UMC
UNITED
MEDICAL CENTER

General Board Meeting

Date: March 27, 2019
Location: Conference Rooms 2/3

2019 BOARD OF DIRECTORS

LaRuby Z. May, Chair
Dr. Malika Fair
Wayne Turnage
Dr. Konrad Dawson
Brenda Donald
Angell Jacobs
Girume Ashenafi
Velma Speight
Millicent Gorham
Dr. Dennis Haghighat
Matthew Hamilton
Jackie Bowens
William Sherman
Robert Bobb
Dr. Marilyn-McPherson Corder

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

UMC

UNITED
MEDICAL CENTER

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.

UMC
UNITED
MEDICAL CENTER

NFPHC Board of Directors General Meeting
Wednesday, March 27, 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 **9:00 a.m. on Wednesday, March 27, 2019**. The meeting will be held at the United Medical Center, 1310 Southern Ave., SE, Washington, DC 20032 in the Conference Room. Notice of a location, time change, or intent to have a closed meeting will be published in the D.C. Register, posted in the Hospital, and/or posted on the Not-For-Profit Hospital Corporation's website (www.united-medicalcenter.com).

DRAFT AGENDA

I. CALL TO ORDER

II. DETERMINATION OF A QUORUM

III. APPROVAL OF AGENDA

IV. READING AND APPROVAL OF MINUTES
February 28, 2018

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

VII. EXECUTIVE MANAGEMENT REPORT
Matthew Hamilton, Chief Executive Officer

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

IX. PUBLIC COMMENT

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

XI. ANNOUNCEMENTS

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

UMC
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Not-For-Profit Hospital Corporation
Wednesday, Feb 1, 2019

Present: Chair LaRuby May, Dr. Malika Fair, Wayne Turnage, Dr. Konrad Dawson, Angell Jacobs, Girume Ashenafi, Ms. Velma Speight, Ms. Millicent Gorham, Brenda Donald, Dr. Dennis Haghighat, Matthew Hamilton, Dr. Marilyn-McPherson Corder

Agenda Item	Discussion	Action Item
Call to order	The meeting was called to order at 9:12 AM.	
Determination of Quorum	A quorum was determined by: Michael S. Austin.	
Approval of the Agenda	Agenda approved as written.	
Committee Reports:	**Patient Safety and Quality Committee: Dr. Malika Fair** • PSQ met on 1/29. • Sprinkler leak on fourth floor caused a flood in the ICU • Behavioral Health Unit had 2 recent DOH visits. 2 outstanding reports needed from DOH.	

	• SNF Survey: Statement of deficiencies were submitted. Plan of corrections were submitted. DOH returned last week and SNF was found to be in full compliance. • ED Sentinel Event: 1/10/19 web conference with Joint Commission to review root cause analysis which was accepted. UMC also received a letter from the Joint Commission that said the root cause analysis was accepted. **Finance Committee: Director Wayne Turnage** • $19% lower than budget for the month of November; 14% year to date • Unrealized initiatives in the area of Psych volume growth, managed care contracts, and revenue cycle due to lower activities. • Clinic budgets are lower than budget and prior year for the month by 24% and 8% respectively. • Salaries and wages are on target for the month, management and supervision salary as well as overtime costs continue to increase. • Contract labor continues to increase	
Announcement	Meeting adjourned at 11:00am	

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General Board Meeting

Date: March 27, 2019
Location: Conference Rooms 2/3

CMO Report

Prepared by:
Dr. Dennis Haghighat
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.

March 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

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

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

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

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

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

Psychiatry.....*Dr. Surendra Kandel*

Radiology.....*Dr. Raymond Tu*

Surgery.....*Dr. Gregory Morrow*

Departmental Reports

Key

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

Chief Medical Officer

Dennis P. Haghighat, M.D

Since the Board of Directors last met, the UMC team was able to prepare an area on our 5th floor to serve as a temporary ICU. We would like to thank DC Health and DC Fire, who went out of their way to give UMC the required regulatory approvals, and our staff for assuring that all was in order for the inspections. Our current capacity is 14 patients. The prior ICU had a 16-bed capacity and our ICU census averages 10. The former ICU location will be most likely not be ready to reopen for 4 to 6 months.

UMC is working hard to establish the level of imaging services that the residents of Ward 7 and 8 deserve. Current projects include the removal and replacement of a damaged MRI unit with a goal of accomplishing both by the end of May. We continue to work on our long awaited Fluoroscopy. This project is now in the permitting phase with a completion date in the fall of 2019. In the meantime, a transfer agreement is in place with another District hospital to assure than UMC patient can receive these services should the need arise during their hospitalization.

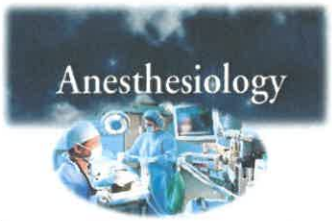
UMC continues to work in a collaborative fashion to work on all aspect of patient flow. Efforts are ongoing to address staffing, ancillary test times and flow of admitted patients both to the medical and BHU floors. GW and UMC leadership are meeting weekly and multidisciplinary flow teams meet twice monthly to assure we stay on track.

Despite the reduction in ER volumes, surgical volumes at UMC continue to grow with the first two months of the year showing a volume increase of over 10% compared to the first two months of 2018.

We received final reports from DC Department of Health regarding the incidents in our ER (maternal patient in October) and the BHU (several incidents) and these reports did not show any significant new findings beyond the findings we already identified and corrected based on our internal performance improvement processes.

Infection rates at the hospital continue to be significantly below national rates and we continue to have major initiatives to improve the care of the septic (patients with severe infection) patient at UMC.

UMC passed its annual DC Health licensing survey and we are proud to say that the number of findings was significantly reduced. Although there is always room for improvement, the major pharmacy and Infection Control issues from the 2018 survey were resolved and showed no evidence of recurrence.



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

February

PERFORMANCE SUMMARY:
The overall cases for the month of FEBRUARY 2019 were 180, a decrease from 210 in January 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.

We are pleased to announce that renovation has commenced in the Anesthesia work room. This is part of a renovation project to address some issues with the old section of the Operating Room. We hope that this will be expedited to resolve the Anesthesia storage and Work room concerns.

We are still hoping to secure an Anesthesia Information Management System (AIMS). This will centralize all documentations, quality metrics and facilitate efficient revenue cycle management. We have completed a vendor review process to select the best system for the hospital. Discussions on how best to proceed are on-going with the Health Information Department.

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

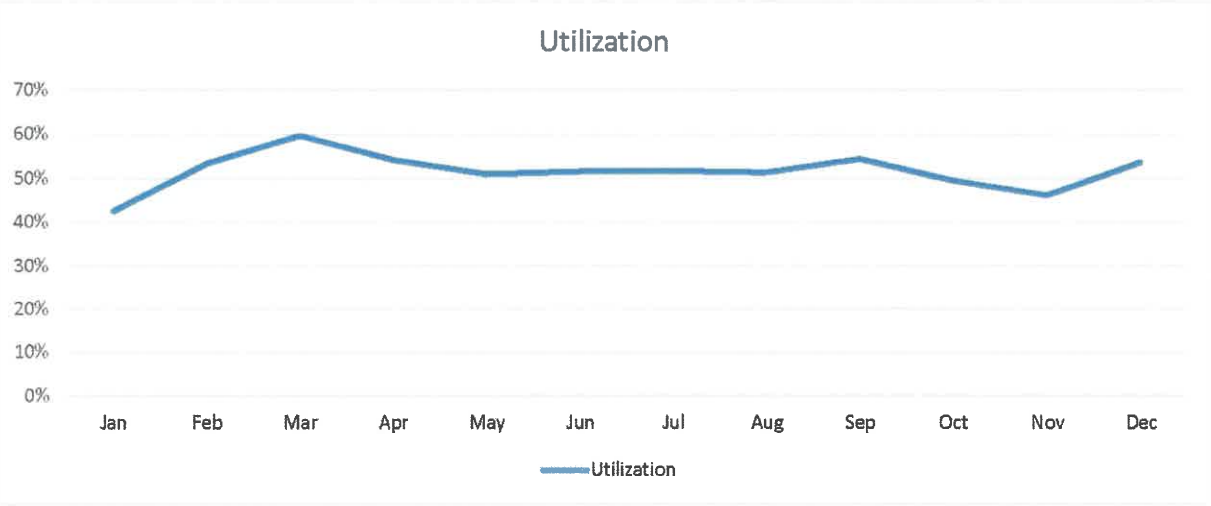
EVIDENCE-BASED PRACTICE:

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.

Utilization Rates
United Medical Center - 2018



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Procedures	135	169	185	160	172	155	162	168	160	162	139	149
Total Time (minutes)	9094	9598	12160	10532	10769	10003	10524	10914	9968	10506	9425	10575
Turnover Time	2025	2535	2775	2400	2580	2325	2430	2520	2400	2430	2085	2235

Utilization	42%	53%	60%	54%	51%	51%	52%	51%	54%	49%	46%	54%

Assumptions:
Procedures with start times Monday thru Friday 8:00AM thru 5:30PM
Allows for 15 minutes turnover time between cases

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.

DR. AMAECHI ERONDU, MD, MS, CPE

CHAIRMAN, ANESTHESIOLOGY DEPARTMENT

Mina Yacoub, M.D., Chairman

February

PERFORMANCE SUMMARY

In February 2019 the Intensive Care Unit had a low census month with 55 admissions, 51 discharges, and 239 Patient Days, with an Average Length of Stay (ALOS) of 4.7 days. The ICU managed 58 patients in February with 8 deaths, for an overall ICU mortality rate of 14 %. The ICU managed 31 patients with severe sepsis and septic shock in February with five deaths attributed to severe sepsis/septic shock. The sepsis specific ICU mortality rate was 16 %. One patient was transferred to Washington Hospital Center for a cardiac catheterization.

We are seeing increased incidence of contaminated blood culture specimens for patients presenting to UMC. This impacts clinical decision making, and has risk and cost implications. Working with Pathology Department and Quality Department for further investigation and correction. Pathology Department and ED are completing a staff education process for proper specimen collection. Performance is being monitored.

Nursing staffing in the ICU continues to be a challenge, with increased ED wait times for ICU patients coming up to ICU.

One new physician joined the critical care team in February.

QUALITY OUTCOMES

Sepsis Core Measures Performance

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

Morbidity and Mortality Reviews

1. **ICU Mortality**

ICU had 8 deaths for 58 patients managed, with an overall ICU mortality rate of 14% for February. Mortality review is conducted in monthly Critical Care Committee meeting with Quality Department.

2. **Severe Sepsis and Septic Shock**

ICU managed 31 patients with severe sepsis and septic shock in February. Five ICU deaths were directly attributable to severe sepsis and septic shock, with an ICU sepsis specific mortality rate of 16 %. Continuing to monitor performance.

3. **Infection Control Data**

For February, the ICU had 118 ventilator days with no Ventilator Associated Pneumonias (VAP), 93 Central Line device days with no Central Line Associated Blood Stream Infections (CLABSI) and 174 Urinary Indwelling Catheter days with no Catheter Associated Urinary Tract Infections (CAUTI). ICU infection rates continue to be much lower than national averages. ICU infection rate data is reported regularly to the National Healthcare Safety Network (NHSN).

