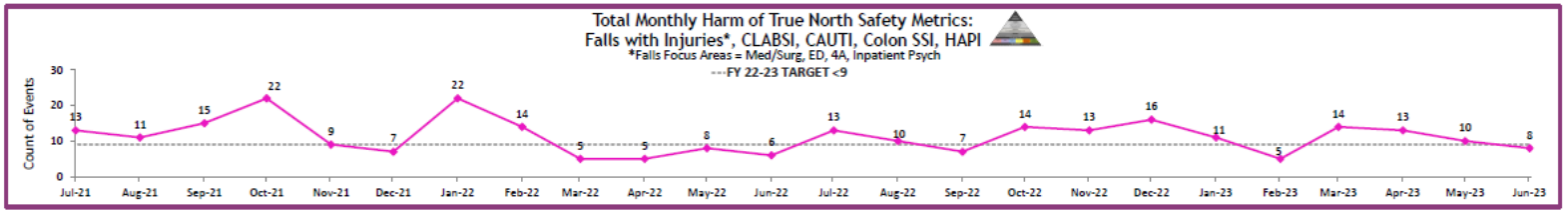
Outcome Metrics and Targets

ZSFG Harm Dashboard

ZSFG Hospital Wide Patient Safety Dashboard – June 2023

Med/Surg, Critical Care, 2nd Floor, Emergency Department, Psychiatry, Surgery, SNF

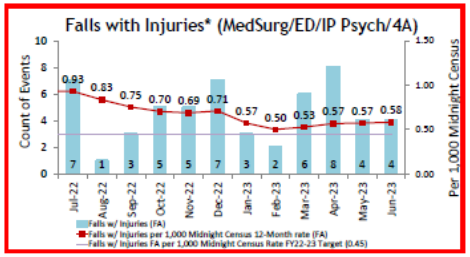
Aim: Reduce preventable harm to zero

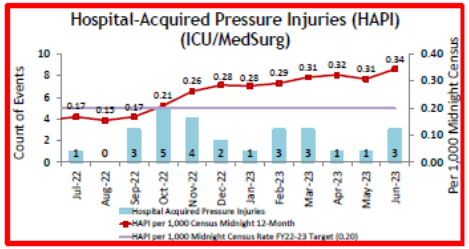


DASHBOARD DRIVER METRICS

DRIVER METRICS

Pt Care Events

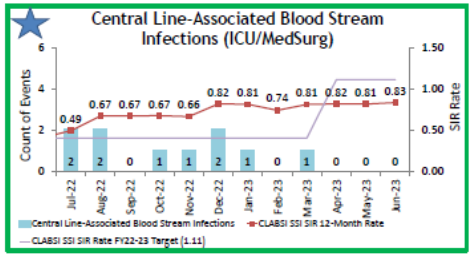


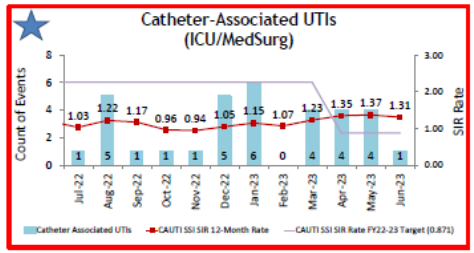


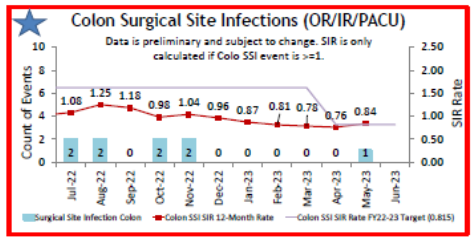
*Colon SSI data is provided on a 60-day lag cycle. As a result, Total Harm counts are subject to change within a 60-day window as well.

