General Board Meeting

Date: January 23, 2019
Location: Conference Rooms 2/3

2019 BOARD OF DIRECTORS

LaRuby Z. May, *Chairman*
Matthew Hamilton *CEO*

Dr. Malika Fair, Vice Chair
Brenda Donald
Jaqueline Bowens
Girume Ashenafi
Wayne Turnage
Dr. Konrad Dawson
Velma Speight
Millicent Gorham
Angell Jacobs
Lilian Chukwuma
Dr. Marilyn-McPherson Corder

Prepared and Filed by:
Mike Austin, Corporate Secretary
Office of the Secretary of the Corporation

OUR MISSION

United Medical Center is dedicated to the health and well-being of individuals and communities entrusted to our lives.

OUR VISION

UMC is an efficient, patient-focused provider of high-quality of healthcare the community needs.

UMC will employ innovative approaches that yield excellent experiences.

UMC will improve the lives of District residents by providing high value, integrated and patient-centered services.

UMC will empower healthcare professionals to live up to their potential to benefit our patients.

UMC will collaborate with others to provide high value, integrated and patient-centered services.

NFPHC Board of Directors General Meeting
Wednesday, January 23, 2019

Table of Contents

Agenda……………………………………………………………………………………………….Tab 1

Meeting Minutes……………………………………………………………………………………Tab 2

Consent Agenda……………………………………………………………………………………Tab 3

A. Dr. Dennis Haghighat, Chief Medical Officer
B. Dr. Marilyn McPherson-Corder, Medical Chief of Staff

Executive Management Report…………………………………………………………………Tab 4

Matthew Hamilton, Chief Executive Officer

Committee Reports…………………………………………………………………………………Tab 5

Patient Safety and Quality Committee - Dr. Malika Fair, Chair

Finance Committee – Wayne Turnage, Chair

THE NOT-FOR-PROFIT HOSPITAL CORPORATION
BOARD OF DIRECTORS
NOTICE OF PUBLIC MEETING

LARUBY Z. MAY, BOARD CHAIR

The monthly Governing Board meeting of the Board of Directors of the Not-For-Profit Hospital Corporation, an independent instrumentality of the District of Columbia Government, will convene at **9:00 a.m. on Wednesday, January 23, 2019**. The meeting will be held at the United Medical Center, 1310 Southern Ave., SE, Washington, DC 20032 in the Conference Room. Notice of a location, time change, or intent to have a closed meeting will be published in the D.C. Register, posted in the Hospital, and/or posted on the Not-For-Profit Hospital Corporation's website (www.united-medicalcenter.com).

DRAFT AGENDA

I. CALL TO ORDER

II. DETERMINATION OF A QUORUM

III. APPROVAL OF AGENDA

IV. READING AND APPROVAL OF MINUTES
November 28, 2018

V. CONSENT AGENDA
A. Dr. Dennis Haghighat, Chief Medical Officer
C. Dr. Marilyn McPherson-Corder, Medical Chief of Staff

VII. EXECUTIVE MANAGEMENT REPORT
Chief Executive Officer, Matthew Hamilton

VIII. COMMITTEE REPORTS
Patient Safety and Quality
Finance Committee

IX. PUBLIC COMMENT

X. OTHER BUSINESS
A. Old Business
B. New Business

XI. ANNOUNCEMENTS

NOTICE OF INTENT TO CLOSE. The NFPHC Board hereby gives notice that it may close the meeting and move to executive session to discuss collective bargaining agreements, personnel, and discipline matters. D.C. Official Code §§2 -575(b)(2)(4A)(5),(9),(10),(11),(14).

Not-For-Profit Hospital Corporation
GENERAL BOARD MEETING
Wednesday, November 28, 2018

Phoned in: LaRuby May, Wayne Turnage, Brenda Donald, Dr. Konrad Dawson Velma Speight, Millicent Gorham, Angell Jacobs, Matthew Hamilton, Dr. Malika Fair, Girume Ashenafi, Lilian Chukwuma, Dr. Mina Yacoub
Absent: Jackie Bowens

Agenda Item	Discussion	Action Item
Call to Order	Meeting called to order at 9:11 AM. Quorum determined by Michael Austin.	
	Meeting chaired by LaRuby May.	
Approval of the Agenda	Motion. Second. Agenda approved as written.	
Approval of the Minutes	Motion. Second. Minutes approved as written.	
Discussion	**CONSENT AGENDA** **CHIEF MEDICAL OFFICER REPORT: Dr. Haghighat** • The positive trends that began in September in inpatient volumes and inpatient surgery has continued through the month of October and thus far into November.	

- MediCare and DC MediCaid Case Mix index continued their upward trend that started around the same time. BHU volume continues to trend at a rate 40% above calendar 2017 volumes.

- DOH visited UMC four times. Unlike the prior month, the hospital has experienced several regulatory visits in October and this trend has persisted into the current month. Several of these visits were related to Behavioral Health Unit patients, one to an ER related incident, and one related to temperatures within the hospital. These incidents are in various states of investigation by DOH and UMC has yet to receive final recommendations from DOH for any of the visits. UMC has completed internal root cause analysis on all incidents and implemented changes to improve patient safety and care based on these internal investigations.

- UMC's performance on national quality benchmarks continues largely unchanged with superior infection prevention scores, good mortality scores for the treatment of common diseases, slightly higher spending rates than benchmark for MediCare beneficiary, and the relatively poor patient satisfaction scores.

- The Patient Relations and Nursing Departments are working on implementing staff training with the goal of strengthening a culture of attentiveness to the patients spoken and unspoken needs.

MEDICAL CHIEF OF STAFF REPORT: Dr. Yacoub

- At the Quarterly Medical Staff meeting on December 12th, 2018, The Medical Executive Committee will announce the election results of officers for the

2019/2020 MEC term. Also at the Quarterly Medical Staff meeting, recommendations for updates to Medical Staff Bylaws will be voted on.

- Dr. Marilyn McPherson-Corder is the incoming Chief of UMC Medical Staff, and her term would start on January 1st 2019. Dr. Corder is a 1978 graduate of Howard University College of Medicine. Dr. Corder completed her residency in Pediatrics and went on to do two fellowships one in Medical Genetics and the other in Adolescent Medicine at Howard University Hospital. Dr. Corder currently serves as Assistant Professor in the Pediatric Department at Howard University College of Medicine, the George Washington College of Medicine, University of Maryland Allied Health and Duke University Medical School. She is the CEO and President of her private pediatric practice, Children's Medical Care Center of DC since 1982.

EXECUTIVE REPORT

- UMC had two recent successful events: Vendor Day, where community vendors were able to speak with UMC purchasing staff to be added to find out about vending opportunities; and Veterans Day, where UMC honored those employees who served this country.
- Open Enrollment for UMC for benefits eligible employees begins on December 3 through December 17. The organization is increasing its contribution to 80 percent to make the Kaiser HMO plan more attractive and to increase employee participation
- Streamline the Hiring and Onboarding Process: implementation of technology for the onboarding process and inclusion of new hire documentation on Intranet "New Hire Portal" accessible to all new hires
- Address exterior entrance refurbish needs, update all lighting to LED, entrance and elevator cleaning, landscaping campus wide, power washing main

	entrances, identify projects for back entrances updates (UDC, Security entrance). Identified vendor for employee entrance, security entrance and UDC – install date beginning of December. New matting at all 3 entrances: Main Hospital entrance, ED entrance, and MOB entrance (11/24/18). • New Stryker beds were delivered. In-services were provided for staff regarding use of beds with a live demonstration. Staff was also able to use a skills checklist to learn and provide a return demonstration on bed functions. • The Quality Department is working collaboratively with multiple departments to facilitate the transition of the current policy and procedure process to a fully electronic management process. Currently the policies and procedures are being reviewed/verified for correct version to ensure the most up to date policies are uploaded to the Navex system which will serve as a policy revision tool, approval routing system, and policy repository. The Policy and Procedure Committee will meet on a bi-weekly basis to continue to identify, review, approve policies and procedures in preparation for subsequent upload into Navex. **COMMITTEE REPORTS** **FINANCE COMMITTEE: Director Turnage** • Revenue is 14% higher than budget and 14% higher than last year. The net patient revenue shows a favorable variance in both budget and prior year • Whereas expenses are lower than budget by 12% but higher than prior year activity • Patient days are below both budget and prior year by 7% 8% respectively. **Vote to return to Enter Closed Session:**	

<table>
<tr><td></td><td>Roll Call: Quorum determined to enter closed session.

Voter Return to Open Session:
Roll Call: Quorum determined to exit closed session.

Closed Session Minutes transcribed separately.

Public Comment
n/a

Other Business
n/a

Announcements

November 2018 Board Meeting Adjourned after 1 hours and 45 mins by Chair May.</td><td></td></tr>
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UMC

UNITED
MEDICAL CENTER

General Board Meeting
Date: January 23, 2019

CMO REPORT

Presented by:
Dennis Haghighat, MD
Chief Medical Officer

The Not-for-Profit Hospital Corporation, commonly known as United Medical Center or UMC, is a District of Columbia government hospital (not a private 501(c)(3) entity) serving Southeast DC and surrounding Maryland communities

Our Mission:

United Medical Center is dedicated to the health and well-being of individuals and communities entrusted in our care.

Our Vision:

- UMC is an efficient, patient-focused, provider of high quality healthcare the community needs.
- UMC will employ innovative approaches that yield excellent experiences.
- UMC will improve the lives of District residents by providing high value, integrated and patient-centered services.
- UMC will empower healthcare professionals to live up to their potential to benefit our patients.
- UMC will collaborate with others to provide high value, integrated and patient-centered services.

***Dennis P. Haghighat*, M.D.**

January 2019

Medical Staff Summary

Medical Staff Committee Meetings

Medical Executive Committee Meeting, ***Dr. Mina Yacoub, Chief of Staff***
The Medical Staff Executive Committee (MEC) provides oversight of care, treatment, and services provided by practitioners with privileges on the UMC medical staff. The committee provides for a uniform quality of patient care, treatment, and services, and reports to and is accountable to the Governing Board. The Medical Staff Executive Committee acts as liaison between the Governing Board and Medical Staff.