4. **Rapid Response and Code Blue Teams**

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

5. **Care Coordination/Readmissions/Transfers**

In February, 58 patients were managed in the ICU. There were no readmissions to the ICU within 48 hours of transfer out. One patient was transferred to WHC for a cardiac catheterization.

Evidence-Based Practice (Protocols/Guidelines)

Evidence based practices continue to be implemented in ICU with multidisciplinary team rounding, ventilator weaning, infection control practices, and patient centered practices. New initiative being implemented with Infection Prevention team is Hand Hygiene. ICU staff hand hygiene compliance in February was 93 %. Infection Prevention Department is continuing to monitor.

Growth/Volumes

ICU is staffed 24/7 with in-house physicians and has a 14 bed capacity and is looking forward to operating at full capacity and full potential.

Stewardship

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

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

Financials We are requesting feedback on ICU financial performance.

Needed Steps to Improve Performance

We would need to return to the 4th floor ICU once repairs are complete after the flooding. Nursing staffing continues to be a challenge and we need more effective critical care nurse recruitment, and importantly, nurse retention. Goal is to continue to provide safe and high quality patient care, caring for patients with increased illness acuity, providing best evidence based practice, all while keeping ALOS low and preventing Hospital Acquired infections and complications. Working closely with Quality Department and Infection preventionist to ensure we continue to meet benchmarks.

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

January

UMC's ED key measures are standard measurements for Emergency Departments, and many are the same that are reported by Medicare (Hospital Compare). The first portion describes a series of basic ED volume statistics including the number of patients who register and their dispositions. The second portion of the report deals specifically with the intervals that comprise the ED visits.

It should be noted that the data used for this and past ED reports was derived from Meditech data with the analysis performed independently of the hospital's IT department and Meditech software. It is likely that differences exist between this data and data previously reported. For example, reported percentages and times may be higher (or lower) than what was reported in the past.

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

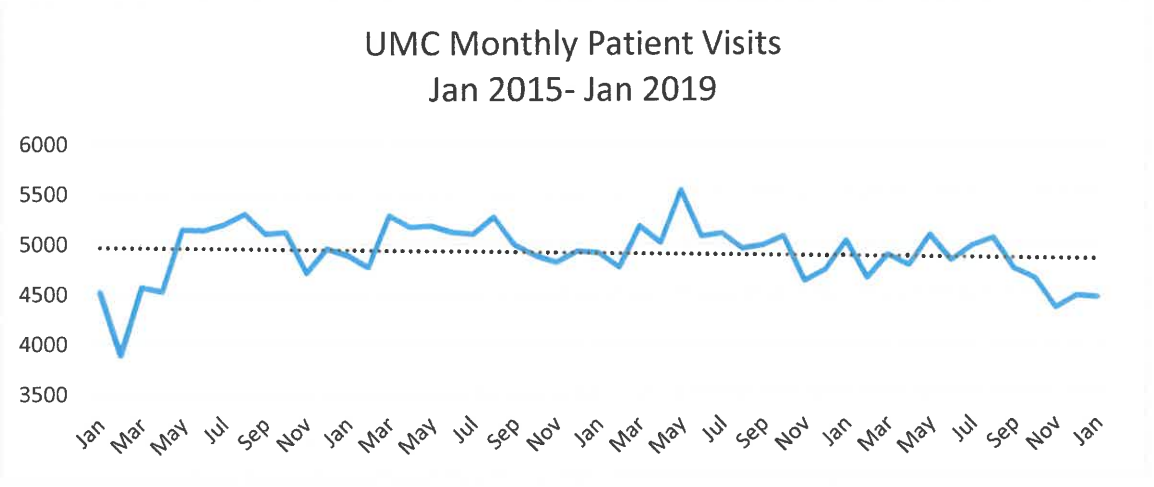
Door to Departure: This is the total time the patient is in the ED. It is measured from the first point of patient contact until the patient physically departs from the ED. It is made up of the following subintervals:

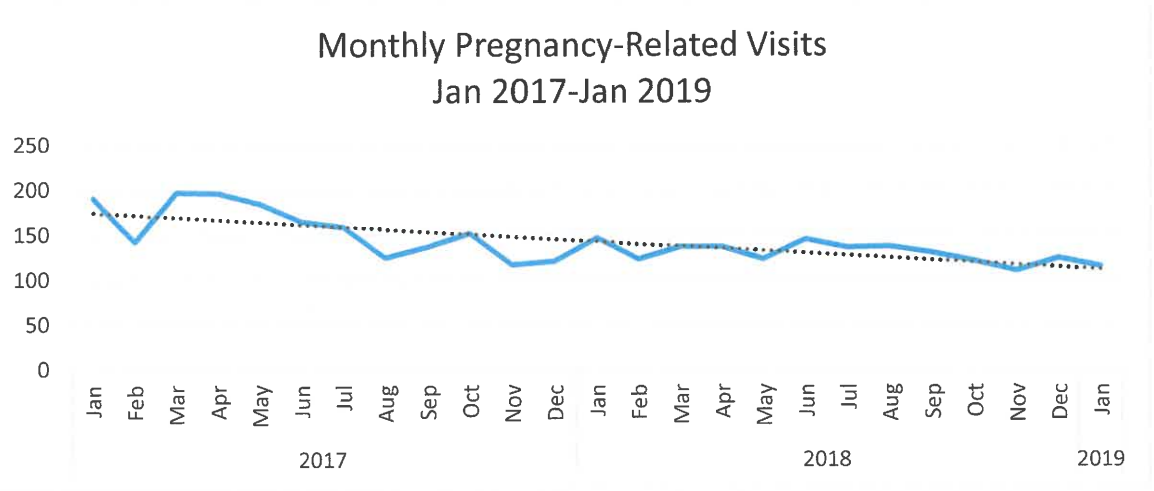
- **Door to Triage-** The time between when a patient arrives at the hospital seeking care and when they are evaluated by the triage nurse

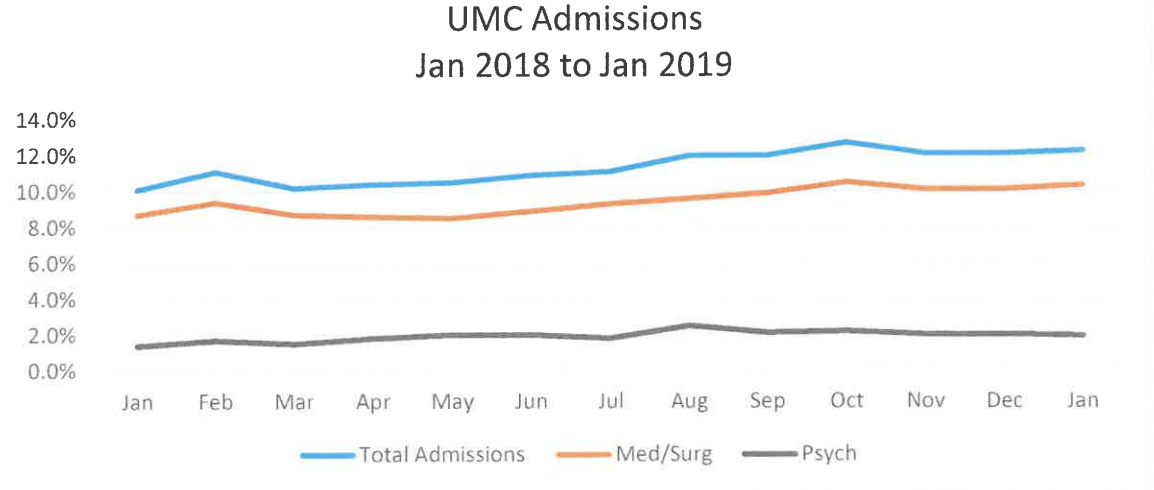
- **Triage to Room-** The time between the nursing triage evaluation and when a patient is placed in a treatment room
- **Room to Provider-** The time that a patient is waiting in a treatment room to see a provider
- **Provider to Decision-** The interval between when a provider first sees a patient 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.

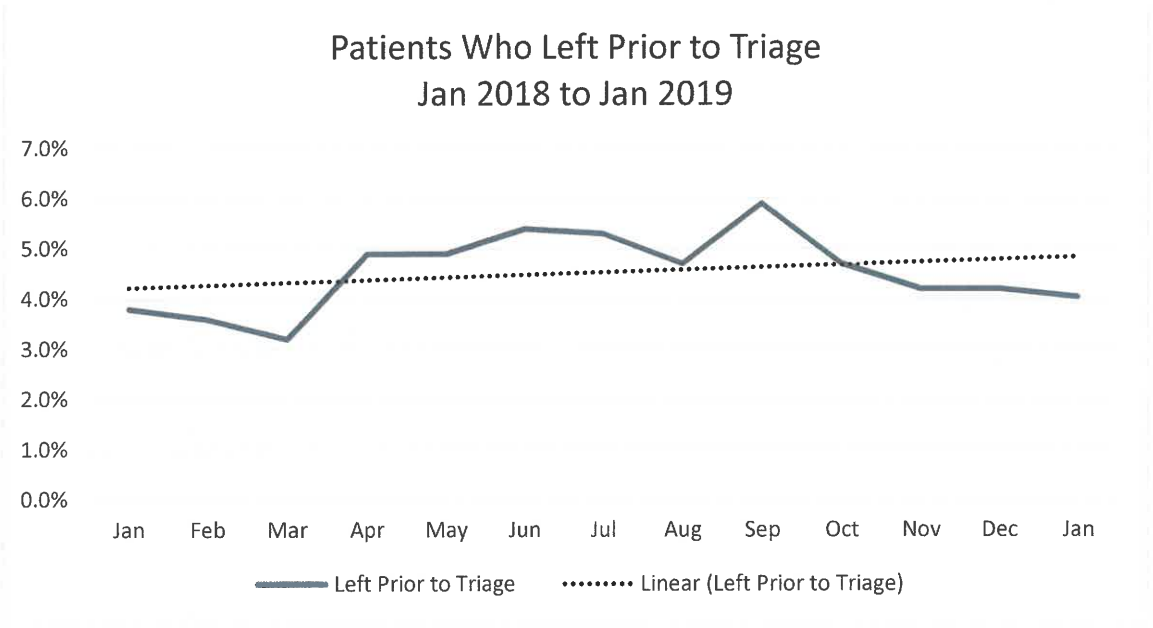
Data tables:

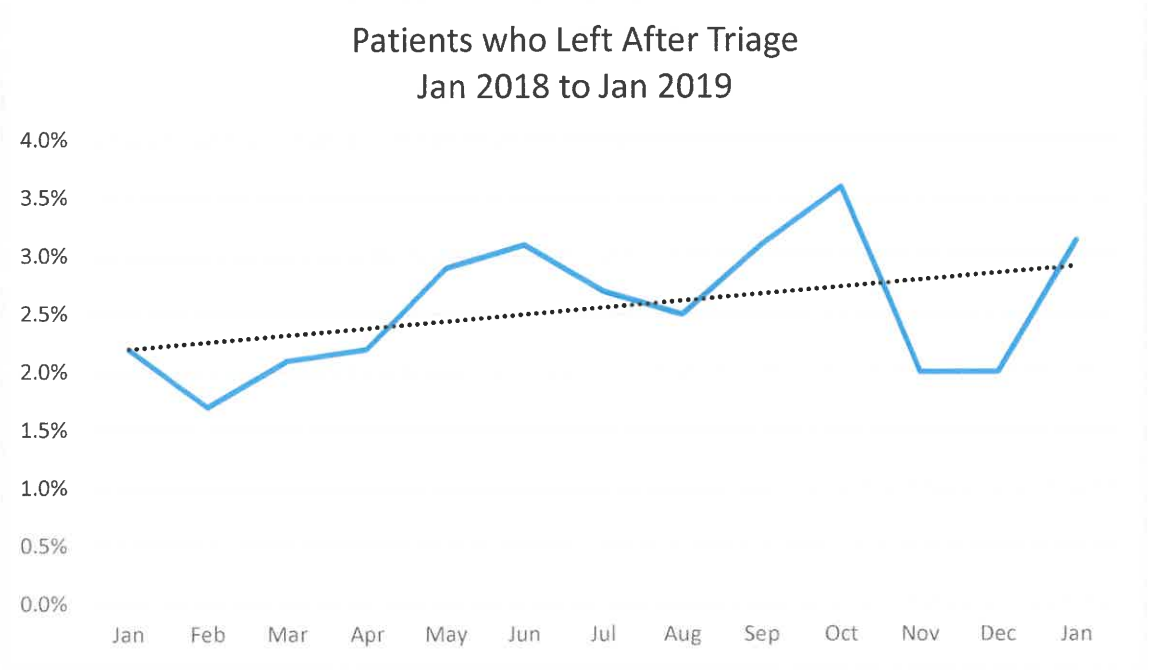
ED Volume and Events				
	Jan 2018	**%**	**Jan 2019**	**%**
Total patients	5027		4459	
Daily Avg Census	162		144	
Admit	507	10.1%	547	12.3%
• **Med Surg**	436	8.7%	461	10.3%
• **Psych**	71	1.4%	86	1.9%
Transfer	60	1.2%	61	1.4%
AMA	73	1.5%	49	1.1%
Eloped	36	0.7%	82	1.8%
LWBS	298	6.0%	320	7.1%-
• **Left After Triage**	109	2.2%	140	3.1%
• **Left Prior to Triage**	189	3.8%	180	4.0%
Ambulance Arrivals	1541	30.7%	1154	25.9%


UMC Monthly Patient Visits
Jan 2015- Jan 2019
6000
5500
5000
4500
4000
3500
Jan Mar May Jul Sep Nov Jan Mar May Jul Sep Nov Jan Mar May Jul Sep Nov Jan Mar May Jul Sep Nov Jan


Monthly Pregnancy-Related Visits
Jan 2017-Jan 2019
250
200
150
100
50
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan
2017
2018
2019

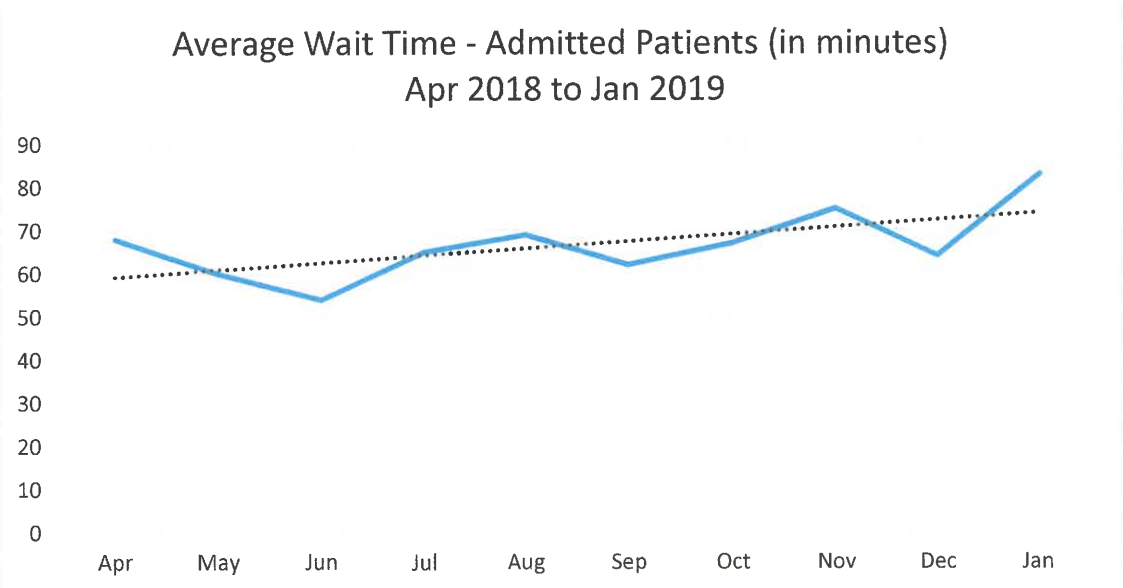

UMC Admissions
Jan 2018 to Jan 2019
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan
Total Admissions
Med/Surg
Psych

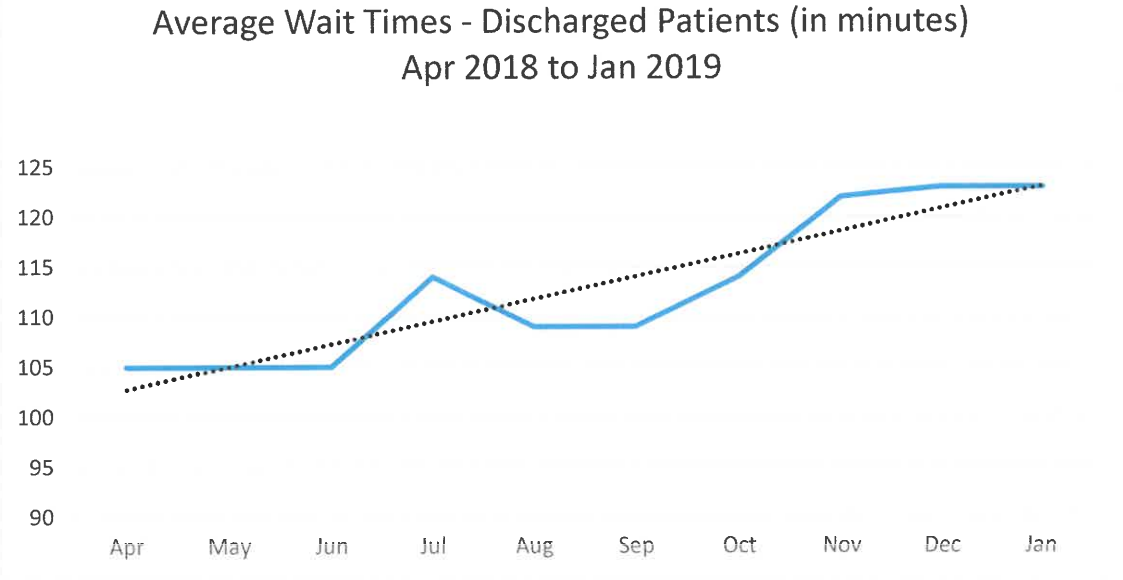

Patients Who Left Prior to Triage
Jan 2018 to Jan 2019
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Left Prior to Triage
Linear (Left Prior to Triage)

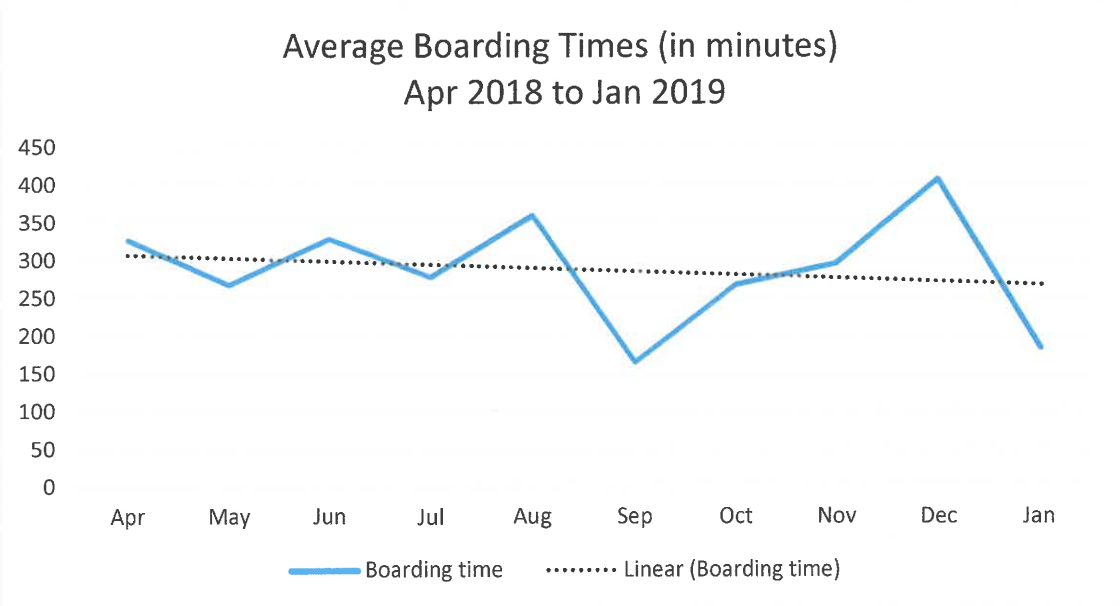

Patients who Left After Triage
Jan 2018 to Jan 2019
4.0%
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan

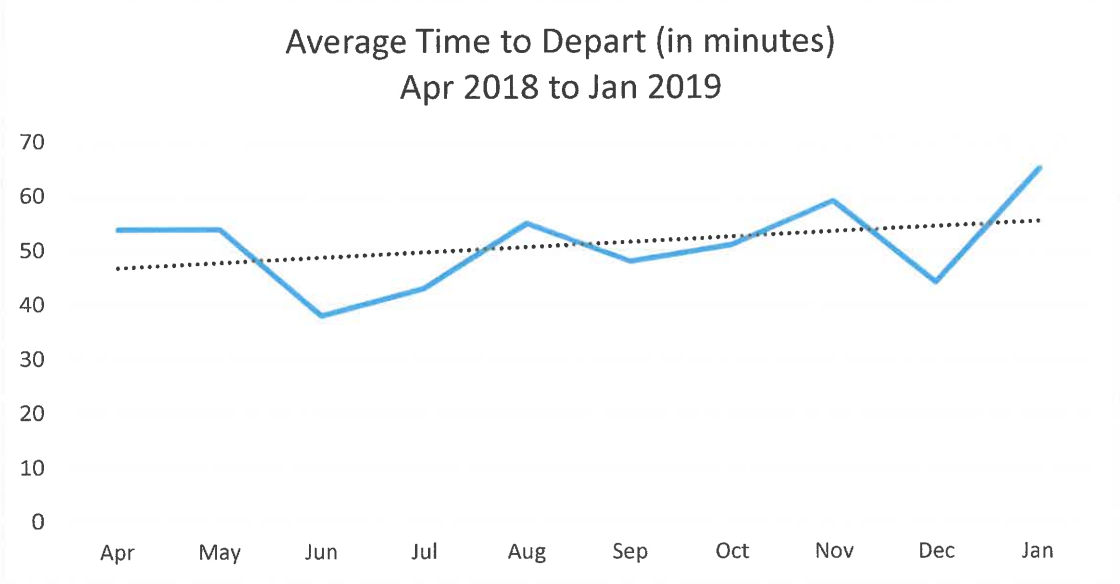
ED Throughput January 2019 (time in minutes)		
	Median Times	**Mean Time**
Admissions		
Door to triage	17	29
Triage to Room	23	54
Room to provider	0	0
Provider to decision	227	240
Decision to departure	34	183
Door to departure	**301**	**506**
Discharges		
Door to triage	16	24
Triage to room	73	99
Room to provider	4	2
Provider to decision	128	114
Decision to departure	60	65
Door to Departure	**281**	**304**
Transfers		
Door to triage	11	21
Triage to room	14	42
Provider to room	5	6
Room to decision	216	238