★ = Direct Measure in Star Rating

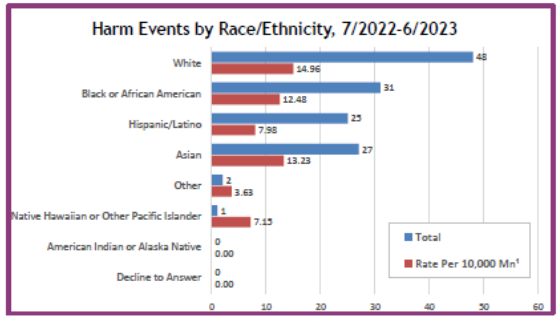
Hospital-Acquired Infections







DEMOGRAPHIC STRATIFICATION

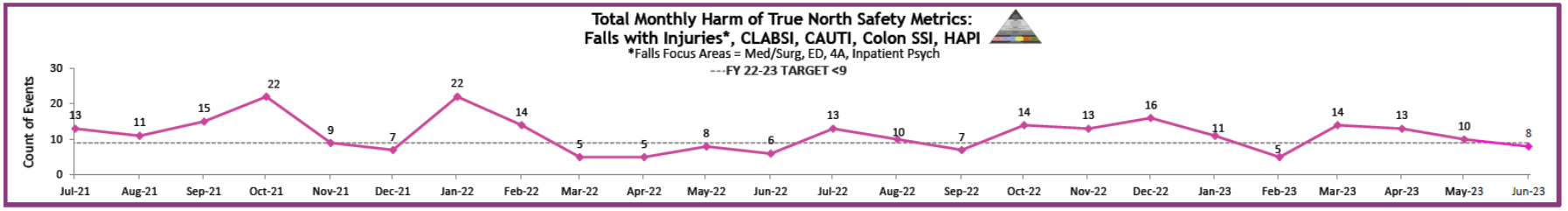


Harm Events by Race/Ethnicity, 7/2022-6/2023			
Race/Ethnicity	Total	Midnight Census	Rate Per 10,000 Mn[1]
Decline to Answer	0	842	0.00
American Indian or Alaska Nativ	0	509	0.00
Native Hawaiian or Other Pacifi	1	1,399	7.15
Other	2	5,509	3.63
Asian	27	20,401	13.23
Hispanic/Latino	25	31,331	7.98
Black or African American	31	24,849	12.48
White	48	32,078	14.96
Total	134	116,918	11.46

[1]10,000 Midnights based on (Bldg 5, 25). Rate set to per 10,000 for enhanced graph scaling.

Outcome Metrics and Targets

ZSFG Harm Dashboard



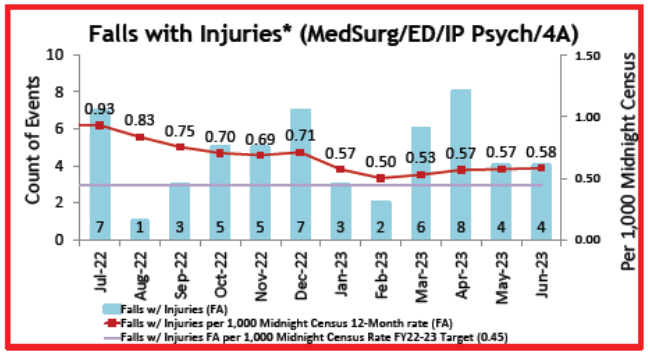
Overall, we remain above target of less than 9 harm events per month, but we improved from 11.1 events per month to 10.1 events per month from CY 22 to CYTD 23, and met monthly target in June 2023.

