ZUCKERBERG SAN FRANCISCO GENERAL
Hospital and Trauma Center

True North Scorecard CY 2021
2/15/2022
Owner: ZSFG Executive Team
Unit/Dept: ZSFG-Wide

Purpose Statement: To track our performance in achieving True North, using focused driver metrics aligned with organization-wide strategies.

↑/↓ Desired direction of improvement
On-Target
Off-Target

True North Pillar Measure	Executive Owner (Local Owner)	Measure Unit	CY Baseline	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	CYTD*	On- Off-Target	Target CY2021 (unless otherwise noted)
EQUITY																		
Departments Driving Equity	Ehrlich, Turner	% of PIPs and DMS departments	30% ↑	50%	75%	33.3%	100%	60%	75%	60%	25%	40%	71%	29%	38%	51%		50%
SAFETY																		
Patient Safety Composite Score ★	Winston, Smith	Individual Composite Items	↑	25%	25%	50%	50%	50%	50%	50%	50%	75%	50%	50%		50%[E]		75% (3 out of 4)
Catheter Associated Urinary Tract Infections (CAUTI)		(rate/1,000 urinary catheter days)	Rate = 2.82 YTD Count = 38 ↓	Rate = 3.12 Count = 7	Rate = 2.95 Count = 2	Rate = 2.86 Count = 3	Rate = 2.83 Count = 3	Rate = 2.75 Count = 2	Rate = 2.70 Count = 2	Rate = 4.28 Count = 5	Rate = 2.53 Count = 1	Rate = 2.19 Count = 2	Rate = 2.85 Count = 6	Rate = 2.45 Count = 1		Rate = 2.85 Count = 6		Rate = 2.26 YTD = 30
Central Line Associated Bloodstream Infections (CLABSI)		(rate/1,000 central line days)	Rate = 0.97 YTD Count = 10 ↓	Rate = 0.90 Count = 2	Rate = 0.80 Count = 0	Rate = 0.82 Count = 1	Rate = 0.75 Count = 0	Rate = 0.78 Count = 1	Rate = 0.74 Count = 0	Rate = 1.31 Count = 1	Rate = 0.57 Count = 0	Rate = 0.38 Count = 0	Rate = 0.57 Count = 1	Rate = 0.69 Count = 1		Rate = 0.60 Count = 1		Rate = 0.77 YTD = 8
Colon Surgical Site Infections (COLO SSI)		(infections/ procedure count)	Rate = 1.62 YTD Count = 13 ↓	Rate = 1.31 Count = 1	Rate = 1.36 Count = 0	Rate = 1.25 Count = 0	Rate = 1.27 Count = 1	Rate = 1.34 Count = 2	Rate = 1.28 Count = 1	Rate = 0.00 Count = 0	Rate = 0.00 Count = 0	Rate = 0.34 Count = 1	Rate = 1.36 Count = 4	Rate = 1.24 Count = 1		Rate = 1.36 Count = 4		Rate = 1.62 YTD = 10
Falls with injury (med surg, 4A, ED, inpatient psych)		Falls/1,000 midnight census	Rate = 0.28 YTD Count = 51 ↓	Rate = 0.75 Count = 7	Rate = 0.77 Count = 6	Rate = 0.71 Count = 2	Rate = 0.79 Count = 11	Rate = 0.75 Count = 3	Rate = 0.79 Count = 8	Rate = 0.98 Count = 7	Rate = 1.12 Count = 9	Rate = 1.21 Count = 10	Rate = 1.22 Count = 9	Rate = 1.15 Count = 6		Rate = 1.22 Count = 9		Rate = 0.22 YTD = 40
QUALITY																		
Access & Flow During COVID-19	Day, Dentoni	Individual Composite Items	↑	50% (2 out of 4)	50% (2 out of 4)	60% (3 out of 5)	60% (3 out of 5)	60% (3 out of 5)	40% (2 out of 5)	20% (1 out of 5)	20% (1 out of 5)	20% (1 out of 5)	20% (1 out of 5)	20% (1 out of 5)	20% (1 out of 5)	36% (21 out of 58)		80% (4 out of 5)
Emergency Department - Diversion Rate	Staconis, Colwell	% of time on Diversion	58.30% ↓	31.90%	22.60%	29.80%	39.90%	39.60%	41.90%	63.50%	69.60%	73.60%	67.60%	60.40%	60.50%	50.00%		40%
Dept of Care Coordination - Lower Level of Care Patient Days	Kanzaria, Hamilton	Patient Days	1192 ↓	838	629	849	785	840	720	863	785	940	1041	1028	990	863.8		950
