UMC
UNITED
MEDICAL CENTER

General Board Meeting

Date: July 24, 2019
Location: United Medical Center
1310 Southern Ave., SE, Auditorium
Washington, DC 20032

2019 BOARD OF DIRECTORS

LaRuby Z. May, *Chair*
Ira Gottlieb, *Interim CEO*

Girume Ashenafi
Jacqueline Bowens
Eric Li, MD
Konrad Dawson, MD
Brenda Donald
Malika Fair, MD
Millicent Gorham
Angell Jacobs
William Sherman
Velma Speight
Robert Bobb
Wayne Turnage
Marilyn McPherson-Corder, MD

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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.

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NFPHC Board of Directors General Meeting
Wednesday, July 24, 2019

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UMC UNITED MEDICAL CENTER

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 1310 Southern Avenue, SE, Washington, DC, 20032 at **9:00 a.m. on Wednesday, July 24, 2019**. Any 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
July 1, 2019

V. CONSENT AGENDA
A. Dr. Eric Li, Interim Chief Medical Officer
B. Dr. Marilyn McPherson-Corder, Medical Chief of Staff

VI. EXECUTIVE MANAGEMENT REPORT
Ira Gottlieb, Interim Chief Executive Officer

VIII. COMMITTEE REPORTS
Patient Safety and Quality, Dr. Malika Fair
Finance Committee, Deputy Mayor Wayne Turnage

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).

UMC
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Not-For-Profit Hospital Corporation
GENERAL BOARD MEETING
Monday, July 1, 2019

Present: Chair LaRuby May, Dr. Malika Fair, Director Brenda Donald, Director Girume Ashenafi, Director Turnage, Director Velma Speight, Director Millicent Gorham, Director Angell Jacobs, Director Bobb, Director Sherman, Dr. Dawson, Interim CEO Ira Gottlieb, CMO Dr. Haghighat, CFO Lilian Chukwuma

Agenda Item	Discussion	Action Item
Call to Order	Meeting called to order at 9:22 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** • Surgical and inpatient admission volumes were both down between 6 and 7 percentage points compared to May of 2018. Some of the decline in surgical volume is attributable to provider vacation time away from work as there are	

	only two general surgeons on the call panel and elective surgery volume suffers when one of them is away • The Behavioral Health Volume continues to be a relative bright spot as the unit admitted 134 patients during the month of May a rise of over 17 percent compared to April and a rise of over 41% compared to the 95 admissions in March. The number of patients admitted from the District's BHU program (CPEP) was sharply up over the most recent quarter as the number of CPEP admissions were 22, 28 and 51 respectively for March, April and May. This rise has important financial implications for future cash flow as UMC is reimbursed at a higher rate than average for CPEP admissions. This increase in CPEP admissions is due almost entirely to our BHU manager and his intake team that was brought in house beginning in March. They should be commended for their hard work. • Overall quality of care metrics at UMC continue to be excellent in the area of the prevention of hospital acquired infections as once again there were no ventilator associated pneumonias, urinary catheter related infections, and central line associated infections for the month of May. The mortality rate associated with the diagnosis of severe sepsis was 12% for the month of May, down from 18% for the month of April. • The MRI replacement project continues to move forward but did experience a several week delay attributable to compliance with the District's procurement requirement for choosing vendors. The projected resumption of MRI services is now estimated to occur in early to mid-August. The prior projection was for the	

last week of July. The resumption of services in the flood damaged ICU continues to be estimated to be in January of 2020.

MEDICAL CHIEF OF STAFF: Dr. Marilyn McPherson-Corder

- Medical Staff is concerned about the CMO role with the departure of Dr. Haghighat.
- Medical staff is concerned about budget cuts and what that will mean for services at UMC.
- Medical staff is working hard day-to-day despite these changes.

EXECUTIVE REPORT: Ira Gottlieb

- Simulated a power outage in ICU by removing UPS to ensure monitors do not power down – simulation successful
- After DOH visit, Wound Care has launched a corrective action plan aimed at strengthening the nurses' documentation, preventing skin/wound breakdown, and reacting to a Braden Scale score less than 18. This project includes a mandatory PowerPoint presentation, auditing the charts in 'real" time, and working collaboratively with the managers to assure wound care documentation compliance.
- The DC Health Annual Licensure Survey Plan of Correction (PoC) was sent to DC Health on April 8, 2019. UMC is currently waiting for an acceptance of the PoC
- UMC will continue to meet monthly with department leaders for the Patient Safety Meeting. UMC makes it a priority to adhere to the National Patient Safety Goals and to emphasize transparency with staff on near misses.

COMMITTEE REPORTS

PATIENT SAFETY AND QUALITY: Dr. Fair

- PSQ Committee last met on May 14, 2019. And will meet again at the end of July.

FINANCE COMMITTEE: Deputy Mayor Turnage

- Total operating revenue is higher than budget by 22% for the month
- Net patient revenues are higher than budget for the month by 4% but lower by 22% year-to-date.
- Total operating expenses are higher than budget for the month by 10%
- Cash on hand is 33 days

Vote to return to Enter Closed Session:

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

Union representatives spoke regarding the new hospital and the need for continued partnership with the UMC Board.

Other Business
n/a

Announcements

July 2019 Board Meeting Adjourned after 4 hours and 16 mins by Chair May.

UMC

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General Board Meeting

Date: July 24, 2019

CMO REPORT

Presented by:

Eric Li, MD
Interim 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.

***Eric Li*, M.D.**
Interim Chief Medical Officer
July 2019

Medical Staff Summary

Medical Staff Committee Meetings

Medical Executive Committee Meeting, ***Dr. Marilyn McPherson-Corder, 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. Haimanot Haile, 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. Dianne Thompson, 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. Asghar Shaigany. 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.

Health Information Management Committee, ***Dr. Russom Ghebrai, Committee Chairman***
The Health Information Management Committee Mortality and Morbidity Committee were formed to review the appropriateness of the medical record documentation and the integrity of the medical record.

Mortality and Morbidity Committee, ***Dr. Amaechi Erondu, Committee Chairman***
The Mortality and Morbidity Committee was formed to provide the Medical Staff a routine forum for the open examination of adverse events, complications, and errors that may have led to complications or death in patients at United Medical Center.

DEPARTMENT CHAIRPERSONS

Ambulatory Care Services.....*Dr. Janelle Dennis*

Anesthesiology.....*Dr. Amaechi Erondu*

Critical Care.....*Dr. Mina Yacoub*

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

Gynecology.....*Dr. Deborah Wilder*

Medicine.....*Dr. Musa Momoh*

Pathology.....*Dr. Eric Li*

Psychiatry.....*Dr. Shanique Cartwright*

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

Chief Medical Officer

Eric Li, M.D

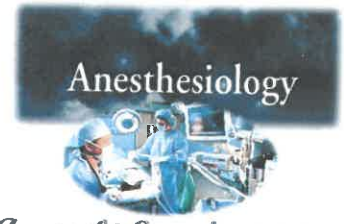
Interim CMO

July 2019 CMO Board Report

SATISFACTION
There continues to be extensive discussions pertaining to the current state of events at the hospital. There are a lot of concerns among our employees, patients, and providers regarding budgetary constraints, possible reductions-in-force, and impending hospital-closure. As Interim Chief Medical Officer, I strongly believe our hospital is here to stay until a new hospital is built and operational. With continued support from the city of DC, City Council, and community, the hospital can continue its focus to provide excellent quality care to the community it serves.

CLINICAL QUALITY						
	April	**May**	**June**			
Healthcare Associated Rate %		C. Difficile -2- VRE 0 MRSA 0				
Medication Errors			7			
Patient Falls %			6			

OPERATIONAL						
	April	**May**	**June**			
Hospital Admissions		Observation 143 Regular 326				
Psychiatry		134				
Surgeries		186				
Emergency Room Visits			4245			



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

June

PERFORMANCE SUMMARY:

The overall cases for the month of June 2019 was 177 a decrease from 186 in May 2019. This is a 9.5% decrease in overall surgical volume compared to last month.
Endoscopy had the highest number of cases: 89, followed by General Surgery: 23. Vascular: 21 and orthopedic cases;11.

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.

OR UTILIZATION:

We are working with the surgeons and perioperative staffs to improve on-time surgical case start; turnover times and downtimes to improve the overall OR utilization.
We are tracking after-hour elective cases by surgeons to ensure appropriate use of the OR. After-hour elective cases make it impossible for the OR to attend to surgical emergencies.

EVIDENCE-BASED PRACTICE:

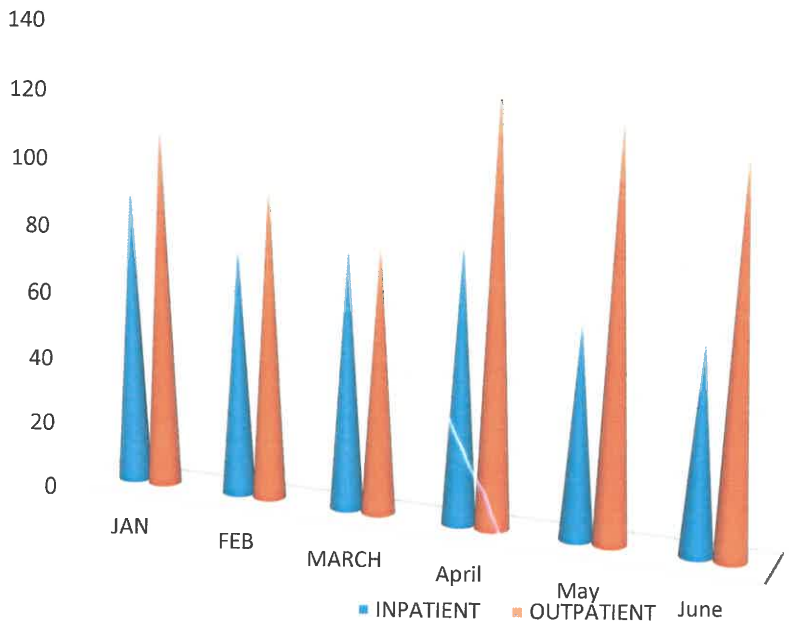
We are working with the **Orthopedic group** to develop a system throughput for the patients including a Pain management protocol.

The **Mortality and Morbidity Conference** continues with increasing interest among the Provider community.

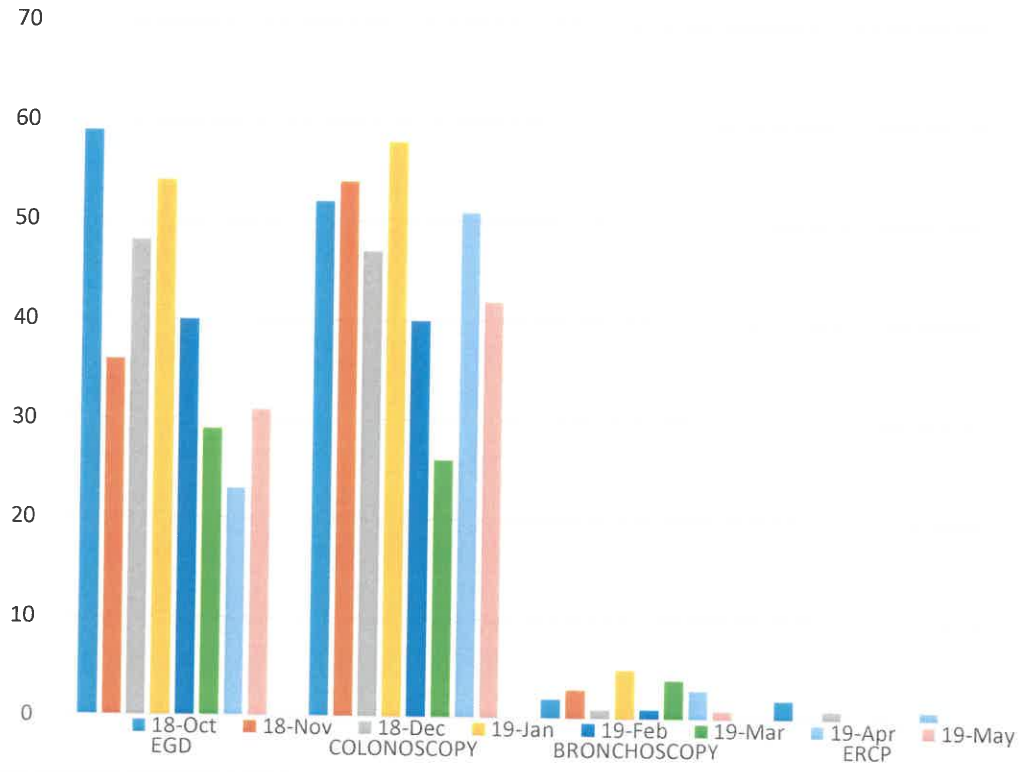
SERVICE (HCAHPS) SATISFACTION:
The Anesthesia Providers continue to provide quality service to our patients. We continue to provide real-time performance assessment of the anesthesia providers. We provide standardized service that ensures patient satisfaction.