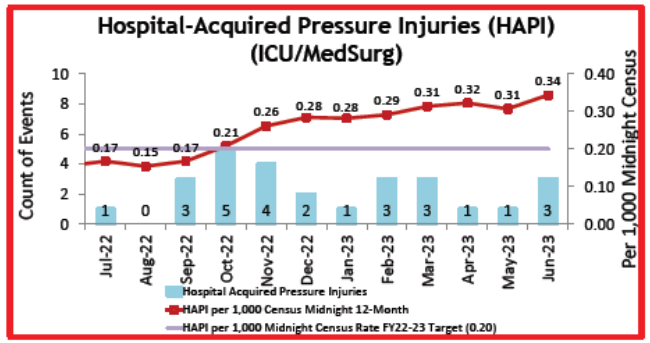
Outcome Metrics and Targets

ZSFG Harm Dashboard

DRIVER METRICS

Pt Care Events





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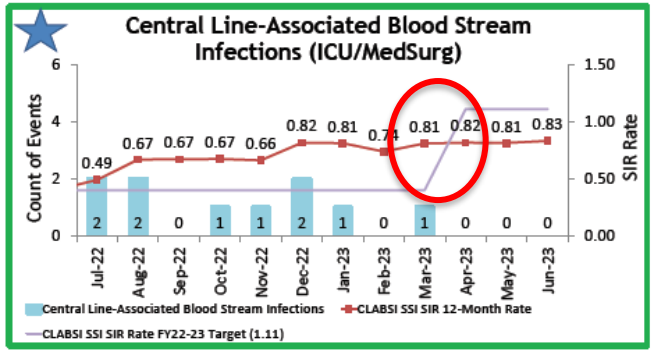
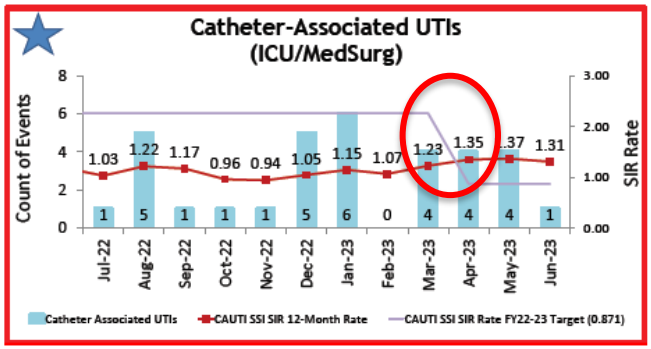
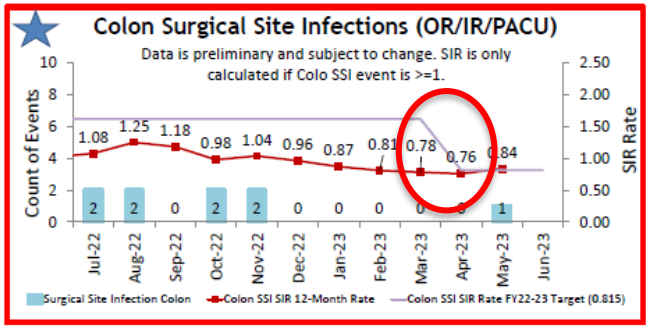


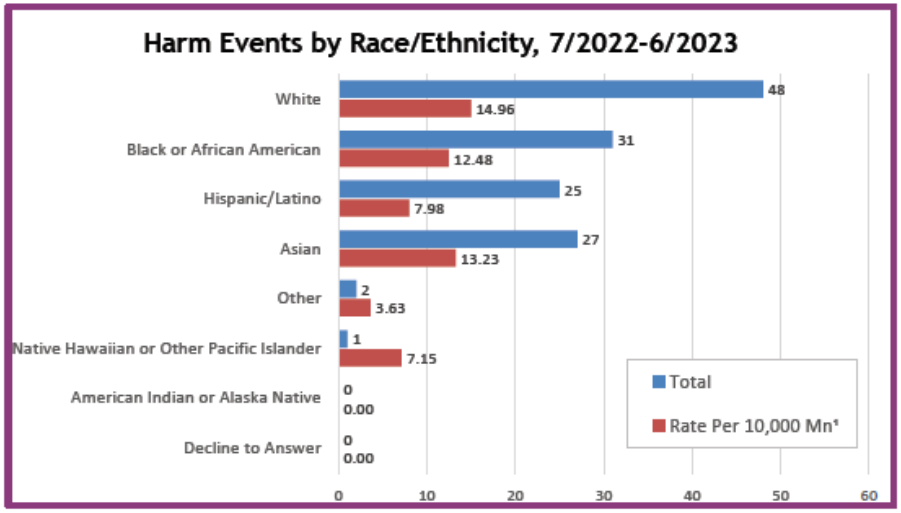




Targets for HAI Events revised to match CMS Star Rating Targets and Goals, including the April – March timeline

Embedding Equity

DEMOGRAPHIC STRATIFICATION



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ACHIEVEMENT

The Total Monthly Harm Events have now been stratified by Race and Ethnicity.