Peer-Review Committee, ***Dr. Gilbert Daniel, Committee Chairman***
The purpose of peer review is to promote continuous improvement of the quality of care provided by the Medical Staff. The role of the Medical Staff is to provide evaluation of performance to ensure the effective and efficient assessments and education of the practitioner and to promote excellence in medical practices and procedures. The peer review function applies to all practitioners holding independent clinical privileges.

Pharmacy and Therapeutics Committee, ***Dr. Eskender Beyene, Committee Chairman***
The Pharmacy and Therapeutics Committee discusses all policies, procedures, and forms regarding patient care, medication reconciliation, and formulary medications prior to submitting to the Medical Executive Committee for approval.

Credentials Committee, ***Dr. Barry Smith, Committee Chairman***
The Credentials Committee is comprised of physicians who review all credential files to ensure all items such as applications, dues payment, etc. are appropriate. Once approved through Credentials Committee, files are submitted to the Medical Executive Committee and the Governing Board.

Medical Education Committee, ***Dr. Jerome Byam, Committee Chairman***
The Medical Education Committee was formed to review all upcoming Grand Rounds presentations. The committee discusses improvements and new ideas for education of clinical staff.

Bylaws Committee, ***Dr. David Reagin, Committee Chairman***
Members include physicians who meet to discuss implementation of new policies and procedures for bylaws, as it pertains to physician conduct.

The Medical Staff Bylaws, Rules and Regulations have been revised in preparation for the upcoming Joint Commission inspection. The changes were reviewed, discussed and approved by the Bylaws Committee and will be forwarded to the Medical Executive Committee and then the Board of Directors for review and approval.

Physician IT Committee
Members include physicians who meet to discuss the implementation of the new hospital-wide Meditech upgrade, as well as the physician documentation for ICD-10.

DEPARTMENT CHAIRPERSONS

Anesthesiology...*Dr. Amaechi Erondu*

Critical Care...*Dr. Mina Yacoub*

Emergency Medicine...*Dr. Francis O'Connell*

Medicine...*Dr. Musa Momoh*

Pathology...*Dr. Eric Li*

Psychiatry...*Dr. Surendra Kandel*

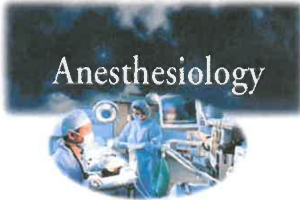
Radiology..*Dr. Raymond Tu*

Surgery...*Dr. Gregory Morrow*

Departmental Reports

Key

ABO Rh	Blood Typing and Rhesus Factor
ALOS	Average Length of Stay
AMA rate	Against Medical Advice Rate
BHU	Behavior Health Unit
BI RADS	Breast Imaging Reporting and Data System
CAUTI	Catheter Associated Urinary Tract Infection
CCHD	Critical Congenital Heart Defect
CLABSIs	Catheter Associated Urinary Tract Infections
CPEP	Comprehensive Psychiatric Emergency Program
CT	Computerized Tomography
ED	Emergency Department
EGD	Esophagogastroduodenoscopy
ERCP	Endoscopic Retrograde Cholangiopancreatography
FT FTE	Full-time employee
ESR Control	Erythrocyte Sedimentation Rate
HELLP Syndrome	Hemolysis, Elevated Liver Enzymes, Low Platelet Counts
HCAHP	Hospital Consumer Assessment of Healthcare Providers and Systems
HIM	Health Information Management
HTN/PIH	Hypertension/Pregnancy-Induced Hypertension
ICD 10	International Classification of Diseases
ICU	Intensive Care Unit
IMC	Intermediate Care Unit
LWBS	Left without Being Seen
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-Resistant Staphylococcus Aureus
NICU	Neonatal Intensive Care Unit
NHSN	National Healthcare Safety Network
NASCET	North American Symptomatic Carotid Endarterectomy
OR	Operating Room
PI	Performance Improvement
PICC	Peripherally Inserted Central Venous Catheter
PIW	Psychiatry Institute of Washington
PP Hemorrhage	Post-Partum Hemorrhage
RRT	Rapid Response Team
SW	Social Worker
VAP	Ventilator Associated Pneumonias
VAE	Ventilator Associated Event
VBAC	Vaginal Birth After Cesarean
VTE	Venous Thromboembolism



Amaechi Erondu, **M.D.,** Chairman

November

PERFORMANCE SUMMARY:
The overall cases for the month of NOVEMBER 2018 were 196.Total surgical cases was 105 while Endoscopy cases was 88.

QUALITY INITIATIVES AND OUTCOME:
SCIP protocol is consistently ensured for all our patients with no fall outs. Surgical and anesthesia time outs are followed per protocol including preoperative antibiotics, temperature monitoring and all relevant quality metrics.

Review of the facility anesthesia performance benchmarked with Age and co-morbidity compares well with other facilities.(See Attached)

We are awaiting the completion of the Anesthesia storage and work room. This provides storage for all anesthesia-related patient equipment. Still pending.

We are hoping to secure an Anesthesia Information Management System (AIMS). This will centralize all documentations, quality metrics and facilitate efficient revenue cycle management. Still pending.

PERIOPERATIVE CONFERENCE:
We would commence a PeriOperative conference that focus on OR related topics for all OR providers. This will include the Nurse, Extenders and physicians. Our goal is to ensure adequate team building for quality patient care.

EVIDENCE-BASED PRACTICE:
Anesthesia department is continuing to review all current policies and update them to align with the best practices. Our Providers continuously provide evidence based practice and peer review to ensure quality patient care

SERVICE (HCAHPS) SATISFACTION:
The Anesthesia Providers continue to provide quality service to our patients. We continue to provide real-time performance assessment of the anesthesia providers. We provide standardized service that ensures patient satisfaction.

BILLING AND REVENUE CYCLE MANAGEMENT:
We have ensured that our providers are oriented to the ICD 10 requirements for both the anesthesia and hospital billing portions. We monitor closely documents and chart by our providers to ensure chart completion at the appropriate time.

December

PERFORMANCE SUMMARY:
The overall cases for the month of DECEMBER 2018 were 192. Total surgical cases was 95 while Endoscopy cases was 97.

QUALITY INITIATIVES AND OUTCOME:
SCIP protocol is consistently ensured for all our patients with no fall outs. Surgical and anesthesia time outs are followed per protocol including preoperative antibiotics, temperature monitoring and all relevant quality metrics.

Review of the facility anesthesia performance benchmarked with Age and co-morbidity compares well with other facilities.

We are awaiting the completion of the Anesthesia storage and work room. This provides storage for all anesthesia-related patient equipment.

We are hoping to secure an Anesthesia Information Management System (AIMS). This will centralize all documentations, quality metrics and facilitate efficient revenue cycle management.

PERIOPERATIVE CONFERENCE:
We would commence a PeriOperative conference that focus on OR related topics for all OR providers. This will include the Nurse, Extenders and physicians. Our goal is to ensure adequate team building for quality patient care.

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Anesthesia department is continuing to review all current policies and update them to align with the best practices. Our Providers continuously provide evidence based practice and peer review to ensure quality patient care.

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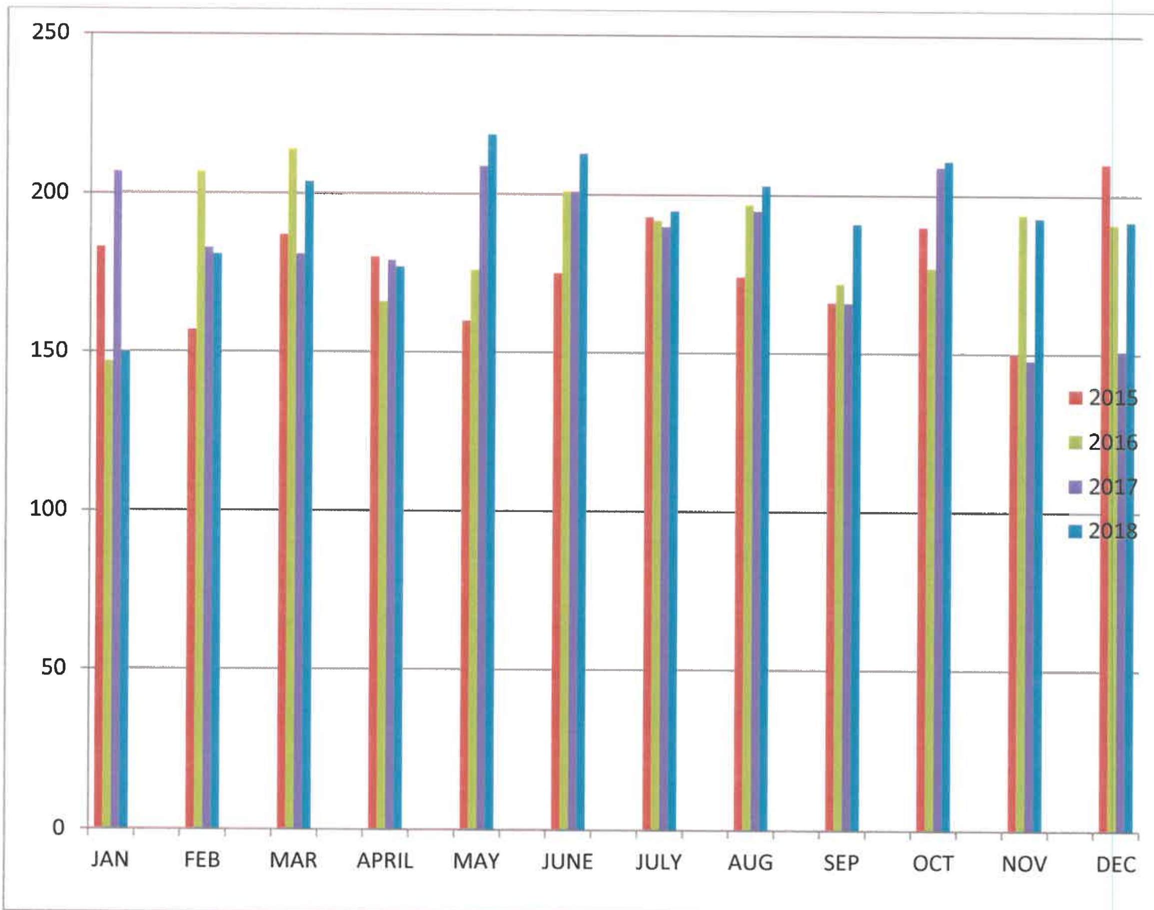
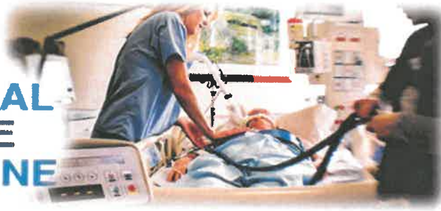
We have ensured that our providers are oriented to the ICD 10 requirements for both the anesthesia and hospital billing portions. We monitor closely documents and chart by our providers to ensure chart completion at the appropriate time.