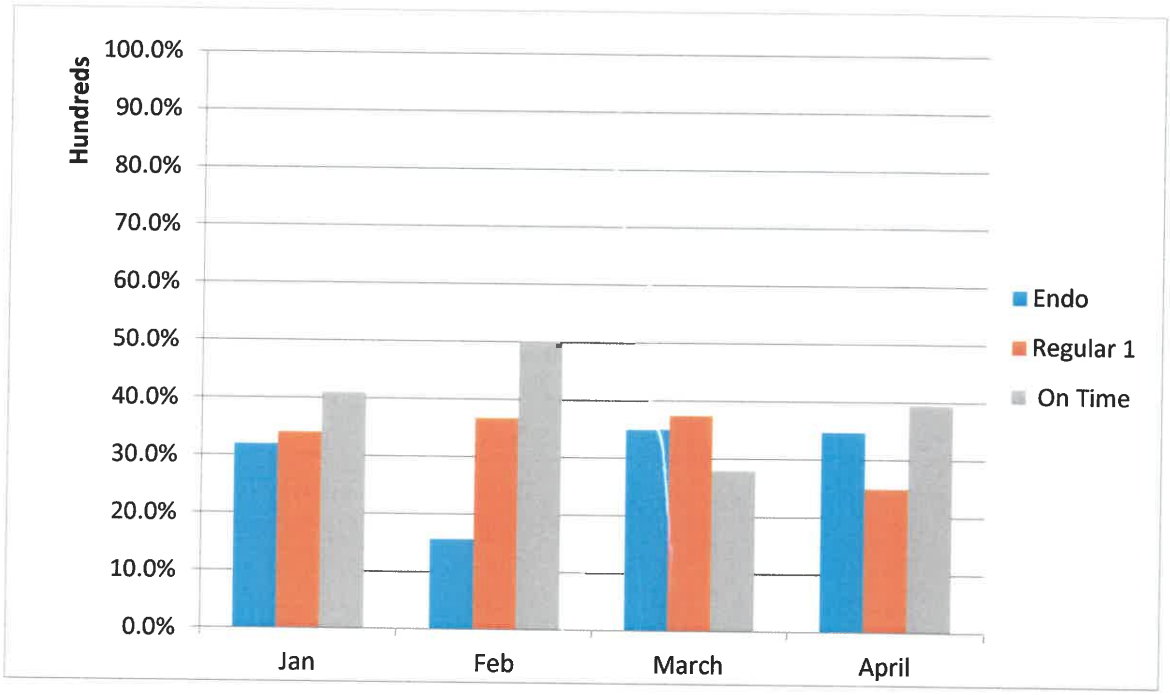
BILLING AND REVENUE CYCLE MANAGEMENT:

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.



Monthly Endoscopy Cases





FIRST CASE ON-TIME START

AMAECHI ERONDU, MD, MS, CPE
CHAIRMAN, DEPARTMENT OF ANESTHESIOLOGY

Mina Yacoub, M.D., Chairman

June

In June, the Intensive Care Unit had 75 admissions, 78 discharges, and 274 Patient Days, with an Average Length of Stay (ALOS) of 3.5 days. ICU managed 84 patients in June. There were 4 deaths for 78 discharges, with an overall ICU mortality rate of 5.1%. ICU managed 26 patients with severe sepsis and septic shock in June with 2 deaths attributed to severe sepsis/septic shock. Sepsis specific ICU mortality rate was 7.7 %. One patient was transferred to GW University Hospital per family request. There was one readmission to ICU within 48 hours of transfer. Contamination rate of blood culture specimens drawn in ED for ICU patient remains above acceptable national benchmarks and continues to be a challenge affecting clinical decision making, increasing risk and cost for patients. Consideration would be to require blood culture draws in the ED to be performed by phlebotomy team rather than ED staff.

1. **ICU Mortality**

   ICU had 4 deaths for 78 discharges, with an overall ICU mortality rate of 5.1 % for June. Mortality review is conducted in monthly Critical Care Committee meeting with Quality Department.

2. **Severe Sepsis and Septic Shock**

   ICU managed 26 patients with severe sepsis and septic shock in June. Two ICU deaths were directly attributable to severe sepsis and septic shock, with an ICU sepsis specific mortality rate of 7.7 %. The UMC Sepsis committee has been reconvened under directorship of Quality Department for continued support and monitoring of performance.

3. **Infection Control Data**

   For June, the ICU had 82 ventilator days with no Ventilator Associated Pneumonias (VAP), 102 Central Line device days with no Central Line Associated Blood Stream Infections (CLABSI) and 166 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). ICU Hand Hygiene compliance was 95 % in June.

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 June, 84 patients were managed in the ICU. There was one readmission to the ICU within 48 hours of transfer out. The patient signed out against medical advice from the ICU and left the hospital. The patient returned to UMC ICU within 12 hours with drug overdose. In June, one patient was transferred from UMC ICU to GW University ICU per family request.

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. Infection Prevention team is monitoring performance on Hand Hygiene initiative.

Growth/Volumes

ICU is staffed 24/7 with in-house physicians and has a 14 bed capacity in the current temporary ICU located on 5E. Hospital is anticipating repairs of the original ICU on 4th floor to be completed within several months. ICU 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.

Mina Yacoub, MD
Chairman, Department of Critical Care Medicine

Francis O'Connell, M.D., Chairman

May

Enclosed is a summary of United Medical Center's (UMC) Emergency Department (ED) volume, key measures, and throughput data for May 2019. Also included are graphic tables to better highlight historical trends for key measures.

It should be noted that the data used for this and past ED reports was derived from Meditech (hospital EMR) data with the analysis performed independently of the hospital's IT department and Meditech software. We continue to work closely with the IT department to derive a common data analysis process.

Definitions of the terms used in this report are as follows:

- **Total Patients**: number of patients who register for treatment in the ED
- **Admit**: number of admissions to UMC
- **LWBS:** Left without being seen rate is the number of patients who leave prior to seeing a provider and is made up of two categories: LAT and LPTT
  - **LAT**: All patients who leave after nursing triage
  - **LPTT**: All patients who leave after registration but prior to being triaged
- **Eloped**- a patient who has been seen by a provider but leaves the ED without having completed the exam and received a disposition from a provider

Throughput intervals

Door to Departure: This is the total time the patient is in the ED. It is measured from the first point of patient contact until the patient physically departs from the ED. It is made up of the following subintervals:

- **Door to Triage-** The time between when a patient arrives at the hospital seeking care and when they are evaluated by the triage nurse
- **Triage to Room-** The time between the nursing triage evaluation and when a patient is placed in a treatment room
- **Room to Provider**- The time that a patient is waiting in a treatment room to see a provider

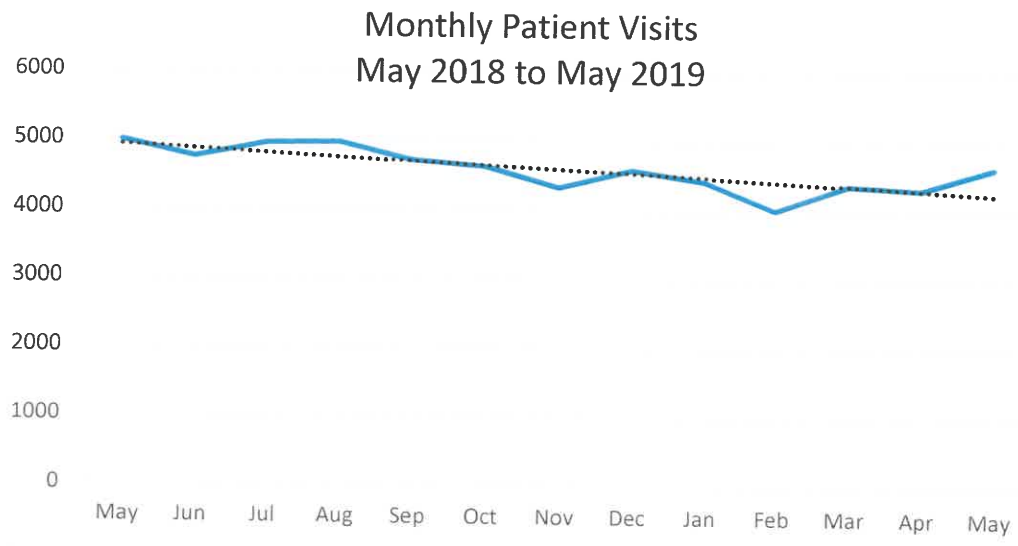
- **Provider to Decision-** The interval between when a provider first sees a patient and the provider makes a decision to admit, discharge, or transfer the patient

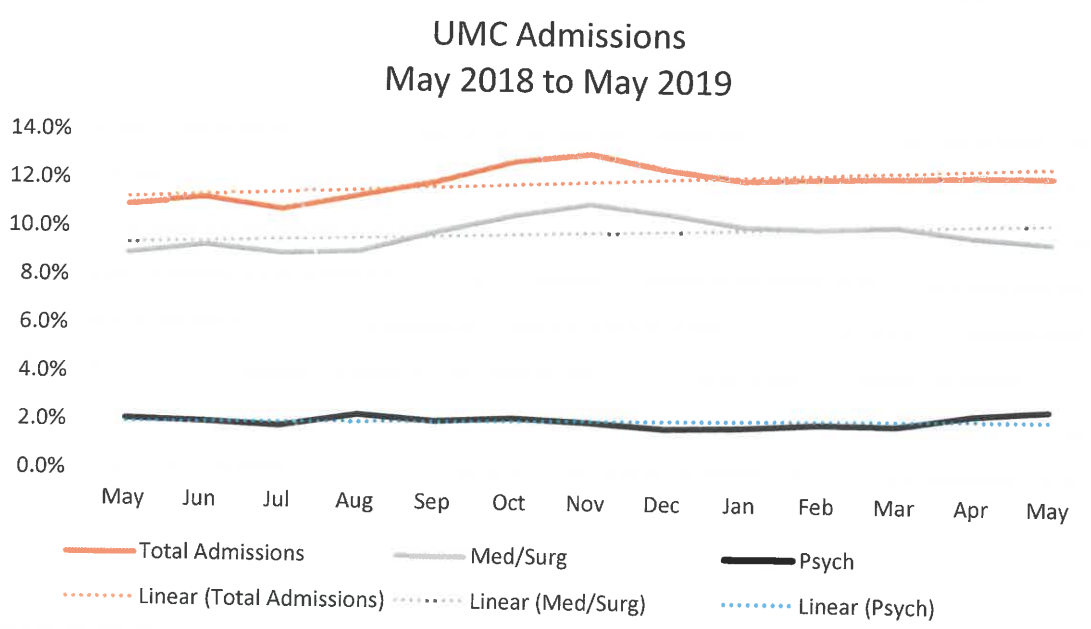
- **Decision to Departure-** the interval between a provider's decision and when the patient physically leaves the ED.