CHALLENGE

Stratification by language has not been achieved at this time

Process Metrics and Targets

Timely Harm Dashboard Publication

- **Baseline** — **60 (+) day Lag**
- **Target** — **30 Day Lag**
- **Current performance** — **35 day lag**

Process Metrics and Targets

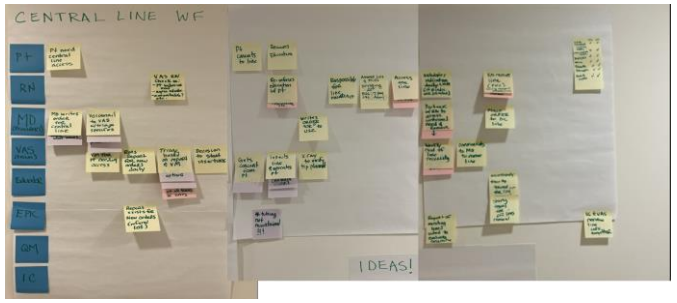
Departments Driving/Watching Harm Metrics

5 departments (M/S, ICU, Psych, Periop, 4A) have either a watch and/or driver out of a possible 6 departments = ***83%***

Department	Falls	HAPI	CAUTI	CLABSI	COLO SSI
M/S	Watch	PIPS Driver	Watch	Watch	Watch
ICU		PIPS Driver	Watch	Watch	
ED	Upcoming PDSA linked to "Age Friendly ED" project and upcoming PDSA				
Psych	Watch (in all areas?)				
4A	Getting started; PIPS driver				
Periop					Watch

Harm Taskforces

Countermeasures



HAPI

Team Lead(s): Ossie Gabriel (CNS)

- Over 10 countermeasures implemented in ICU and MS including skin rounds and equipment updates

FALLS

Team Lead(s): Dana Freiser (RN), Lawrence Chyall (CNS)

- Relaunch of the falls program on 4A and campus engagement exploring new workflow practices

CAUTI

Team Lead(s): Elaine Dekker (IC RN), Lisa Winston (MD)

- 2 SBARS in approval process to help with correct orders and catheter removal

CLABSI

Team Lead(s): Shirley ODonnell (RN VABC)