ED Throughput Comparison (median times in minutes)		
	Jan 2018	**Jan 2019**
Admissions (Med/Surg)		
Door to triage	13	17
Triage to room	19	23
Room to provider	1	0
Provider to decision	226	227
Decision to departure	43	34
Door to Departure	302	301
Discharges		
Door to triage	15	16
Triage to room	73	73
Room to provider	14	4
Provider to decision	126	128
Decision to departure	45	60
Door to Departure	273	281
Transfers		
Door to triage	13	11
Triage to room	14	14
Room to provider	1	5
Provider to decision	215	216


Average Wait Time - Admitted Patients (in minutes)
Apr 2018 to Jan 2019
90
80
70
60
50
40
30
20
10
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan


Average Wait Times - Discharged Patients (in minutes)
Apr 2018 to Jan 2019
125
120
115
110
105
100
95
90
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan





Analysis:

1. There is slight decline in patient census over the past 3 years. Some of this is likely explained with a reduction of obstetric visits. There is a trend of decreasing obstetric visits (approximately 200 visits in January 2017 decreasing to 120 visits in Jan 2019). Additionally, January 2019 saw a decline in ambulance traffic (critical patients were routed to nearby hospitals) during the period when ICU capability was diminished.

2. 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 high and remained elevated throughout the year. We suspect this LWBS rate existed for years and is directly connected to long ED wait times, especially for patients with minor complaints, as the average wait time for minor ailments is approximately 2 hours but can exceed 6 hours. This creates a full waiting room where new patients may arrive and register but then depart quickly (prior to triage) when they perceive there is little movement in the queue.

3. The difference between mean and median times for lengths of stay (door to departure) are normal for an ED, as a small percentage of complex patients are often responsible for lengthening the mean times. In general, the use of median rather than mean times better reflect the ED system's performance. With that said, we would expect a difference between median and average provider to decision times as complex or intoxicated patients have longer diagnostic and treatment times. This does not bear out in the analysis. Instead, the January 2019 data demonstrates differences between the mean and median times for door to triage, triage to room, and time to departure (for all patient types). This suggests that factors other than patient complexity account for the observed differences. We suspect this is the likely the result of hospital staffing shortages leading to extended wait room times and delays in departure of patients from the ED.

The ED at UMC has significant nursing and technician shortages. This typically means one or more sections of the ED may be closed to patients and/or a single nurse may be asked to cover more beds. Shortages affecting ED throughput have also been experienced in patient transporters, sitters for high risk patients, and social workers. ED throughput is dependent on the presence of all of these job categories. We strongly believe that an analysis comparing each day's ED LWBS rate to the number of hours staffed during that 24 hour period would show a strong negative correlation and suggest a way forward for improvement. Unfortunately, I do not have access to all of the data necessary to run the analysis.

I strongly believe that if we improve the ED throughput, we will see an increase in both ambulance and ambulatory patients and a reduction in the LWBS rate. We should consider the low volume in Jan 2019 was significantly affected by ambulance diversions related to the ICU.

Future analysis should attempt to establish a relationship between hospital staffing, total length of stay and the LWBS. This is something that we are working with hospital administration and IT. We continue to hold each provider responsible for their decision making and establish targets in an attempt to improve the areas of throughput directly affected by providers.
In the meantime, GW continues to work with the hospital leadership to identify ways to improve throughput in the ED and identifying ways to facilitate the transport of women in labor, late term obstetric emergencies, and other critically ill patients.

Musa Momoh, M.D., Chairman

January

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

- Admissions:
  - Observation admissions: Medicine 126; Hospital 126; Percentage: 100%
  - Regular admissions: Medicine 350; Hospital 442; Percentage: 79%
- Discharges:
  - Observation discharges: Medicine 132; Hospital 132; Percentage: 100%
  - Regular discharges: Medicine 298; Hospital 378; Percentage: 79%
- Procedures
  - Hemodialysis 223
  - EGD's 53
  - Colonoscopy 48
  - ERCP 1
  - Bronchoscopy 5
- Quality
  - Cases referred to peer review: 0
  - Cases reviewed: 0

February

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

- Admissions:
  - Observation admissions: Medicine 118 (100%); Hospital 118
  - Regular admissions: Medicine 245 (76%); Hospital 323
- Discharges:
  - Observation discharges: Medicine 118 (100%); Hospital 118
  - Regular discharges: Medicine 221 (75%); Hospital 293
- Procedures
  - EGD's 40
  - Colonoscopies 40
  - ERCP 0
  - Bronchoscopies 1
  - Dialysis 113
- Performance Improvement
  - Cases reviewed: 0
  - Cases closed: 0
- Morbidity and Mortality is scheduled for 3/20/2019
- Department of Medicine quarterly meeting was held on 12/12/2018.
- Next Department of Medicine meeting is scheduled for 03/13/2019.

Pathology

Eric Li, M.D., Chairman

MONTH	JAN	FEB	MAR	APR	MAY	JUN
Reference Lab Test – Intake PTH 90% 2 days	100% 21	97% 30				
Reference Lab specimen Pickups 90% 3 daily/2 weekend/holiday	100% 16/16	100% 16/16				
Review of Performed ABO Rh confirmation for Patient with no Transfusion History. Benchmark 90%	100%	100%				
Review of Satisfactory/Unsatisfactory Reagent QC Results Benchmark 90%	100%	100%				
Review of Unacceptable Blood Bank specimen Goal 90%	97%	100%				
Review of Daily Temperature Recording for Blood Bank Refrigerator/Freezer/incubators Benchmark <90%	100%	100%				
Utilization of Red Blood Cell Transfusion/ CT Ratio 1.0 – 2.0	1.2	1.3				
Wasted/Expired Blood and Blood Products Goal 0	1	5				
Measure number of critical value called with documented Read Back 98 or >	100%	100%				
Hematology Analytical PI Body Fluid	100% 15/15	100% 16/16				
Sickle Cell	0/0	0/0				
ESR Control	100% 26/26	100% 28/28				
Delta Check Review	100% 202/208	99% 170/171				
Blood Culture Contamination – Benchmark 90%	92%	100%				
ER HOLDING	98%	90%				
ICU	92%	91%				
STAT turnaround for ER and Laboratory Draws <60 min Benchmark 80%						
ER	83%	84%				
LAB	80%	85%				

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.

Psychiatry

Surendra Kandel, M.D., Chairman

DESCRIPTION	01	02	03	04	05	06	YTD
ADMISSIONS							
ALOS (Target <7 days)	6.26	5.67					5.9
Voluntary Admissions	22	33					55
Involuntary Admissions	47	52					99
Total Admissions	**69**	**85**					**154**
REFERRAL SOURCES							
CPEP	22	11					33
UMC ED	66	74					140
GWU	2	0					2
Providence	1	0					1
Georgetown	0	0					0
Sibley	1	0					1
UMC Medical/Surgical Unit	3	0					3
Children's Hospital	0	0					0
Howard	2	0					2
Laurel Regional Hospital	0	0					0
Washington Hospital Center	0	0					0
Suburban	0	0					0
PIW	0	0					0
Washington Adventist Hospital	0	0					0
Other/Not Listed	0	0					0
OTHER MEASURES							
Average Throughput Target: <2 hours	3.8	3.1					3.4
Psychological Assessments (Target: 100%)	95%	98%					96.5%
DISCHARGE APPOINTMENTS							
Discharge Appointments for those d/c > 72 hours	68	74					142
Discharged to home without appointments/No discharge appointment information provided	5	11					16
Discharge Appointments for those d/c > 72 hours (Target: 100%)	**93%**	**87%**					**90%**
OTHER							
Patients who went to Court	3	0					3

February

Performance Summary:

	INP		ER		OUT		TOTAL	
EXAM TYPE	**EXAMS**	**UNITS**	**EXAMS**	**UNITS**	**EXAMS**	**UNITS**	**EXAMS**	**UNITS**
CARDIAC CATH	2				2		4	
CT SCAN	116		478		172		766	
FLUORO	18		2		17		37	
MAMMOGRAPHY					127		127	
MAGNETIC RESONANCE ANGIO							0	
MAGNETIC RESONANCE IMAGING							0	
NUCLEAR MEDICINE	21		1		2		24	
SPECIAL PROCEDURES	17				5		22	
ULTRASOUND	127		200		232		559	
X-RAY	180		906		757		1843	
ECHO								
CNMC CT SCAN			20				20	
CNMC XRAY			380				380	
GRAND TOTAL	481		1987		1314		3782	

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 area including the equipment room and Philips 1.5T Intera system itself remains closed with ongoing study for a mobile unit solution. UMC radiology did well at the DCHealth radiation inspection with no findings.

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:** N/A

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 presented at the February meeting of the Washington DC Chapter of the American College of Radiology on recent DC Council updates on February 28, 2019 at the Cosmos Club, Washington, DC including preauthorization. Dr. Tu introduced Dr. Robert Zeman who reviewed coronary artery imaging.

Dr. Tu at The American College of Radiology District of Columbia Chapter,
The Cosmos Club, Washington DC.

Dr. Tu provided his president's report at the Medical Society of the District of Columbia monthly board meeting and met with the Chairman of the Southeast Delegation of the American Medical Association on February 25, 2019. Dr. Tu provided important updates on Current Procedural Terminology and the Resource Based Relative Value Scale which have implications for all District of Columbia patients and providers.

Dr. Tu with Medical Society of the District of Columbia leadership and William Clark, MD president of the Southeast Delegation, board members and medical student representative of the District of Columbia chapter of the American Medical Association.

Dr. Tu was the invited speaker at the Annual Meeting of the American Society of Spine Radiology on February 23, 2019 and reviewed recent updates on Medicaid and important updates of Medicaid expansion which have implications for the underserved communities as well unintended consequences on diversity and access for underrepresented groups. Dr. Tu discussed importance of optimization of wait times in radiology departments both with scheduling as well as transportation to the appointment. There is a liner relationship with wait times and failure to obtain the imaging study, a missed care opportunity (MCO).

Dr. Tu speaking at the American Society of Spine Radiology on Medicaid.

<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.