Mina Yacoub, **M.D.**, Chairman

November

In November 2018, the Intensive Care Unit had 69 admissions, 71 discharges, and 243 Patient Days, with an Average Length of Stay (ALOS) of 3.4 days. The ICU managed 74 patients in November, with 5 deaths, for an overall ICU mortality rate of 6.8%. The ICU managed 25 patients with severe sepsis and septic shock in November with 3 deaths attributed to severe sepsis/septic shock for a sepsis specific ICU mortality rate of 12 %. Two patients were transferred to Tertiary Care Hospitals for indicated higher level specialized services.

QUALITY OUTCOMES

Sepsis Core Measures Performance
ICU continues to work with Quality Department to meet sepsis metrics. The past few months have shown ICU severe sepsis and septic shock mortality to be well below national averages.

Morbidity and Mortality Reviews

1. **ICU Mortality**
   ICU had 5 deaths for 74 patients managed, with an overall ICU mortality rate of 6.8 % for November. Mortality review is conducted in monthly Critical Care Committee meeting with Quality Department.

2. **Severe Sepsis and Septic Shock**
   ICU managed 25 patients with severe sepsis and septic shock in November. Three ICU deaths were directly attributable to severe sepsis and septic shock, with an ICU sepsis specific mortality rate of 12 %.

3. **Infection Control Data**
   For November, the ICU had 99 ventilator days with no Ventilator Associated Pneumonias (VAP), 88 Central Line device days with no Central Line Associated Blood Stream Infections (CLABSI) and 145 Urinary Indwelling Catheter days with no Catheter

Associated Urinary Tract Infections (CAUTI). ICU infection rates continue to be much lower than national averages. ICU infection rate data is reported regularly to the National Healthcare Safety Network (NHSN).

4. **Rapid Response and Code Blue Teams**
   ICU continues to lead, monitor and manage the Rapid Response and Code Blue Teams at UMC. Reports are reviewed monthly in Critical Care Committee meeting with Nursing and Quality Department. Goal is to increase utilization of Rapid Response Teams in order to decrease cardiopulmonary arrest episodes on the medical floors, and improve patient outcomes.
5. **Care Coordination/Readmissions**
   In November, 74 patients were managed in the ICU. There were no readmissions to the ICU within 48 hours of transfer out. Two patients were transferred to Tertiary Care Hospitals for higher level care. One patient was transferred to GWU for emergent cardiac surgery, and the second was transferred to GTU for embolization of active gastrointestinal bleeding.

Evidence-Based Practice (Protocols/Guidelines)

Evidence based practices continue to be implemented in ICU with multidisciplinary team rounding, ventilator weaning, infection control practices, and patient centered practices. New initiative being implemented with Infection Prevention team is Hand Hygiene. Initial performance data is encouraging, but need to monitor for consistency. Infection Prevention team is monitoring performance.

Growth/Volumes

ICU is staffed 24/7 with in-house physicians and has a 16 bed capacity and is looking forward to operating at full capacity and full potential.

Stewardship

ICU continues to implement and monitor practices to keep ICU ALOS low and to keep hospital acquired infections and complications low.

ICU continues to precept George Washington University Physician Assistant students during their clinical rotations in UMC ICU.

Financials We are requesting feedback on ICU financial performance.

Needed Steps to Improve Performance

Nursing staffing continues to be a challenge and we need more effective critical care nurse recruitment, and importantly, nurse retention. Goal is to continue to provide safe and high quality patient care, caring for patients with increased illness acuity, providing best evidence based practice, all while keeping ALOS low and preventing Hospital Acquired infections and complications. Working closely with Quality Department and Infection preventionist to ensure we continue to meet benchmarks.

December

PERFORMANCE SUMMARY

December 2018 was a notably low volume month for the ICU for this time of the year. In December 2018, the Intensive Care Unit had 68 admissions, 65 discharges, and 232 Patient Days, with an Average Length of Stay (ALOS) of 3.6 days. The ICU managed 71 patients in December with 5 deaths, for an overall ICU mortality rate of 7 %. The ICU managed 23 patients with severe sepsis and septic shock in December with three deaths attributed to severe sepsis/septic shock. The sepsis specific ICU mortality rate was 13 %, which remains below national averages. Two patients were transferred to Tertiary Care Hospitals for needed higher levels of care.

QUALITY OUTCOMES

Sepsis Core Measures Performance
ICU continues to work with Quality Department to meet sepsis metrics. The past few months have shown ICU severe sepsis and septic shock mortality to be well below national averages.

Morbidity and Mortality Reviews

1. **ICU Mortality**
   ICU had 5 deaths for 71 patients managed, with an overall ICU mortality rate of 7% for December. Mortality review is conducted in monthly Critical Care Committee meeting with Quality Department.

2. **Severe Sepsis and Septic Shock**
   ICU managed 23 patients with severe sepsis and septic shock in December. Three ICU deaths were directly attributable to severe sepsis and septic shock, with an ICU sepsis specific mortality rate of 13 % which remains below national averages.

3. **Infection Control Data**
For December, the ICU had 83 ventilator days with no Ventilator Associated Pneumonias (VAP), 79 Central Line device days with no Central Line Associated Blood Stream Infections (CLABSI) and 150 Urinary Indwelling Catheter days with no Catheter Associated Urinary Tract Infections (CAUTI). ICU infection rates continue to be much lower than national averages. ICU infection rate data is reported regularly to the National Healthcare Safety Network (NHSN).

4. **Rapid Response and Code Blue Teams**
ICU continues to lead, monitor and manage the Rapid Response and Code Blue Teams at UMC. Reports are reviewed monthly in Critical Care Committee meeting with Nursing and Quality Department. Goal is to increase utilization of Rapid Response Teams in order to decrease cardiopulmonary arrest episodes on the medical floors, and improve patient outcomes.

5. **Care Coordination/Readmissions**
In December, 71 patients were managed in the ICU. There were no readmissions to the ICU within 48 hours of transfer out. One patient was transferred to Georgetown University Hospital for higher level of care, needing embolization of active intestinal bleeding. Another patient was transferred to GW for cardiac bypass surgery.

Based Practice (Protocols/Guidelines) Evidence-

Evidence based practices continue to be implemented in ICU with multidisciplinary team rounding, ventilator weaning, infection control practices, and patient centered practices. New initiative being implemented with Infection Prevention team is Hand Hygiene.

Growth/Volumes

ICU is staffed 24/7 with in-house physicians and has a 16 bed capacity and is looking forward to operating at full capacity and full potential.

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ICU continues to precept George Washington University Physician Assistant students during their clinical rotations in UMC ICU.

Financials We are requesting feedback on ICU financial performance.

Needed Steps to Improve Performance

Nursing staffing continues to be a challenge and we need more effective critical care nurse recruitment, and importantly, nurse retention. Goal is to continue to provide safe and high quality patient care, caring for patients with increased illness acuity, providing best evidence based practice, all while keeping ALOS low and preventing Hospital Acquired infections and complications. Working closely with Quality Department and Infection preventionist to ensure we continue to meet benchmarks.

Francis O'Connell, **M.D., Chairman**

Attached are the summary of Emergency Department (ED) volume, key measures and throughput data for November and December 2018 as well as data from the preceding months of 2018.

The daily census dropped slightly from the previous months, however this is something that the hospital historically sees during the months of November and December.

With regards to hospital admissions, the proportion of general psychiatric and med/surg admissions have remained steady month to month.

With regards to throughput, boarding was a problem that we dealt with more during the past two months (reflected in the average boarding times in November and December).

We continue to work with the hospital leadership to identify ways to improve throughput in the Emergency Department and identifying ways to facilitate the transport of women in labor, late term obstetric emergencies, and other critically ill patients.

