General Board Meeting

Date: July 1, 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
Dennis Haghighat, MD
Konrad Dawson, MD
Brenda Donald
Malika Fair, MD
Millicent Gorham
Angell Jacobs
William Sherman
Velma Speight
Wayne Turnage
Robert Bobb
Marilyn McPherson-Corder, MD

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
Monday, July 1, 2019

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Finance Committee – Deputy Mayor 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 1310 Southern Avenue, SE, Washington, DC, 20032 at **10:00 a.m. on Monday, July 1, 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
April 24, 2019

V. CONSENT AGENDA
A. Dr. Dennis Haghighat, 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
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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, April 24, 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, CEO Matthew Hamilton, CMO Dr. Haghighat, CFO Lilian Chukwuma

Agenda Item	Discussion	Action Item
Call to Order	Meeting called to order at 9:19 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 OF MEDICAL STAFF REPORT: Dr. Haghighat** • A rise in surgical case volumes that was seen early in the year was reversed in recent months. ER volumes rose in March relative to the same month in 2018, reversing a recent downward trend and this trend reversal has continued thus far into the early days of April	

- UMC received a final plan of deficiency from DC Health following its annual licensing visit. The deficiencies were as described in the exit interview and UMC submitted its official plan of correction on 4/8/19. Official acceptance by DC Health is pending, but acceptance will trigger a timeline for a revisit from DC Health to assure compliance with the plan of correction. We are anticipating a repeat visit either in late May or the month of June. UMC also continues to move forward plans for both Fluoroscopy and Bronchoscopy rooms which were findings on prior licensing surveys. DC Health was updated on plans for both of these projects during their April visit.
- Although new service disruptions occurred in the month of March UMC continues to experience the residual effects of the lack of MRI services (12/18) and the ICU flood (1/19). The UMC leadership team met with DC Health in both March and again in early April to keep the department up to date on plans to resume full services in both areas. The prior ICU location continues to undergo lead abatement in a contained area while our architects are working on plans for rebuilding the ICU once the lead abatement has been completed. UMC will be without MRI services until late July of 2019. The timeline includes safe removal of the old MRI unit, building a cement pad as a foundation for the new permanent MRI, construction of a connection between the main building and the new MRI, and then placement of the new MRI unit. Each one of these steps also has required permitting and inspection approvals prior to moving to the next and once the MRI is in place clearance by DC Fire, DC Health, and a physicist (for the magnet) as further requirements.

EXECUTIVE REPORT: CEO Hamilton

- A vendor has been identified for renovation of the employee entrance, security entrance, and UD entrance.
- UMC is continuing to install new ceiling tiles, corner panel moldings, baseboards, and additional lighting to main hallways

- UMC has our Spring Cleaning initiative ongoing to declutter and organize clinical and administrative areas.
- HR has created an electronic HR shared drive to better organize contracts, meeting minutes, union documents, and recruits.
- UMC continues with the Performance Improvement Committee meetings. In March, eight departments presented information for performance improvement projects.
- Diabetes Center is currently focusing on improving insulin administration.
- UMC Quality Department is revamping the Quality Dashboard.

COMMITTEE REPORTS

PATIENT SAFETY AND QUALITY: Dr. Fair

- PSQ met on March 21, 2019.
- PSQ received a tracker for ICU remodeling so the Committee can track progress.
- ICU continues to be in a temporary space. The current ICU is on the fourth floor and has 14 beds and given the damage a total renovation is needed for the old ICU.
- 0 deliveries in the ED for February 2019.
- Length of Stay is averaging 5.3 days. And a new ambulatory transportation company is in use for non-emergencies.
- Transfer policy for Children's and the ED is currently with Children's Legal Team.
- UMC will have a Mock Survey. The CNO will take the lead.

	FINANCE COMMITTEE: Deputy Mayor Turnage • Finance Committee met on April 13, 2019. • CEO and OCFO to review the Gap Closing Plan to make certain it reflects the Committee's April 19th discussion, real trends, and represents what is realistically achievable in the remaining 6mo of the FY. • Total operating revenue is higher than budget by 8% (962K) for the month but lower by 3% ($2.4M) Year-To-Date (YTD). • Contributing Factors: Net patient revenues are below budget for the month and YTD by 4% (336K) and 7% (3.7M), due to shortfalls in activity. Admissions are below budget for the month and YTD by 10% and 2%. Although Psych volume is up, Med. Surg. and other admissions are down with a negative impact of $3.3M. Inpatient surgeries are below budget for the month and YTD by 18% and 13%. Outpatient surgeries are below budget for the month and YTD by 23% and 9%. ER visits are below budget for the month and YTD by 11%. Clinics visits are below budget for the month and YTD by 43% and 41%. • Total operating expense is higher than budget for the month and YTD by 17% (2M) and 2% (1M). • Contributing Factors: Salaries are higher than budget by 11% (569K) for the month, due to the timing of an expense accrual, but below budget by 1% (196K) YTD. Contract labor is higher than budget for the month and YTD by 45% ($75K) and 12% ($173K). Supplies are higher than budget for the month and YTD by 14% ($116K) and 18% ($839K). Purchased services are higher than budget for the month and YTD by 41% (619K) and 7% (604K). Other expenses are higher than budget for the month and YTD by 87% (808K) and 13% (754K). **BOARD GOVERNANCE REFRESHER**	

	• Chair May launched a refresher course for Board members that will span several Board meetings. The goal is to become more effective at serving the community. Topics included: Board composition, good governance methods, Board skills and qualifications, attendance, Board roles, By-law review, Board Accountability. • Next meeting will focus on effective Board oversight and ways to improve systems for the Board's duties. • The Board also participated in a pop quiz to test their knowledge of various Board governance duties and responsibilities. **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** **April 2019 Board Meeting Adjourned after 3 hours and 5 mins by Chair May.**	

General Board Meeting

Date: July 1, 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.**

May 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. 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

Dennis P. Haghighat, M.D

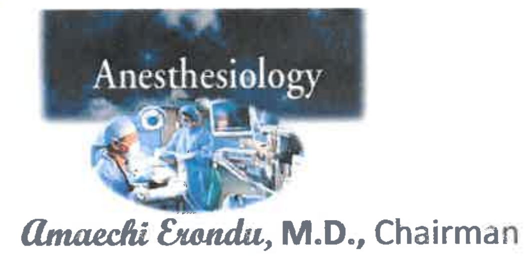
May 2019 CMO Board Report

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.



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

May

PERFORMANCE SUMMARY:

The overall cases for the month of May 2019 were 186 a decrease from 211 in April 2019. This is almost 9% decrease in total surgical volume compared to April, 2019.

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:

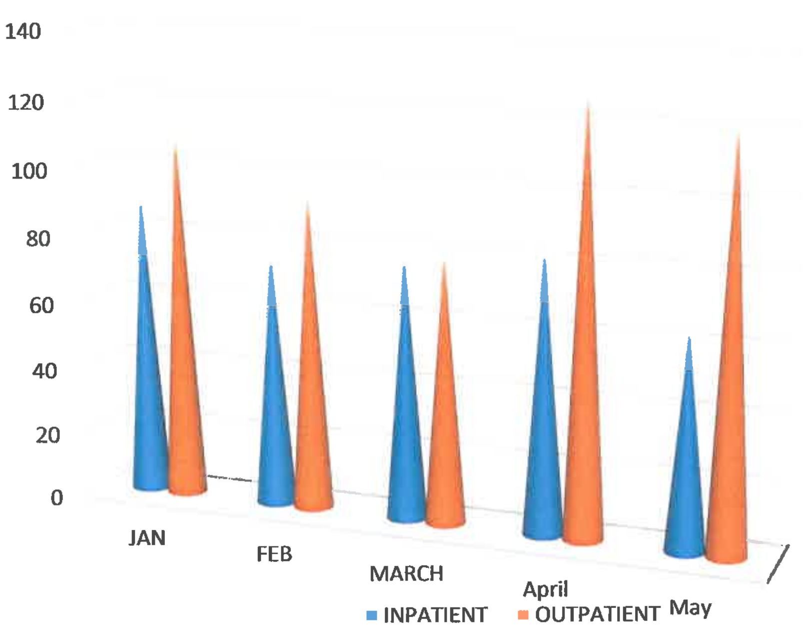
We are working with the **Orthopedic group** to develop a system throughput for the patients including a Pain management protocol.

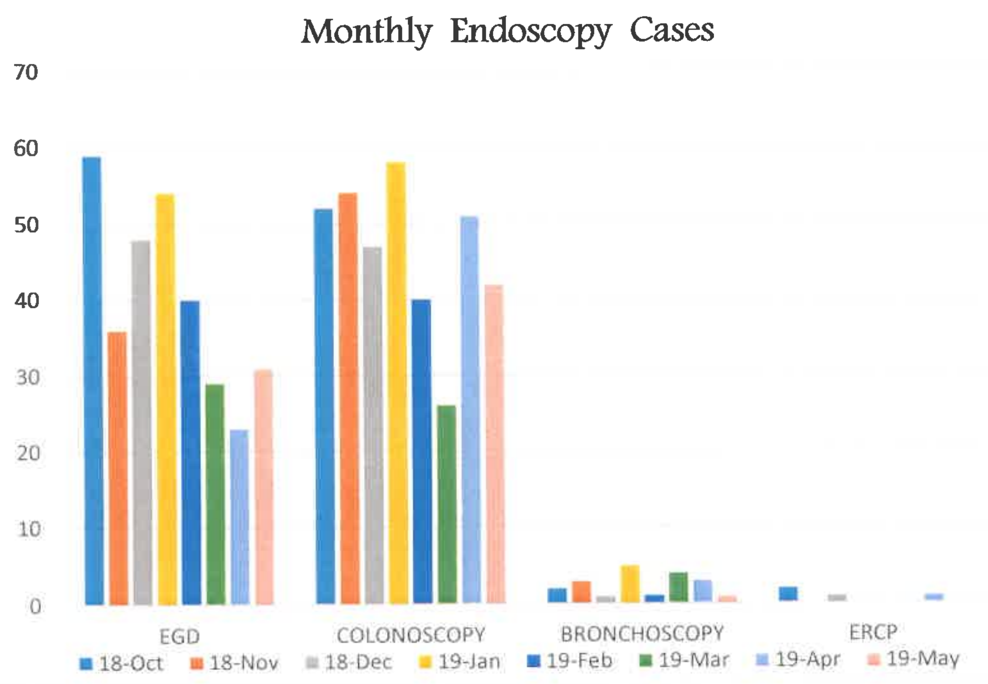
The **Mortality and Morbidity Conference** continues with increasing interest among the Provider community.

