ALAMEDA COUNTY MEDICAL CENTER

Highland Campus • Fairmont Campus
John George Psychiatric Pavilion • Ambulatory Healthcare Services

QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING

Thursday, February 16, 2012

Central Administration Offices Located at Highland Hospital
1411 East 31st Street, Oakland, CA 94602
Barbara L. McElroy, Clerk of the Board
(510) 437-8468

MINUTES

TAB #1 CLOSED SESSION

OPEN SESSION: THE MEETING WAS CALLED TO ORDER AT 4:50 PM.

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT:

Barbara Price, Daniel Boggan, Jr., Anthony Slimick, and Barry Zorthian, MD.

Valerie D. Lewis, Esq was excused.

NON-VOTING MEMBERS PRESENT:

Lyn Berry, MD and Taft Bhuket, MD.

TAB #2 ACTION: Approval of Minutes

ACTION: A motion was made, seconded, and unanimously approved the Minutes from the January 19, 2012 Quality Professional Services Committee Meeting as presented.

MOTION: Trustee Slimick
SECOND: Trustee Boggan

TAB #3 ACTION: Medical Staff / Organizational Policies and Procedures

Kerin Bashaw, VP, Quality, reported that the majority of the policies and procedures presented for adoption by the Committee were a result of the Joint Commission survey:

A. Endoscope Reprocessing ***(as presented)***
B. Advance Directives ***(a newer version of the policy was presented at the meeting, Sang-ick Chang, MD, Chief Medical Officer, explained that the language was necessary to clarify the policy.)*** He gave a brief history of the policy and the significant ethical issue in healthcare to explain the Advance Directive process to patients.
C. Materials Management: Managing Outdates ***(page 33 of agenda packet - #4, language unclear with regards to "par levels"; Ms. Bashaw will reword the policy to clarify)***
D. FNS: Nutrition Screening and Assessment in the NICU ***(as presented)***
E. Infection Control Procedures for Food and Nutrition Services ***(page 39 of the agenda packet – under Education and Training there is a #3 without any content; page 40 - #6 "The scoop is washed daily" replace "is" with "shall be")***
F. Ordering of Non-Formulary Enteral Feeding ***(as presented)***
G. Master Clock Policy ***(as presented)***
H. Mitigation of Improper Disclosures ***(as presented)***
I. Patient Privacy Protection ***(as presented)***
J. Disclosures of HIV/AIDS Related Information ***(as presented)***
K. Disclosures of Protected Health Information for Treatment, Payment and Health Care Operations ***(as presented)***
L. Authorization for Uses and Disclosures Other Than Treatment, Payment and Health Care Operations ***(as presented)***
M. Patient's Right to Request Restrictions on Certain Uses and Disclosures of Protected Health Information ***(as presented)***
N. Notification ***(as presented)***

ACTION: A motion was made, seconded, and unanimously approved to adopt the Organization Policies and Procedures as amended.

MOTION: Trustee Zorthian
SECOND: Trustee Boggan

TAB #4 UPDATE: Harm Reduction Team Updates

Dr. Chang began the presentation by framing the discussion. The Harm Reduction Team began the process 18 months ago. The two part presentation will begin with a close out of the first 18 months with a final number in overall harm reduction. The second part of the presentation will be recommendations for Phase II: Sustain, Spread, and Embed.

Kathleen Clanon, MD, Quality Department, presented the following:

In July 2010, ACMC launched an unprecedented effort to reduce errors and improve patient safety on its 3 acute campuses. The Harm Reduction Team Project at Alameda County Medical Center was an 18-month effort aimed at reducing harm to patients by 50% in ten key areas by December 31, 2011.

The ten areas of harm were:

1. Code Blue events outside the ICU
2. Device-Associated Infections
3. Hospital Acquired Pressure Ulcers
4. Harm from Intubations
5. Unplanned NICU admissions (Chorioamnionitis & Hyperbilirubinemia)
6. Medication Errors
7. Mortality Due to Severe Sepsis
8. Surgical Site Infections
9. Assaults with injury
10. Falls with injury

Leaders and staff in each area were engaged and committed, and interdisciplinary teams were formed with joint physician and nursing leadership, and line staff involvement across all disciplines. The primary goal was to reduce harm by 50 percent, and overall the teams achieved this goal, with a combined reduction of 48% below baseline for the last month of the project.

Bottom Line Results:

- Overall reached 48% reduction in harm by December 2011
- 9/10 teams reached or exceed goal of 50% reduction
- Compared to base line, 411 fewer patients harmed over the 18 months

Beyond the basic harm reduction goal, the ACMC leadership aimed to enhance organizational capacity and prepare the institution to meet the coming challenges under health care reform. The HRT project mobilized the entire institution in a common patient safety effort, and served as a vehicle for increasing interdisciplinary teamwork and making ACMC an environment for positive change. We have observed a renewed sense of efficacy and ability to improve our care in the community of staff who were involved.