ED Volume and Events 2018

	Jan	%	Feb	%	Mar	%	Apr	%
Total patients	5027		4656		4881		4783	
Daily Avg Census	162		166		157		159	
Admit	507	10.1%	515	11.1%	498	10.2%	496	10.4%
- **Med/Surg**	436	8.7%	437	9.4%	425	8.7%	409	8.6%
- **Psych**	71	1.4%	78	1.7%	73	1.5%	87	1.8%
Transfer	60	1.2%	55	1.2%	86	1.8%	90	1.9%
AMA	73	1.5%	55	1.2%	56	1.1%	49	1.0%
Eloped	36	0.7%	35	0.8%	45	0.9%	38	0.8%
LWBS	109	2.2%	79	1.7%	101	2.1%	107	2.2%
Left Prior to Triage	189	3.8%	168	3.6%	156	3.2%	235	4.9%
Ambulance Arrivals	1541	30.7%	1364	29.3%	1453	29.8%	1314	27.5%

ED Volume and Events 2018

	May	%	Jun	%	Jul	%	Aug	%
Total patients	5071		4832		4981		5032	
Daily Avg Census	169		161		161		163	
Admit (total)	533	10.5%	526	10.9%	556	11.1%	606	12%
- **Med/Surg**	431	8.5%	429	8.9%	465	9.3%	481	9.6%
- **Psych**	102	2.0%	97	2.0%	91	1.8%	125	2.5%
Transfer	90	1.8%	69	1.4%	87	1.7%	90	1.8%
AMA	40	0.8%	44	0.9%	59	1.1%	54	1.1%
Eloped	45	0.9%	36	0.7%	47	0.9%	63	1.3%
LWBS	148	2.9%	149	3.1%	136	2.7%	128	2.5%
Left Prior to Triage	249	4.9%	260	5.4%	268	5.3%	239	4.7%
Ambulance Arrivals	1468	28.9%	1319	27.3%	1492	30.0%	1471	29.2%

ED Volume and Events 2018

	Sep	%	Oct	%	Nov	%	Dec	%
Total patients	4750		4652		**4357**		**4476**	
Daily Avg Census	158		150		**145**		**144**	
Admit	572	12%	592	12.7%	**573**	**13.1%**	**544**	**12.1%**
- **Med/Surg**	472	9.9%	490	10.5%	**482**	**11%**	**454**	**10.1%**
- **Psych**	100	2.1%	102	2.2%	**91**	**2.1%**	**90**	**2%**
Transfer	82	1.7%	70	1.5%	**97**	**2.2%**	**75**	**1.7%**
AMA	58	1.2%	58	1.2%	**71**	**1.6%**	**64**	**1.4%**
Eloped	60	1.3%	36	0.7%	**44**	**1%**	**58**	**1.3%**
LWBS	149	3.1%	166	3.6%	**105**	**2.4%**	**90**	**2%**
Left Prior to Triage	280	5.9%	218	4.7%	**148**	**3.4%**	**189**	**4.2%**
Ambulance Arrivals	1340	28.2%	1248	26.8%	**1191**	**27.3%**	**1258**	**28.1%**

ED Throughput November 2018 (time in minutes)		
	Median Times	**Average Time**
Admissions		
Door to triage	13	25
Door to room	34	75
Door to provider	35	75
Door to decision	261	298
Door to departure	304	593
Time to provider	1	0
Time to admit decision	226	223
Boarding time	43	295
Discharges		
Door to triage	15	23
Door to room	88	122
Door to provider	102	133
Door to decision	228	242
Door to departure	273	301
Time to provider	14	11
Time to discharge decision	126	109
Waiting to depart	45	59
Transfers		
Door to triage	13	20
Door to room	27	66
Door to provider	28	66
Door to decision	243	273
Time to provider	1	0
Time to transfer decision	215	207

ED Throughput December 2018 (time in minutes)		
	Median Times	**Average Time**
Admissions		
Door to triage	14	25
Door to room	24	64
Door to provider	26	64
Door to decision	255	284
Door to departure	311	691
Time to provider	2	0
Time to admit decision	219	220
Boarding time	56	407
Discharges		
Door to triage	15	24
Door to room	97	123
Door to provider	105	132
Door to decision	223	249
Door to departure	269	293
Time to provider	8	9
Time to discharge decision	118	117
Waiting to depart	46	44
Transfers		
Door to triage	10	20
Door to room	33	56
Door to provider	33	56
Door to decision	182	221
Time to provider	0	0
Time to transfer decision	149	165

ED Throughput 2018 (median times in minutes)

	Jan	Feb	Mar	Apr	May
Admissions (Med/Surg)					
Door to triage	17	16	15	19	15
Door to room	22	23	25	32	27
Door to provider	22	23	25	33	27
Door to decision	245	264	245	256	265
Door to departure	271	286	261	300	296
Time to provider	0	0	0	1	0
Time to admit decision	223	241	220	223	238
Boarding time	26	22	16	44	31
Discharges					
Door to triage	22	22	19	24	24
Door to room	63	65	51	81	84
Door to provider	75	78	67	92	95
Door to decision	187	188	180	229	220
Door to departure	233	234	222	276	270
Time to provider	12	13	16	11	11
Time to discharge decision	112	110	113	137	125
Waiting to depart	46	46	42	47	50
Transfers					
Door to triage	16	15	13	12	14
Door to room	24	22	22	26	36
Door to provider	24	28	26	29	36
Door to decision	266	267	291	221	239
Time to provider	0	6	4	3	0
Time to transfer decision	242	239	265	192	203

ED Throughput 2018 (median times in minutes)

	Jun	Jul	Aug	Sep	Oct
Admissions (Med/Surg)					
Door to triage	13	15	15	15	16
Door to room	28	31	35	30	30
Door to provider	28	31	35	32	30
Door to decision	256	276	254	264	267
Door to departure	492	502	288	304	295
Time to provider	0	0	0	2	0
Time to admit decision	228	245	219	232	237
Boarding time	236	226	34	40	28
Discharges					
Door to triage	21	24	20	24	19
Door to room	80	84	81	81	79
Door to provider	91	95	88	93	87
Door to decision	231	238	214	211	217
Door to departure	265	277	262	265	260
Time to provider	11	11	7	12	8
Time to discharge decision	140	143	126	118	130
Waiting to depart	34	39	48	54	43
Transfers					
Door to triage	14	12	13	15	15
Door to room	37	35	31	43	30
Door to provider	37	35	31	43	33
Door to decision	228	244	241	284	289
Time to provider	0	0	0	0	3
Time to transfer decision	191	209	210	241	256

ED Throughput 2018 (median times in minutes)		
	Nov	**Dec**
Admissions (Med/Surg)		
Door to triage	13	14
Door to room	34	24
Door to provider	35	26
Door to decision	261	255
Door to departure	304	311
Time to provider	1	2
Time to admit decision	226	219
Boarding time	43	56
Discharges		
Door to triage	15	15
Door to room	88	97
Door to provider	102	105
Door to decision	228	223
Door to departure	273	269
Time to provider	14	8
Time to discharge decision	126	118
Waiting to depart	45	46
Transfers		
Door to triage	13	10
Door to room	27	33
Door to provider	28	33
Door to decision	243	182
Time to provider	1	0
Time to transfer decision	215	149

Musa Momoh, M.D., Chairman

November

The Department of Medicine remains the major source of admissions to and discharges from the hospital.

- Admissions:
  - Observation admissions: Medicine 153 (100%)
  - Observation admissions: Hospital 153
  - Regular admissions: Medicine 347 (78%)
  - Regular admissions: Hospital 443
- Discharges:
  - Observation discharges: Medicine 151 (100%)
  - Observation discharges: Hospital 151
  - Regular discharges: Medicine 295 (78%)
  - Regular discharges: Hospital 380

- Procedures
  - EGD's 36
  - Colonoscopies 54
  - ERCP 0
  - Bronchoscopies 3
  - Dialysis 249
- Performance Improvement
  - Cases reviewed: 3
  - Cases closed: 3

- Department of Medicine quarterly meeting is on 12/12/2018.

December

The Department of Medicine remains the major source of admissions to and discharges from the hospital.

- Admissions:
  - Observation admissions: Medicine 166 (100%)
  - Observation admissions: Hospital 166
  - Regular admissions: Medicine 336 (77%)
  - Regular admissions: Hospital 438
- Discharges:
  - Observation discharges: Medicine 161 (100%)
  - Observation discharges: Hospital 161

- Regular discharges: Medicine 303 (77%)
- Regular discharges Hospital 392

- Procedures
  - EGD's 48
  - Colonoscopies 57
  - ERCP 1
  - Bronchoscopies 1
  - Dialysis Data not available

- Performance Improvement
  - Cases reviewed: 1
  - Cases closed: 1

- Morbidity and Mortality is scheduled for 1/16/2019
- Department of Medicine quarterly meeting was held on 12/12/2018.

Eric Li, M.D., Chairman

Month	07	08	09	10	11	12
Reference Lab test – Urine Protein 90% 3 days	98.6% 76	96% 91	100% 72	97% 67	96% 49	100% 23
Reference Lab specimen Pickups 90% 3 daily/2 weekend/holiday	100% 16/16	98% 15/16	100% 20/20	75% 12/16	100% 16/16	100% 20/20
Review of Performed ABO Rh confirmation for Patient with no Transfusion History (Benchmark 90%)	100%	100%	100%	100%	100%	100%
Review of Satisfactory/Unsatisfactory Reagent QC Results (Benchmark 90%)	100%	100%	100%	99%	100%	100%
Review of Unacceptable Blood Bank specimen (Goal 90%)	99%	100%	100%	100%	100%	100%
Review of Daily Temperature Recording for Blood Bank Refrigerator/Freezer/incubators (Benchmark <90%)	100%	100%	100%	100%	100%	100%
Utilization of Red Blood Cell Transfusion/ CT Ratio – 1.0 – 2.0	1.1	1.2	1.2	1.1	1.2	1.2
Wasted/Expired Blood and Blood Products (Goal 0)	8	4	1	2	0	4
Measure number of critical value called with documented Read Back 98 or >	100%	100%	100%	100%	100%	100%
Hematology Analytical PI Body Fluid	100% 12/12	100% 9/9	100% 14/14	100% 11/11	100% 12/12	100% 11/11
Sickle Cell	0.0	0/0	0/0	0/0	0/0	0/0
ESR Control	100% 27/27	100% 30/30	100% 62/30	100% 26/26	100% 30/30	100% 26/26
Delta Check Review	100% 172/172	99% 257/258	100% 195/195	100% 189/189	100% 167/167	100% 166/166
Blood Culture Contamination Benchmark 90%			92% ER 92.6% ERG ICU 95%	81% ER holding 100% ERG 76% Non-comp ICU 100%	100% ER Holding 85% ERG noncomp ICU 100%	100% ER Holding 79.4% ERG noncomp ICU 83%
STAT turnaround for ER and Laboratory Draws <60 min. Benchmark					84% ER 83% Lab	83% ER 81% Lab

LABORATORY PRODUCTIVITY RESULTS - We developed performance indicators we use to improve quality and productivity.