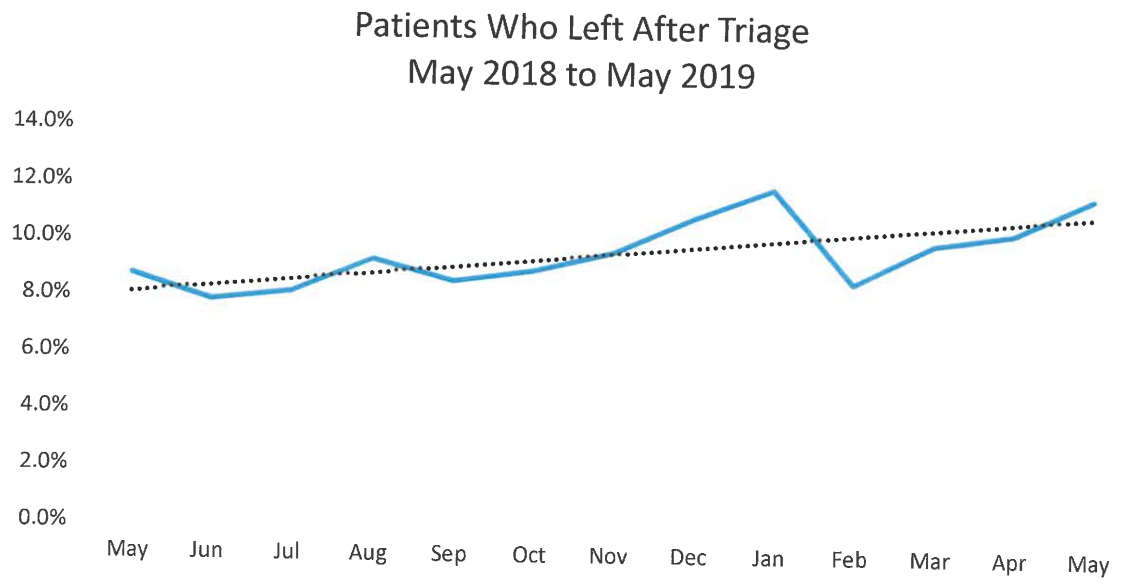
Data tables:

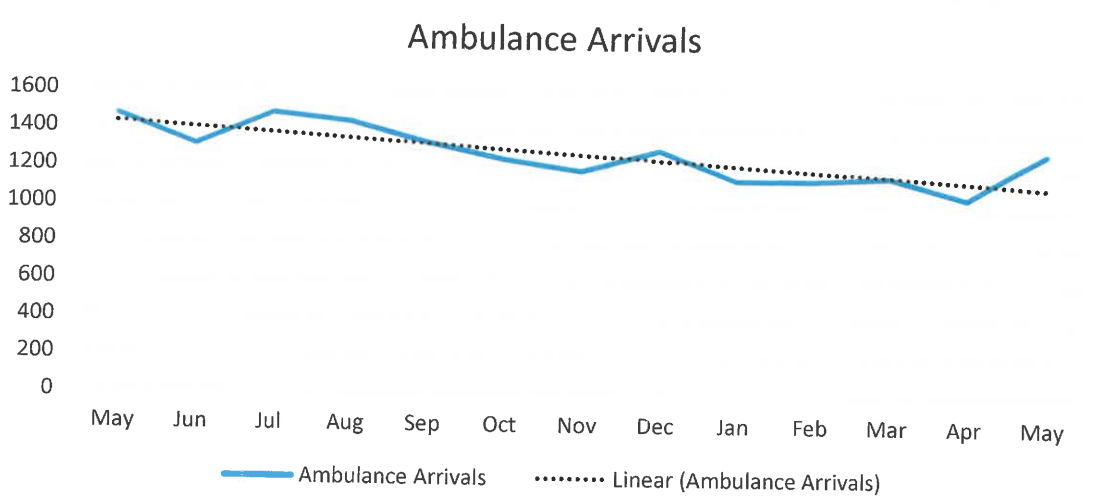
ED Volume and Events

	May 2018	%	May 2019	%
Total patients	4982		4664	
Daily Avg Census	161		150	
Admit	546	11.0%	582	12.5%
• Med Surg	444	8.9%	453	9.7%
• Psych	102	2.0%	129	2.8%
Transfer	85	1.7%	86	1.8%
AMA	40	1.5%	70	1.5%
Eloped	86	1.7%	67	1.4%
LWBS	614	12.3%	758	16.3%
• Left Prior to Triage	179	3.6%	215	4.6%
• Left After Triage	435	8.7%	543	11.6%
Ambulance Arrivals	1468	29.5%	1295	27.8%




UMC Admissions
May 2018 to May 2019
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May
Total Admissions
Med/Surg
Psych
Linear (Total Admissions)
Linear (Med/Surg)
Linear (Psych)


Patients Who Left After Triage
May 2018 to May 2019
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May

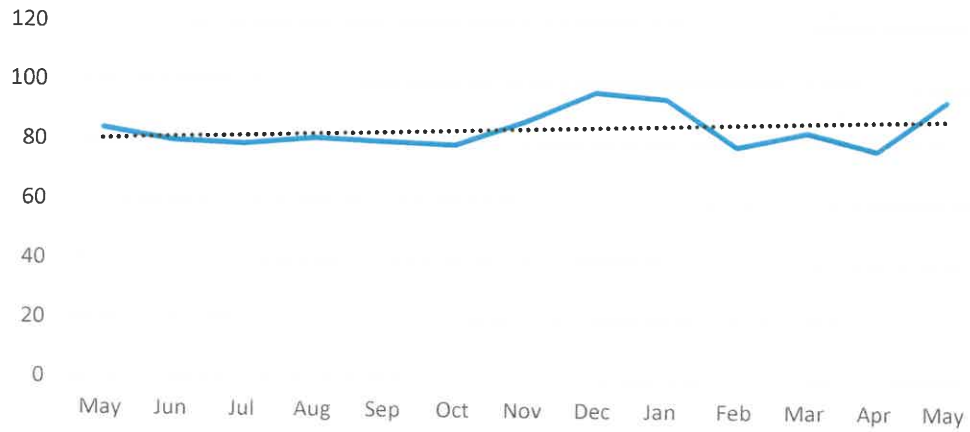

Ambulance Arrivals
1600
1400
1200
1000
800
600
400
200
0
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Ambulance Arrivals
Linear (Ambulance Arrivals)

ED Throughput May 2019 (time in minutes)

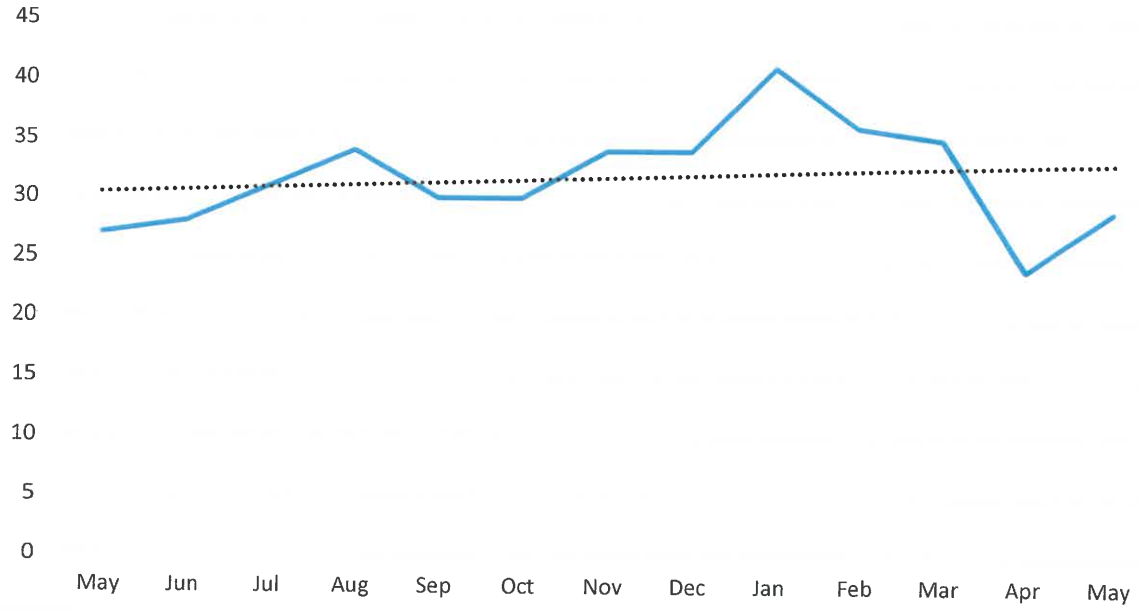
	Median Times	Mean Time
Admissions		
Door to triage	11	22
Triage to Room	18	38
Room to provider	0	0
Provider to decision	223	229
Decision to departure	58	452
Door to departure	310	738
Discharges		
Door to triage	14	22
Triage to room	81	101
Room to provider	3	0
Provider to decision	126	122
Decision to departure	55	66
Door to departure	278	310
Transfers		
Door to triage	16	22
Triage to room	18	37
Provider to room	0	0
Provider to decision	198	201
Decision to departure	223	211
Door to departure	441	452

ED Throughput Comparison (median times in minutes)		
	May 2018	**May 2019**
Admissions (Med/Surg)		
Door to triage	19	11
Triage to room	13	18
Room to provider	1	0
Provider to decision	223	223
Decision to departure	44	58
Door to departure	300	310
Discharges		
Door to triage	24	14
Triage to room	57	81
Room to provider	11	3
Provider to decision	137	126
Decision to departure	47	55
Door to departure	276	278
Transfers		
Door to triage	12	16
Triage to room	14	18
Room to provider	3	0
Provider to decision	192	198
Decision to departure	407	223
Door to departure	434	441

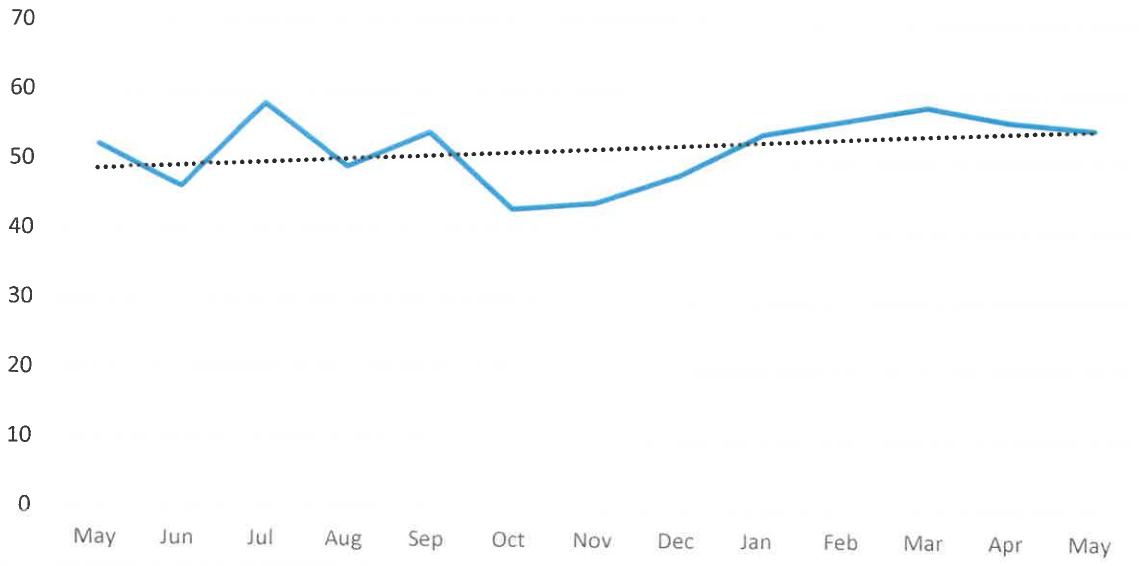
Median Wait Time - Discharged Patients (in minutes)
May 2018 to May 2019

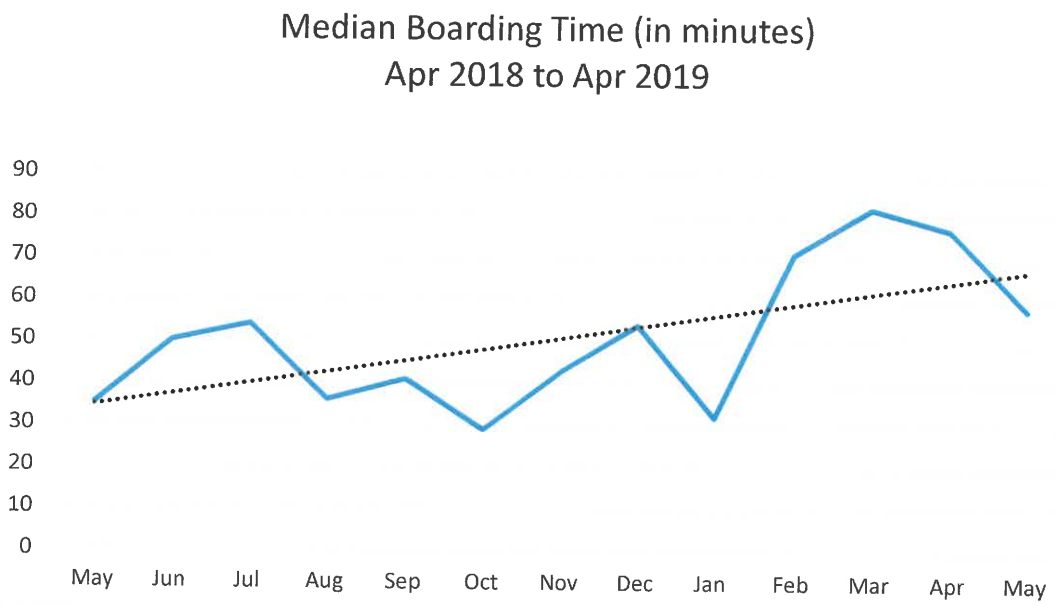


Median Wait Time - Admitted Patients (in minutes)
May 2018 to May 2019



Median Time to Depart - Discharged Patients
(in minutes)
May 2018 to May 2019





Analysis:

1. The census has declined over the past 12 months with a large percentage of that appearing to be related to a decrease in ambulance traffic over the same time period

2. The percentage of patients being admitted has steadily risen over the last year. This appears to be related to both a steady rise in behavioral health patients along with a rise in the percentage of med/surg patients suggesting that we are seeing a sicker cohort of patients.