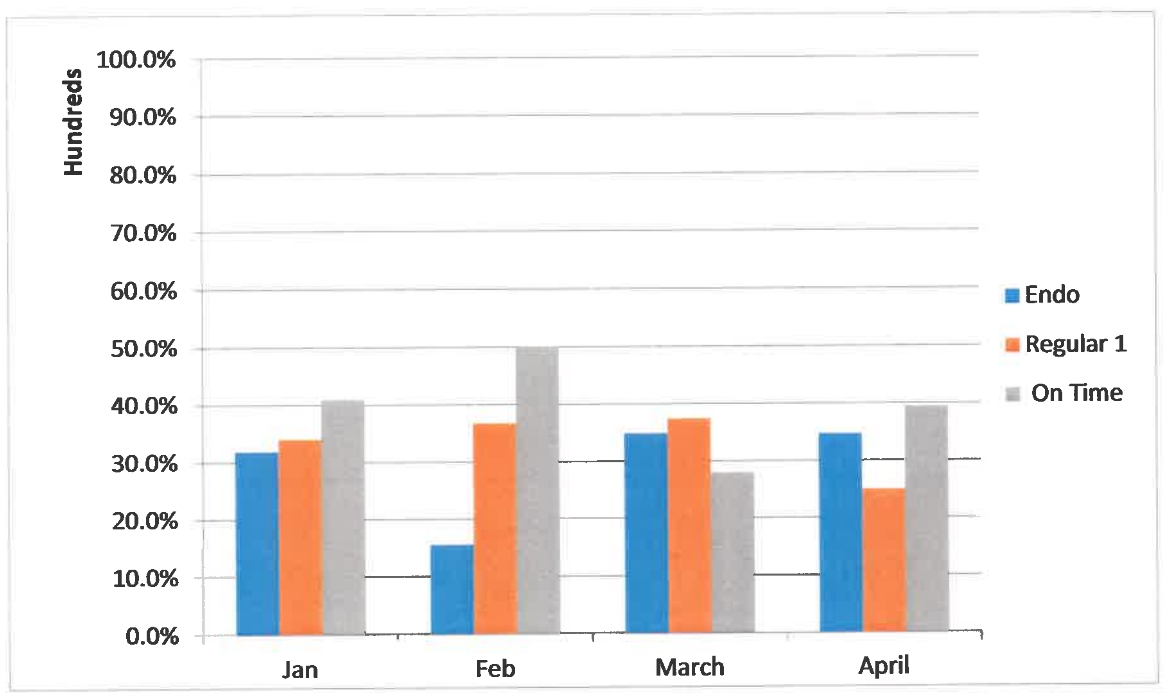
SERVICE (HCAHPS) SATISFACTION:
The Anesthesia Providers continue to provide quality service to our patients. We continue to provide real-time performance assessment of the anesthesia providers. We provide standardized service that ensures patient satisfaction.

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.


140
120
100
80
60
40
20
0
JAN
FEB
MARCH
April
May
INPATIENT
OUTPATIENT


Monthly Endoscopy Cases
70
60
50
40
30
20
10
0
EGD
COLONOSCOPY
BRONCHOSCOPY
ERCP
18-Oct
18-Nov
18-Dec
19-Jan
19-Feb
19-Mar
19-Apr
19-May



FIRST CASE ON-TIME START

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

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

May

In May, the Intensive Care Unit had 60 admissions, 57 discharges, and 262 Patient Days, with an Average Length of Stay (ALOS) of 4. 6 days. ICU managed 67 patients in May. There were 8 deaths for 57 discharges, with an overall ICU mortality rate of 14%. ICU managed 25 patients with severe sepsis and septic shock in May with 3 deaths attributed to severe sepsis/septic shock. Sepsis specific ICU mortality rate was 12 %. Two patients were transferred to GW University Hospital for higher level of care. There were two readmissions to ICU within 48 hours of transfer. Both were for newly developed medical conditions. Contamination 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. Critical Care Department has invited Washington Regional Transplant Consortium to attend UMC Critical Care Committee meetings Quarterly to provide performance summary and help identify areas for improvement. The ICU encountered one case of Legionella pneumonia from the community. The case was reported to DOH by Infection Prevention Staff.

1. **<u>ICU Mortality</u>**

   ICU had 8 deaths for 57 discharges, with an overall ICU mortality rate of 14 % for May. Mortality review is conducted in monthly Critical Care Committee meeting with Quality Department.

2. **<u>Severe Sepsis and Septic Shock</u>**

   ICU managed 25 patients with severe sepsis and septic shock in May. Three ICU deaths were directly attributable to severe sepsis and septic shock, with an ICU sepsis specific mortality rate of 12 %. The UMC Sepsis committee has been reconvened under directorship of Quality Department for continued support and monitoring of performance.

3. **<u>Infection Control Data</u>**

   For May, the ICU had 114 ventilator days with no Ventilator Associated Pneumonias (VAP), 88 Central Line device days with no Central Line Associated Blood Stream Infections (CLABSI) and 197 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 83 % in May.

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 May, 67 patients were managed in the ICU. There were two readmissions to the ICU within 48 hours of transfer out. One was for newly developed pulmonary embolism, and the second was for newly developed cardiac arrhythmias. In May, two patients were transferred from UMC ICU to GW University ICU for higher level care, needing angiography with embolization services not provided at UMC.

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

Musa Momoh, **M.D., Chairman**

May

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

- Admissions:
  - Observation admissions: Medicine 142; Hospital 143; Percentage: 99%
  - Regular admissions: Medicine 218; Hospital 326; Percentage: 67%
- Discharges:
  - Observation discharges: Medicine 131; Hospital 132; Percentage: 99%
  - Regular discharges: Medicine 194; Hospital 297; Percentage: 65%
- Procedures
  - Hemodialysis 119
  - EGD's 46
  - Colonoscopy 50
  - Bronchoscopy 1
- Quality
  - Cases referred reviewed: 3
  - Cases closed: 2

Department of Medicine met on June 12, 2019.
The next meeting is on September 11, 2019.
Morbidity and Mortality is scheduled for June 19, 2019.

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

Eric Li, M.D., Chairman

May

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	
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	
Review of Performed ABO Rh confirmation for Patient with no Transfusion History. Benchmark 90%	100%	100%	100%	100%	100%	
Review of Satisfactory/Unsatisfactory Reagent QC Results Benchmark 90%	100%	100%	100%	100%	100%	
Review of Unacceptable Blood Bank specimen Goal 90%	97%	100%	100%	99%	100%	
Review of Daily Temperature Recording for Blood Bank Refrigerator/Freezer/incubators Benchmark <90%	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	
Wasted/Expired Blood and Blood Products Goal 0	1	5	10	2	3	
Measure number of critical value called with documented Read Back 98 or >	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	
Sickle Cell	0/0	0/0	1/1	0/0	1/1	
ESR Control	100% 26/26	100% 28/28	100% 70/31	100% 68/27	100% 60/27	
Delta Check Review	100% 202/208	99% 170/171	99% 184/185	100% 184/184	100% 204/204	
Blood Culture Contamination – Benchmark 90%	92%	100%	94%	100%	100%	
ER HOLDING	98%	90%	89%	87%	88%	
ICU	92%	91%	95%	100%	92%	
STAT turnaround for ER and Laboratory Draws <60 min Benchmark 80%						
ER	83%	84%	82%	82%	83%	
LAB	80%	85%	87%	86%	90%	

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

Surendra Kandel, M.D., Chairman

DESCRIPTION	01	02	03	04	05	06	YTD
ADMISSIONS							
ALOS (Target <7 days)	6.26	5.67	5.70	4.98	4.64		5.5
Voluntary Admissions	22	33	41	54	54		204
Involuntary Admissions	47	52	54	60	80		293
Total Admissions	**69**	**85**	**95**	**114**	**134**		**497**
REFERRAL SOURCES							
CPEP	22	11	22	28	51		134
UMC ED	66	74	72	84	77		347
GWU	2	0	0	1	1		4
Providence	1	0	0	0	0		1
Georgetown	0	0	0	0	1		1
Sibley	1	0	0	0	0		1
UMC Medical/Surgical Unit	3	0	1	2	2		8
Children's Hospital	n/a	n/a	n/a	n/a	n/a		n/a
Howard	2	0	0	0	1		3
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		2
OTHER MEASURES							
Average Throughput Target: <2 hours	3.8	3.1	3.8	4.5	3.56		3.75
Psychological Assessments (Target: 100%)	95%	98%	90%	85%	99%		93.4%
DISCHARGE APPOINTMENTS							
Discharge Appointments for those d/c > 72 hours	68	74	87	95	114		438
Discharged to home without appointments/No discharge appointment information provided	5	3 (AMA)	5	3	14		30
Discharge Appointments for those d/c > 72 hours (Target: 100%)	**93%**	**87%**	**91.5%**	**92%**	**85%**		**89.7%**
OTHER							
Patients who went to Court	3	0	0	0	0		3

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

May

MONTHLY DEPARTMENT CHAIR REPORT

Performance Summary:

	INP		ER		OUT		TOTAL	
EXAM TYPE	**EXAMS**	**UNITS**	**EXAMS**	**UNITS**	**EXAMS**	**UNITS**	**EXAMS**	**UNITS**
CARDIAC CATH					1		1	
CT SCAN	107		609		193		909	
FLUORO	16		4		15		35	
MAMMOGRAPHY					130		130	
MAGNETIC RESONANCE ANGIO							0	
MAGNETIC RESONANCE IMAGING							0	
NUCLEAR MEDICINE	22		1		1		24	
SPECIAL PROCEDURES	25		0		4		29	
ULTRASOUND	111		241		226		578	
X-RAY	172		1092		829		2093	
ECHO	83		3		47		133	
CNMC CT SCAN			37				37	
CNMC XRAY			546				546	
GRAND TOTAL	536		2533		1446		4515	

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

2. Radiology staff continues to work to improve the turnaround of patients for radiology procedures. The MRI replacement solution is ongoing.