TURNAROUND TIME - Turnaround time is a critical factor that directly influences customer satisfaction.

CUSTOMER SATISFACTION - The key to business is providing great customer service, superior quality, and creating a unique customer experience.

COMPLAINTS - Complaints are an important metric for evaluating the quality of our laboratory processes.

EQUIPMENT DOWNTIME - It is important that laboratories track, monitor, and evaluate equipment failure rates and down time.

Surendra Kandel ,M.D., Chairman

	July	Aug	Sept	Oct	Nov	Dec	YTD
Admissions							
AlOS (Target <7 Days)	4.78	4.9	6.11	5.9	6.04	5.27	5.483333333
Voluntary Admissions	55	74	68	51	48	43	558
Involuntary Admissions	42	50	42	56	48	47	595
Total Admissions	97	124	110	107	96	90	1153
Referral Sources							
CPEP	11	17	6	12	12	8	200
UMC ED	78	102	99	93	78	75	965
GWU	0	0	0	0	0	1	5
PROVIDENCE	0	0	0	0	0	0	4
GEORGETOWN	0	0	0	1	0	0	9
SIBLEY	0	0	0	1	0	0	3
UMC MEDICAL SURGICAL unit	6	4	3	0	5	5	32
CHILDREN HOSPITAL	0	0	0	0	0	0	0
HOWARD	0	0	1	0	1	0	7
LAUREL REGIONAL HOSPITAL	0	0	0	0	0	0	1
WASHINGTON HOSPITAL CENTER	0	0	0	0	0	0	2
SUBURBAN	0	0	0	0	0	0	0
PIW	0	1	0	0	0	0	1
WASHINGTON ADVENTIS HOSPITAL	0	0	1	0	0	0	1
OTHER/NOT LISTED	0	0	0	0	0	1	21
Other Measures							
ED to Psych Admissions (Target:<2 hrs.)	2.3	2.5	2.6	3.6	3.1	3.4	3.133333333
Psychosocial Assessments (Target: 100%)	89%	87%	82%	82%	82%	80%	86%
Discharge Appointments for those D/C'ed>7 hours (Target: 100%)	88%	81%	91%	96%	95%	93%	91%
Treatment Planning (Target: 100%)	74%	57%	65	56%	71%	80%	72%
Discharge Appointments							
# Discharged to home without appointments/No discharge appointment information provided	1	3	5	3	4	4	30
Patient declines outpatient services	0	0	1	0	0	1	7
Discharged to medical unit	1	3	3	0	4	0	27
Patient left AMA	1	2	0	1	0	1	5
Transferred to St. Elizabeth's	1	3	1	3	3	3	29
Discharge Appointments for those D/C'ed>72 hours (Target: 100%)	88%	81%	91%	96%	95%	93%	91%
Other							
Patients who went to court	0	1	0	0	1	1	10

Raymond Tu, **M.D., MS, FACR,** Chairman

November

Performance Summary:

	INP		ER		OUT		TOTAL	
EXAM TYPE	EXAMS	UNITS	EXAMS	UNITS	EXAMS	UNITS	EXAMS	UNITS
CARDIAC CATH	4		0		0		4	
CT SCAN	86		551		205		842	
FLUORO	22		3		9		34	
MAMMOGRAPHY					136		136	
MAGNETIC RESONANCE ANGIO	1		1				2	
MAGNETIC RESONANCE IMAGING	34		5		30		69	
NUCLEAR MEDICINE	19		1		5		25	
SPECIAL PROCEDURES	16		0		4		20	
ULTRASOUND	109		195		201		505	
X-RAY	176		926		800		1902	
ECHO	90		1		37		128	
CNMC CT SCAN			24				24	
CNMC XRAY			469				469	
GRAND TOTAL	557		2176		1427		4160	

<u>Quality Initiatives, Outcomes, etc.</u>

Core Measures Performance

100% extra cranial carotid reporting using NASCET criteria

100% fluoroscopic time reporting

100% presence or absence hemorrhage, infarct, mass

100% reporting <10% BI RADS 3

Radiology staff continues to work to improve the turnaround of patients for CT and MRI of the brain through the department. Solution to the issues in the MRI area are actively being addressed.

Morbidity and Mortality Reviews: There were no departmental deaths.

Code Blue/Rapid Response Teams ("RRTs") Outcomes: There was no rapid response.

Care Coordination/Readmissions: N/A

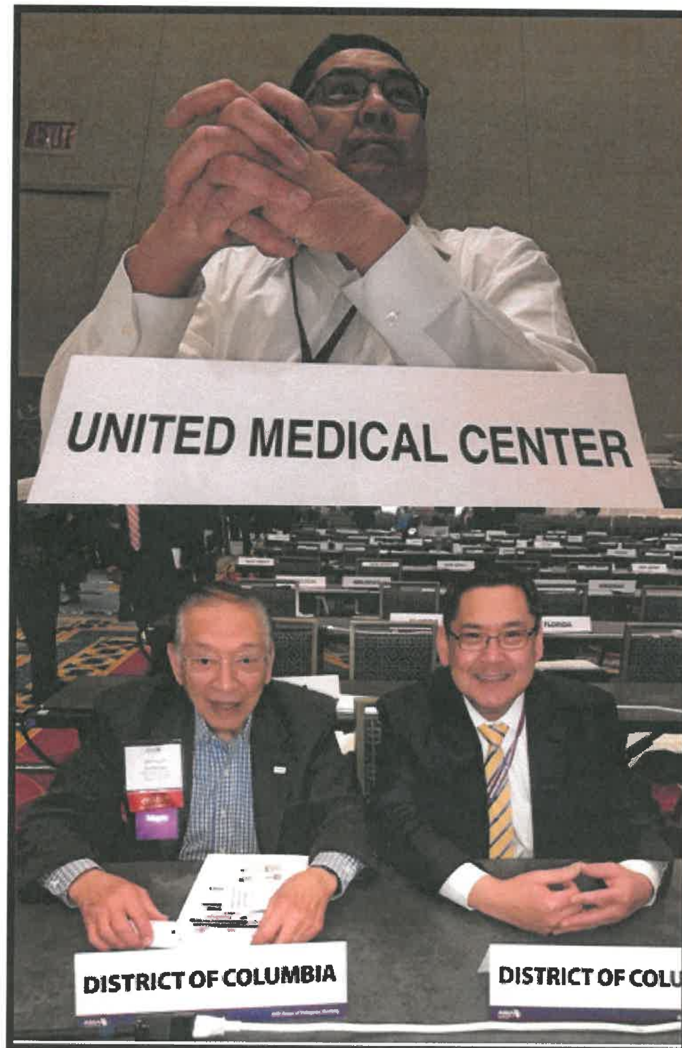
Evidence-Based Practice (Protocols/Guidelines) We continue to improve patient transportation into and out of the emergency department. Imaging protocols and reporting are being reviewed and improved. Dr. Tu is working with UMC and GW PACS administrators to improve image sharing and integration into each system as patients obtain care at both facilities.

Service (HCAHPS Performance/Doctor Communication)

Stewardship: Dr. Tu spoke at various medical meetings and attended several association events in November. Dr. Tu presented an invited lecture at the Health Policy Session with Medicaid Updates regarding the midterm election implications at the Annual meeting of the Radiological Society of North America in Chicago Tuesday November 27th.

Dr. Tu and Ms. Alicia Blakely Medicaid Network Staff American College of Radiology at Medicaid Updates Radiology Society of North America, Chicago, Illinois.

Dr. Tu presented at the American Medical Association Interim Meeting at National Harbor, Maryland as State Chair of the Organized Medical Services Section November 8th.



Joseph Gutierrez MD FACS Delegation Chair and Raymond Tu FACR at the American Medical Association Interim Meeting, National Harbor, MD.

Dr. Tu attended the District of Columbia Hospital Association celebrating the 40 year anniversary of DCHA seated at the table with DC Health Care Finance.

Dr. Tu at DC Hospital Association 40th year Anniversary with DCHA CEO Ms. Bowens, and leaders of DC Health, DC Health Care Finance, DC Council, Bridgepoint Hospital, CEO AmeriHealth Ms. Dale

Dr. Tu at Howard University School of Medicine 150th year gala with Dr. Epps, Dean Mighty, Michael and Sabrina Crawford, Diana Lapp MD and Janelle Goetcheus, MD Unity Clinic.

Financials: Active Steps to Improve Performance: The active review of staff performance and history to be provided for radiologic interpretation continues. Ongoing program and feedback for improved history at the time of service.

December

Performance Summary:

	INP		ER		OUT		TOTAL	
EXAM TYPE	EXAMS	UNITS	EXAMS	UNITS	EXAMS	UNITS	EXAMS	UNITS
CARDIAC CATH	5				1		6	
CT SCAN	104		519		219		842	
FLUORO	13		1		14		28	
MAMMOGRAPHY					67		67	
MAGNETIC RESONANCE ANGIO	4		1		10		15	
MAGNETIC RESONANCE IMAGING							0	
NUCLEAR MEDICINE	14		2		3		19	
SPECIAL PROCEDURES	24		0		3		27	
ULTRASOUND	127		197		206		530	
X-RAY	173		957		831		1961	
ECHO	102		51		4		157	
CNMC CT SCAN			22				22	
CNMC XRAY			437				437	
GRAND TOTAL	566		2187		1358		4111	

Quality Initiatives, Outcomes, etc.

Core Measures Performance
100% extra cranial carotid reporting using NASCET criteria
100% fluoroscopic time reporting
100% presence or absence hemorrhage, infarct, mass
100% reporting <10% BI RADS 3

Radiology staff continues to work to improve the turnaround of patients for radiology procedures. The MRI area including the equipment room and Philips 1.5T Intera system itself underwent necessary improvements, inspection by DC Health and awaiting final approval to resume clinical services.