The project has also contributed to an enriched quality improvement program that will support ACMC in becoming an ever safer and more effective healthcare provider into the future. The quality improvement infrastructure has an improved ability to produce data, greater staff capacity in data analysis, and has strengthened cross-disciplinary, cross-function and cross-campus relationships and teamwork.

What It Took

The Harm Reduction Team project was successful thanks to an extraordinary investment of organizational and personal resources.

- Ten harm reduction teams and one companion project in reducing preventable readmissions, comprising more than 160 individuals, 19 disciplines, 9 clinical departments, and 3 campuses, held more than 170 team meetings.
- Quality department staff added new duties, and changed and grew their roles to meet the challenge.
- Eleven interns brought their passion, "beginner eyes", and countless hours to gather data, develop documents, and record action items to support the teams.
- Outside experts were hired by ACMC leadership to put their shoulders to the wheel, and to help develop internal capacity.
- Board and executive leaders showed their commitment and helped maintain focus, at Quality Council (15 meetings), QPSC (14 reports), Board meetings (9 reports), and many formal and informal discussions.

What Made The Difference

There were four critical factors that made this challenging process improvement effort both innovative and successful:

1. **A clear and ambitious goal.**
    - ACMC leaders decided up front that we would focus on harm to individual patients – not ratios, not benchmarks, but people.
    - Choosing a goal of 50% reduction across all the areas was bold, challenging and memorable and kept attention focused on the effort – we were never sure we would make it.
2. **Leadership attention.**
    - Board and executive leaders were the authors of the initiative, and their close and sustained engagement was key to the success of the teams.
    - The Board of Trustees challenged the staff to articulate both the problems and the successes in a way that could be understood by non-experts.
3. **Data focus.**
    - Teams and quality department staff were driven to obtain reliable, relevant data, and use it to guide the projects.
    - ACMC made the decision to have a completely transparent process. The data are available on our intranet and can be seen by anybody at ACMC and made available to those outside ACMC.
4. **Involvement of all hospital communities.**
    - The multidisciplinary teams comprised a range of relevant staff: physicians, nurses, and social workers, but also engineering, environmental services, and many others.

- The involvement of line staff and multidisciplinary leadership has helped to mobilize the entire institution in a common effort to improve patient safety and care.

More about Leadership

Regular reporting up the leadership chain all the way to the Board was structured into the project, and this turned out to be even more important than we anticipated.

The Board members brought a different perspective to the effort than staff, and throughout the period challenged the organization to deliver on its high aspirations.

The members of the Board and the Quality and Professional Services Committee brought their personal experiences to the conversation. They were there to represent the point of view of the patient and lay people—fulfilling the true role of a Board of Trustees. Thus they probed and questioned—why is it hard to change this? Why can't we make the experience more patient-centered? What do these data mean? They helped the staff to articulate both the problems and the successes in a way that could be understood by non-experts. And, importantly, they reaffirmed repeatedly the significance of counting whole lives, rather than statistics.

In addition, the teams reported on their progress quarterly to the Quality Council, which comprised senior leaders such as the CEO, CMO and others. The QC helped problem-solve barriers to progress and identify successful strategies that should be spread and incorporated across the medical center. HRT leaders met on a consistent basis with medical staff leadership and ACMC executive leadership to review the initiative's progress.

This level of sustained interest and investment on the part of leadership was a critical factor in the dedicated, sustained effort that led to success. The teams knew that they had both the scrutiny and the support of ACMC leadership, which helped them in turn to sustain the added energy, creativity and effort that was required.

ACMC's achievement in reducing patient harm is a testament to the commitment of its leadership, clinicians and other staff, as well as the collaboration, transparency and urgency with which the teams worked together.

Trustee Price encouraged staff to copyright the results of the process.

Dr. Chang presented the next phase of the process, "Phase II - Sustain, Spread, and Embed"

1. The Harm Reduction Team Initiative was highly successful and should continue as an organizational initiative and priority.

2. The next 18 months should focus on sustaining, spreading and embedding gains, rather than setting a new organization-wide reduction percentage.

3. Teams will be given the following renewal charge:
    - Is your "work" complete? (i.e., embedded in the normal way things are done)
    - If complete, should you close the team and transfer monitoring to the department, or is there another part of the organization that you need to spread to?
    - If your work is not complete,
        - do you need to combine with another team?
        - Do you need to set a higher bar?
    - If you work is not complete, what work remains to sustain and embed your work in the way we do things at ACMC?
        - What are your "SMART" Objectives for the year to sustain and embed? (e.g., "increase use of Central Line Insertion Documentation form to 80%", "include skin inspection competency in annual nursing competency evals", etc.)
    - Some new harm reduction teams may be formed, e.g., in ambulatory

4. We will ensure Harm Reduction continues as an organizational priority and initiative by:
    - Quality will continue to measure and report harm numbers, by team, to QPSC monthly, and full board in written and verbal report
    - Teams will continue to report in person to the Quality Council on a Quarterly basis, reporting both the number, and progress toward their "sustain and embed" Objectives.
    - By July 1, 2012, all teams will present FY 2013 SMART Objectives which may or may not include a new performance target, but will include the steps to spread and embed.