3. The percentage of patients who left without seeing a provider (LWBS), both those who were triaged (LAT) and those who departed prior to triage (LPTT) is now re-incorporated into the report. We appreciate the IT department's responsiveness and coordination with the ED to produce the raw data for analysis. As we suspected, the LWBS rate is elevated with a large number of patients departing both before and after triage.

4. Median boarding times for admitted patients continue to trend upwards with times to departure for discharged patients continuing to remain elevated and slightly increasing over the last 12 months.

5. The difference between mean and median times for lengths of stay (door to departure) are normal for an ED, as a certain percentage of complex and boarding patients are often responsible for lengthening the mean times. We are using median times as they better reflect the ED system's performance.

6. The May 2019 data demonstrate differences between the mean and median times for door to triage, triage to room, and time to departure (for discharged patients). Mean and median

provider times to decision are almost identical for all patient types and improved from 2018 data suggesting that factors other than patient complexity and provider decision making account for the observed differences.

Despite provider performance improving from 2018 to 2019 and providers seeing patients almost immediately upon arrival, the LWBS continues to rise. We suspect that there are problems inherent to the current footprint and care-delivery model at UMC. Staffing shortages continue to plague the ED and inpatient units. These factors combined with a lack of support staff and floorplan limitations contribute to longer lengths of stays in the ED, delays in departures, increased boarding times, rising LWBS and patient dissatisfaction, along with a drop in ambulance traffic due to rerouting because of ambulance offloading delays.

There is a clear opportunity for improvements in the current care-delivery model at United Medical Center. Elevated wait times for lower acuity patients (discharged patients) suggest that lower acuity patients are waiting longer and departing the ED prior to seeing a provider. Augmenting the current ED space with an onsite integrated urgent and primary-care presence would provide additional space and resources to capture the lower acuity ED population while making resources available for higher acuity patients in the ED. Additionally, concurrent improvements in ED throughput would facilitate a more rapid recognition, treatment and management of critically ill patients and more expeditious transport of transferred patients, women in labor, and late term obstetric emergencies.

Francis O'Connell M.D.
Chairman, Department of Emergency Medicine

Musa Momoh, M.D., Chairman

June

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

ACTIVITY	JAN	FEB	MAR	APR	MAY	JUN	TOTAL
OBSERVATION							
MEDICINE	126	118	132	102	142	125	745
HOSPITAL	126	118	132	102	143	125	746
PERCENTAGE	**100%**	**100%**	**100%**	**100%**	**99%**	**100%**	**99%**
REGULAR							
MEDICINE	350	245	219	247	218	221	1500
HOSPITAL	442	323	292	347	326	330	2060
PERCENTAGE	**79%**	**76%**	**75%**	**71%**	**67%**	**67%**	**73%**
OBSERVATION							
MEDICINE	132	118	127	97	131	137	742
HOSPITAL	132	118	127	97	132	137	743
PERCENTAGE	**100%**	**100%**	**100%**	**100%**	**99%**	**100%**	**99%**
REGULAR							
MEDICINE	298	221	189	193	194	190	1285
HOSPITAL	378	293	261	272	297	283	1784
PERCENTAGE	**79%**	**75%**	**72%**	**71%**	**65%**	**67%**	**72%**
HEMODIALYSIS	223	113	118	171	119	122	865
EGD'S	53	40	26	49	46	37	251
COLONOSCOPY	48	40	31	49	50	50	248
ERCP	1	0	0	1	0	0	2
BRONCHOSCOPY	5	1	4	3	1	4	18
Cases Referred to Peer Review	0	0	0	0	0	0	0
Cases Reviewed	0	0	0	0	3	0	3
Cases Closed	0	0	0	0	2	0	2

Department of Medicine met on June 12, 2019.
The next meeting is on September 11, 2019.
Morbidity and Mortality is scheduled for July 16, 2019.

Musa Momoh, M.D.
Chairman, Department of Medicine

athology

Eric Li, M.D., Chairman

June

MONTH	JAN	FEB	MAR	APR	MAY	JUN
Reference Lab Test – Intake PTH 90% 2 days	100% 21	97% 30	96% 28	87% 23	96% 26	100% 3
Reference Lab specimen Pickups 90% 3 daily/2 weekend/holiday	100% 16/16	100% 16/16	100% 20/20	94% 15/16	94% 15/16	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%	100%	100%	100%
Review of Unacceptable Blood Bank specimen Goal 90%	97%	100%	100%	99%	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	1.2	1.3	1.4	1.5	1.3	1.3
Wasted/Expired Blood and Blood Products Goal 0	1	5	10	2	3	0
Measure number of critical value called with documented Read Back 98 or >	100%	100%	100%	100%	100%	100%
Hematology Analytical PI Body Fluid	100% 15/15	100% 16/16	100% 12/12	100% 16/16	100% 7/7	100% 13/13
Sickle Cell	0/0	0/0	1/1	0/0	1/1	0/0
ESR Control	100% 26/26	100% 28/28	100% 70/31	100% 68/27	100% 60/27	100% 56/27
Delta Check Review	100% 202/208	99% 170/171	99% 184/185	100% 184/184	100% 204/204	100% 167/167
Blood Culture Contamination – Benchmark 90%	92%	100%	94%	100%	100%	100%
ER HOLDING	98%	90%	89%	87%	88%	81.18%
ICU	92%	91%	95%	100%	92%	100%
STAT turnaround for ER and Laboratory Draws <60 min Benchmark 80%						
ER	83%	84%	82%	82%	83%	85%
LAB	80%	85%	87%	86%	90%	93%

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.

Eric Li, M.D.
Chairman, Department of Pathology

Psychiatry

Surendra Kandel ,M.D., Chairman

DESCRIPTION	01	02	03	04	05	06
ADMISSIONS						
ALOS (Target <7 days)	6.26	5.67	5.70	4.98	4.64	4.83
Voluntary Admissions	22	33	41	54	54	56
Involuntary Admissions	47	52	54	60	80	72
Total Admissions	**69**	**85**	**95**	**114**	**134**	**128**
REFERRAL SOURCES						
CPEP	22	11	22	28	51	35
UMC ED	66	74	72	84	77	88
GWU	2	0	0	1	1	1
Providence	1	0	0	0	0	0
Georgetown	0	0	0	0	1	0
Sibley	1	0	0	0	0	0
UMC Medical/Surgical Unit	3	0	1	2	2	3
Children's Hospital	n/a	n/a	n/a	n/a	n/a	n/a
Howard	2	0	0	0	1	1
Laurel Regional Hospital	0	0	0	0	0	0
Washington Hospital Center	0	0	0	0	0	0
Suburban	0	0	0	0	0	0
PIW	0	0	0	0	0	0
Holy Cross Hospital	0	0	0	1	1	0
OTHER MEASURES						
Average Throughput Target: <2 hours	3.8	3.1	3.8	4.5	3.56	3.8
Psychological Assessments (Target: 100%)	95%	98%	90%	85%	99%	86%
DISCHARGE APPOINTMENTS						
Discharge Appointments for those d/c > 72 hours	68	74	87	95	114	110
Discharged to home without appointments/No discharge appointment information provided	5	3 (AMA)	5	3	14	8
Discharge Appointments for those d/c > 72 hours (Target: 100%)	**93%**	**87%**	**88%**	**83%**	**87%**	**93%**
OTHER						
Patients who went to Court	3	0	0	0	0	0

Surendra Kandel, M.D.
Chairman, Department of Psychiatry

Department of RADIOLOGY

Raymond Tu, M.D.,

June

MONTHLY DEPARTMENT CHAIR REPORT

Performance Summary:

	INP		ER		OUT		TOTAL	
EXAM TYPE	EXAMS	UNITS	EXAMS	UNITS	EXAMS	UNITS	EXAMS	UNITS
CARDIAC CATH	3						3	
CT SCAN	76		558		148		782	
FLUORO	8		1		19		28	
MAMMOGRAPHY					122		122	
MAGNETIC RESONANCE ANGIO							0	
MAGNETIC RESONANCE IMAGING							0	
NUCLEAR MEDICINE	13		0		4		17	
SPECIAL PROCEDURES	24		0		9		33	
ULTRASOUND	99		203		161		463	
X-RAY	170		946		778		1894	
ECHO	80		48		1		129	
CNMC CT SCAN			38				38	
CNMC XRAY			404				404	
GRAND TOTAL	473		2198		1242		3910	

Quality Initiatives, Outcomes, etc.

1. **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 replacement solution is ongoing.

2. **Morbidity and Mortality Reviews:** There were no departmental deaths.

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

4. **Care Coordination/Readmissions:** Transfer of patients from UMC to other facilities proactively and as needed ongoing.

5. **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) Stewardship:

Dr. Tu represented the District of Columbia as President of the Medical Society of the District of Columbia at the American Medical Association House of Delegates here at the Southeast Delegation.

Dr. Tu with President of the Virginia Society of Virginia President Dr. Richard Szucs (*left*) and Dr. Desiree Pineda at the House of Delegates of the American Medical Association June 11, 2019 advocating coverage for imaging screenings coverage by Medicaid and Medicare.

Dr. Tu was invited faculty for the graduation of his radiology resident and fellows at The George Washington University Department of Radiology on June 20, 2019.

Dr. Tu pictured with his neuroradiology fellow Dr. F Huda (*left*) and Dr. A. Goyal (*right*), and section of Neuroradiology with Dr. Mark Monteferrante, UMC radiologist and GW Faculty (*center*).

Dr. Tu met with Congresswoman Eleanor Holmes Norton on June 25 2019 at Mayfair Mansions to advocate for health care for residents of Wards 7 and 8 and the Disproportionate Share Hospital funding, known as DSH, for safety net hospitals as United Medical Center.

Congresswoman Eleanor Holmes Norton (*center front*), now in her fifteenth term as the Congresswoman for the District of Columbia, is the Chair of the House Subcommittee on Highways and Transit.

Financials: Active Steps to Improve Performance: The active review of staff performance and history to be provided for radiologic interpretation continues. The reinstitution of fluoroscopy and MRI services will improve patient care and provide greater depth of services for the hospital. Progressive Radiology continues to advocate for clinical decision support to provide optimal use of resources while enhancing our publicly reported rating while facilitating compliance of federal regulations.

Raymond K. Tu, M.D., MD, MS, FACR
Chairman, Department of Radiology

Gregory Morrow, M.D., Chairman

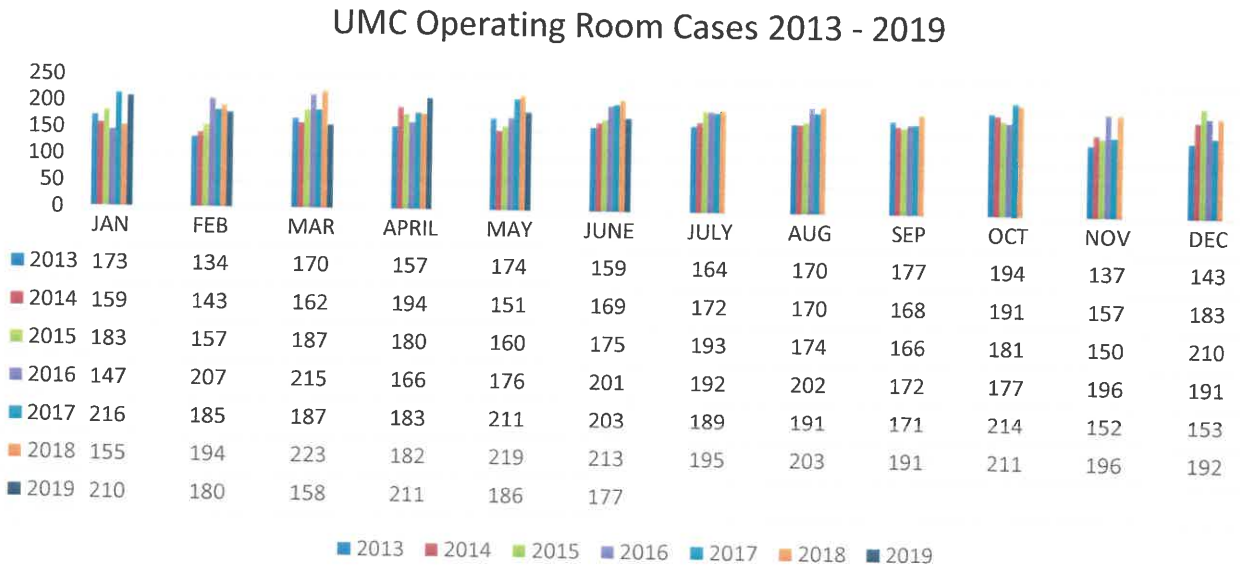
June

SUMMARY REPORT FOR JUNE 2019

For the month of June 2019, the Surgery Department performed a total of 177 procedures.