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

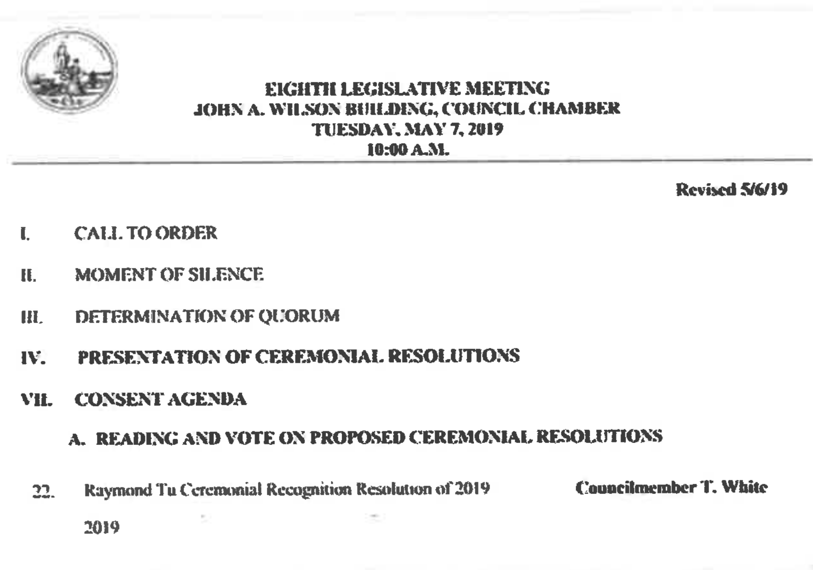
4. **Code Blue/Rapid Response Teams ("RRTs") Outcomes:** There was no rapid response.

6. **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 was recognized May 7th at the DC Council 8th Legislative Meeting for work in the District, locally at United Medical Center and DC Health Board of Medicine member and nationally as chair of the American College of Radiology Medicaid Network.



EIGHTH LEGISLATIVE MEETING
JOHN A. WILSON BUILDING, COUNCIL CHAMBER
TUESDAY, MAY 7, 2019
10:00 A.M.

Revised 5/6/19

I. CALL TO ORDER

II. MOMENT OF SILENCE

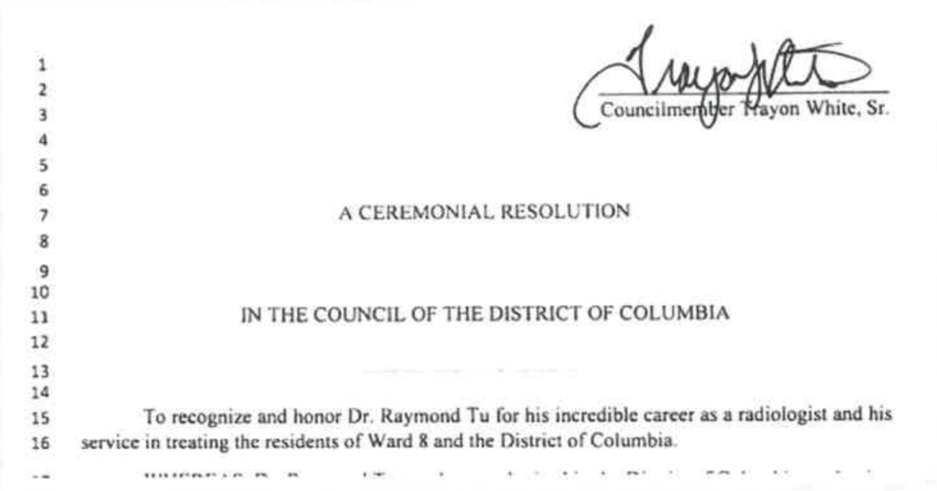
III. DETERMINATION OF QUORUM

IV. PRESENTATION OF CEREMONIAL RESOLUTIONS

VII. CONSENT AGENDA

A. READING AND VOTE ON PROPOSED CEREMONIAL RESOLUTIONS

22. Raymond Tu Ceremonial Recognition Resolution of 2019 — Councilmember T. White
2019



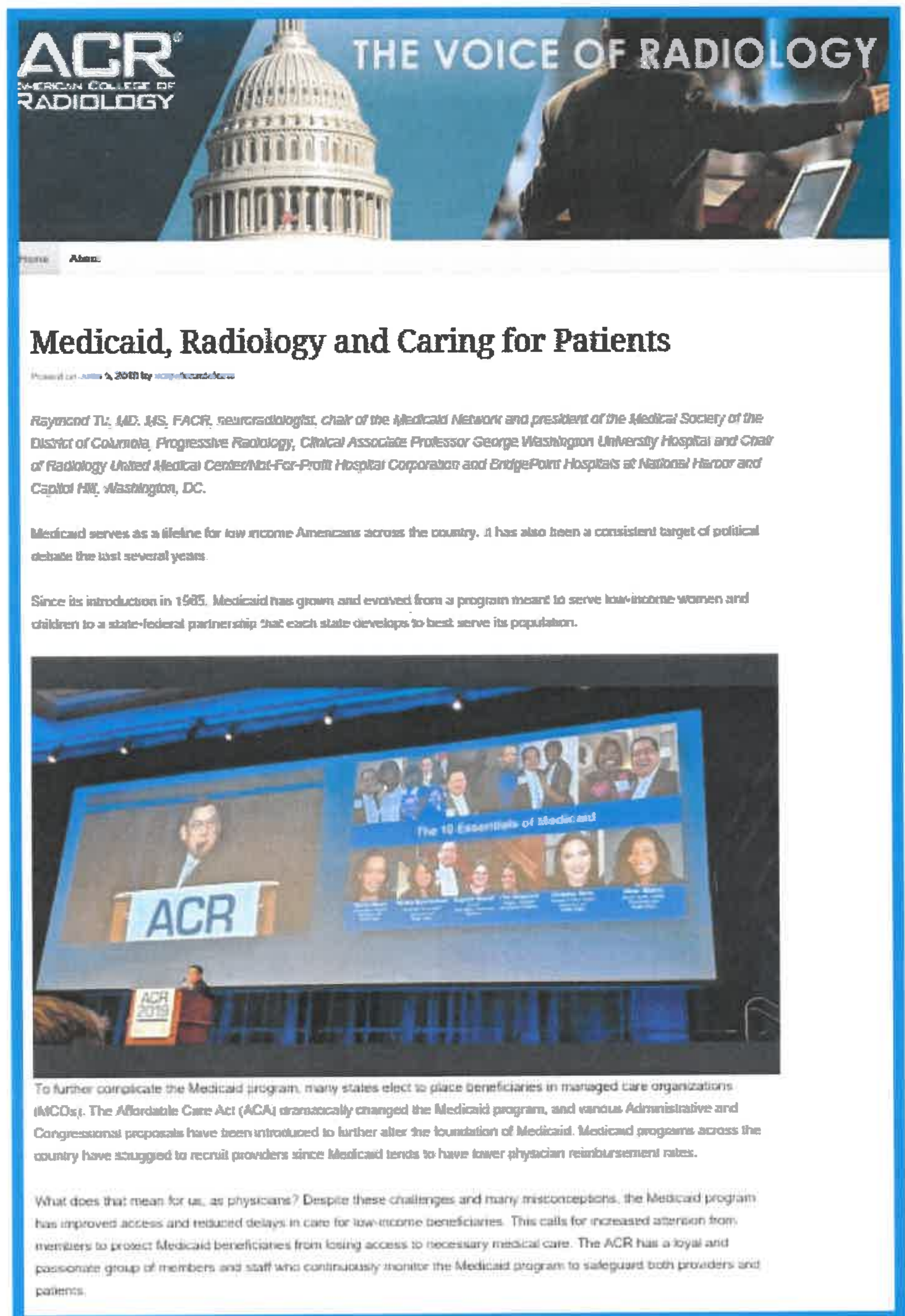
Councilmember Trayon White, Sr.

A CEREMONIAL RESOLUTION

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To recognize and honor Dr. Raymond Tu for his incredible career as a radiologist and his service in treating the residents of Ward 8 and the District of Columbia.

Annual meeting of the American College of Radiology (ACR) at Marriot Wardman, Washington, DC May 20th Dr. Tu Chair of the ACR Medicaid Network, session to the entire Counsel, and receiving award for Overall Chapter Excellence.



Medicaid, Radiology and Caring for Patients

Raymond Tu, MD, MS, FACR, neuroradiologist, chair of the Medicaid Network and president of the Medical Society of the District of Columbia, Progressive Radiology, Clinical Associate Professor George Washington University Hospital and Chair of Radiology United Medical Center/Not-For-Profit Hospital Corporation and BridgePoint Hospitals at National Harbor and Capitol Hill, Washington, DC.

Medicaid serves as a lifeline for low income Americans across the country. It has also been a consistent target of political debate the last several years.

Since its introduction in 1965, Medicaid has grown and evolved from a program meant to serve low-income women and children to a state-federal partnership that each state develops to best serve its population.

To further complicate the Medicaid program, many states elect to place beneficiaries in managed care organizations (MCOs). The Affordable Care Act (ACA) dramatically changed the Medicaid program, and various Administrative and Congressional proposals have been introduced to further alter the foundation of Medicaid. Medicaid programs across the country have struggled to recruit providers since Medicaid tends to have lower physician reimbursement rates.