Perioperative Dept - OR Block Utilization	Lang, Coggan	% surgical services above 80% utilization	60% ↑	Due to surge, adjustments were made to OR blocks		90%	90%	90%	90%	70%	70%	50%	70%	80%	60%	76%		80%
EVS - Bed Turnaround Time	Williams	Minutes	86.5 ↓	75	80	82	85	79	80	74	75	68	72	69	73	76.0		60
Specialty Clinics - Third Next Available Appointment	Tuot, Ferrer	% all Clinics with less than 21 days TNAA	84.80% ↑	76.79%	80.36%	80.70%	78.90%	75.40%	70.20%	73.60%	72.00%	73.10%	82.70%	78.80%	75.50%	75.60%		90%
CARE EXPERIENCE																		
Real-time Survey Implementation	Johnson	% of measures achieved by departments	N/A ↑	Establishing real-time survey vendor and workflows					23.8%	33.3%	42.9%	42.9%	42.9%	42.9%	52.0%	52.0%		33% by 8/31 66% by 9/30 100% by 10/31
DEVELOPING OUR PEOPLE																		
Operationalizing Thriving at Work Strategy Composite	Johnson, Woods, Damiano	% of targets achieved by focus group	N/A ↑	Establishing strategy and measures behind "Thriving at Work" implementation					33.3%	33.3%	66.7%	66.7%	66.7%	66.7%	81.0%	81.0%		33% by 7/31 66% by 8/31 100% by 12/31
FINANCIAL STEWARDSHIP																		
Salary Variance	Boffi, Nguyen	$ in Millions Variance	$-2.48[A] ↑	-$8.700	-$9.623	-$10.706	-$12.404	-$13.815	-$16.799	-$1.430	-$2.600	-$3.415	-$4.250	-$5.180	-$4.670	-$4.67[A]		$0.000
TRUE NORTH OUTCOME METRICS																		
Black/African-American Heart Failure (HF) Readmissions	Ehrlich	% B/AA HF discharges with 30-day readmission	31.1%[B] ↓	23.8%	29.2%	18.2%	23.8%	11.8%	50.0%	9.1%	18.2%	20.0%	8.3%	15.8%	22.2%	20.9%		34.3%
CMS Star Rating ★	Ehrlich	# stars	1-star ↑	1-Star												1-Star		2-Star
Likelihood to Recommend Hospital to Friends & Family ★	Ehrlich	% positive responses	75.4% ↑	81.4%	78.1%	83.9%	79.1%	94.1%	75%[D]	80.8%	73.7%	78.0%				78.3%		80%
Likelihood to Recommend ZSFG as a Workplace ★	Ehrlich	Weighted Average	3.66 ↑	3.66												3.66		3.76
General Fund Spend To Not Exceed Budgeted Amount	Ehrlich	$ in Millions	$17.34M[C] ↓	$231.21M			$82.13M									$82.13M		$133.20M

★ = Included in CMS Star Ratings HAC = Included in CMS Hospital-Acquired Conditions Reduction Program RRP = Included in CMS Readmissions Reduction Program PRIME = Included in PRIME = Included in QIP

Footnotes:
A = **Salary Variance** Baseline and Target are on a Fiscal Year (FY) not Calendar Year (CY); COVID-19-related labor costs have not yet been separated out of our operating fund leading to an inflated salary variance. COVID operations and COVID sick time account for approximately $12,000,000 in labor expenses
B= **Black/African American Heart Failure Readmissions** outcome metric is in coordination with DPH/SFHN, clinical experts and readmissions task force
C= **General Fund** values are not cumulative, but a projected estimate of GF fund spend through the end of the fiscal year based on actual revenues and expenditures at the end of each quarter
D= **Likelihood to Recommend Hospital to Friends & Family** sample size from April to June has significantly decreased (April = 68 responses; May = 14 responses; June = 4 responses)
E= **Patient Safety Composite** Harm events YTD reset on Fiscal Year