Morbidity and Mortality Reviews: There were no departmental deaths.

Code Blue/Rapid Response Teams ("RRTs") Outcomes: There was no rapid response.

Care Coordination/Readmissions: N/A

Evidence-Based Practice (Protocols/Guidelines) We continue to improve patient transportation into and out of the emergency department. Imaging protocols and reporting are being reviewed and improved. Radiology protocols are being reviewed and optimized to reduce the need for repeat procedures if patients are transferred to other facilities.

Service (HCAHPS Performance/Doctor Communication)

<u>Stewardship:</u> Dr. Tu met with the National Hispanic Medical Association on December 7, 2018 to discuss collaboration with the needs of the Hispanic community particularly within the DC Medicaid Program. The Spanish speaking community face challenges with accessing health care in the setting of private insurance through employment often through construction and food service occupations and high deductible health plans making payment of coinsurance unaffordable for many.

National Hispanic Medical Association (NHMA). Dr. Tu; Dr. Elena Rios, president NHMA (*left*); Dr. Fernando Llorca Ambassador of Costa Rica (*right*).

Dr. Tu lead the meeting with DC Health at their headquarters on December 10, 2018 to discuss opportunities to work with physicians throughout the District of Columbia particularly with the community served at the east end of the District in Wards 7 and 8.

DC Health. Dr. Tu, Dr. Andrea Anderson, Mr. Frank Meyers, Dr. LaQuandra S. Nesbitt, Dr. Jacqueline Watson, and DC Health Staff.

Dr. Tu attended the Medico-Churgical Society of the District of Columbia annual gala on December 21, 2018 networking with the physician community on health care in the UMC community. The event was very well attended by physicians, stakeholders and members of DC government.

Medico-Chirugical Society of the District of Columbia.
Dr. Anthony Ibe, past president; Pia Duryea; Dr. Barry Lewis, Medical Director Amerigroup; Councilmember Vincent Gray, Chairman Committee on Health (*left to right*).

Financials: Active Steps to Improve Performance: The active review of staff performance and history to be provided for radiologic interpretation continues. Improvements to heating ventilation and air condition system ongoing with remediation of MRI suite and awaiting Department of Health inspection to resume operations.

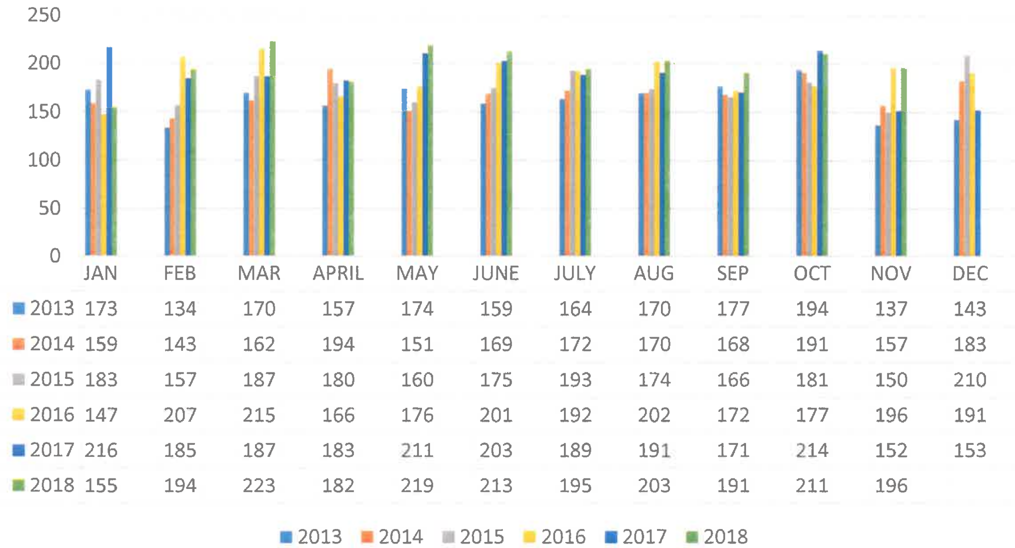
Gregory Morrow, M.D., Chairman

November

For the month of November 2018, the Surgery Department performed a total of 196 procedures.

The chart and graft below show the annual and monthly trends over the last 6 calendar years:

	2013	2014	2015	2016	2017	2018
JAN	173	159	183	147	216	155
FEB	134	143	157	207	185	194
MAR	170	162	187	215	187	223
APRIL	157	194	180	166	183	182
MAY	174	151	160	176	211	219
JUNE	159	169	175	201	203	213
JULY	164	172	193	192	189	195
AUG	170	170	174	202	191	203
SEP	177	168	166	172	171	191
OCT	194	191	181	177	214	211
NOV	137	157	150	196	152	196
DEC	143	183	210	191	153	



	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG	SEP	OCT	NOV	DEC
2013	173	134	170	157	174	159	164	170	177	194	137	143
2014	159	143	162	194	151	169	172	170	168	191	157	183
2015	183	157	187	180	160	175	193	174	166	181	150	210
2016	147	207	215	166	176	201	192	202	172	177	196	191
2017	216	185	187	183	211	203	189	191	171	214	152	153
2018	155	194	223	182	219	213	195	203	191	211	196	

SURGERY SUMMARY REPORT FOR NOVEMBER 2018

The fourth quarter surgical volumes for 2018 reveal a consistent increase over the corresponding months of the previous years and are on pace to exceed the previous year's growth pattern. This has been due, in part, to our increase in Orthopedic Surgical procedures.

We continue to work diligently to increase our efficiencies and productivity while, at the same time, delivering the highest quality of care.

We continue to meet and / or exceed the quality measures outlined for the Surgery Department.

These include Selection of Prophylactic Antibiotics, VTE Prophylaxis, Anastomotic Leak Interventions and Unplanned Reoperations.

The following projects are going well and will undergo continuous evaluation and modification as necessary:

1. ***Weekly OR Rounds*** where the major surgical procedures to be performed on any given week will be discussed including Diagnosis, Indications and Appropriateness of Planned Procedures, Alternative Therapies and Anticipated Outcomes. This will begin with the General Surgery Department with the other subspecialties to follow. This will be a Prospective Review.

2. ***Monthly / Bi-Monthly Morbidity and Mortality Rounds*** where ALL Complications and Adverse outcomes for patients will be analyzed. This will be a multidisciplinary conference including but not limited to Surgery, Internal Medicine, Anesthesia, Pathology and ICU. This will be a Retrospective Review. The next conference is scheduled for January 2019.

It is our goal to use these initiatives to improve standardization and reduce unnecessary variability of care and to bolster patient satisfaction and outcomes.

Surgery and Perioperative Services continue to collaborate with Finance to obtain vital data that will allow for better evaluation our current volumes as they relate to the needs of the community and current allocation of resources. This is an ongoing process and will continue to be modified as necessary to meet the outlined goals and objectives.

The ultimate goals being:

1. To identify the SERVICE LINES that are best suited for UMC and the community
2. To develop a STRATEGIC PLAN that will focus of meaningful and sustainable growth in the market place NOT just the volume of cases alone
3. To improve our PATIENT CARE AND SAFETY objectives

With the recent announcement of the closure of in-patient services at Providence Hospital effective December 14, 2018, we are anticipating recruiting and credentialing new surgeons that hopeful will bring a better mix of elective surgeries to UMC.

We are now entering into the final stages of completing the agreements for the joint educational venture with the Howard University Surgery Department regarding reinstitution a surgery residency "Major Participating Site" program here at UMC. This is another in a series of steps to make our surgical program more robust and attractive to more community physicians.

Finally, our perioperative manager, Boyoung Frost, has put in her letter of resignation with her last day being December 30, 2018. We would like to thank her for her years of committed service to the department and wish her all the best in her new transition.

December

For the month of December 2018, the Surgery Department performed a total of 192 procedures.

The chart and graft below show the annual and monthly trends over the last 6 calendar years:

	2013	2014	2015	2016	2017	2018
JAN	173	159	183	147	216	155
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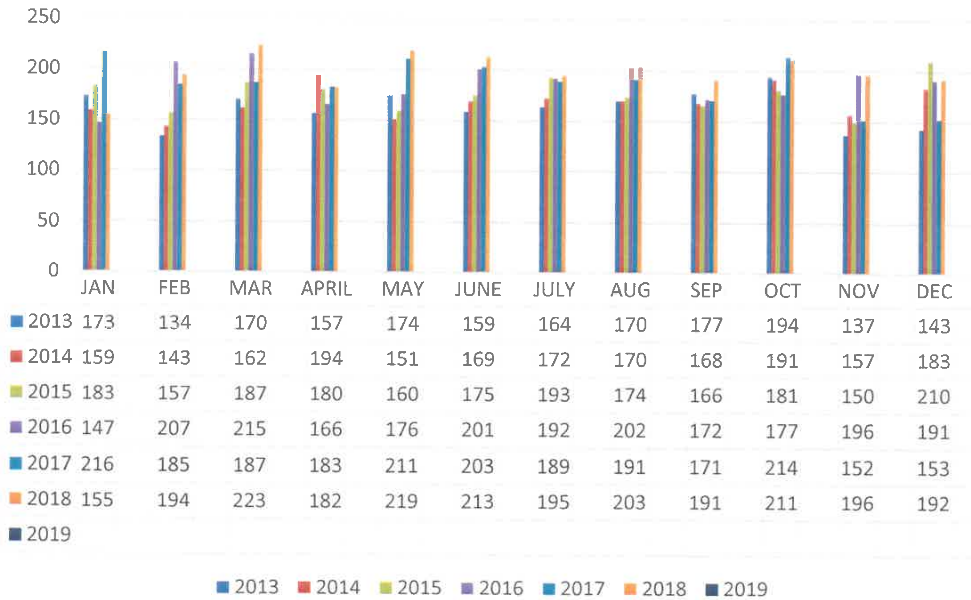
JULY	164	172	193	192	189	195
AUG	170	170	174	202	191	203
SEP	177	168	166	172	171	191
OCT	194	191	181	177	214	211
NOV	137	157	150	196	152	196
DEC	143	183	210	191	153	192
TOTAL	1952	2019	2116	2242	2255	2374



The fourth quarter surgical volumes for 2018 reveal a consistent increasing trend over the corresponding months of the previous years. We ended the year with a total of 2374 procedures, a volume increase of 5.3% over last years and 22% since 2013.