What does that mean for us, as physicians? Despite these challenges and many misconceptions, the Medicaid program has improved access and reduced delays in care for low-income beneficiaries. This calls for increased attention from members to protect Medicaid beneficiaries from losing access to necessary medical care. The ACR has a loyal and passionate group of members and staff who continuously monitor the Medicaid program to safeguard both providers and patients.

<u>Financials:</u> 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

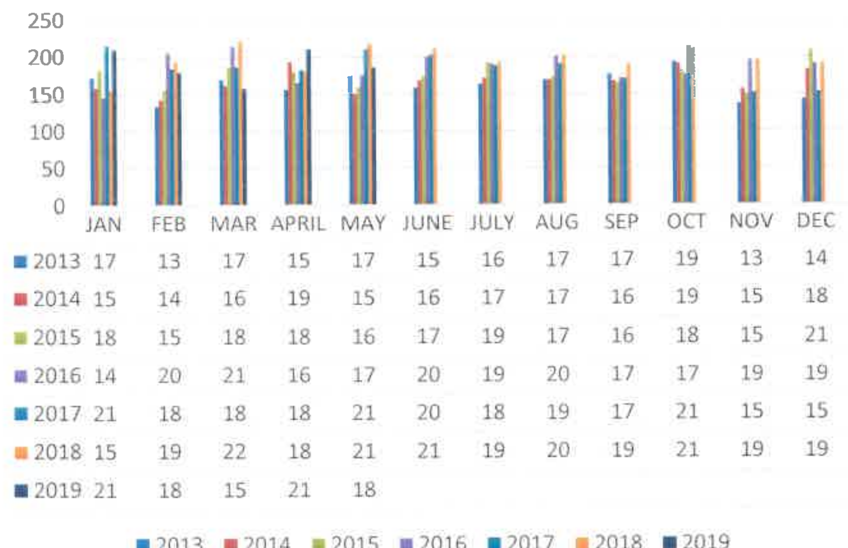
May

SUMMARY REPORT FOR MARCH 2019

For the month of May 2019, the Surgery Department performed a total of 186 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	
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 experienced a significant drop in surgical volume due, in part, to 1.) Vacation of 2 higher volume providers and 2.) the recent news of budget shortfalls and reduced subsidy payments to the hospital which lead to a few patients cancelling their planned surgery or not showing up because they thought the hospital was closed.

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 19, 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

Sarah Davis, CPMSM, Manager of Medical Affairs

APPLICATIONS IN PROCESS
(Applications received through May 31, 2019)

Department	# of Application in Process
Allied Health Practitioners	5
Anesthesiology	0
Emergency Medicine	7
Medicine	6
Pathology	0
Psychiatry	1
Radiology	3
Surgery	4
TOTAL	26

DEPARTMENT HIGHLIGHTS AND ANNOUNCEMENTS

	2015	2016	2017	2018	2019 Through May 31st
Total Number of Initial Appointments	48	30	23	89	27

	Jan	Feb	Mar	Apr	May
Total Number of Initial Appointments in 2019	3	9	6	0	9

MEDICAL STAFF CREDENTIALING ACTIVITY
JANUARY - MAY 2019

NEW APPOINTMENTS

Eyad Abu-Hamda, M.D. (Critical Care Medicine)
Matthew Bernetich, D.O. (Internal Medicine)
John Carroll, M.D. (Radiology)
Shanique Cartwright, M.D. (Psychiatry)
Acquanetta Frazier, M.D. (Gastroenterology)
Eleanor Frye, PA-C (Emergency Medicine)
Mikel Hofmann, M.D. (Internal Medicine)
Alisha Howell, PA-C (Emergency Medicine)
Nusirat Jinadu, M.D. (Nephrology)
Jonathan Johnson, M.D. (Wound Care – SNF)
Krishnan Kartha, M.D. (Radiology)
Laila Kassa, PA-C (Emergency Medicine)
Deborah Kelly-Williams, NP (Internal Medicine)
Jerome B. Klein, M.D. (Radiology)
Kumapley Lartevi, M.D. (Internal Medicine)
Gedeon F. Longtchi, NP (Internal Medicine)
Lia Losonczy, M.D. (Emergency Medicine)
Jeffrey N. Love, M.D. (Emergency Medicine)
Melissa Maloof, PA-C (Emergency Medicine)
Robert L. McKinney, PA-C (Emergency Medicine)
Michael L. Meadows, M.D. (Radiology)
Ijeoma Nwuju, DPM (Podiatry)
John D. Pavlus, M.D. (Radiology)
Jaime Salvatore, DO (Radiology)
Robert J. Shroyer, M.D. (Radiology)
Ismael H. Tura, M.D. (Critical Care Medicine)
Caitlin Ward, PA-C (Emergency Medicine)

RESIGNATIONS

Erin Athey, NP
Siobhan Burke, M.D.
Abbott B. Huang, M.D.
David Kim, M.D.
Anne Lesburg, M.D.
Joelle L. Mays, M.D.
Eric S. Postal, M.D.
Umar F. Rahman, M.D.
Kevin Semelrath, M.D.
Joylene W. Thomas, M.D.

General Board Meeting
Date: July 1, 2019

Medical Chief of Staff Report

Presented by:

Marilyn McPherson-Corder MD, Medical Chief of Staff

Chief of Staff Report
Board of Directors Meeting
May 22, 2019

MARCH

1. The Medical Executive Committee submitted the following action items to the Board of Directors during the 1st Quarter of 2019:

MONTH	ACTION ITEM
JANUARY	1. Requests for initial appointment, reappointment, change in category, and resignation in good standing from the Credentials Committee. 2. Revision of Form 162 – AMA/Elopement Form 3. Revision to Patient Rights and Responsibility Form
FEBRUARY	1. Requests for initial appointment, reappointment, change in category, and resignation in good standing from the Credentials Committee.
MARCH	1. Requests for initial appointment, reappointment, change in category, and resignation in good standing from the Credentials Committee.

APRIL

1. Oncology Services – An article that appeared in the April 4, 2019 issue of the *Washington City Paper* reported that the hospital's partnership with Sibley will be ending in 90 days, closing the Oncology Clinic on United Medical Center's campus based on communications received from hospital leadership. The Medical Staff was periodically updated by Hospital Administration of the impending closure at Medical Executive Committee meetings in October 2018 and April 2019.

2. Peer Review Case – The Medical Staff completed a peer review investigation involving a surgeon on staff, which resulted in restriction of privileges. The provider requested a hearing which was concluded on April 5, 2019 and a decision to uphold the restriction of privileges was made. The provider has exercised his right to appeal the decision of the Hearing Committee at the Board level by submitting a letter dated April 29, 2019.

Submitted by: Marilyn McPherson-Corder, M.D.
Chief of Staff

General Board Meeting
Date: July 1, 2019

Management Report

Presented by:
**Ira Gottlieb,
Interim Chief
Executive Officer**

United Medical Center
Management Report
Operations Summary – June 2019

QUALITY

Patient Safety

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. Discussions during this meeting included the "Good Catch Program." The Quality department is looking for feedback from the leaders on how to encourage safety reporting from staff and a reward and recognition program. All feedback is welcome at this time. The Quality department goal is to complete the LeapFrog hospital survey which will be submitted by June 30, 2019. The survey results will assist UMC in its journey to becoming a high reliability organization internally and externally with our staff and customers.

Sepsis Committee

The Quality team met with nursing leaders and physicians to discuss the fundamentals of a Sepsis Committee. The Sepsis Bundles and increasing the compliance rate with sepsis bundles were discussed, and metrics were reviewed. We will continue to meet monthly to formulate a foundation for UMC to meet the measures of the Surviving Sepsis Campaign.

Quality Assessment and Performance Improvement (QAPI)

This month UMC had six departments submit performance improvement projects. Some projects highlighted included Respiratory Services and Information Technology. The Respiratory Services presented on adherence to nebulizer treatments. This performance improvement project will assist in providing safe and quality care with optimal patient outcomes when patients are receiving treatments timely. Lastly, Information Technology highlighted methods of improving the performance and fixing security vulnerabilities through patching. The goal is to ensure tracking and timely patching is occurring in order to protect the organization and network from cyber-attacks.

During the QAPI meeting, the QAPI dashboard was discussed and also presented. Each department will have a copy of their performance improvement project dashboard. This dashboard will include the numerator and denominator of the performance measures being tracked for compliance. The dashboard will also display the compliance rate.

The most important aspect of the dashboard will be the summary of results and analysis and the action plan and follow-up section. These sections will assist leaders to ensure the data is being analyzed. It will also assist meeting the benchmark/thresholds with an action plan and follow-up.

EMERGENCY DEPARTMENT→ QAPI MEETING																			
DOOR TO TRAIGE TIME							BENCHMARK-												
# Patients Triaged		30	30	30	30									90	30	0	0	120
# Patients Met Triage Goal		30	30	30	30									90	30	0	0	120
% Compliance		100%	100%	100%	100%	-	-	-	-	-	-	-	-	100%	100%	-	-	100%

SUMMARY OF RESULTS & ANALYSIS	ACTION PLAN & FOLLOW UP
The emergency Department has exceeded the benchmark by triaging patients less than 30 minutes upon arrival.	*Continuous monthly audits and training of new staff will be ongoing.*

The Hospital Quality Dashboard was complete and presented on May 1, 2019. A copy of the dashboard will be sent to the Board of Directors monthly for review. As mentioned previously the dashboard will highlight areas such as Blood Products Management, Fall Prevention, Infection Prevention and Control and other areas suggested for tracking by The Joint Commission. This dashboard will be included with the monthly Quality Operations Summary.

REGULATORY 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 department leaders continue to educate staff on regulatory guidelines, audits for compliance are being completed, and daily surveillance with rounding occurs. UMC senior leaders have met with the Quality department to ensure the plan of correction was addressed and areas of concern were mitigated. Leaders have met 2-4 times per week to ensure compliance. UMC departments continue to work in their areas to ensure compliance with hospital regulations as well as policy and procedures.

The Quality department continues to meet with departments weekly for any updates/reviews/archives of policies. These meetings will transition to the formal Policy and Procedures Committee at the end of August and will meet monthly. At the end of August, the plan will be to upload all policies into the PolicyTech software system.