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

	2013	2014	2015	2016	2017	2018	2019
JAN	173	159	183	147	216	155	210
FEB	134	143	157	207	185	194	180
MAR	170	162	187	215	187	223	158
APRIL	157	194	180	166	183	182	211
MAY	174	151	160	176	211	219	186
JUNE	159	169	175	201	203	213	177
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	



This month continues a significant reduction in surgical volumes as we end the second quarter. This volume drop has been due mainly to the recent news of budget shortfalls and reduced subsidy payments to the hospital which has led to speculation that the hospital was *CLOSED, CLOSING OR REDUCING VITAL SERVICES.* The second quarter did, however, outperform the first quarter but is still lagging in comparison to historical data from prior years.

Despite these obstacles, 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 June 17, 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

Our current Peri-Operative Performance Improvement activities include:

1. Improving First Case On-Time Start
2. Curbing Weekday Late Cases and Weekend Cases

We were in 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. However, this process has been placed on HOLD for undisclosed reasons. We are waiting for further details regarding this process. This is another in a series of steps to make our surgical program more robust and attractive to more community physicians and enhance the services that we provide to our patients.

Gregory D. Morrow, M.D., F.A.C.S.
Chairman, Department of Surgery

MEDICAL STAFF CREDENTIALING ACTIVITY
JUNE 2019

NEW APPOINTMENTS

Kennedy Foryoung, M.D. (Radiology)
Nevena Puletic, N.P. (Internal Medicine)
Kenneth Segel, M.D. (Radiology)
Jordan Selzer, M.D. (Emergency Medicine)
Andrew Simmons, M.D. (Emergency Medicine)

CHANGE IN STATUS

Sangeeta Desai, M.D. (Emergency Medicine) Provisional to Active
Haimanot Haile, M.D. (Internal Medicine) Provisional Active
India Rogers, DDS (Dentistry) Reappointed to Active

RESIGNATIONS

Fahad Abuguyan, M.D. (Emergency Medicine)
Abel Batuure, M.D. (Anesthesiology)
Babak Behseta, M.D. (Emergency Medicine)
Shona Chandon-Cooke, PA-C (Emergency Medicine)
Rachel Ernzen, PA-C (Emergency Medicine)
Natalie Giles, M.D. (Internal Medicine – Hospitalist)
Richard Lapin, M.D. (Internal Medicine – Hospitalist)
Caroline Pratt, N.P. (Emergency Medicine)

UMC

UNITED
MEDICAL CENTER

General Board Meeting
Date: July 24, 2019

Medical Chief of Staff REPORT

Presented by:
Marilyn McPherson-Corder, MD
Chief Medical Officer

UMC

UNITED
MEDICAL CENTER

General Board Meeting

Date: July 24, 2019

Management Report

Presented by:
Ira Gottlieb,
Interim Chief Executive Officer

MANAGEMENT REPORT JULY 2019

UMC

UNITED
MEDICAL CENTER

Introduction and Executive Summary

During the past month, much of our effort has continued to be focused on balancing the budget while maintaining the quality of care. Key accomplishments and challenges encountered include the following:

Challenges

The Hospital has continued to face numerous challenges in terms of fiscal stability and infrastructure deterioration. Major challenges during the past month included:

- Reduction in District of Columbia annual subsidy by $25M on an ongoing basis in accordance with the Not-For-Profit Hospital Corporation Fiscal Oversight and Transition Planning Amendment Act of 2019
- Continued renovation of the ICU which was flooded resulting in the need to move all patients to another location and contributed to increased expenses as well as diversion of executive attention and staff time
- The MRI continued to be down due to mold contributing to a reduction in patient volume; in the process of finalizing an agreement for a mobile MRI
- Repair of damage from flood in HIM area which is planned to be completed by end of July
- Loss of backup for chillers and cooling towers increasing risk to delivery of services
- Hospital insurance policies expired with little notice and an increase in the premiums
- Patient days dropped by 11% from previous year slightly better than YTD trend of -15% (thru May)
- Emergency visits are down by 10% from the previous year continuing the downward trend

Introduction and Executive Summary (cont.)

Highlights of July 2019

During Julyl 2019, significant effort was once again devoted to reducing expenditures while maintaining quality of care. Within each of the 5 pillars some of the key areas of progress were:

Staffing

- Maintained reduced staffing level; for the month, the FTEs were at 849
- To comply with the mandate to have a balanced budget in FY19 and FY20 we are in the process of implementing a reduction in force; as of July 19 the non-union component of the RIF has been completed; the RIF of union employees will be completed on August 12
- Created a system to verify and maintain licenses for the facility to ensure compliance with DOH regulations

Patient Safety and Quality

- Maintained strong record of preventing hospital acquired infections; recorded no central line, urinary catheter or ventilator associated infections
- Overall, Press Ganey scores have improved during the past year from 25.6% to 52.4%

GAP/Finance

- On target to meet the FY19 budget through the received subsidies of $34M along with the increased efforts tied to our GAP Measures Initiatives. As of May 31, 2019, we realized $25.5M in revenue/savings out of the adjusted $28.1M target.
- In collaboration with the CFO, developed balanced budgets for FY19 and FY20 without reducing clinical services to the community which was certified by the OCFO.
- Started contract negotiations with Children's Hospital to extend lease/provider services agreement

Introduction and Executive Summary (cont.)

Clinical Services

- Implemented scanning of supplies by nursing staff streamlining process and improving availability of critical supplies
- Implemented DOH recommendations for nurse attestation of ED wound assessments and calculation of daily weight fluctuations greater than 5%

Infrastructure

- Scheduled CBE vendor open house for construction projects July 24
- Replacement of backup chiller and cooling towers mitigating risk (to be completed by end of July)
- Completed roofing repairs thus eliminating structural concerns
- Completed encryption of all data at rest for UMC data center systems
- Implemented screen locks on devices throughout UMC

UMC Hospital Pharmacy Department Highlights

Report Update	Upon Arrival	Current Status YTD
1. **Medication Budget**	• FY18 Pharmacy Drug Spend $2.9M	• 14% ($400K) savings on FY18 overall drug spend; all off-contract vendor use for drugs has been discontinued
1. **Hospital Medication Formulary**	• Clearly defined Hospital Pharmacy Formulary was not established creating problem of therapeutic duplication of meds	• 29 medications have been approved and/or removed from UMC Pharmacy Formulary by Pharmacy and Therapeutics Committee
1. **Hospital Diversion Committee**	• No Diversion Protocol or Policy	• Diversion Committee established • Diversion Policy created • Diversion Action Flow Chart Protocol established • Over-rides [RNs retrieving medications from the Pyxis machine without a physician/provider order] have been discontinued on ALL medications with the exception of : i) Code Cart Meds ii) Nausea, vomiting , diarrhea Allergic reaction medications iii) Chest pain medications iv) Seizure medications *Decrease in over-rides, increases patient safety. Reduces wrong med to wrong patient.
1. **IV Room Status**	• FY2018 IV Room did not comply with USP 797 conditions	• 1 new Horizontal Laminar Flow Hood and 1 new Biological Safety Cabinet (for hazardous drug compounding) purchased for safe compounding of IV medications • Installed USP compliant IV room flooring • Mobile HEPA filter has been added to improve air exchange by two-fold • Air particle count has improved overall to ISO class 7
1. **Antimicrobial Stewardship Program**	• ASP Program not established	• Clinical Pharmacist attended 3 day education program to establish ASP Committee • Restricted Antibiotic Policy created (requires approval from Infectious Disease Physicians for prior use of certain antibiotics) decreasing risks of antibiotic misuse and resistance
1. **Narcan Kit Program**	• DC Health established Narcan Kit for District Hospitals	• Collaborating with UMC ED, DC Health and DCHA to obtain Narcan Kit for UMC ED in accordance with Opioid Overdoses Treatment Program • Anticipated go-live in August 2019, will start with 30 kits

UMC QUALITY Dashboard					At or Exceeds Target				Within 10% of Target				Target not Met			Amended		
2019	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
BLOOD PRODUCTS MANAGEMENT																		
BLOOD TRANSFUSION REACTIONS																		
# Transfusion Reaction Cases		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Allergic Reaction		0	0	0	0	0	0							0	0	0	0	0
Febrile Reaction		0	0	0	0	0	0							0	0	0	0	0
Hemolytic Reaction		0	0	0	0	0	0							0	0	0	0	0
Non-Specific Reaction		0	0	0	0	0	0							0	0	0	0	0
BLOOD TRANSFUSION RECORD REVIEW																		
Transfusions		233	122	100	130	149	114	0	0	0	0	0	0	455	393	0	0	848
Cryoprecipitate Transfusions		2	0	0	0	5	0							2	5	0	0	7
Fresh Frozen Plasma Transfusions		39	7	19	0	14	4							65	18	0	0	83
Platelet Transfusions		6	2	10	13	14	1							18	28	0	0	46
RH Immunge Globulin (RhIG)		0	2	3	0	1	2							5	3	0	0	8
Total Red Blood Cells (RBCs) Transfused		186	111	68	117	115	107							365	339	0	0	704
Total RBC units Crossmatched		229	148	97	178	147	134							474	459	0	0	933
Crossmatch/Transfusion Ratio Threshold <2		1.2312	1.3383	1.4269	1.5214	1.2783	1.2523	-	-	-	-	-	-	1	1	0	0	1.36049
BLOOD TRANSFUSION JUSTIFICATION																		
# Times O- BLOOD TRANSFUSED TO NON O- PT.		15	0	0	8	10	7							15	25	0	0	40

UMC QUALITY Dashboard																			
		At or Exceeds Target							Within 10% of Target					Target not Met			Amended		
2019	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
BLOOD TRANSFUSION DOCUMENTATION	**THRESHOLD 100%**																	
Crossmatch Compatibility						100%	100%								100%			100%
MD Order Confirmed						100%	100%								100%			100%
Consent Signed						88%	91%								90%			90%
2 RN Signature						100%	100%								100%			100%
Transfusion Reaction		0%	0%	0%	0%	0%	0%							0%	0%			0%
FALL PREVENTION																		
# Falls Housewide		8	11	14	10	10	6							33	26	0	0	59
# Falls - ED		0	1	3	1	2	0							4	3	0	0	7
# Falls - Outpatient		0	0	0	0	0	0							0	0	0	0	0
# Falls - Inpatient		8	10	11	9	7	6							29	22	0	0	51
# Falls - Visitor		0	0	0	0	1	0							0	1	0	0	1
Inpatient Days (Includes Observations.)		1980	1666	1769	2339	2140	2360							5415	6839	0	0	12254
# Falls - With Injury		0	0	3	0	1	0							3	1	0	0	4
INPATIENT FALL RATE		4.0	6.0	6.2	3.8	3.3	2.5	-	-	-	-	-	-	5.4	3.2	-	-	4.2
INFECTION PREVENTION AND CONTROL																		
NPSG: REDUCE THE RISK OF HEALTHCARE ASSOCIATED INFECTIONS																		
INFECTION SURVEILLANCE - DEVICE ASSOCIATED HAI																		

UMC QUALITY Dashboard		At or Exceeds Target							Within 10% of Target				Target not Met			Amended		
2019	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTION (CLABSI)	**THRESHOLD <1/YR**																	
CLABSI -Medical/Surgical Telemetry (MS/T)		0	0	0	0	0	0							0	0	0	0	0
MS/T CLABSI RATE		0	0	0	0	0	0							0	0	0	0	0
CLABSI-Critical Care Unit (CCU)		0	0	0	0	0	0							0	0	0	0	0
CCU CLABSI RATE		0	0	0	0	0	0							0	0	0	0	0
CATHETER ASSOCIATED URINARY TRACT INFECTON (CAUTI)	**THRESHOLD < 1/YR**																	
CAUTI -MS/T		0	0	0	0	0	0							0	0	0	0	0
CAUTI -MS/T RATE		0	0	0	0	0	0							0	0	0	0	0
CAUTI -CCU		0	0	0	0	0	0							0	0	0	0	0
CAUTI -CCU RATE		0	0	0	0	0	0							0	0	0	0	0
VENTILATOR ASSOCIATED EVENTS	**THRESHOLD < 1/YR**																	
Ventilator Associated Condition (VAC)		0	0	0	0	0	0							0	0	0	0	0
Ventilator Associated Condition Rate		0	0	0	0	0	0							0	0	0	0	0
MULTI DRUG RESISTANT ORGANISMS (MDRO)	**THRESHOLD RATE <1/YR**																	
MRSA-HAI (Healthcare Acquired Infection)		0	0	0	0	0	0							0	0	0	0	0
MRSA Rate		0	0	0	0	0	0							0	0	0	0	0
CLOSTRIDIUM DIFFICILE (C.DIFF)	**THRESHOLD RATE <1/YR**																	
C.Diff-HAI (Healthcare Acquired Infection)		0	0	0	1	1	0							0	2	0	0	2