We continue to work diligently to increase our efficiencies and productivity while, at the same time, delivering the highest quality of care.

We continue to meet and / or exceed the quality measures outlined for the Surgery Department.

These include Selection of Prophylactic Antibiotics, VTE Prophylaxis, Anastomotic Leak Interventions and Unplanned Reoperations.

The following projects are going well and will undergo continuous evaluation and modification as necessary:

1. ***Weekly OR Rounds*** where the major surgical procedures to be performed on any given week will be discussed including Diagnosis, Indications and Appropriateness of Planned Procedures, Alternative Therapies and Anticipated Outcomes. This will begin with the General Surgery Department with the other subspecialties to follow. This will be a Prospective Review.

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Surgery and Perioperative Services continue to collaborate with Finance to obtain vital data that will allow for better evaluation our current volumes as they relate to the needs of the community and current allocation of resources. This is an ongoing process and will continue to be modified as necessary to meet the outlined goals and objectives.

The ultimate goals being:

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5. To improve our PATIENT CARE AND SAFETY objectives

We are now entering into the final stages of completing the agreements for the joint educational venture with the Howard University Surgery Department regarding reinstitution a surgery residency "Major Participating Site" program here at UMC. This is another in a series of steps to make our surgical program more robust and attractive to more community physicians.

I want to thank every department involvement in with making the Operating Room and Perioperative Services run effectively and efficiently. We are looking forward to a robustly successful year in 2019.

General Board Meeting
Date: January 23, 2019

Medical Chief of Staff REPORT

Presented by:
Marilyn McPherson-Corder, MD
Medical Chief of Staff

General Board Meeting

Date: January 23, 2019

Management Report

Presented by:

Matthew Hamilton, Chief Executive Officer

General Board Meeting

Date: January 23, 2019

Patient Safety & Quality Committee

Dr. Malika Fair, Chair

Not-For-Profit Hospital Corporation
Patient Safety & Quality Committee Meeting Agenda
December 13, 2018

Present:

Absent:

Attachments: Quality Dashboard, Corrective Action Summary Document, Leapfrog Results, Hospital PS Committee Charter

Agenda Item	Discussion	Action Item
Call to Order		
Approval of the Agenda		
Discussion		
Meeting Discussion	**New DOH visits/notifications** - Behavioral Health (2 visits) - SNF Survey - ED Sentinel Event - MRI air sampling	

<table>
<tr>
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<td>- Bathroom remodel

Standing Reports
- Executive Quality Dashboard (including core measures, sepsis, and SSE)
- Deliveries in ED
- Length of Stay

Regulations & Accreditation (Updates on Plans of Correction Items)
- Medication Reconciliation
- Fluoroscopy/ Bronchoscopy update
- ED/Children’s Transfer policy
- Pharmacy & Sterile Processing Department remodel
- ED (Staffing, Behavioral health risk, Peds/OB Mock Drills)
- Sanitation of physical environment (Behavioral health, lab, SPD, ED)
- Committee Updates (Pharmacy, Infection Control, Safety/EOC, Patient Safety)
- Mock Survey in 2019

Other Topics
- Medical Office Building – medical emergencies
- Hospital Patient Safety Committee
- Leapfrog</td>
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Not-For-Profit Hospital Corporation
Patient Safety & Quality Committee Meeting Minutes
October 11, 2018

Present: Dr. Fair, Director Ashenafi, Director Gorham, Dr. Haghighat, Andrea Gwyn, Shirlitta Cropper, Dr. Hammad, Dr. Yacoub, Marcela Maamari, Derrick Lockhart

Absent:

Agenda Item	Discussion	Action Item
Call to Order	Meeting was called to order at 4:04 PM. Quorum determined by Mike Austin.	
Approval of the Agenda	Agenda approved as written.	
Discussion	Previous meeting minutes approved.	
Meeting Discussion	• Dr. Fair welcomed Dr. Hammad as the new VP of Quality. • Dr. Hammad committed to standing up a robust performance improvement plan and improving quality measures.	

	Standing Reports <u>New Quality Dashboard</u> • Dr. Hammad noted that dashboard will be populated by the next PSQ meeting • Will use a data visualization tool called, LOOKER, that will ensure that the data is accurate for a comprehensive picture of the organization. • There is flexibility to add other indicators as the PSQ Committee deems appropriate <u>Deliveries in ED</u> • For August 2018 there was 1 live birth in the ED. Year-to-date there were 8 births at UMC and 6 through the end of September 2018. • There have been no challenges transporting pregnant patients out of UMC. <u>Length of Stay</u> • Dr. Haghighat: Length of stay is 9-10 days which is high. A majority of those patients (10-11 total) are waiting on SNF beds throughout DC, so if we subtract those outlier patients then the average stay is 4 or 5 days. • Also exploring waiver option to expedite this issue. • New case management is providing new granular information. **Regulations & Accreditation** (Updates on Plans of Correction Items) Medication Reconciliation • Will send info before next meeting Fluoroscopy/ Bronchoscopy update	

	• Complete. Survey will be later this week. DOH will be notified later this week. Training for technicians starts next week. • A dedicated room is necessary for UMC. Pharmacy & Sterile Processing Department remodel • New pharmacy is underway. The current pharmacy will maintain while this new one is built out. ED (Staffing, Behavioral health risk, Peds/OB Mock Drills) • Plan for Mock Drills on 10/31 and another by the end of calendar year. • Proposed changes for the ED: we will work out how to reduce the BHU patients' risk • Based on internal improvements (not DOH) this is to prevent elopement Sanitation of physical environment (Behavioral health, lab, SPD, ED) • Andrea Gwyn: We have weekly rounds to maintain the deep clean issues. Crothal transition where a new manager will be following up. New EVS Director and Assistant Director of Biomed have a group where they are making rounds and going into patient rooms – they started that this week. Committee Updates (Pharmacy, Infection Control, Safety/EOC, Patient Safety) • Cropper: Infection control issues remain below the national average. We've have 11 infection control issues this year and none of them were hospital acquired. 36 cases of MRSA and none were hospital-acquired. • Introducing MedMine for antibiotics stewardship Mock Survey in 2019 • Mock Survey first quarter of new year.	

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<td>Intracycle Monitoring (ICM) update
• Intracyle Monitoring was submitted timely. The next ICM profile is due Sep 2019.

Patient ID:
• Dr. Yacoub: We need to update our software to catch patients who come in with different names.
• Dr. Haghighat: Master Patient Index software exists and it catches different names for the same person. While it reduces the number of duplicate persons it does not eliminate the problem. Ideally, you merge the charts after this patient’s visit. We’ve raised the issue to IT and the solution right now diligence by our registration team is the best option.

Meeting Adjourned at 4:45pm</td>
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UMC Leapfrog Hospital Safety Grade Breakdown

Measure Domain	Measure	UMC's Measure Score	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	100	2018 Leapfrog Hospital Survey	2018	2017 AHA Annual Survey IT Supplemental[i]	2018
	Bar Code Medication Administration (BCMA)	50	2018 Leapfrog Hospital Survey	2018	2017 AHA Annual Survey IT Supplemental[i]	2018
	ICU Physician Staffing (IPS)	100	2018 Leapfrog Hospital Survey	2018	2016 AHA Annual Survey[ii]	2016
	Safe Practice 1: Leadership Structures and Systems	92.31	2018 Leapfrog Hospital Survey	2018	N/A	N/A
	Safe Practice 2: Culture Measurement, Feedback & Intervention	0	2018 Leapfrog Hospital Survey	2018	N/A	N/A
	Safe Practice 4: Identification and Mitigation of Risks and Hazards	72.73	2018 Leapfrog Hospital Survey	2018	N/A	N/A
	Safe Practice 9: Nursing Workforce	94.12	2018 Leapfrog Hospital Survey	2018	N/A	N/A
	Safe Practice 19: Hand Hygiene	42	2018 Leapfrog Hospital Survey	2018	N/A	N/A
	H-COMP-1: Nurse Communication	83	CMS Hospital Compare	10/01/2016 - 09/30/2017	N/A	N/A
	H-COMP-2: Doctor Communication	88	CMS Hospital Compare	10/01/2016 - 09/30/2017	N/A	N/A
	H-COMP-3: Staff Responsiveness	63	CMS Hospital Compare	10/01/2016 - 09/30/2017	N/A	N/A
	H-COMP-5: Communication about Medicines	70	CMS Hospital Compare	10/01/2016 - 09/30/2017	N/A	N/A
	H-COMP-6: Discharge Information	70	CMS Hospital Compare	10/01/2016 - 09/30/2017	N/A	N/A
Outcome Measures	Foreign Object Retained	0	Data.cms.gov	10/01/2015 - 06/30/2017	MHCC[ii]	10/01/2015 - 06/30/2017
	Air Embolism	0	Data.cms.gov	10/01/2015 - 06/30/2017	MHCC[ii]	10/01/2015 - 06/30/2017
	Falls and Trauma	0	Data.cms.gov	10/01/2015 - 06/30/2017	MHCC[ii]	10/01/2015 - 06/30/2017
	CLABSI	0	2018 Leapfrog Hospital Survey	01/01/2017 - 12/31/2017	CMS Hospital Compare	10/01/2016 - 09/30/2017
	CAUTI	0	2018 Leapfrog Hospital Survey	01/01/2017 - 12/31/2017	CMS Hospital Compare	10/01/2016 - 09/30/2017
	SSI: Colon	N/A	2018 Leapfrog Hospital Survey	01/01/2017 - 12/31/2017	CMS Hospital Compare	10/01/2016 - 09/30/2017
	MRSA	3.383	2018 Leapfrog Hospital Survey	01/01/2017 - 12/31/2017	CMS Hospital Compare	10/01/2016 - 09/30/2017
	C. Diff.	0.376	2018 Leapfrog Hospital Survey	01/01/2017 - 12/31/2017	CMS Hospital Compare	10/01/2016 - 09/30/2017
	PSI 3: Pressure Ulcer Rate	0.54	CMS Hospital Compare	10/01/2015 - 06/30/2017	MHCC[iii]	10/01/2015 - 06/30/2017
	PSI 4: Death Rate among Surgical Inpatients with Serious Treatable Conditions	N/A	CMS Hospital Compare	10/01/2015 - 06/30/2017	MHCC[iii]	10/01/2015 - 06/30/2017
	PSI 6: Iatrogenic Pneumothorax Rate	0.25	CMS Hospital Compare	10/01/2015 - 06/30/2017	MHCC[iii]	10/01/2015 - 06/30/2017
	PSI 11: Postoperative Respiratory Failure Rate	N/A	CMS Hospital Compare	10/01/2015 - 06/30/2017	MHCC[iii]	10/01/2015 - 06/30/2017
	PSI 12: Perioperative PE/DVT Rate	3.01	CMS Hospital Compare	10/01/2015 - 06/30/2017	MHCC[iii]	10/01/2015 - 06/30/2017
	PSI 14: Postoperative Wound Dehiscence Rate	1.31	CMS Hospital Compare	10/01/2015 - 06/30/2017	MHCC[iii]	10/01/2015 - 06/30/2017
	PSI 15: Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate	1.70	CMS Hospital Compare	10/01/2015 - 06/30/2017	MHCC[iii]	10/01/2015 - 06/30/2017