Gregory Morrow, M.D., Chairman

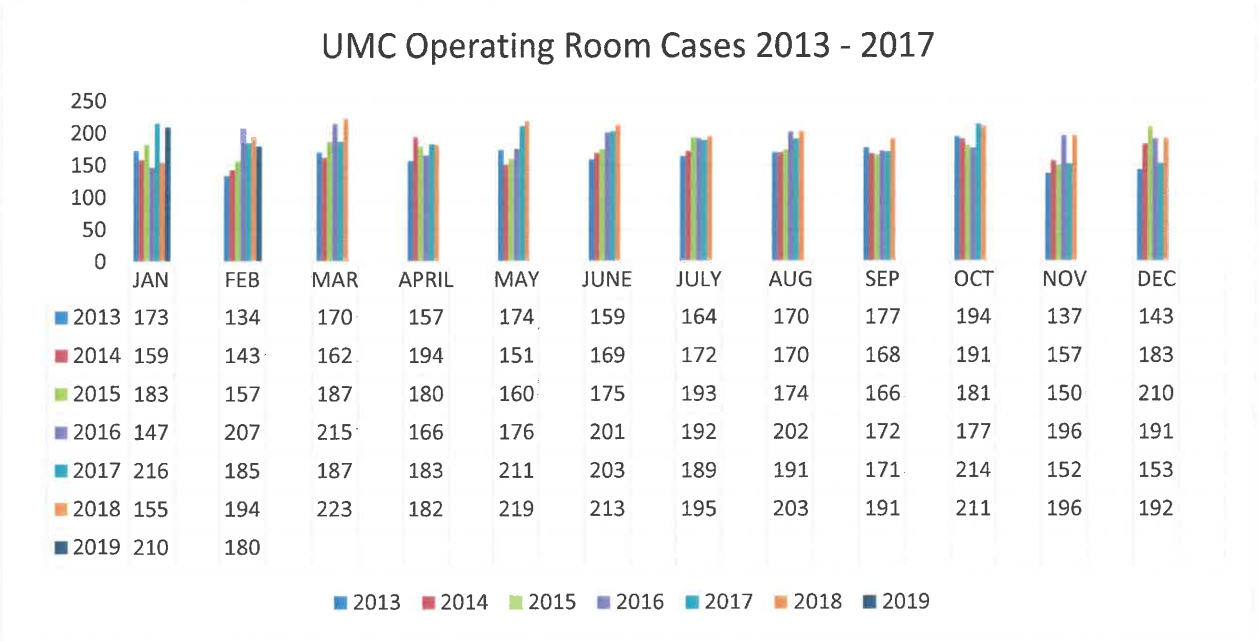
February

SUMMARY REPORT FOR FEBRUARY 2019

For the month of February 2019, the Surgery Department performed a total of 180 procedures.

The chart and graft 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	
APRIL	157	194	180	166	183	182	
MAY	174	151	160	176	211	219	
JUNE	159	169	175	201	203	213	
JULY	164	172	193	192	189	195	
AUG	170	170	174	202	191	203	
SEP	177	168	166	172	171	191	
OCT	194	191	181	177	214	211	
NOV	137	157	150	196	152	196	
DEC	143	183	210	191	153	192	



SURGERY SUMMARY REPORT FOR FEBRUARY 2019 (Continued)

We have started 2019 relatively strong with volume that has kept in line with the growing trend of operative procedures experienced the previous years.

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 March 20, 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

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.

UMC
UNITED
MEDICAL CENTER

General Board Meeting

Date: March 27, 2019
Location: Conference Rooms 2/3

Executive Management Report

Prepared by:
Matthew Hamilton
Chief Executive Officer

UMC
UNITED
MEDICAL CENTER

United Medical Center
Management Report
Operations Summary – March 2019

QUALITY

Patient Safety
UMC endured a flood to the critical care unit in January. As the Critical Care Unit (CCU) on the 4th floor is currently closed UMC reopened, with approval from DC Health, a temporary CCU on the 5th floor. With the interdepartmental collaboration, UMC was able to ensure the area had all that was needed to run a critical care department. The temporary CCU has 14 beds and maintains quality, patient safety and the standards of care for all patients on a daily basis.

Environment of Care (EC)
UMC hosted a training on AuditPro in collaboration with the Quality, Safety and Security departments to train new leaders on the use and capabilities of this software. AuditPro is utilized during the environment of care rounds to capture findings that are non-compliant with The Joint Commission (TJC) environment of care standards. This software also allows the opportunity to follow up with identified findings to the designated departments. We will be utilizing this hospital wide to ensure we are maintaining and remaining in compliance with TJC standards.

Performance Improvement (PI)
UMC held a Performance Improvement Committee Meeting in February. The goal of the meeting is to use data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality. During this meeting the new PI reporting template was utilized by the departments scheduled to present. The PI reporting template highlights the department areas such as staffing, accomplishments, challenges, regulatory/corrective action follow-up, and the PI project focus. The PI projects highlighted were from the Laboratory and Radiology departments. Laboratory is currently focusing on decreasing blood culture contamination. Training on techniques to collect blood culture specimens have commenced with goals to decrease the contamination rates. Radiology is currently focusing on reducing repeat rates. This project will decrease the unnecessary radiation exposure to patients.

Regulatory Compliance
UMC welcomed surveyors from DC Health on February 22, 2019. They announced they would be conducting UMC's Annual Licensure Survey. The survey period was from February 22nd through March 1, 2019 and included both hospital and clinics. Some of the preliminary observations discussed at the debriefing session included the water intrusion incident. DC Health noted overall improvement throughout the hospital and named multiple departments and individuals since the last survey. DC Health will provide an official report of the survey within ten calendar days.

PATIENT CARE SERVICES

8W - TELEMETRY

Month	Admission	ADC	Falls	Elopement	AMA	Restraints	Code Blue	Rapid Response
February	212	35.5	2	2	5	0	2	5

Education:

- 12 Lead EKG lead placement and testing
- Priming Y-tubing for blood administration
- Use of TTY phone
- Implementation of new SBAR communication tool
- NO PASS ZONE reiterated for call lights, bed alarms, phones and vents
- Post mortem care
- Cardinal SCD pump trial

PI Initiatives:

- 100% Compliance with Positive Patient Identification (DOH plan of correction)
- Accurate and timely Insulin administration and documentation
- Screening and identification of isolation patients (DOH plan of correction)
- Peer to peer education on best practice for PPID (DOH plan of correction)
- Pressure injury prevention and management
- Supply chain management
- HCAPS monitoring and action planning

Service Recovery:

- Manager proactively rounds on all new admissions daily.
- Charge nurses round on patients Monday, Wednesday and Friday and as needed to address any questions comments or concerns.
- Manager conducts discharge/follow up phone calls to patients 24-48 hours post discharge.
- Coaching and counseling done with staff to address effective interpersonal communication with patients and families.
- Patients and or family will receive customer service letter as follow up to complaint.

5W- MEDICAL SURGICAL

Month	Admission	ADC	Falls	Elopement	AMA	Restrains	Code Blue	Rapid Response
February	152	19	5	0	6	0	0	1

Education:

- 75% of RNs have been in-serviced on the new Vantage Point needle system. Manager is working with nursing educator to implement a venipuncture in-service/ class, as well as a class on care of post-op orthopedic (joint replacement) patients.
- RNs scheduled to attend remediation Telemetry classes.
- SBAR report has been implemented an in use by RNs for end-of-shift reporting.

PI Initiatives:

- 22 charts were reviewed for allergies, 91% (20 charts) were completely updated and 9% (2) were not. Improvement noted in this area from 73% last month.
- 29 charts were reviewed for pain reassessment for the month of January. There was 100% compliance with reassessment, 2 reassessments were late.
- Wireless telephones were distributed by IT department early February. This has improved care delivery through better/faster communication amongst interdisciplinary team members as evidenced by a noticeable decrease in patients' complaints.

BEHAVIORAL HEALTH

Month	ADM	ADC	AMA	Disch.	Falls	Elop.	Seclusion	Rapid Response	Restraints	Diabetic Event
February	85	23.3	6	84	2	0	0	2	3	0

Education:

- Collaborating with Education to solidify UMC's Comprehensive Crisis Management (CCM) de-escalation training. Significant lapses with a number of training opportunities still exist. With help from Nursing Administration, BHU has garnered help from Education in hopes of helping the Director of Security build a reliable and timely CCM (de-escalation) training schedule.

PI Initiatives:

- Successfully completed: Moving into the next few months, the plan is to ask more from our part-time and PRN employees which will decrease overtime payout even further.
- Successfully completed and sent to Mr. Hamilton: Develop a staffing matrix which would give everyone a numerical staffing blueprint. For example, if BH's ADC is averaging 20 patients daily, 3 RN's (RN: Pt Ration = 6.3 pts per RN) would be required in order to safely care for the BH clients and falls below national BH staffing ratio.
- In process with moving EDOP/Intake in-house, streamlining BH's staffing issues now will provide a stable staffing foundation when EDOP/Intake moves in-house.