UMC QUALITY Dashboard		At or Exceeds Target							Within 10% of Target				Target not Met			Amended		
2019	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
C.Diff Rate		0	0	0	0	0	0							0	0	-	-	0
VANCOMYCIN RESISTANT ENTEROCOCCUS (VRE)	THRESHOLD RATE <1/YR																	
VRE Healthcare Acquired Infection		1	0	0	0	0	0							1	0	0	0	1
VRE Rate		1	0	0	0	0	0	-	-	-	-	-	-	0	0	-	-	0
INFLUENZA & PNEUMOCOCCAL																		
PATIENT INFLUENZA VACCINATION																		
HCW INFLUENZA VACCINATION																		
PNEUMOCOCCAL VACCINE RATE																		
INFECTION SURVEILLANCE : SURGICAL SITE INFECTIONS (SSI)	THRESHOLD <4 INCIDENCE/YR																	
# Colon Surgeries		3	1	1	2	1	0							5	3	0	0	8
# SSI from Colon Surgeries		0	0	0	0	0	0							0	0	0	0	0
# Major Orthopedic Surgeries		2	2	5	3	3	2							9	8	0	0	17
# SSI fromOrthopedic Surgeries		0	0	0	0	0	0							0	0	0	0	0
DEVICE UTILIZATION RATE (DUR)																		
# PATIENT DAYS-TOTAL		1980	1666	1769	2339	2140	1794	0	0	0	0	0	0	5,415	6,273	0	0	11,688
# Patient Days - MS		447	435	430	683	435	507							1,312	1,625	0	0	2,937
#Patient Days-Tele		1288	995	1114	1389	1146	1194							4,786	3,729	0	0	7,126
#Patient Days MS/T		1735	1430	1544	2072	1581	1701	0	0	0	0	0	0	4,709	5,354	0	0	10,063

UMC QUALITY Dashboard		At or Exceeds Target							Within 10% of Target				Target not Met			Amended		
2019	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
# Patient Days - CCU		245	236	225	267	69	93							706	429	0	0	1,135
FOLEY DUR						THRESHOLD: < 1/YR												
# Foley Days - MS		48	26	27	54	22	27							101	103	0	0	204
FOLEY DUR - MS		0.11	0.06	0.06	0.08	0.05	0.05	-	-	-	-	-	-	0.08	0.06	-	-	0.07
#Foley Days-Tele							97								97	0	0	97
FOLEY DUR - Tele							0.08	-	-	-	-	-	-		0.03	-	-	0.01
# Foley Days - CCU		182	174	145	167	197	166							668	530	0	0	1031
FOLEY DUR - CCU		0.74	0.74	0.64	0.63	2.86	1.78	-	-	-	-	-	-	0.95	1.24	-	-	0.91
# Foley Days - TOTAL		48	26	27	54	22	124	0	0	0	0	0	0	101	200	0	0	301
CENTRAL LINE DUR						THRESHOLD: MS< 1/YR TELE < 1/YR CCU < 1/YR												
# Central Line Days - MS		36	20	31	42	50	1							87	93	0	0	180
CENTRAL DUR - MS		0.08	0.05	0.07	0.06	0.11	0.00	-	-	-	-	-	-	0.07	0.06	-	-	0.06
#Central Line Days-Tele							13											
CENTRAL DUR TELE							0.0109	-	-	-	-	-	-		0.00	-	-	
# Central Line Days - CCU		97	93	102	101	88	102							292	291	0	0	583
CENTRAL DUR - CCU		0.40	0.39	0.49	0.38	1.28	1.10	-	-	-	-	-	-	0.41	0.68	-	-	0.51
# Central Line Days - TOTAL		133	113	133	143	138	116	0	0	0	0	0	0	379	397	0	0	776
VENTILATOR DUR						THRESHOLD: TELE< 1/YR CCU 1/YR												

UMC QUALITY Dashboard																		
		At or Exceeds Target							Within 10% of Target				Target not Met			Amended		
2019	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
# Ventilator Days - 8W		0	0	0	0	0	0							0	0	0	0	0
VENT DUR - 8W		0.00	0.00	0.00	0.00	0.00	0.00	-	-	-	-	-	-	0.0	0.0	-	-	0.0
# Ventilator Days - CCU		109	118	74	102	114	82							301	298	0	0	599
VENT DUR - CCU		0.44	0.50	0.33	0.38	1.65	0.88	-	-	-	-	-	-	0.43	0.69	-	-	0.53
# Ventilator Days - TOTAL		109	118	74	102	114	82	0	0	0	0	0	0	301	298	0	0	599
TRANSMISSION BASED PRECAUTIONS																		
Airborne-MS/T		2	2	4	6	2	3							8	11	0	0	19
Airborne-CCU		0	0	0	0	0	0							0	0	0	0	0
Airborne-Total		2	2	4	6	2	3	0	0	0	0	0	0	8	11	0	0	19
Droplet - MS/T		3	1	5	4	2	1							9	7	0	0	16
Droplet - CCU		0	0	2	0	0	0							2	0	0	0	2
Droplet - TOTAL		3	1	7	4	2	1	0	0	0	0	0	0	11	7	0	0	18
Contact - MS/T		173	102	117	25	35	29							392	89	0	0	481
Contact - CCU		23	15	9	4	14	11							47	29	0	0	76
Contact - Total		196	117	126	29	49	40	0	0	0	0	0	0	439	118	0	0	557
Contact Enteric - MS/T		5	3	1	1	3	4							9	8	0	0	17
Contact Enteric - CCU		2	1	0	0	2	3							3	5	0	0	8
Contact Enteric - TOTAL		7	4	1	1	5	7	0	0	0	0	0	0	12	13	0	0	25

UMC QUALITY Dashboard					At or Exceeds Target				Within 10% of Target				Target not Met			Amended		
2019	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
Neutropenic - MS/T		0	0	1	1	1	0							1	2	0	0	3
Neutropenic - CCU		0	0	0	0	0	0							0	0	0	0	0
Neutro - TOTAL		0	0	1	1	1	0	0	0	0	0	0	0	1	2	0	0	3
HAND HYGIENE COMPLIANCE		THRESHOLD >90%																
# Hand Hygiene Compliance		130	135	138	145	120	130							403	395	0	0	798
# Hand Hygiene Obs.		150	150	150	160	150	138							450	448	0	0	898
% Hand Hygiene Compliance-Hospital Wide		87%	90%	92%	91%	80%	94%	-	-	-	-	-	-	90%	88%	-	-	89%
HAND HYGIENE COMPLIANCE STRATIFIED PER ROLE		THRESHOLD>90%																
# Obs. EMPLOYEE		115	106	119	138	131	110							340	379	0	0	719
# Compliant Obs. Employee		101	100	114	126	101	104							315	331	0	0	646
EMPLOYEE RATE		88%	94%	96%	91%	77%	95%	-	-	-	-	-	-	93%	87%	-	-	90%
# Obs. PROVIDER		35	44	31	22	19	28							110	69	0	0	179
# Compliant Obs. PROVIDER		29	35	24	19	16	26							88	61	0	0	149
PROVIDER RATE		83%	80%	77%	86%	84%	93%	-	-	-	-	-	-	80%	88%	-	-	84%
# Obs. VISITOR														0	0	0	0	0
# Compliant Obs. VISITOR														0	0	0	0	0
VISITOR RATE								-	-	-	-	-	-	-	-	-	-	-
HAND HYGIENE COMPLIANCE STRATIFIED PER PATIENT CARE DEPARTMENT		THRESHOLD 90%																

UMC QUALITY Dashboard		At or Exceeds Target							Within 10% of Target					Target not Met			Amended		
2019	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
# Obs. ED		30	30	30	30	30	30							90	90	0	0	180
# Compliant Obs.ED		24	20	19	22	20	28							63	70	0	0	133
ED RATE		80%	67%	63%	73%	67%	93%	-	-	-	-	-	-	70%	78%	-	-	74%
# Obs. PeriOperative (PeriOP)		30	30	30	30	10	30							1	70	0	0	160
# Compliant Obs. PeriOp		30	30	30	30	5	28							90	63	0	0	153
PeriOp Services RATE		100%	100%	100%	100%	50%	93%	-	-	-	-	-	-	100%	90%	-	-	96%
# Obs. MS/T		60	60	60	80	80	57							180	217	0	0	397
# Compliant Obs. MS/T		50	57	59	73	74	54							166	201	0	0	367
MS/T RATE		83%	95%	98%	91%	93%	95%	-	-	-	-	-	-	82%	93%	-	-	92%
# Obs. CCU		30	30	30	20	30	21							90	71	0	0	161
# Compliant Obs. CCU		26	28	30	18	25	20							84	63	0	0	147
CCU RATE		87%	93%	100%	90%	83%	95%	-	-	-	-	-	-	93%	89%	-	-	91%
TERMINAL CLEANING VALIDATION OF THE OR ROOMS - THRESHOLD 100%																		
OR Room 1 Cleanings						31	30							0	61	0	0	61
OR Room 1 Validation						31	30							0	61	0	0	61
OR Room 1 Cleaning Rate	100%					100%	100%	-	-	-	-	-	-	-	100%	-	-	100.0%
OR Room 2 Cleanings						31	30							0	61	0	0	61
OR Room2 Validation						31	30							0	61	0	0	61

UMC QUALITY Dashboard																			
		At or Exceeds Target							Within 10% of Target				Target not Met			Amended			
2019	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
OR Room 2 Cleaning Rate	100%					100%	100%	-	-	-	-	-	-	-	100%	-	-	100%
OR Room 3 Cleanings						31	30							0	61	0	0	61
OR Room 3 Validation						31	30							0	61	0	0	61
OR Room 3 Cleaning Rate	100%					100%	100%	-	-	-	-	-	-	-	100%	-	-	100%
OR Room 4 Cleanings						31	30							0	61	0	0	61
OR Room 4 Validation						31	30							0	61	0	0	61
OR Room 4 Cleaning Rate	100%					100%	100%	-	-	-	-	-	-	-	100%	-	-	100%
MEDICATION SAFETY																		
BARCODE MEDICATION ADMINISTRATION (BCMA) - Hospital Wide		THRESHOLD >95%																
%Pt Scanned		99.80%	100%	100%	100%	100%	99.95%							99.93%	100.00%			99.96%
%Medications Scanned		76.00%	79%	84%	86.21%	87.74%	88.12%							75.17%	87.36%			81.28%
MEDICATION RECONCILIATION COMPLETED - INPATIENT ADMISSION		THRESHOLD >95%																
# Patient Records Reviewed						4361	4007							0	8368	0	0	8368
# Records Med Rec Complete						3285	2983							0	6268	0	0	6268
% Med. Reconciliations completed						75.3%	74.4%	-	-	-	-	-	-	-	74.9%	-	-	74.9%
MEDICATION ERRORS REPORTED																		
# TOTAL ERRORS		4	3	4	2	2	7	0	0	0	0	0	0	11	11	0	0	22
ERROR TYPE																		

UMC QUALITY Dashboard		At or Exceeds Target							Within 10% of Target				Target not Met			Amended		
2019	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
MED-GIVEN IN SPITE OF DOCUMENTED ALLERGY		0	0	0	0	0	0							0	0	0	0	0
MED-DELAY		2	0	2	0	1	0							4	1	0	0	5
MED-WRONG STRENGTH		0	0	1	0	0	0							1	0	0	0	1
MED-OMISSION		0	0	0	0	1	0							0	1	0	0	1
MED-UNORDERED MED.		0	0	0	0	0	0							0	0	0	0	0
MED-OTHER		2	3	1	2	0	2							6	4	0	0	10
MED-WRONG DOSE		0	0	0	0	0	4							0	4	0	0	4
MED-WRONG MEDICATION		0	0	0	0	0	0							0	0	0	0	0
MED-WRONG PATIENT		0	0	0	0	0	1							0	1	0	0	1
MED-WRONG RATE		0	0	0	0	0	0							0	0	0	0	0
MED-WRONG TIME		0	0	0	0	0	0							0	0	0	0	0
PATIENT SATISFACTION/PERCEPTION OF CARE																		
#Grievances/Complaints		6	13	8	15	20	19							81	54	0	0	81
Recommend Hospital %		24%	33%	33%	22%	60%	27%							33%	22%	0	0	33%
Overall Hospital Rating %		30.80%	50%	42.80%	49.70%	47.90%	34.50%							0.4105	0.507	0	0	0.45867
STAR Rating		1	1	1	1	1	1							6	3	0	0	6
CLINICAL OUTCOMES																		
Total Code Blue Events (outside of CCU)		5	5	2	3	5	2							12	10	0	0	22