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
Febrile Reaction		0	0	0	0	0								0	0	0	0	0
Hemolytic Reaction		0	0	0	0	0								0	0	0	0	0
Non-Specific Reaction		0	0	0	0	0								0	0	0	0	0
BLOOD TRANSFUSION RECORD REVIEW																		
Transfusions		233	122	100	130	149	0	0	0	0	0	0	0	455	279	0	0	734
Cryoprecipitate Transfusions		2	0	0	0	5								2	5	0	0	7
Fresh Frozen Plasma Transfusions		39	7	19	0	14								65	14	0	0	79
Platelet Transfusions		6	2	10	13	14								18	27	0	0	45
RH Immunge Globulin (RhIG)		0	2	3	0	1								5	1	0	0	6
Total Red Blood Cells **(RBCs)** Transfused		186	111	68	117	115								365	232	0	0	597
Total RBC units Crossmatched		229	148	97	178	147								474	325	0	0	799
Crossmatch/Transfusion Ratio Threshold <2		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	-	-	-	-	-	-	-	1	1	0	0	1.35812
BLOOD TRANSFUSION JUSTIFICATION																		
# Times O- BLOOD TRANSFUSED TO NON O- PT.		15	0	0	8	10								15	18	0	0	33

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%
MD Order Confirmed						100%									100%			100%
Consent Signed						88%									88%			88%
2 RN Signature						100%									100%			100%
Transfusion Reaction		0%	0%	0%	0%	0%								0%	0%			0%
FALL PREVENTION																		
# Falls Housewide		8	11	14	10	10								33	20	0	0	53
# Falls - ED		0	1	3	1	2								4	3	0	0	7
# Falls - Outpatient		0	0	0	0	0								0	0	0	0	0
# Falls - Inpatient		8	10	11	9	7								29	16	0	0	45
# Falls - Visitor		0	0	0	0	1								0	1	0	0	1
Inpatient Days (Includes Observations.)		1980	1666	1769	2339	2140								5415	4479	0	0	9894
# Falls - With Injury		0	0	3	0	1								3	1	0	0	4
INPATIENT FALL RATE		4.0	6.0	6.2	3.8	3.3	-	-	-	-	-	-	-	5.4	3.6	-	-	4.5
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
MS/T CLABSI RATE		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
CCU CLABSI RATE		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
CAUTI -MS/T RATE		0	0	0	0	0								0	0	0	0	0
CAUTI -CCU		0	0	0	0	0								0	0	0	0	0
CAUTI -CCU RATE		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
Ventilator Associated Condition Rate		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
MRSA Rate		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	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
C.Diff Rate																-	-	
VANCOMYCIN RESISTANT ENTEROCOCCUS (VRE)						**THRESHOLD RATE <1/YR**												
VRE Healthcare Acquired Infection																0	0	
VRE Rate		1					-	-	-	-	-	-	-			-	-	
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								5	3	0	0	8
# SSI from Colon Surgeries																0	0	
# Major Orthopedic Surgeries		2	2	5	3	3								9	6	0	0	15
# SSI fromOrthopedic Surgeries																0	0	
DEVICE UTILIZATION RATE (DUR)																		
# PATIENT DAYS-TOTAL		1980	1666	1769	2339	2140	0	0	0	0	0	0	0	5,415	4,479	0	0	9,894
# Patient Days - MS		447	435	430	683	435								1,312	1,118	0	0	2,430
#Patient Days-Tele		1288	995	1114	1389	1146								4,786	2,535	0	0	5,932
#Patient Days MS/T		1735	1430	1544	2072	1581	0	0	0	0	0	0	0	4,709	3,653	0	0	8,362

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								706	336	0	0	1,042
FOLEY DUR	THRESHOLD: < 1/YR																	
# Foley Days - MS		48	26	27	54	22								101	76	0	0	177
FOLEY DUR - MS		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	-	-	-	-	-	-	-	[illegible]	[illegible]	-	-	[illegible]
#Foley Days-Tele															0	0	0	0
FOLEY DUR - Tele							-	-	-	-	-	-	-		0.00	-	-	0.00
# Foley Days - CCU		182	174	145	167	197								668	364	0	0	865
FOLEY DUR - CCU		[illegible]	[illegible]	[illegible]	[illegible]	2.86	-	-	-	-	-	-	-	0.95	1.08	-	-	[illegible]
# Foley Days - TOTAL		48	26	27	54	22	0	0	0	0	0	0	0	101	76	0	0	177
CENTRAL LINE DUR	THRESHOLD: MS< 1/YR TELE < 1/YR CCU < 1/YR																	
# Central Line Days - MS		36	20	31	42	50								87	92	0	0	179
CENTRAL DUR - MS		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	-	-	-	-	-	-	-	[illegible]	[illegible]	-	-	[illegible]
#Central Line Days-Tele																		
CENTRAL DUR TELE							-	-	-	-	-	-	-		0.00	-	-	
# Central Line Days - CCU		97	93	102	101	88								292	189	0	0	481
CENTRAL DUR - CCU		[illegible]	[illegible]	[illegible]	[illegible]	1.28	-	-	-	-	-	-	-	[illegible]	[illegible]	-	-	[illegible]
# Central Line Days - TOTAL		133	113	133	143	138	0	0	0	0	0	0	0	379	281	0	0	660
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
VENT DUR - 8W		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	-	-	-	-	-	-	-	[illegible]	[illegible]	-	-	[illegible]
# Ventilator Days - CCU		109	118	74	102	114								301	216	0	0	517
VENT DUR - CCU		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	-	-	-	-	-	-	-	[illegible]	[illegible]	-	-	[illegible]
# Ventilator Days - TOTAL		109	118	74	102	114	0	0	0	0	0	0	0	301	216	0	0	517
TRANSMISSION BASED PRECAUTIONS																		
Airborne-MS/T		2	2	4	6	2								8	8	0	0	16
Airborne-CCU		0	0	0	0	0								0	0	0	0	0
Airborne-Total		2	2	4	6	2	0	0	0	0	0	0	0	8	8	0	0	16
Droplet - MS/T		3	1	5	4	2								9	6	0	0	15
Droplet - CCU		0	0	2	0	0								2	0	0	0	2
Droplet - TOTAL		3	1	7	4	2	0	0	0	0	0	0	0	11	6	0	0	17
Contact - MS/T		173	102	117	25	35								392	60	0	0	452
Contact - CCU		23	15	9	4	14								47	18	0	0	65
Contact - Total		196	117	126	29	49	0	0	0	0	0	0	0	439	78	0	0	517
Contact Enteric - MS/T		5	3	1	1	3								9	4	0	0	13
Contact Enteric - CCU		2	1	0	0	2								3	2	0	0	5
Contact Enteric - TOTAL		7	4	1	1	5	0	0	0	0	0	0	0	12	6	0	0	18

UMC QUALITY Dashboard		At or Exceeds Target (green)						Within 10% of Target (yellow)				Target not Met (red)		Amended (blue)		
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								1	2	0	0	3
Neutropenic - CCU		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								403	265	0	0	668
# Hand Hygiene Obs.		150	150	150	160	150								450	310	0	0	760
% Hand Hygiene Compliance-Hospital Wide		87%	[illegible]	[illegible]	[illegible]	80%	-	-	-	-	-	-	-	[illegible]	[illegible]	-	-	[illegible]
HAND HYGIENE COMPLIANCE STRATIFIED PER ROLE THRESHOLD>90%																		
# Obs. EMPLOYEE		115	106	119	138	131								340	269	0	0	609
# Compliant Obs. Employee		101	100	114	126	101								315	227	0	0	542
EMPLOYEE RATE		88%	[illegible]	[illegible]	[illegible]	77%	-	-	-	-	-	-	-	[illegible]	[illegible]	-	-	[illegible]
# Obs. PROVIDER		35	44	31	22	19								110	41	0	0	151
# Compliant Obs. PROVIDER		29	35	24	19	16								88	35	0	0	123
PROVIDER RATE		83%	80%	77%	86%	84%	-	-	-	-	-	-	-	80%	85%	-	-	82%
# 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								90	60	0	0	150
# Compliant Obs.ED		24	20	19	22	20								63	42	0	0	105
ED RATE		80%	67%	63%	73%	67%	-	-	-	-	-	-	-	70%	70%	-	-	70%
# Obs. PeriOperative (PeriOP)		30	30	30	30	10								1	40	0	0	130
# Compliant Obs. PeriOp		30	30	30	30	5								90	35	0	0	125
PeriOp Services RATE		100%	100%	100%	100%	50%	-	-	-	-	-	-	-	100%	88%	-	-	96%
# Obs. MS/T		60	60	60	80	80								180	160	0	0	340
# Compliant Obs. MS/T		50	57	59	73	74								166	147	0	0	313
MS/T RATE		83%	95%	98%	91%	93%	-	-	-	-	-	-	-	92%	92%	-	-	92%
# Obs. CCU		30	30	30	20	30								90	50	0	0	140
# Compliant Obs. CCU		26	28	30	18	25								84	43	0	0	127
CCU RATE		87%	93%	100%	90%	83%	-	-	-	-	-	-	-	93%	86%	-	-	91%
TERMINAL CLEANING VALIDATION OF THE OR ROOMS - THRESHOLD 100%																		
OR Room 1 Cleanings						31								0	31	0	0	31
OR Room 1 Validation						31								0	31	0	0	31
OR Room 1 Cleaning Rate	100%					100%	-	-	-	-	-	-	-	-	100%	-	-	100.0%
OR Room 2 Cleanings						31								0	31	0	0	31
OR Room2 Validation						31								0	31	0	0	31