5. This Phase II HRT should be "branded" with a variation on the name to reflect the ongoing quest for performance: e.g., "Harm Elimination Initiative: The Quest for Zero".

6. A new inspiring and unifying organizational message and framework will be developed around the new objectives, once they are completed in July, e.g., around "reducing variation", "reaching zero", etc.

The committee discussed how the process is going to move forward to identify objectives of Phase II and that the Harm Reduction Teams continue to report on a regular basis to the Quality Professional Services Committee.

Dr. Chang thanked the Committee for their commitment to the project.

TAB #5 REPORT: Medical Executive Committee

Lyn Berry, MD, President, ACMC Medical Staff, reported that the process to review the Medical Staff By-Laws and Rules & Regulations is underway.

As part of strategic planning, KSA will be working with the medical staff to involve them in the process of developing a plan for ACMC.

Jeanette Louden-Corbett, Chief Human Resources Officer, attended the last MEC meeting to discuss ways in which ACMC will be working with the medical staff to achieve a feeling of integration within the organization.

Dr. Berry announced that the most recent change is the email process will no longer identify physicians as "contract" staff, but simply show the name of the physician.

Dr. Berry introduced Evan Seevak, MD, Chair, Department of Ambulatory and Preventive Medicine. Dr. Seevak provided an overview of the presentation made to MEC in November of the Department of Ambulatory and Preventive Medicine.

TAB #6 REPORT: Chief Medical Officer

Dr. Chang reported that the medical staff are continuing the performance evaluation and reappointment recommendation process for the chairs of departments. This year the two departments to be reviewed are Emergency Medicine and Anethesia. Reviews occur every four year with feedback provided annually.

Dr. Chang also reported that the Medical Staff attended a leadership retreat a few weekends ago; there was 43 attendees, 40 of them physician leaders. This was the highest attendance rate to date.

Finally, Dr. Chang reported that medical staff is working to improve teamwork across departments by pairing departments to set smart objectives for the following year to develop in collaboration with each other.

TAB #7 REPORT: VP, Quality

Ms. Bashaw provided a Norovirus update. The cluster at John George Psychiatric Pavilion has resolved. The cluster involved 39 individuals. The team is to be commended for containing the cluster and it's resolution.

Regulatory update:

- Joint Commission – Findings from our survey are broken down into the need to correct the findings in either 45 days or 60 days. The 45 day action plan has been accepted by the Joint Commission. We are still waiting to hear about our 60 day action plan. All corrective action plans requiring measures of success (data monitoring) will be reported to the quality committee.
- OBRA Survey – We are still awaiting our final report.
- CMS Validation Survey – We are still awaiting the findings

Culture of Safety:

We have assessed and believe there are several immediate actions that will assist us with enhancing our culture of safety. Quality has reviewed and changed the initial NEO to better message support for reporting and resolution of errors.

We are in the process of revising the orientation and annual review modules; these will be completed in March.

Leadership has received feedback from the Employee forums. A request to implement a Hotline for anonymous risk reporting was requested. The number has been identified and will be rolled out in March 2012 as well.

Trustee Boggan asked if procedures were in place for the Hotline?

Ms. Bashaw reported that when the hot line is rolled out a policy will be in place.

The Culture of Safety survey was done approximately a year ago. In the past we have resurveyed every 2 years, instead of waiting 2 years, we are looking to roll out the survey earlier this June, 2012.

TAB #8 INFORMATION: Issue Tracking & Follow-up

Trustee Price reported that the item requesting that QPSC have the authority to approve policies & procedures was approved at the February 9, 2012 Governance Committee meeting. The item will move to the full Board meeting on March 27, 2012 recommending approval and recommendation to the Board of Supervisors as a revision to ACMC By-laws.

Ms. Bashaw reported that the process to follow up on changes to policies & procedures has been developed. Post QPSC meeting, the Clerk of the Board will work with Quality Department staff to provide immediate reporting on the action taken at QPSC for policies & procedures.

TAB #9 REPORT: Legal Counsel's Report on Action Taken in Closed Session

Douglas B. Habig, General Counsel, reported that in Closed Session the Committee considered confidential peer review matters and approved credentialing.

Public Comments: None.

Board of Trustees Remarks: None.

ADJOURNMENT: The meeting adjourned at 6:15 pm.

Respectfully Submitted,

Barbara L. McElroy
Clerk of the Board

APPROVED AS TO FORM:

Reviewed by: _____
Douglas B. Habig, Esq.,
General Counsel