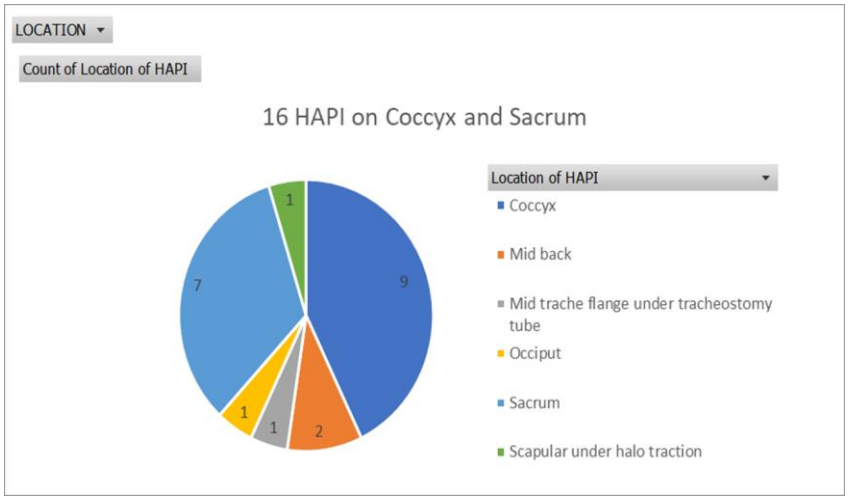
- Unit engagement in line management

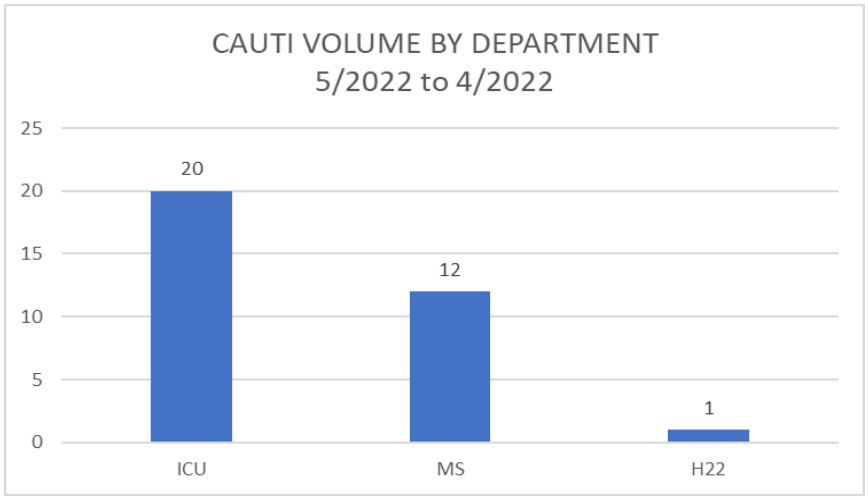
COLON SSI

Team Lead(s): Nandini Palaniappa (MD), Sandhya Kumar (MD)

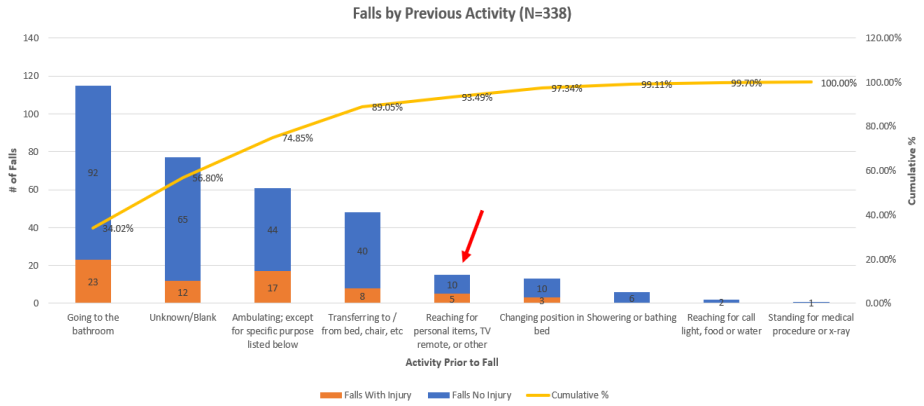
- Early Recovery After Surgery (ERAS) electronic workflow going live

Learnings/Analysis





Most falls are affiliated with toileting needs



Next Steps: New Countermeasures

Action	Who	When
Continue Monthly Patient Safety Strategy meetings / tiered reporting	Patien Safety Taskforce	2023
Continue Taskforce level work for all 5 organizational drivers	Taskforce stakeholders	2023
Continue education efforts on pulling data in SAFE system	Risk Management, Patient Safety	2023
Assess core educational modules across the campus on patient safety topics	Winston, Freiser	2023
Continue to engage staff on patient safety topics using DMS structures (huddles, UBLT)	Huen, Smith, Freiser	2023
Continue to assess harm events based on REAL data and equity considerations	Patient Safety Team	2023

Recommendations for HOSHIN

Continue to prioritize **HAPI** & **Falls** on Harm Dashboard & as part of Hoshin

Transition all three **HAI Metrics** to the departmental PIPS Reports as drivers for 2024, continue to follow on Harm Dashboard as watch metrics

Prioritize **SEPSIS** as a new Harm Dashboard Diver, focus on outcome and compliance with best practice treatment guidelines