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%
OR Room 3 Cleanings						31								0	31	0	0	31
OR Room 3 Validation						31								0	31	0	0	31
OR Room 3 Cleaning Rate	100%					100%	-	-	-	-	-	-	-	-	100%	-	-	100%
OR Room 4 Cleanings						31								0	31	0	0	31
OR Room 4 Validation						31								0	31	0	0	31
OR Room 4 Cleaning Rate	100%					100%	-	-	-	-	-	-	-	-	100%	-	-	100%
MEDICATION SAFETY																		
BARCODE MEDICATION ADMINISTRATION (BCMA) - Hospital Wide						THRESHOLD >95%												
%Pt Scanned		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]								[illegible]	[illegible]			[illegible]
%Medications Scanned		[illegible]	[illegible]	[illegible]	86.21%	87.74%								[illegible]	86.98%			[illegible]
MEDICATION RECONCILIATION WITHIN 24 HOURS - INPATIENT ADMISSION						THRESHOLD >95%												
# Patient Records Reviewed						4361								0	4361	0	0	4361
# Records Med Rec Complete						3285								0	3285	0	0	3285
% Med. Rec. Within 24 Hours						75.3%	-	-	-	-	-	-	-	-	75.3%	-	-	75.3%
MEDICATION ERRORS REPORTED																		
# TOTAL ERRORS		4	3	4	2	2	0	0	0	0	0	0	0	11	4	0	0	15
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
MED-DELAY		2	0	2	0	1								5	1	0	0	5
MED-WRONG STRENGTH		0	0	1	0	0								1	0	0	0	1
MED-OMISSION		0	0	0	0	1								1	1	0	0	1
MED-UNORDERED MED.		0	0	0	0	0								0	0	0	0	0
MED-OTHER		2	3	1	2	0								8	2	0	0	8
MED-WRONG DOSE		0	0	0	0	0								0	0	0	0	0
MED-WRONG MEDICATION		0	0	0	0	0								0	0	0	0	0
MED-WRONG PATIENT		0	0	0	0	0								0	0	0	0	0
MED-WRONG RATE		0	0	0	0	0								0	0	0	0	0
MED-WRONG TIME		0	0	0	0	0								0	0	0	0	0
PATIENT SATISFACTION/PERCEPTION OF CARE																		
#Grievances/Complaints		6	13	8	15	20								62	35	0	0	62
Recommend Hospital %		24%	33%	55%	27%	69%								34%	22%	0	0	34%
Overall Hospital Rating %		30.8	50	42.3	45.7	47.9								41.033	48.8	0	0	64.19
STAR Rating		1	1	1	1	1								5	2	0	0	5
CLINICAL OUTCOMES																		
Total Code Blue Events (outside of CCU)		5	5	2	3	5								12	8	0	0	20

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	-	-	-	-	-	-	-	2.5579	1.8095	0	0	2.25855
Patient Days		1735	1430	1544	2339	2140								4709	4479	0	0	9188
Tele		3	4	2	1	2								9	3	0	0	12
M/S		2	0	0	1	1								2	2	0	0	4
BHU		0	1	0	0	1								1	1	0	0	2
Dialysis		0	0	0	1	0								0	1	0	0	1
OR		0	0	0	0	0								0	0	0	0	0
PACU		0	0	0	0	1								0	1	0	0	1
Radiology		0	0	0	0	0								0	0	0	0	0
Total Rapid Response Events		8	16	7	11	12								31	23	0	0	54
Rapid Response Rates		4.611	11.189	4.5337	4.7029	5.6075	-	-	-	-	-	-	-	6.5831	5.1351	-	-	5.87723
Tele		6	11	5	7	5								22	12	0	0	34
M/S		1	2	1	4	1								4	5	0	0	9
BHU		1	3	0	0	1								4	1	0	0	5
Dialysis		0	0	1	0	4								1	4	0	0	5
OR		0	0	0	0	0								0	0	0	0	0
PACU		0	0	0	0	1								0	1	0	0	1
Radiology		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	0	0.00%
VTE Prophylaxis MS/T Compliance %		95%	92%	97%	90%	93%								93.00%	91.33%	0	0	92.40%
VTE Prophylaxis CCU Compliance %		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	0	0	1
Restraint Rate					0.004	0									0.004	0	0	0.004
Deliveries in the ED		0	0	0	0	1								1	1	0	0	1
SQ Insulin Administration Adherence %		97%	55%	96%	[illegible]	[illegible]								[illegible]	[illegible]			[illegible]
PRESSURE ULCERS				THRESHOLD <6%														
Total Patient Days		1980	1666	1769	2339	2140								5415	4479	0	0	9894
# Present on admission		50	65	65	56	34								270	90	0	0	270
Prevalance Rate		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	-	-	-	-	-	-	-	[illegible]	[illegible]			[illegible]
# Hospital Acquired Pressure Injuries		2	1	3	3	1								6	4	0	0	10
Incidence Rate		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	-	-	-	-	-	-	-	[illegible]	[illegible]			[illegible]
OCCURRENCE REPORTS																		
# OCCURRENCE REPORTS		113	124	134	109	116	0	0	0	0	0	0	0	371	225	0	0	596
EQUIPMENT		1	1	1	2	2								3	4	0	0	7
FALLS		8	11	14	10	10								33	20	0	0	53
MEDICATION		5	3	4	2	2								12	4	0	0	16

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		99	109	115	95	102								520	197	0	0	520
# NEAR MISSES		UNK	UNK	UNK	UNK	UNK								0	0	0	0	0
# SENTINEL EVENTS		0	0	0	0	0								0	0	0	0	0
SEPSIS MEASURES																		
Sepsis (Principal DX) 30 Day Readmit		0	0	1	0	0								1	0	1	0	0
Simple Severe Sepsis w/Shock		17	11	8	8	8								36	27	24	16	8
Sepsis Patients Observed Mortality (APR DRG 720)		0	0	0	0	0								0	0	0	0	0
Sepsis Patients Volume (APR DRG 720)		40	29	27	31	22								96	87	80	53	22
CASE MANAGEMENT				THRESHOLD LOS < 5.5														
Average Length of Stay		5.98	[illegible]	5.99	5.6	[illegible]	-	-	-	-	-	-	-	5.82333	[illegible]			5.684

PATIENT CARE SERVICES

8W

Month	Admission	ADC	Falls	Elopement	AMA	Restrains	Code Blue	Rapid Response
May	158	42.4	4	0	15	1	3	2

Education:

- New Sharps and Hazardous Waste Containers
- DOH Corrective Action Plan Wound Department*RELIAS module
- Proper positioning of medical devices for wound prevention
- New Type and Screen/Type and Cross Checklist
- Sepsis Core Measures and Treatment that Improves Patient Outcomes
- Updated Accu-Chek Inform Lab Policy
- Drug Shortage Bulletin

PI Initiatives:

- 100% Compliance with Positive Patient Identification (DOH PoC)
- Screening and identification of isolation patients (DOH PoC)
- Implement Press Ganey strategies to improve performance and patient satisfaction
- Remove locks from patient bathroom doors
- Get 8W brochure approved for distribution
- Increase Insulin administration compliance
- Improve on narcotic waste documentation
- Wound treatment and prevention

Service Recovery:

- Continue to implement Heart-Head-Heart Language of Caring
- HCAPS monitoring and action planning
- Manager proactively rounds on all new admissions daily
- Charge nurses round daily on patients and as needed to address any questions comments or concerns
- Manager conducts discharge/follow-up phone calls to patients 24-48 hours post discharge
- Coach/counsel staff to use effective interpersonal communication with patients and families
- Patients and or family will receive customer service letter as follow up to complaint

5W

Month	Admission	ADC	Falls	Elopement	AMA	Restrains	Code Blue	Rapid Response
May	78	11	2	0	2	1	1	1

Education:

- There has been 100% compliance with DOH Corrective Action Plan - Wound Training in Relias.

PI Initiatives:

Pain Management

- 12 charts were reviewed for pain reassessment for the month of May. There was 100% compliance with reassessment, 0 reassessments were late.

Allergies

- 14 charts were reviewed for allergies. 100% were completely updated however only 40% of patients with allergies (2/5) had allergy bracelets applied.

Medication Reconciliation

- 14 charts were reviewed for medication reconciliation. 93% (13) were in compliance.

Wounds

- There were a total of 28 wounds noted. Six (6) were pressure wounds and 22 were non-pressure (surgical, diabetic, venous, arterial, skin tears and blisters).
- There were no HAPIs for the month of May.
- Wound prevention intervention initiative implemented in collaboration with Wound Care department. Daily audits conducted and disciplinary action taken in instances of non-compliance.

Falls

- There were two (2) reported falls in the month of May, 0 variance from April. Both were unwitnessed and in both instances the Morse scale assessments were completed prior. None of the falls resulted in injury.
- Fall prevention interventions continue.

Elopement

- There were no elopements for the month of May.

Service Recovery:

- A total of 66 patient rounds were done for the month of May by nursing leadership. 31% of concerns were related to pain management, 6% related to discharge planning, 6% to diet/food, 7% to MD communication and 50% related to other factors. Staff continues to be educated on how to address patient complaints and other issues related to patient safety in staff meetings and huddles.

BEHAVIORAL HEALTH

Month	ADM	ADC	AMA	Discharge	Falls	Elopements	Seclusion	Rapid Response	Physical/Chemical Restraints	Diabetic Event
May	134	21.0	2	131	0	0	2	0	0/0	0

Note: Transfers to St. Elizabeth's = 2
Transfers to Medical floor = 1

Education:

- UMC's first Comprehensive Crisis Management (CCM) training was jointly launched on 5-30-2019 by Education and BHU. Four (4) staff were present for the training.
- April's psychosocial coaching resulted in 99% assessment completion. Case Managers were coached on psychosocial accuracy and documentation.
- Screening, Brief Intervention and Referral to Treatment (SBIRT) and Medication Assistance Therapy (MAT) Peer Recovery Coaches encountered, educated and offered MAT along with outpatient referral to 541 Emergency Room patients since May 1st, 2019.
- DOH: Education with attestation on the importance of Q 15 minute observational rounding continues.
- DOH: Single-Use blood pressure cuffs and accurate refrigerator/freezer documentation coaching continues.