UMC QUALITY Dashboard		At or Exceeds Target							Within 10% of Target				Target not Met			Amended		
2019	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
Code Blue Rates		2.8818	3.4965	1.2953	1.2826	2.3364	0.8475	-	-	-	-	-	-	2.5579	1.4888	0	0	2.02337
Patient Days		1735	1430	1544	2339	2140	2360							4709	6839	0	0	11548
Tele		3	4	2	1	2	2							9	5	0	0	14
M/S		2	0	0	1	1	0							2	2	0	0	4
BHU		0	1	0	0	1	0							1	1	0	0	2
Dialysis		0	0	0	1	0	0							0	1	0	0	1
OR		0	0	0	0	0	0							0	0	0	0	0
PACU		0	0	0	0	1	0							0	1	0	0	1
Radiology		0	0	0	0	0	0							0	0	0	0	0
Total Rapid Response Events		8	16	7	11	12	2							31	25	0	0	56
Rapid Response Rates		4.611	11.189	4.5337	4.7029	5.6075	0.8475	-	-	-	-	-	-	6.5831	3.6555	-	-	4.84932
Tele		6	11	5	7	5	1							22	13	0	0	35
M/S		1	2	1	4	1	1							4	6	0	0	10
BHU		1	3	0	0	1	0							4	1	0	0	5
Dialysis		0	0	1	0	4	0							1	4	0	0	5
OR		0	0	0	0	0	0							0	0	0	0	0
PACU		0	0	0	0	1	0							0	1	0	0	1
Radiology		0	0	0	0	0	0							0	0	0	0	0

UMC QUALITY Dashboard		At or Exceeds Target							Within 10% of Target					Target not Met			Amended		
2019	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
Mortality Rate%		0.01%	0.00%	0.00%	0.00%	0.00%	0.00%							0.00%	0.00%	0	0	0.00%
VTE Prophylaxis MS/T Compliance %		95%	92%	92%	90%	93%	93%							93.00%	92.00%	0	0	92.50%
VTE Prophylaxis CCU Compliance %		100%	100%	100%	100%	100%	100%							100.00%	100.00%	0	0	100.00%
CLINICAL SAFETY INDICATORS																		
Number of Restraint Days Behavioral Health Unit					1	0	1								2	0	0	2
Restraint Rate					0.004	0	1.76								1.764	0	0	1.764
Deliveries in the ED		0	0	0	0	1	0							1	1	0	0	1
SQ Insulin Administration Adherence %, >95%		97%	95%	96%	94%	96%	92%							95%	94%			95%
PRESSURE ULCERS					THRESHOLD <6%													
Total Patient Days		1980	1666	1769	2339	2140	2360							5415	6839	0	0	12254
# Present on admission		50	65	65	56	34	33							180	123	0	0	303
Prevalance Rate		2.5253	3.9016	3.6744	2.3942	1.5888	1.3983	-	-	-	-	-	-	3.3241	1.7985	-	-	2.47266
# Hospital Acquired Pressure Injuries		2	1	3	3	1	1							6	5	0	0	11
Incidence Rate		0.101	0.06	0.1696	0.1283	0.0467	0.0424	-	-	-	-	-	-	0.1108	0.0731	-	-	0.08977
OCCURRENCE REPORTS																		
# OCCURRENCE REPORTS		113	124	134	109	116	98	0	0	0	0	0	0	371	323	0	0	694
EQUIPMENT		1	1	1	2	2	1							3	5	0	0	8
FALLS		8	11	14	10	10	6							33	26	0	0	59
MEDICATION		5	3	4	2	2	7							12	11	0	0	23

UMC QUALITY Dashboard																			
		At or Exceeds Target							Within 10% of Target				Target not Met			Amended			
2019	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD	
OTHER																			
# NEAR MISSES		99	109	115	95	102	70							590	267	0	0	590	
		UNK	UNK	UNK	UNK	UNK	UNK							0	0	0	0	0	
# SENTINEL EVENTS		0	0	0	0	0	0							0	0	0	0	0	
SEPSIS MEASURES																			
Sepsis (Principal DX) 30 Day Readmit		0	0	1	0	0	0							1	0	0	0	1	
Simple Severe Sepsis w/Shock		17	11	8	8	8	6							36	22	0	0	58	
Sepsis Patients Observed Mortality (APR DRG 720)		0	0	0	0	0	0							0	0	0	0	0	
Sepsis Patients Volume (APR DRG 720)		40	29	27	31	22	18							96	71	0	0	167	
CASE MANAGEMENT					THRESHOLD LOS < 5.5														
Average Length of Stay		5.98	5.5	5.99	5.6	5.35	4.63	-	-	-	-	-	-	5.82333	5.2			5.511667	

UMC QAPI Master Dashboard		At or Exceeds Target		Within 10% of Target		Target not Met		Amended										
2019	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
CASE MANAGMENT→ UTLIZATION REVIEW																		
AVOIDABLE DISCHARGE PLANNING DELAYS		**BENCHMARK- <50%**																
Total # Avoidable Days		241	206	257	209	157								704	366	0	0	1070
Avoidable Days d/t DC Planning		78	127	240	159	148								445	307	0	0	752
% Compliance		32%	62%	93%	76%	94%	-	-	-	-	-	-	-	62%	85%	####	####	72%

SUMMARY OF RESULTS & ANALYSIS	ACTION PLAN & FOLLOW UP
In Jan 2019 (32.4%) the benchmark was met to achieve avoidable delays attributed to discharge planning causes at 50% or less *•In Feb 2019 (67.1%), March 2019 (93.4%) and April (76.1%) the benchmark was not met to achieve avoidable delays attributed to discharge planning causes at 50% or less* *•In April 2019 (76.1%) there was a decrease in discharge planning delays as compared to March 2019 (93.4%)* *• In May 2019 (94.3%) we saw an increase over April 2019 (76.1%) in discharge planning avoidable delay causes.*	*CM conducts ALOS (Acute Length of Stay) rounds with the GW-MFA hospitalist and Physician Advisor three (3) times per week* *•CM Assistant contacts DC Skilled Nursing Facilities daily regarding availability of Medicaid beds.* *•CM Assistant responsible for tracking all DC & MD Medicaid level of care* *•Monthly tracking of avoidable delays*

UMC QAPI Master Dashboard		At or Exceeds Target		Within 10% of Target		Target not Met		Amended										
2019	**Threshold**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**
DIABETES CENTER→ QAPI MEETING																		
INSULIN ADMINISTRATION COMPLIANCE									**BENCHMARK- 95%**									
Total Insulin Given		385	915	185	84	558								1485	642	0	0	2127
Total Insulin Given Correctly		373	869	178	79	533								1420	612	0	0	2032
% Compliance		97%	95%	96%	94%	96%	-	-	-	-	-	-	-	96%	95%	-	-	96%

SUMMARY OF RESULTS & ANALYSIS	ACTION PLAN & FOLLOW UP
Purpose of Analysis is to insure that insulin is administered safely and meets the policies and protocols of United Medical Center - Trends noted are missed doses of correction (most frequent), late insulin administration > 15 minutes past the 60 minute delivery time, giving insulin ordered TID w/meals at bedtime and documentation of insulin administration time before the glucose was done *Missed correction insulin - happens most frequently for glucose between 150-199mg/dl. Late insulin administration - another glucose should be done if insulin is not administered within 60 minutes post poc glucose. Nurse is not documenting why the another glucose was not done - (i.e. patient refused)* *Giving insulin ordered with meals only at bedtime - this error only takes place with the night shift. It is infrequent. This is most likely due to not reading the order well.* *Documentation of insulin administration time before the glucose was done - this is error that occurs with new hires, selecting the default time rather than the actual time the insulin was given or a typographical error.* *April result of 94% had a low # of data points due to focus on the annual Accuchek Competency*	*Continue with providing managers with opportunity notices to speak with team members re: gaps. Work with IT determine if insulin orders can be grouped together in the EMAR to decrease the chance that the order for correction is missed. Deliver huddles to re-educated re: the adult insulin order set protocols, the importance of accurate documetation and careful review of insulin orders at the beginning of the shift.*

UMC QAPI Master Dashboard		At or Exceeds Target	Within 10% of Target	Target not Met	Amended

2019	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
EMERGENCY DEPARTMENT→ QAPI MEETING																		
DOOR TO TRIAGE TIME	**BENCHMARK- 90% (Triage within 30 minutes)**																	
# Patients Triaged	—	30	30	30	30	30								90	60	0	0	150
# Patients Met Triage Goal	—	30	30	30	30	30								90	60	0	0	150
% Compliance	↘	100%	100%	100%	100%	100%	-	-	-	-	-	-	-	100%	100%	-	-	100%

SUMMARY OF RESULTS & ANALYSIS

The emergency Department has exceeded the benchmark by triaging patients less than 30 minutes upon arrival.

ACTION PLAN & FOLLOW UP

Continuous monthly audits and training of new staff will be ongoing.

UMC QAPI Master Dashboard		At or Exceeds Target	Within 10% of Target	Target not Met	Amended

2019	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
FACILITIES→ QAPI MEETING																		
WORK ORDER CLOSURE TIMES	**THRESHOLD >95%**																	
#MONTHLY WORK ORDERS					193	100								0	293	0	0	293
# ORDERS COMPLETED WITHIN GOAL TIME					190	90								0	280	0	0	280
% Compliance		-	-	-	98%	90%	-	-	-	-	-	-	-	-	96%	-	-	96%

SUMMARY OF RESULTS & ANALYSIS	ACTION PLAN & FOLLOW UP
Work orders received in maintenance connection, audit pro and emails sent to facilities. *Out of 193 work orders 3 work orders were deemed incomplete as a result outside vendor scheduling.* *Work orders received in maintenance connection for the month of May were less than the previous month due to team members address POC issues. Out of 100 work orders*	*Assess availability of various vendors that can complete task in a timely manner.* *Ensure facilities department has a stock of materials to complete tasks.*

UMC QAPI Master Dashboard		At or Exceeds Target	Within 10% of Target	Target not Met	Amended

2019	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
INFECTION CONTROL → INFECTION CONTROL COMMITTEE → QAPI																		
HAND HYGIENE COMPLIANCE	**THRESHOLD >90%**																	
# Hand Hygiene Observed		150	150	150	150	120								450	270	0	0	720
# Hand Hygiene Compliance		130	135	138	145	96								403	241	0	0	644
% Compliance		87%	90%	92%	97%	80%	-	-	-	-	-	-	-	90%	89%	-	-	89%

SUMMARY OF RESULTS & ANALYSIS	ACTION PLAN & FOLLOW UP
Hand Hygiene was monitored hospital wide for staff compliance with UMC's policy on hand hygiene and to prevent the spread of infection. Results from March was 92% and the results from April was 97% hospital wide which show the staff eagerness to maintain a safe enviornment free from infections. The results from April showed a slight inprovement with compliance by 5% . This is the direction we hope to continue to keep the hospital safe and free of infection with good hand hygiene practices. Umc continues to be below the national average in NHSN surveillance monitoring in comparision with hospitals in the area. *May-The results from May was 80% a drop by 17% . This is trending down in the wrong direction from last month. The greatest difference in compliance was with Surgery going from 100% down to 50% a big decrease by 50%.Possible cause was a new person doing their hand hygeine observations. ED compliance went down to 67% from 73% last month a slight decrease by 6%. All other units remained essentially the*	*Direction Observation of hand hygeine will continue to be done month with immediate feedback in real time. Education on the hand hygiene and UMC policy that states that all employee must wash their hands . The instructional on how to wash their hands and the time frame of at least 20-30 seconds.*

UMC QAPI Master Dashboard		At or Exceeds Target		Within 10% of Target		Target not Met		Amended											
2019	**Threshold**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**
CRITICAL CARE→ CRITICAL CARE COMMITTEE→QAPI MEETING																			
RAPID RESPONSE	**THRESHOLD**																		
Total # of Rapid Responses		8	16	7	11	12								31	23	0	0	54	
Total # of Evaluations Received		4	10	3	8	5								17	13	0	0	30	
% Compliance		50%	63%	43%	73%	42%	-	-	-	-	-	-	-	55%	57%	-	-	56%	