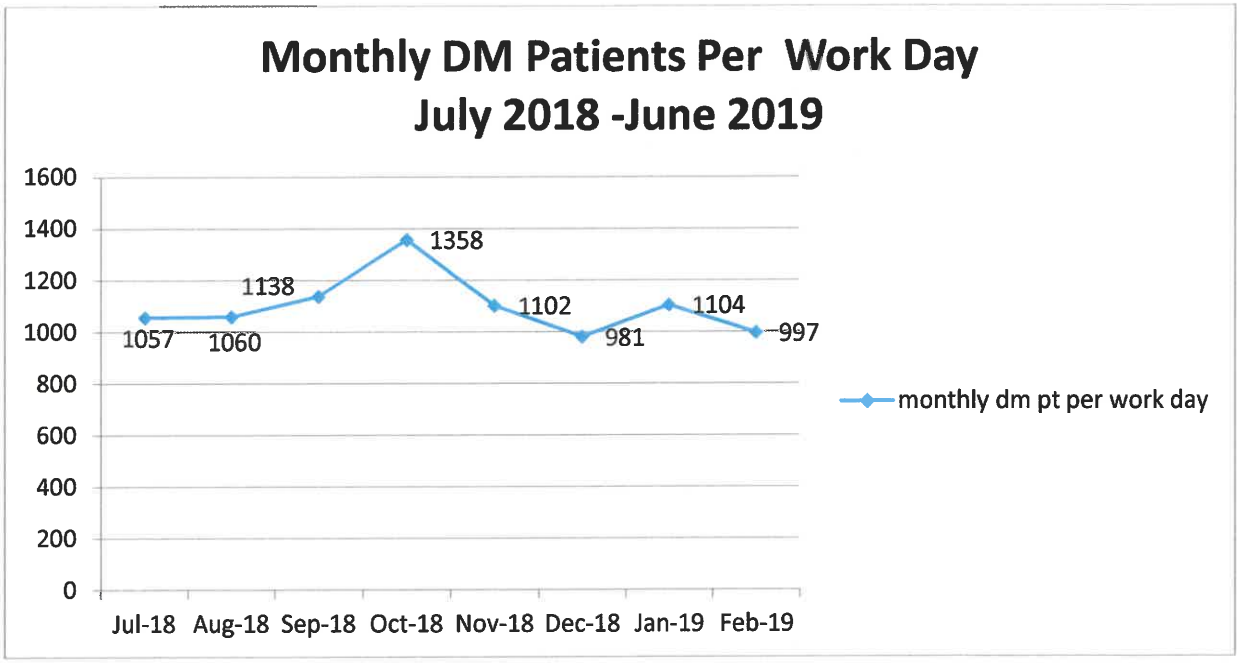
DIABETES CENTER

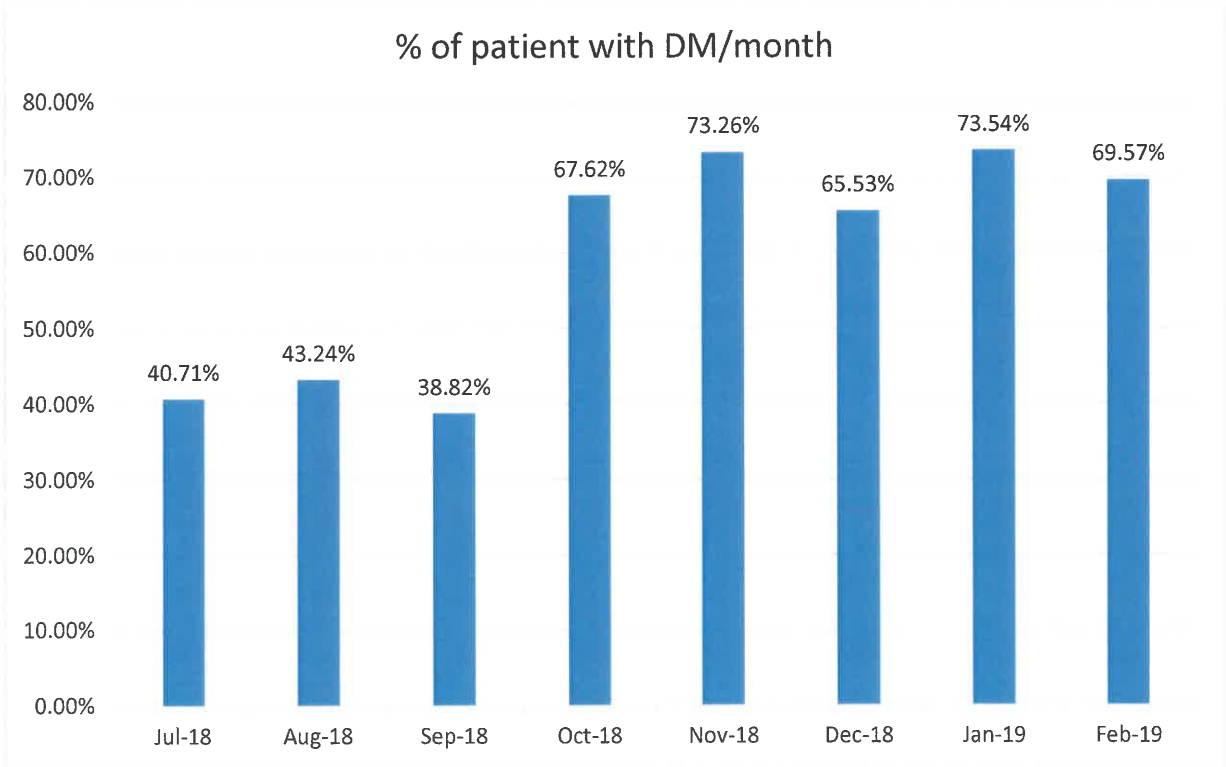
Diabetes Census per Workday:

	Jul-18	Aug-18	Sept-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Monthly DM per work day	1057	1060	1138	1358	1102	981	1104	997
Percent DM days/month	36.57%	34.13%	33.56%	46.71%	40.34%	37.73%	43.33%	44.10%
Avg. Patient per workday	48	48	54	54	52	47	53	50
#Patients DM per month	252	272	257	284	263	287	364	272
Total Hospital Census	619	629	662	420	359	438	495	391
Hospital Patient Days	2890	3106	3391	2907	2732	2600	2548	2261
% of Patients with DM/month	40.71%	43.24%	38.82%	67.62%	73.26%	65.53%	73.54%	69.57%

Education:

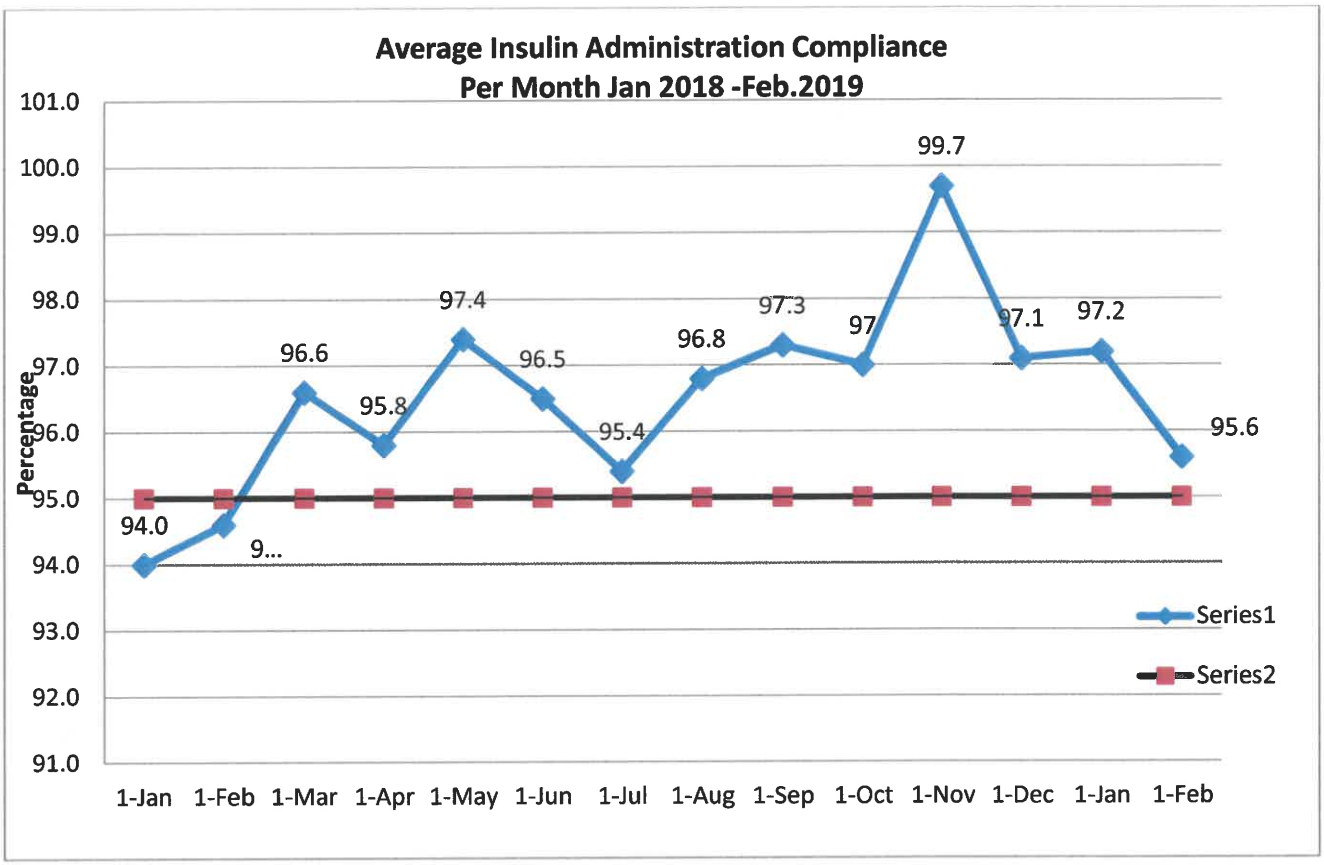
- Insulin administration accuracy is included as part of nursing orientation. Huddles are presented on the nursing unit to address identified knowledge deficits.
- Currently working with the education team to update the competency for the Accuchek Inform II glucose meter. Plan to accomplish annual competency of all users in April 2019.
- Insulin Drip EMAR has been fully implemented in ICU. Staff was instructed by the diabetes educators. Staff has utilized the screen, positive feedback to date.





Insulin Audit

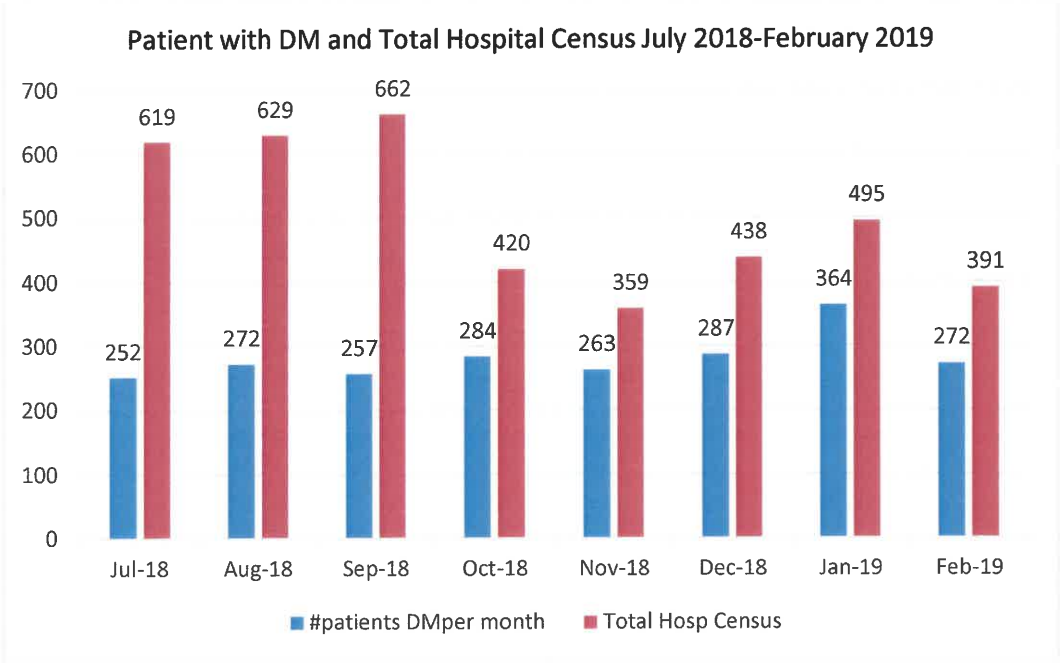
Accurate administration of insulin continues to be monitored. We have been above the benchmark for 12 months.



Most frequent errors continue to be missed insulin without documentation and giving insulin at bedtime that is only ordered three times per day with meals. Results are reported to managers along with supporting documentation. Managers meet with the nurse identified to provide coaching and progressive discipline.

The system fixes have worked well to lessen errors. There is a need for more direct education of the nursing staff via huddle and RELIAS to increase the basic knowledge of diabetes management and develop skills to talk with providers about adjustments to treatment plan such as when the patient is NPO (nothing by mouth).

The correct documentation of insulin drip is tracked by the diabetes educator. The chart is reviewed for the location and start time of the insulin drip, nurses who care for the patient, accurate titration of the drip. The majority of insulin drips are started in the ER and patient is then transferred to the ICU.