PI Initiatives:

- MAT and Peer Recovery Coaches continues to expand here at UMC with a second grant which will provide a 1.6 FTE for an Overdose Survivor Outreach Program (OSOP) coach. The OSOP receives referrals from the ED but provides supports to patients in the community setting.
- Violence and Aggression (Restraints and Seclusion): BHU continues to experience success with de-escalating patients when faced with violence. Although BHU had two seclusions, each seclusion was discontinued immediately when violence ceased. By staff relying on their crisis prevention and de-escalation skills, patient injuries were avoided.
- BHU's waterproofing renovations stemming from the 2018 flood incident has launched.
- Reintegration of male-female patients is in phase II. Proposal letter drafted per CEO Hamilton's recommendations and BHU is working with Quality and Nursing Administration to complete final draft.
- Dr. Jacqueline Payne-Borden performed EOC rounds on BHU.

Service Recovery

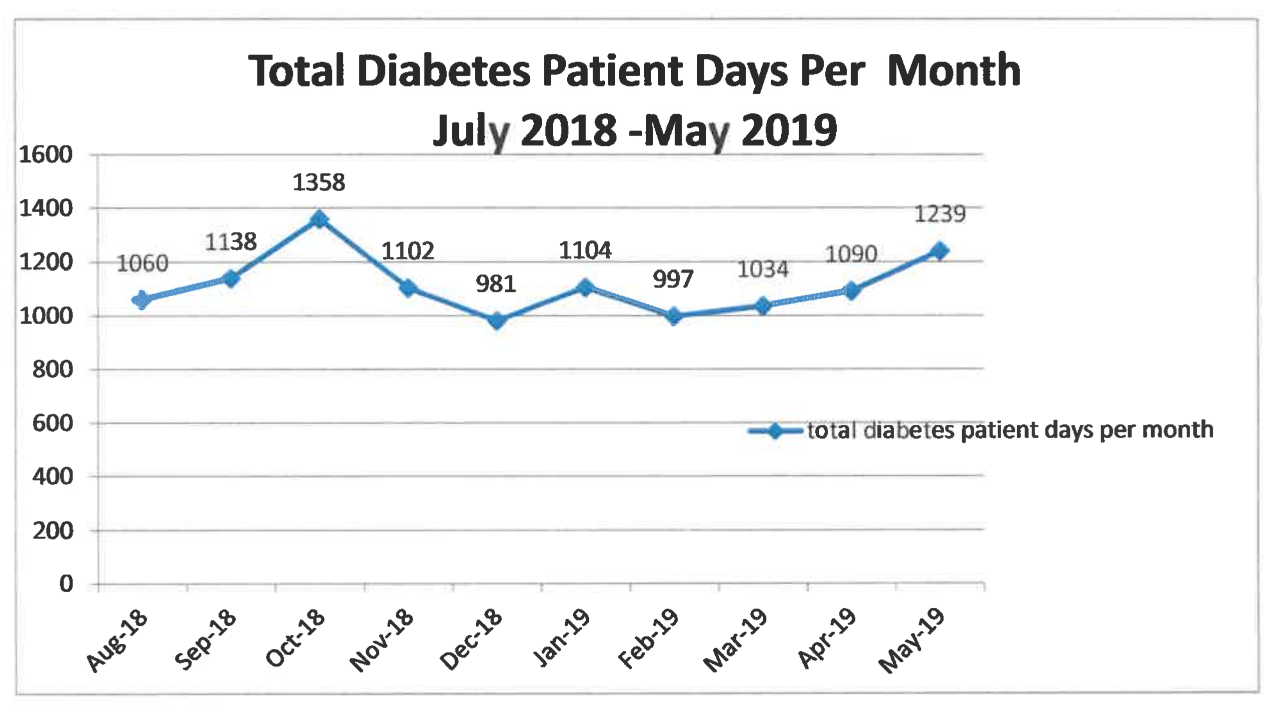
No service recovery highlights for month of May.

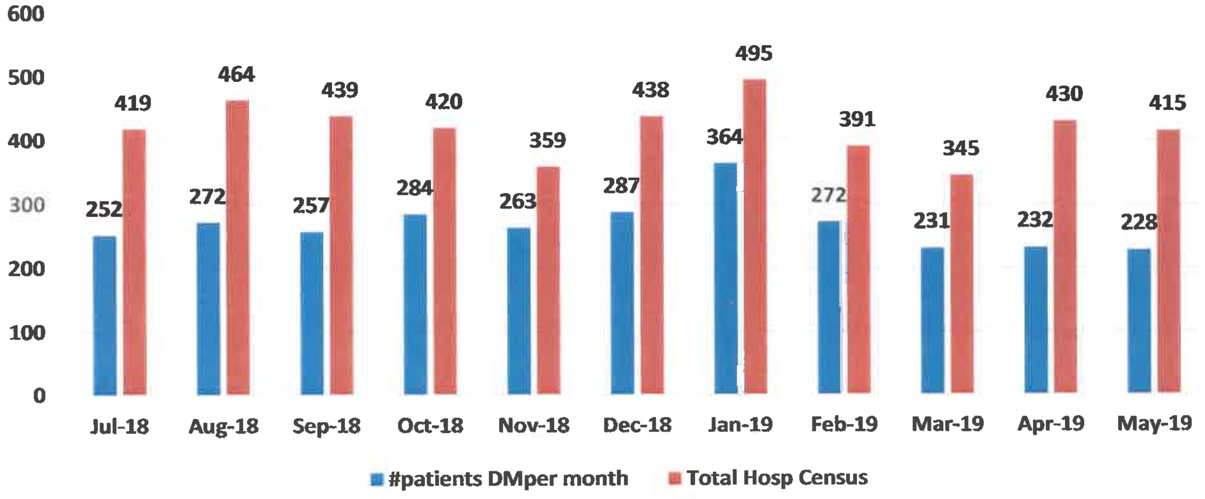
Diabetes Center

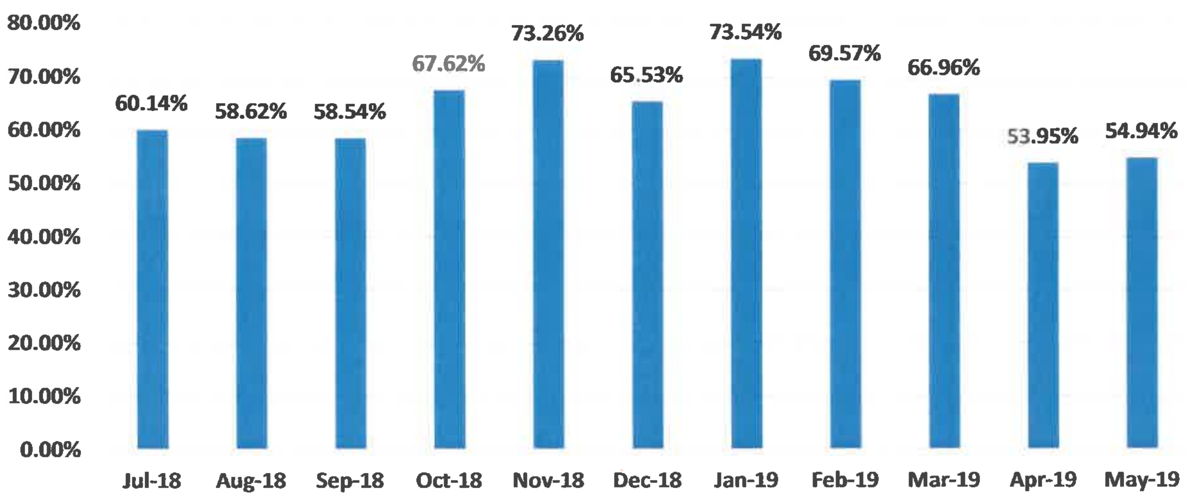
Patients with Diabetes

	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019
Total # DM Days per month	1057	1060	1138	1358	1102	981	1104	997	1034	1090	1239
Percent DM days per month	36.57 %	34.13 %	33.56 %	46.71 %	40.34 %	37.73 %	43.33 %	44.10 %	51.29 %	43.51 %	55.49 %
Average # Pt with DM /work day	48	48	54	54	52	47	53	50	49	47	41
Patients with Diabetes / month	252	272	257	284	263	287	364	272	231	232	228
Total Hospital Census	419	464	439	420	359	438	495	391	345	430	415
Hospital Pt Days	2890	3106	3391	2907	2732	2600	2548	2261	2016	2505	2233
% Patient with Diabetes per month	60.14 %	58.62 %	58.54 %	67.62 %	73.26 %	65.53 %	73.54 %	69.57 %	66.96 %	53.95 %	54.94 %