i 2017 AHA Annual Survey IT Supplement © 2018 Health Forum, LLC

ii 2016 AHA Annual Survey © 2016 Health Forum, LLC

iii The Maryland Health Services Cost Review Commission (HSCRC) Hospital Inpatient Discharge Data set for Medicare Fee-for-Service patients was used to generate HAC and PSI rates for Maryland hospitals only.

Safety Grade Hospital Comparison

Measure Domain	Measure	UMC's Measure Score	Worst Performing Hospital	Avg Performing Hospital	Best Performing Hospital	Howard University Hospital	George Washington University Hospital	MedStar Georgetown	MedStar Washington	Providence	MedStar Southern MD
		Grade: D				Grade: D	Grade: C	Grade: C	Grade: D	Grade: D	Grade: D
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	100	5	69.8	100	70	100	45	45	45	70
	Bar Code Medication Administration (BCMA)	50	5	68.26	100	50	100	45	45	45	25
	ICU Physician Staffing (IPS)	100	5	49.17	100	100	100	75	85	5	100
	Safe Practice 1: Leadership Structures and Systems	92.31	0	117.14	120	110.77	120	Declined to Report	Declined to Report	Declined to Report	120
	Safe Practice 2: Culture Measurement, Feedback & Intervention	0	0	114.64	120	101.54	120	Declined to Report	Declined to Report	Declined to Report	120
	45+B3.K15	72.73	0	98.93	100	81.82	100	Declined to Report	Declined to Report	Declined to Report	72.73
	Safe Practice 9: Nursing Workforce	94.12	29.41	97.68	100	94.12	100	Declined to Report	Declined to Report	Declined to Report	100
	Safe Practice 10: Hand Hygiene	42	6	57.63	60	54	60	Declined to Report	Declined to Report	Declined to Report	54
	H-COMP-1: Nurse Communication	83	78	90.95	96	84	88	91	85	84	86
	H-COMP-2: Doctor Communication	88	82	91.16	96	88	91	90	88	88	89
	H-COMP-3: Staff Responsiveness	63	63	84.2	94	75	79	84	75	73	77
	H-COMP-5: Communication about Medicines	70	61	77.96	89	74	75	78	73	70	72
	H-COMP-6: Discharge Information	70	69	86.88	96	80	85	88	84	79	82
Outcome Measures	Foreign Object Retained	0	0.382	0.021	0	0	0	0	0.048	0	0
	Air Embolism	0	0.045	0.001	0	0	0	0	0	0	0
	Falls and Trauma	0	1.747	0.434	0	0.296	0.237	0.309	0.339	0.359	0.123
	CLABSI	0	2.935	0.789	0	2.935	1.369	0.641	1.007	1.435	2.02
	CAUTI	0	3.163	0.874	0	0.721	1.734	0.431	0.842	0.637	2.311
	SSI. Colon	N/A	3.273	0.859	0	1.963	0.461	0.286	1.651	N/A	0
	MRSA	3.383	3.383	0.881	0	1.868	1.119	0.912	1.334	0.591	1.689
	C. Diff.	0.376	1.988	0.793	0	0	1.492	0.874	1.448	1.166	0.768
	PSI 3. Pressure Ulcer Rate	0.54	1.91	0.38	0.02	0.10	0.64	1.07	0.66	0.42	0.83
	PSI 4: Death Rate among Surgical Inpatients with Serious Treatable Conditions	N/A	204.76	161.65	96.82	N/A	147.99	157.45	163.47	159.51	160.95
	PSI 6: Iatrogenic Pneumothorax Rate	0.25	0.47	0.29	0.11	0.29	0.27	0.33	0.45	0.23	0.23
	PSI 11: Postoperative Respiratory Failure Rate	N/A	17.91	8.23	1.71	8.80	11.31	8.56	10.48	10.78	9.96
	PSI 12: Perioperative PE/DVT Rate	3.01	7.32	3.84	1.2	3.26	3.95	6.60	7.32	4.33	5.31
	PSI 14: Postoperative Wound Dehiscence Rate	1.31	1.9	0.85	0.3	0.81	1.39	0.64	0.73	0.75	0.69
	PSI 15: Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate	1.70	2.15	1.29	0.57	1.67	1.24	1.55	2.16	1.33	1.26

Leapfrog Hospital Safety Grades (2015 - 2018)

Hospital	Fall 2018	Spring 2018	Fall 2017	Spring 2017	Fall 2016	Spring 2016	Fall 2015	Spring 2015
UMC	D	Not Scored	F	C	F	C	C	C
Howard	D	F	F	D	D	D	F	D
George Washington	C	C	D	C	D	Not Scored	C	C
MedStar Georgetown	C	C	C	B	C	C	C	C
MedStar Washington	D	D	D	D	D	D	C	C
Providence	D	F	D	D	D	F	D	F
MedStar Southern MD	D	D	D	Not Scored	Not Scored	Not Scored	Not Scored	Not Scored

Patient Safety Committee Charter

United Medical Center (UMC) has established a Patient Safety (PS) Committee to ensure that an integrated and effective Patient Safety Program (PSP) is maintained throughout the hospital. Effective error reduction requires an integrated approach and a supportive environment in which patients, their families, hospital staff, and leaders can identify, manage, and learn from actual and potential risks.

PURPOSE: This committee will serve to promote a culture of safety in which errors are identified and reported freely without retribution.

GOAL: The goal is to reduce variability and vulnerability for errors in processes. Safety is rooted in the daily operations of the healthcare organization where proactive risk identification, assessment, and control are the foundation for safe and effective healthcare.

MEETING FREQUENCY: There will be at least 10 meetings held per year and at the call of the chairperson(s).

MINUTES: The recorder will prepare the meetings at least one week from the conclusion of the Patient Safety Committee meeting.

MEMBER COMPOSITION:
A culture of patient safety is demonstrated through an organization's commitment to provide safe, high quality patient care with collaborative teamwork, communication, and effective processes. This commitment must be shared by leadership and staff members at all levels.

The members of the committee consist of those individuals designated below and other members. The Committee shall consist of at least five members present at a meeting to constitute a quorum. When a quorum is present votes may pass by a simple majority. Members must designate an alternate who should attend in the member's absence. Membership will be evaluated and updated as the needs of the committee change.

Risk Management	CCU & Dialysis	Compliance
Patient Relations	Emergency Department	Skilled Nursing Facility
Security/Safety	Med/Surg	Wound Care
Patient Access	Perioperative	Outpatient Services
Information Technology	Behavioral Health	Biomed
Pharmacy	Radiology	EVS
Laboratory	Rehab	Facilities
Infection Control	Respiratory	Food and Nutrition
HIM	SPD	Materials Management
Quality	Nursing Admin	Nursing Education

RESPONSIBILITIES:

a. Department/Management/Supervisory staff will:
   1. Ensure Patient Safety Program (PSP) activities are implemented, monitored, and evaluated for effectiveness and actively participate in these processes.
   2. Support a culture at the unit/department level that emphasizes cooperation and communication, encourages reporting of potential and actual Patient Safety events, focuses on error prevention rather than punishment, and improves medical systems and processes to overcome preventable errors.
   3. Actively participate in creating a safe environment which provides quality health care through compliance with the National Patient Safety Goals
   4. Actively participate and facilitate the acknowledgement of reports and timely feedback to individuals (staff, patient, family, and visitors) who report PS events.
   5. Select one high-risk process and ensure completion of a prospective analysis using the Proactive Risk Assessment (PRA). UMC will complete a PRA at least once every 18 months.

b. Supply and Pharmacy will in addition facilitate notification of all product liability complaints/recalls.

c. All UMC personnel will:
   1. Actively participate in creating a safe environment for themselves, peers, patients, families, and visitors by meeting organizational and professional standards, following identified best/safe practices, and proactively mitigate unsafe conditions or situations.
   2. All staff will receive Patient Safety Education and training during their initial orientation.

UMC

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General Board Meeting

Date: January 23, 2019

Finance Committee Report

Wayne Turnage, Chair