SUMMARY OF RESULTS & ANALYSIS	ACTION PLAN & FOLLOW UP
Rapid Response remains the method of identifying a deteriorating patient at UMC early so that appropriate care can be provided quickly. However, we are yet to establish the effectiveness of this method as showed in the above fluctuating chart. There is no national Benchmark on rapid response but at UMC our goal is to attain 100%. ***The review of May 2019 rapid response showed that most of it occurred in the Day time when there is no covering Supervisors therefore there were no evaluations of such responses. Although, the unit Unit Managers/Charge Nurses fill this role, record*** ***showed that the rapid response evaluations are not done in most case. The ones that are done are not completed correctly.***	***Re-educate Unit Managers and Charge Nurse the importance of rapid response evaluation.*** ***Timely Checks on all rapid responses to verify total completion and accurate documentation.***

UMC QAPI Master Dashboard		At or Exceeds Target		Within 10% of Target		Target not Met		Amended										
2019	**Threshold**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**
RADIOLOGY → QAPI MEETING																		
RADIOLOGY REPEAT RATE		**BENCHMARK 98%**																
#Total Xrays		6110	5607	6174	6036	6545								17891	12581	0	0	30472
# Non Repeat Xrays		5927	5439	6020	5894	6368								17386	12262	0	0	29648
% Compliance		**97%**	**97%**	**98%**	**98%**	**97%**	-	-	-	-	-	-	-	**97%**	**97%**	-	-	**97%**

SUMMARY OF RESULTS & ANALYSIS	ACTION PLAN & FOLLOW UP
The result show the countermeasures implemented in September 2018 (which are protocol standardization and introduction of a new x-ray room) are still sustaining. The possible trend is 97-98% compliance. The result also shows a significant improvement from about one year ago where the compliance rate was between 84-88%. Although the trend is in the positive direction, early indications would indicate the countermeasures are working and effective at this time. The data needs to be evaluated for another 2 or 3 more months for a definitive inference.	*Based on early indication, volume is perhaps an dependent variable. As stated before, we will continue with the current countermeasures in place until there is noticeable change with the data.*

PRESS GANEY

CAHPS

Inpatient

United Medical Center

CAHPS	Apr '19	May '19	Jun '19	Jul '19
	Top Box	Top Box	Top Box	Top Box
Rate hospital 0-10	42.9 ▲	60.0 ▲	54.5 ▼	57.1 ▲
Recommend the hospital	22.7 ▼	60.0 ▲	27.3 ▼	42.9 ▲
Cleanliness of hospital environment	68.2 ▲	40.0 ▼	81.8 ▲	71.4 ▼
Quietness of hospital environment	45.0 ▼	50.0 ▲	45.5 ▼	50.0 ▲
Comm w/ Nurses	62.9 ▲	66.7 ▲	66.7	81.0 ▲
Response of Hosp Staff	26.1 ▼	87.5 ▲	75.0 ▼	55.0 ▼
Comm w/ Doctors	66.7 ▼	60.0 ▼	69.7 ▲	85.7 ▲
Hospital Environment	56.6 ▲	45.0 ▼	63.6 ▲	60.7 ▼
Communication About Pain	37.5 ▼	62.5 ▲	40.0 ▼	50.0 ▲
Pain Management	-	-	-	-
Comm About Medicines	61.1 ▲	29.2 ▼	60.0 ▲	37.5 ▼
Discharge Information	73.3 ▼	100 ▲	92.9 ▼	60.0 ▼

Displayed by Received Date

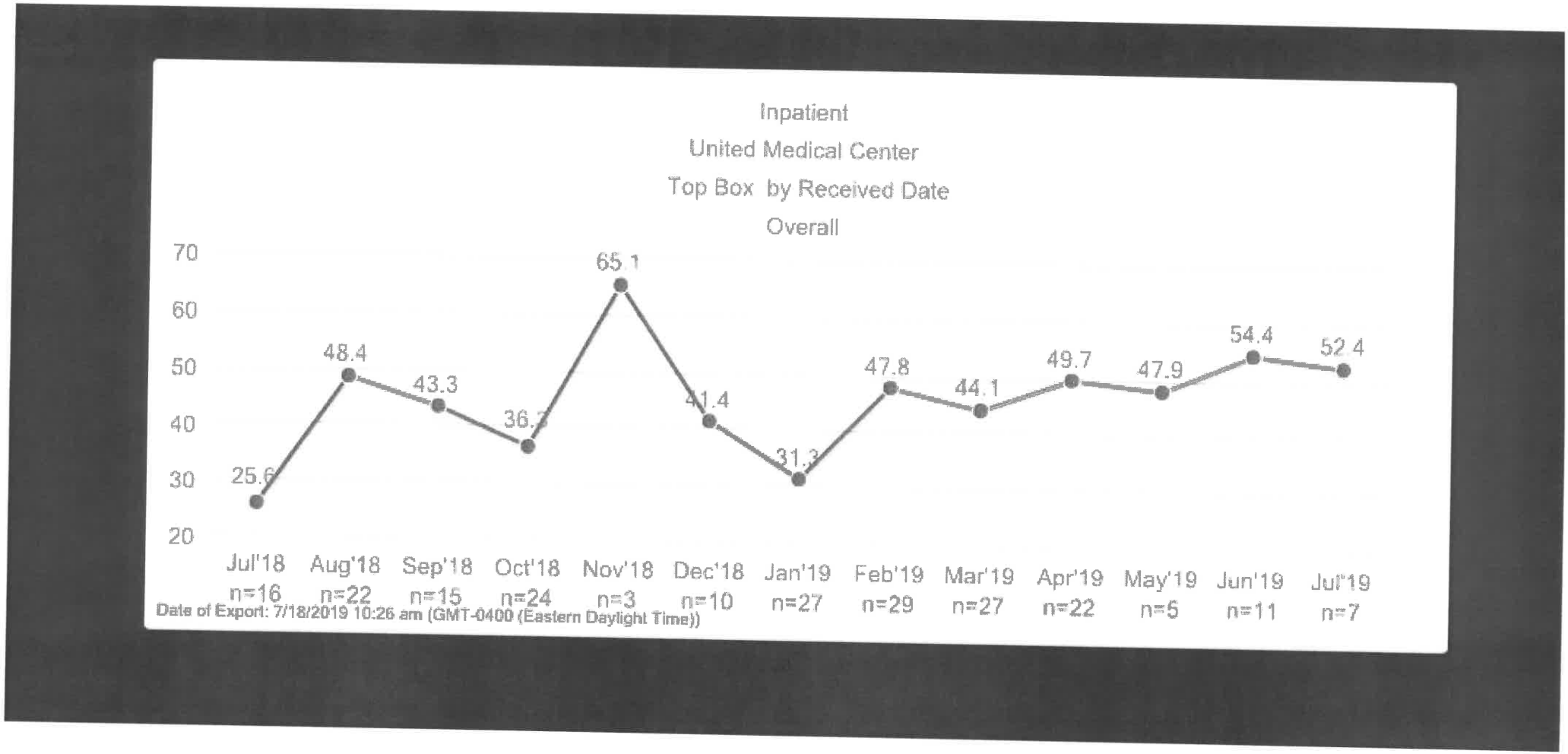
CAHPS

Inpatient

United Medical Center

CAHPS	Apr '19	May '19	Jun '19	Jul '19
	Top Box	Top Box	Top Box	Top Box
Care Transitions	52.4 ▲	35.0 ▼	48.8 ▲	53.3 ▲

Displayed by Received Date


Inpatient
United Medical Center
Top Box by Received Date
Overall
70
60
50
40
30
20
25.6
48.4
43.3
36.7
65.1
41.4
31.3
47.8
44.1
49.7
47.9
54.4
52.4
Jul'18 n=16
Aug'18 n=22
Sep'18 n=15
Oct'18 n=24
Nov'18 n=3
Dec'18 n=10
Jan'19 n=27
Feb'19 n=29
Mar'19 n=27
Apr'19 n=22
May'19 n=5
Jun'19 n=11
Jul'19 n=7
Date of Export: 7/18/2019 10:26 am (GMT-0400 (Eastern Daylight Time))

United Medical Center

#	PROJECT NAME	Vendors	Capital Expenditure Request #	PO#	$	Status	Summary of Project Costs	Anticipated Completion Date	Regulatory Compliance
1	PHARMACY (USP 797/800)	Waldon Studio Architects	CER2019-021; CER2019-019	056148	$ 273,449.00	RFP in progress; ready for permitting; Vendor Fair 7/24/19.	$ 1,000,000.00	11/15/2019	USP 797/800 by Dec 1, 2019 Meeting w/ DC Health 7/2/19
2	IT CLOSET HVAC (Phase 1 &2)	JBN Construction	CER2018-066	055973	$ 132,550.00	Construction/Permit Documents Complete. Drawings submitted to DCRA, should have Permit by 8-1-19. Contract in Final Negotiation. JBN Corporation selected by UMC. Vendor Fair 7/24.	$ 580,000.00		
3	Radiology FLOURO 3 & 4	JBN Construction			$ 400,000.00	Construction/Permit Documents Complete. Permit in Hand. Contract in Final Negotiation. JBN Corporation selected by UMC. Vendor Fair 7/24.	$ 400,000.00	10/1/2019	DC Health
4	Radiology : AHU Replacement	Envise	CER2019-015	055971	$ 784,643.00	In Progress	$ 784,643.00	9/15/2019	
5	Radiology: CT Rooms A/C Units	Envise	CER2019-025	056141	$ 173,836.00	Completed	$ 173,836.00	6/15/2019	DC Health
6	EMERGENCY DEPARTMENT	ON HOLD				ON HOLD	$ 4,080,000.00		DC Health
7	Rehab: PT/OT	ON HOLD	CER2019-020	056165	$ 451,574.00				
8	KITCHEN CART STORAGE	Horizon	CER2019-021;	056148	$ 93,712.00	ON HOLD	$ 750,000.00	11/15/2019	DC Health
			CER2019-018; CER2017-121	055376	$ 71,909.77	Permit resubmitted from 2017 expired permit. Expect to have Permit issued by. 7-31-19.	$ 71,500.00	9/15/2019	
9	KITCHEN REFRIGERATION	EMR	CER2019-020	056165	$ 9,700.00				
			CER2019-017	054010	$ 81,040.00	In Progress	$ 357,500.00	7/15/2019	DC Health
			CER2019-020	056165	$ 34,550.00	In Progress	$ -	7/15/2019	DC Health
10	STERILE PROCESSING	ON HOLD				ON HOLD		ON HOLD	
11	BRONCHOSCOPY/ENDO DESIGN	ON HOLD			$ 350,000.00	ON HOLD	$ 500,500.00	ON HOLD	
12	MRI Mobile (Coach & MRI)	United Imaging	CER2019-016	055972	$ 1,236,154.00	Purchased.	$ 1,236,154.00	8/30/2019	DC Health
13	MRI Modular Demo/Abatement (Modular & MRI)	JBN Construction	CER2019-020	056165	$ 93,600.00	Construction/Permit Documents Complete. Drawings submitted to DCRA - should have Permit by 8-1-19. Contract in Final Negotiation. JBN Corporation selected by UMC. Vendor Fair 7/24.	$ 225,000.00	8/30/2019	DC Health
14	ICU Restoration/Renovation (Post ServPro work)	Environments for Health (E4H) Architecture	CER2019-020	056165	$ 202,700.00	Design is 90% complete. On Temporary Hold pending Architect approval.	$ 2,800,000.00	In Progress	Flooding
20	Chillers & Cooling Towers Repairs	Envise	CER2019-026	056147	$ 99,500.00	To be completed 7/26/19.	$ 99,500.00	7/26/2019	
21	Roofing Repairs	Patuxent Roofing	CER2019-024	056140	$ 197,367.00	Completed	$ 197,367.00	6/15/2019	
22	HVAC Repairs	Envise	CER2019-023	056139	$ 68,000.00	In Progress	$ 68,000.00	In Progress	
23	ICU Siding/Panel Replacements	BECS (Building Envelope Cons)	CER2019-011	055951	$ 15,500.00		$ 15,500.00	In Progress	
24	OR Decomission/Abatement/Demo	JBN Construction	CER2019-020	056165	$ 69,450.00	Contract in Final Negotiation. JBN Corporation selected by UMC. Vendor Fair 7/24.	$ 99,313.50		DC Health
Total					$ 4,839,234.77		$ 13,438,813.50		

UMC

UNITED
MEDICAL CENTER

General Board Meeting

Date: July 24, 2019

Patient Safety & Quality Committee

Dr. Malika Fair, Chair

UMC

UNITED
MEDICAL CENTER

General Board Meeting

Date: July 24, 2019

Finance Committee Report

Wayne Turnage, Chair