DM = Diabetes Mellitus

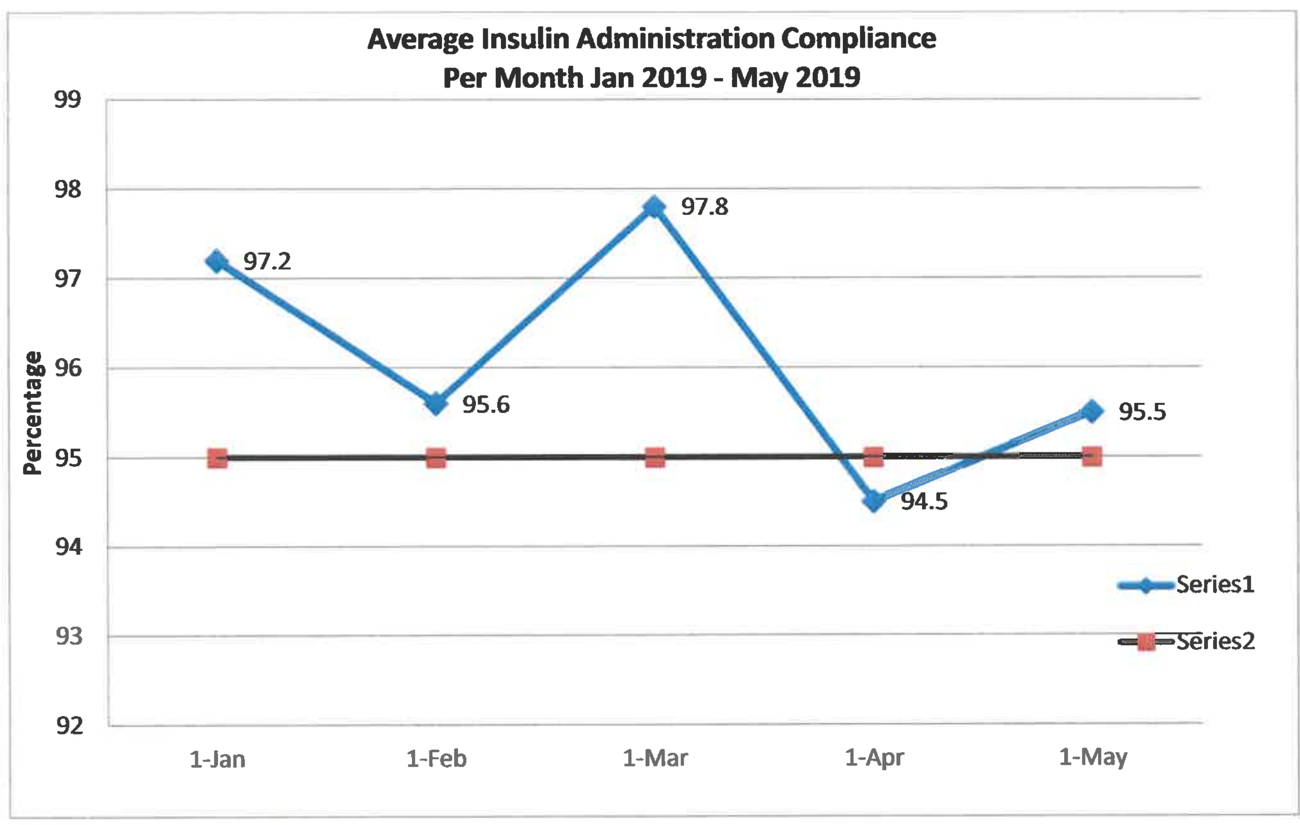

Total Diabetes Patient Days Per Month
July 2018 -May 2019
1600
1400
1200
1000
800
600
400
200
0
1060
1138
1358
1102
981
1104
997
1034
1090
1239
total diabetes patient days per month
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19


Patients with DM and Total Hospital Census July 2018-May 2019
600
500
400
300
200
100
0
419
464
439
420
359
438
495
391
345
430
415
252
272
257
284
263
287
364
272
231
232
228
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
#patients DMper month
Total Hosp Census



Insulin Audit

Accurate administration of insulin continues to be monitored.



Missed insulin without documentation of reason not given continues to be a finding. This occurs most often with the correction (prn) rather than the scheduled fixed dose of insulin. While we have been above the benchmark for over a year except for April, April is an outlier as only a sampling

review was done. Plan to continue with the current insulin audit until our next DOH and The Joint Commission surveys have been completed. Will reassess post the surveys to decrease frequency of review.

Insulin Drip Documentation in the EMAR

There were 12 insulin drips in May 2019. Six of these drips were started in the ED. The majority of insulin drips are started in the ER and patient is then transferred to the ICU.

Implementation of the insulin drip EMAR in the ED is being developed. Some ER nurses are able to document in the EMAR but some are not. IT is assessing what the difference is between nurses who can fully document in the EMAR and those who can't. The rounding note continues to be used. Scanning of meds in ER started in December. Due to limitations of Meditech, the insulin drip can only be scanned one time. ED continues to use the rounding note to document insulin drip.

If an insulin drip is active while the diabetes educator is on site, it is monitored frequently. If a documentation gap is noted, the educator contacts the nurse caring for the patient to update the documentation as soon as possible. Factors that may play into a delay in documentation are nurses having to provide care to other critically ill patients.

Pharmacy and Therapeutics (P&T) Committee

The order time of diabetes medication was approved at the most recent P&T committee meeting. It was decided that pharmacy would develop insulin order times that would allow the pharmacist to adjust the insulin order time to allow for Lantus for 8:00 and 22:00. Pharmacy continues to develop insulin order times. A challenge is if the physician selects a specific time (i.e. 70/30 at HS), the pharmacist cannot change the time to the recommended delivery time of dinner.

Staff Education

The Diabetes Center will be working with the 8W and 5W managers to present the first of a series of back to basic huddles to update staff knowledge in the management of diabetes.

DKA – in process

Diabetes educator is working with intensivist, ER medical director and ER/ICU nursing to review DKA management. It was found that there may be more than one choice of insulin drip orders in the ED. The goal is to have one set of orders for ED and ICU.

Insulin Infusion Protocol (Non-DKA) - this protocol involves four (4) titration levels. It may be utilized for patients on the hypothermia protocol. The protocol was updated in 2012 however the 2009 titration is in Meditech. The educator will work with the ICU educator, pharmacy and IT to get the most recent version entered into Meditech.

Met with IT on 5/7/19 re: The Non-DKA Insulin drip orders. There are some order agreement areas that need to be addressed before the 2012 orders can be entered into the Meditech. Will meet with Dr. Yacoub to review these areas, present to Critical Care Committee, P&T and then forward to IT for implementation.

Plan of Correction – Diabetes Findings:

- Educate 100% of all authorized users on point of care policy. New hires will also be included.
- April 1-30th competency re-education was conducted – At present we are at 100% compliance for authorized users.
- New hires complete the competency as part of orientation.
- Team members who are on FMLA will complete the competency as part of the process for return to work.
- Implemented direct observation of users starting 5/9/18.
- To lessen fear of participation, staff has been given checklist guidelines to review. Explained that the purpose of the exercise is to evaluate the effectiveness of the competency teaching.
- 10/10 observations were done in May with 10/10 done correctly.
- In June will do observations of evening staff, but they will be unannounced.
- Meeting with intensivists to develop a protocol for treatment of hypoglycemia in patients not receiving insulin.
- Met with intensivist on 5/8/19.
- At present there are no guidelines for the management of hypoglycemia in patients not receiving hypoglycemic agent in ICU.
- The current hypoglycemia protocol will be followed.
- Intensivist has requested that an order for finger sticks alone have the hypoglycemia protocol reflex from it.
- Discussed with IT during meeting re: insulin drip EMAR on 5/7/19
- In June will present huddles re: the hypoglycemia protocol.
- Met with IT on 5/7/19 to discuss the ability to group insulin orders together as a means of decreasing chance of missing a correction order. Awaiting their review of options.
- Meditech does not have capacity to group insulin orders.

CRITICAL CARE

Month	Admission	ADC	Sepsis	Code Blue	Rapid Response	Restraints
May	60	8.2	25	26	18	5

Note: Code Blue and Rapid Responses carried out by ICU nurses (in patient units)

Education:

- In-services were provided for staff on ventilator management by RT and hemodynamics

- Monitoring by the Educator
- Re-enforced /reminded the staff to complete their Relias education
- Staff were also in-serviced on the new sharp container by the Vendors
- Clinical orientations of new hires

PI Initiatives:

- Monitoring documentation and evaluation on all code blues and rapid responses
- Monitoring timely narcotic administrations and appropriate waste
- Carrying out DOH corrective actions in preparation for eventual visit
- Re-enforcing wound assessment, measurements and picture taking on all wounds on admission.

Service Recovery:

- Continue to round on patients
- Follow up with patients, family reports and/or concerns
- Reached out to family to address complaint in real time

EDUCATION

# of Classes Provided						
Month	**8W**	**5W**	**ICU**	**BHU**	**ED**	**OR/PACU/ASU**
May	2	0	1	2	1	0

Education:

- CPR
- Clinical Orientation x 3
- New Nurse Program
- New Nurse Telemetry Class
- ED DOH Triage Module
  CCM- BHU
- DOH Chart Audits

PI Initiatives:

Continue to focus on DC Health PoC items.

Service Recovery

None for May

EMERGENCY DEPARTMENT

ED Metrics Empower Data	Jan	Feb	Mar	Apr	May
Visits	4433	4021	4389	4341	4665
Change from Prior Year (Visits)	4919	4557	4826	4760	5087
% Growth	-10.9632	-13.33	-9.956	-9.65	-9.05
LWBS	165	73	112	125	141
Ambulance Arrivals	1142	1143	1163	1055	1295
Ambulance Admission	296	285	314	322	348
% of ED patients arrived by Ambulance	26%	28%	26%	24%	28%
% of Ambulance Patients Admitted	26%	25%	27%	31%	27%
Reroute + Diversion Hours				8	0
Left Against Medical Advice (AMA)					52

ED Metrics Empower Data	Goal	Jan	Feb	Mar	Apr	May
Door to triage	30	26	19	22	20	23
Door to room	45	123	109	111	97	125
Door to provider	60	122	103	110	100	110
Door to departure	150	261	231	249	230	246
Decision to admit to floor	240	304	309	321	289	285

Education:

- Current State of the Hospital
- Mandatory DOH Corrections: Triage Class (onsite/Relias), Wound Assessments (Relias), Fall Risk Assessment, Medication Reconciliation, Decontamination Room and Hand Hygiene Policy IC. 8. G07. Hand Hygiene compliance 2019
- All FD-12 Patients require a sitter
- Implementation FD-12 assessment in electronic medical record (EMR)
- Implementation of blood transfusion documentation into EMR to mimic "inpatient" documentation including a witness signature
- Implementation of 2 witnesses for obtaining type and screen and/or type and cross
- Implementation New Curtis Bay Waste Baskets
- Laboratory Tube System – to be used as the 1st mode of transportation for sending specimens to the lab.
- ED has 2 interpreter telephones and 1 TTY telephone
- All overtime (including incremental) must be approved in advance
- Triage RN responsible for completing medication reconciliation
- Dummy barcodes are used in case of emergency use during Accu-Chek assessment. Requires downtime form to be sent to lab ASAP for reconciliation into patient EMR
- SIRS can be called by any RN notifying the MD immediately after assessment during triage (PCS)
- SBIRT/MAT Recovery Coaches and Trauma Recovery Program