A need has been identified to work with IT and Pharmacy to develop a discharge order set that matches the patient insurance with the approved diabetes medication and monitoring supplies for the plan. This will lessen the chance that post discharge patients are not able to receive the prescribed medications due to insurance issues.

Update: Discharge order set for approved diabetes medications has not been initiated as yet. IT has a number of projects that are currently in process. Diabetes Center is researching the Medicaid Formulary on line to see if there are any changes. The diabetes discharge order set may not be able to be implemented until later in 2019, as plans often make adjustments in formulary during open enrollment.

EDUCATION/PROFESSIONAL DEVELOPMENT

# of Classes Provided						
Month	**8W**	**5W**	**ICU**	**BHU**	**ED**	**OR/PACU/ASU**
February	2	3	2	0	3	2

Education:

- Vanish Point Blood Collection Set In-Service
- Annual Competencies Continuation
- Top 5 Practice Updates
- BLS Instructor Certification for Educators
- Blood Culture Draw Education Module
- Ventilator V500 Education
- Informed Consent Module

PI Initiatives:

- Top 5 Practice Updates to improve clinical practice and patient safety

EMERGENCY DEPARTMENT

ED Metrics Empower Data	Sept	Oct	Nov	Dec	Jan	Feb
Visits	4721	4636	4336	4595	4433	4021
Change from Prior Year (Visits)	4968	5053	4585	4602	4919	4557
% Growth	-5.23%	-8.99	-5.74	-0.15233	-10.9632	-13.33
LWBS	220	185	121	139	165	73
Ambulance Arrivals	1349	1245	1185	1297	1142	1143
Ambulance Patients Admission Conversion	294	356	330	367	296	285
% of ED patients arrived by Ambulance	28.57%	27%	27%	28%	26%	28%
% of Ambulance Patients Admitted	21.79%	29%	28%	28%	26%	25%
Reroute + Diversion Hours	2				264	0
Ambulance PG Median Offloading Times	14					
Ambulance DC Median/Mean Offloading Times	14					

ED Metrics Empower Data	Goal	Sept	Oct	Nov	Dec	Jan	Feb
Door to triage	30	33	27	24	24	26	19
Door to room	45	101	89	113	113	123	109
Door to provider	60	107	100	122	118	122	103
Door to departure	150	251	158	249	250	261	231
Decision to admit to floor	240	286	205	304	294	304	309
Door to transfer		309					

Education:

- Blood Culture Contamination Training/Re-Education was implemented throughout the department
- VanishPoint New Blood Collection System
- Restraint Policy (PCS 02-151)

PI Initiatives:

- Pain Assessment
- Vital Sign Assessment
- Medication/Pyxis audits
- EKG within 10 minutes of arrival

- POCT – critical glucose repeat testing
- Quick Look RN

Service Recovery
Able to accomplish in real time with positive results.

CASE MANAGEMENT
Status:

- The contract with Procare Integrated Health and Transport was fully executed/signed on Friday 3/8/2019 for ambulance/patient transportation services.
- Continue with strategic plan to replace contract labor staff to reduce cost.
- There were four Clinical Social Worker resignations since Dec 2018 (3 voluntary and 1 involuntary).
    - Candidate interviews are underway to backfill Clinical Social Worker positions.
        - 1 candidate accepted position with anticipated start date of 4/1/2019
        - 2nd candidate identified pending internal approval process
- InterQual was recently updated to version 18.3.

Utilization Review
Measurement Period: [19] Denials received January 1, 2019 to January 31, 2019

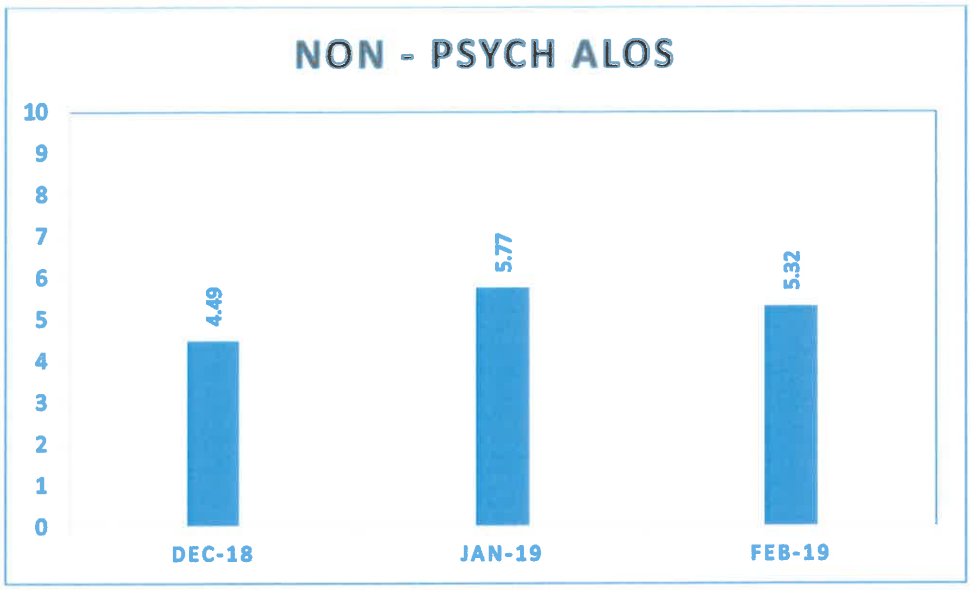
Denials by Payer [19]

- 26.1% AmeriHealth (11/42)
- 25.0% Trusted (2/8)
- 20.0% Maryland Physicians Care (1/5)
- 16.7% Maryland Medicare (1/6)
- 8.7% Amerigroup (2/23)
- 4.5% United Health Care (2/44)

Summary of Denial Outcomes [19]

- 31.6% Submitted to PFS for appeal (6/19)
- 26.2% PA (Physician Advisor) agrees to observation (5/19)
- 10.5% Partial approval appeal denied days (2/19)
- 10.5% Upheld (2/19)
- 5.3% Per PFS Denial Coordinator, bill at lower LOC due to LOS (1/19)
- 5.3% Pending retrospective 3808 review (1/19)
- 5.3% Submitted technical denial sent to PFS for resolution (1/19)
- 5.3% Overturned/Approved (1/19)

Metrics



In February 2019, 5.32 days we saw a decrease in non-Psych ALOS as compared to January 2019, 5.77 days.

Major Barriers

- DC Medicaid outlier cases with length of stay greater than 15 days requiring long-term care placement with no accepting facility
- Limited Clinical Social Worker staff for discharge planning

RESPIRATORY SERVICES

Education

One of our Lead Respiratory Therapist (RT) partnered with the Education Department this month. They provided a refresher course in tracheostomy care to the 8th and 5th floor nursing staff. The nursing staff remarked that this teaching gave them greater confidence when caring for their trach and ventilator patients.

PI Initiatives

In February, 244 Arterial Blood Gases (ABG) were obtained. A total of 2.04% of these ABG results were missing a necessary Read back (RB) to alert medical staff of critical results. This is an improvement from January, which had 3.87% missing a RB notation.

Service Recovery

A sleep apnea patient, on the 8th floor, complained to an RT that she was not being placed on her BIPAP machine in a timely manner at night. The RT spoke with the night shift RT about the patient's complaint and the patient's request was honored the same night. The patient replied with a thank you and was satisfied that her concerns were positively resolved.

WOUND CARE

PI: Unit Based and Wound Stages

Unit	# of Patients	# of Pressure Injuries	# of HAPIs
CCC	10	15	0
BHU	0	0	0
5 Floor	8	13	0
8 Floor	12	37	3
Total	**30**	**65**	**3** **Please see note below**

Unit	Stage I	Stage II	Stage III	Stage IV	Unstageable	DTI	Reportable
CCC							
BHU							
5th Flr							
8th Flr		1	*2				1
Total	0	0	0	0	0	0	*1

There is a total of 3 HAPI(s) but only 1 will be reportable to the state (we report stage 3, 4, unstaged)
Please note the rule of thumb is only 1 wound is reported per patient (despite the number of wounds the patient has).

Education:

- There is a teamwork effect currently with the respiratory team, education, and wound care to develop and execute a prevention decision tree for preventing wound in the OR, ED, ICU and Respiratory department by using foams to fragile areas of the skin prophylactically.

PI Initiatives:

- An updated version of the admission power point was completed and presented for orientation. It highlights all areas of assessments and maintenance of wounds during orientation.
- The veraflo VAC system has been a success and well received by physicians.
- The process of initiating and discharging wound VAC has been up and running seamlessly- the distributors have dropped off and picked up VAC without incidence of loss or misplacement.
- A wound care binder is successfully being utilized by the staff for added reinforcement.

HUMAN RESOURCES

HUMAN RESOURCES (HR) BEST PRACTICES IMPLEMENTATION

HR Recent Successes:

- Successful HR DOH Survey with no findings notated thus far
    - Positive feedback received from DOH to include professionalism and organization of the files.

HR Organizational Efforts:

- Successful progress of the HR team in data analysis, including the cross-reference of approximately 1000 HR files to ensure the proper FTE entry into our Information Systems.
- Meditech fully auditing to ensure the accuracy of all current terminations.
- Continuous timeliness and organization regarding monthly Union dues.
- On-going file maintenance clean-up to be 100% compliant for DOH purposes.

Workers Compensation:

- The organization continues to be 100% compliant with timely recording of Worker's Compensation claims.
- HR led and conducted two Workers Compensation trainings for the UMC Management Council.
- As a result of training and communications delivered to management by HR, Worker's Compensation claims are down by 70 percent across the organization.

Streamlining of Various Processes:

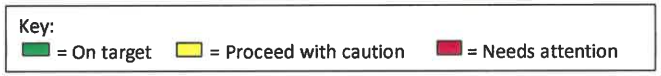
- Implementation of Technology for the Onboarding Process
    - Inclusion of new hire documentation on Intranet "New Hire Portal" accessible to all new hires
- Created a tracking system on various payments and leave:
    - Family and Medical Leave
    - Tuition-CME Reimbursements
    - Invoice Reconciliation
    - Recruitment
    - Contract Rates

Benefits Update:

- The UMC HR benefits team saved the organization $118,341.43 on invoices related to benefits as a result of thorough data analysis and reconciliation.
- An on-going reconciliation process is now in place to ensure continued accuracy in invoice billing and payment.

INFORMATION TECHNOLOGY - March 15, 2019				
Initiative	**IT Leader**	**Status**	**Target**	**Comments**
Update and Expand Applications				
Interface GW's system with Meditech	Tania		Completed	•Daily interface file being sent to GW for their billing; went 'live' February 15, 2019
Interface Meditech and eClinical Works (eCW)	Tania		March 2019	•Includes ADT and billing for eCW; coding and UAT in progress •Go-live target estimated at mid-to-late March
Post Acute Patient Management (NaviHealth)	Tania		Completed	•Facilitates discharge management processes •System successfully went live November 14, 2018
Cost Accounting and Patient Analytics (Premier)	Tania		Completed	•Go-live was successful on December 7, 2018; training of the Finance team has been completed
Technical and Professional charges	Tania		April 2019	•Implement Technical billing charges (started; phasing-in) •Standardize scrubbing and billing of professional charges
Meaningful Use Reporting (Medisolv)	Vineela		Completed	•To improve data capture and reporting of Meaningful Use measures for the Hospital. Completed February 15, 2019.
Meditech Magic release update	Tania		Completed	•Upgraded to current release level on January 31, 2019
Materials Management Inventory	Tania		TBD	•Establish and manage PAR levels; scoping in process
Intelligent Medical Object (IMO) 2.0 upgrade	Tania		TBD	•Tool to facilitate physician documentation and coding in Meditech •Contract needs to be signed; using sunset 1.0 version in interim
Skilled Nursing Facility (SNF) documentation enhancements (Point Click Care)	Vineela		TBD	•CPOE and additional specialty modules will be implemented •Contract and BAA for Core system needs to be signed
Rehab Therapy documentation - SNF	Vineela		TBD	•Following the removal of Optima, we will evaluate Point Click Care (PCC) to internally code the functionality; need Core contract signed
3M360 Medical Records coding (MD Communicator)	Tania		August 2019	•Will enhance data communications between 3M and Meditech •Date estimated; plan and contract to be finalized
Ambulatory EHR Optimization (eCW)	Vineela		TBD	•Enable all modules within eCW and train users to utilize the system •Optimization project will resume once eCW interface is completed
ED Patient Identification Scanning	Tania		Completed	•Successfully enabled 3 rights of med administration in the emergency department
Interqual (Case Management)	Vineela		March 2019	•Version upgrade in progress; end-user training also being arranged
Human Resource Information System - HRIS (Kronos Dimensions)	Vineela		TBD	•Completion date TBD - dependent on contract signature •Will provide improved human resource functionality •May need current system upgrade if new system is not processed
Workflow Management tools (DocuSign)	Vineela		TBD	•Legal counsel teams are working through agreement
Reporting and Dashboard tools	Vineela		TBD	•Not started; contract needs to be signed; we are also evaluating other options to the current proposed solution •To enhance UMC's data management and reporting capabilities
Develop a Corporate Intranet	Vineela		July 2019	•To enhance communications throughout the organization •Working with multi-disciplinary team to obtain "seed" data
Compliance and Policies/Procedures tools (Navex)	Abdul		March 2019	•Begin (pilot) Active Directory sign-on to replace generic logins •After a successful pilot, evaluate/plan for organizational rollout
Work Order software (Maintenance Connection)	Abdul		Completed	•Enabled end-user access throughout the organization

Infrastructure				
Implement formal IT Security Program and remediation of risk assessment items	Abdul		September 2019	•IT staffing is impacting the timeline for completion •Security officer role still outstanding •IT security remediation efforts include: Firewall, intrusion detection, encryption, spam, patches, and anti-virus
Overhaul of cable plant and wiring/communications closets	Abdul		September 2019	•Performing a design analysis in order to facilitate vendor selection for cooling and electrical work; received report; pursuing estimates
Develop Disaster Recovery plan and processes	Abdul		September 2019	•Evaluating alternative solutions to provide disaster recovery for systems housed in UMC's data center
Expand storage for PACS	Abdul		April 2019	•Equipment received; implementation plan in progress
Update Security surveillance server and system	Abdul		March 2019	•Initial build done; finalizing camera configurations with Security
Help Desk software (ServicePro)	Dannette		March 2019	•Update software to improve tracking and resolution of issues
Wireless Communications	Abdul		September 2019	•Wireless network improvements to floor 5 and 1/2 of 4 are done •Wireless phones to floors 8, 5 and ICU are fully deployed •Wireless for entire hospital and MOB will be addressed
Mobile Device Management System	Abdul		May 2019	•Will provide secure, audited remote device management
Server enhancements and management	Abdul		April 2019	•Replace non-supported OS versions •Reconfigure VM and PACs servers to enable redundancy •Inventory servers and apps; implement structured patch schedule
Help Desk management (devices)	Abdul		March 2019	•Develop standard desktop image(s)
Device Management (Citrix)	Abdul		July 2019	•Identify VDI solution to enhance deployment, management and security components for end-user access; Citrix is being trialed
IT Governance and Management				
Develop and implement IT policies and procedures	David		September 2019	•All IT policies and procedures are being reviewed and updated
Align IT organization to support and accomplish Corporate goals; fill critical vacancies	David		March 2019	•Realign security work across Network and Server team •Bring in Agency staff to address telecom operator staffing needs •Adjust project priorities to align with IT staff availability
Achieve Meaningful Use Compliance - 2018 - Stage 2	Vineela		Completed	•Thresholds (results) have been achieved for 2018 •Submitted measures to CMS
Achieve Meaningful Use Compliance - 2019 - Stage 3	Vineela		December 2019 (results) By Feb 29 2020 (submission)	•Implement Meditech add-ins (March) •Identify and plan all required components/projects (March) •Plan for interface updates (target- May)



UMC

UNITED
MEDICAL CENTER

General Board Meeting

Date: March 27, 2019

Location: Conference Rooms 2/3

Patient Safety and Quality

Dr. Malika Fair, Chair

Not-For-Profit Hospital Corporation
Patient Safety & Quality Committee Meeting Minutes
March 21, 2019

Present:

Absent:

Agenda Item	Discussion	Action Item
Call to Order		
Approval of the Agenda		
Discussion		
Meeting Discussion	**DOH visits/notifications** - Exit Briefing/Quality Safety Huddle Overview - ICU Flooding - Water Intrusion - Behavioral Health - SNF Survey	

	- ED Sentinel Event - MRI air sampling - BHU Bathroom remodel **Standing Reports** - Executive Quality Dashboard (including core measures, sepsis, and SSE) - Deliveries in ED - Length of Stay **Regulations & Accreditation** (Updates on Plans of Correction Items) - Medication Reconciliation - Fluoroscopy/ Bronchoscopy update - ED/Children's Transfer policy - Pharmacy & Sterile Processing Department remodel - ED (Staffing, Behavioral health risk, Peds/OB Mock Drills) - Committee Updates (Pharmacy, Infection Control, Safety/EOC, Patient Safety) - Mock Survey in 2019 **Other Topics** - Medical Office Building – medical emergencies	

Not-For-Profit Hospital Corporation
Patient Safety & Quality Committee Meeting Minutes
January 29, 2019

Present: Dr. Fair, Director Gorham, Andrea Gwyn, Dr. Hammad, Shirlitta Cropper, Derrick Lockhart, Ambrose Warren, Dr. Haghighat, Linda Pulley
Absent: Girume Ashenafi

Attachments: Joint Commission Acceptance Letter, Nov Patient Safety Committee minutes

Agenda Item	Discussion	Action Item
Call to Order	Meeting was called to order at 4:04 PM. Quorum determined by Mike Austin.	
Approval of the Agenda	Agenda approved as written.	
Discussion	Previous meeting minutes approved pending a minor edit	
Meeting Discussion	**DOH visits/notifications** • ICU Flood: On 1/21/19 a sprinkler leak on the fourth floor occurred. Restoration is underway. • Behavioral Health Unit had 2 recent DOH visits. 2 outstanding reports needed from DOH.	

	• SNF Survey: Statement of deficiencies were submitted. Plan of corrections were submitted. DOH returned last week and SNF was found to be in full compliance. • ED Sentinel Event: 1/10/19 web conference with Joint Commission to review root cause analysis which was accepted. One outstanding item due to DOH on 5/10/19. Also added a Quick Look Nurse 24 hours a day. • MRI Update: Air sampling done in October. There is fungal growth. Also tested equipment and there is fungal growth. Area has been contained. Purchasing new equipment and treating area. • BHU Bathroom remodel: No issues. In progress. **Standing Reports** • Executive Quality Dashboard (including core measures, sepsis, and SSE): still working on quality dashboard, LOOKER. May not happen, may keep spreadsheet format instead. 3 serious safety events since October; 1 sentinel events. 21 sepsis cases in September. Mortality rate is .09%. • Deliveries in ED: 0 births in January and December; January 80 visits, December 100 visits. • Length of Stay: 7/8 days is the average without outliers the number drops to 4/5 days. **Regulations & Accreditation** (Updates on Plans of Correction Items) • Medication Reconciliation: standing agenda item for PSQ. 89% and 84% compliance in September and October respectively • Fluoroscopy/ Bronchoscopy update: waiting on architect for designs • ED/Children's Transfer policy obtained and under review by legal • Pharmacy & Sterile Processing Department remodel: flooring completed	

	• ED (Staffing, Behavioral health risk, Peds/OB Mock Drills): improvements because of rounding • Sanitation of physical environment (Behavioral health, lab, SPD, ED: notes that environment looks much cleaner than before • Committee Updates (Pharmacy, Infection Control, Safety/EOC, Patient Safety): 0 infections, no cases of MRSA; 99% influenza compliance safety rate; central line 79 devices placed and 0% infection rate; ERE: 13 screened and no cases of hospital infection. • Mock Survey in 2019: plan to have one in first quarter of this year. Previous one occurred in last quarter of 2018. **Other Topics** • Medical Office Building: medical emergencies: signage to instruct visitors to contact 911 being posted. Need to change policy to reflect this as well. • Hospital Patient Safety Committee: creating working group to address MOB issues. Dr. Fair: keep this as a standing agenda item. **Meeting adjourned at 4:32pm**	

INSPECTION TECHNOLOGY Disrupts Inefficient Practices

AuditPRO

A major health care facility found a way to disrupt an inefficient process found in nearly every health care facility. Hospitals spend millions of dollars annually trying to achieve regulatory compliance. The task of determining CMS compliance falls upon contracted agencies that regularly inspect health care facilities. In preparation for inspections health care facilities dedicate thousands of manhours on internal inspections.

PROBLEMS:

Inspections produce **checklists that require content organization,** dissemination and follow-up to ensure identified code violations are addressed.

After committing time to conduct and document findings from a facility walk through, additional time is required for **follow-up on managing inspection sheets** which often take a lower priority against other facility needs.

Inspection sheets end up on a desk somewhere while **identified code violations are delayed** or go unaddressed waiting for some form of action to occur.

Crafting and **sending emails** to the individuals responsible for addressing identified violations takes time.

If a facility does send corrective e-mails or notices to responsible department liaisons, quite often there is **not enough time to follow-up and ensure a violation or corrective was properly addressed.** At some point only the more serious code violations receive priority attention.





SOLUTION:

Using guided inspection software, the head of Security Services at United Medical Center, who is also the Chair of the Environment of Care (EEOC) committee, was able to reclaim a substantial amount of time due to improved efficiencies. Labor-intensive data collection methods were streamlined, and detailed reports became readily available. The accuracy of reported data increased, making the data more useful to guide decision making for the EEOC.

United Medical Center's health and safety inspector reported a substantial labor savings. The reclaimed time was used to conduct additional inspections where 25% more potential code violations were identified which could have placed the facility's accreditation at risk. The ability to send pictures of code violations increased compliance upon reinspection by 33%. Having reminder prompts to recheck areas of concern also increased accountability across the facility. These improvements helped achieve greater efficiencies resulting in a safer environment for patients, visitors and staff.

33%

Gains in environment of care inspection efficiency increased compliance upon reinspection by 33%.

For more information, contact John Nicklin, Managing Member, AuditPro at jnicklin@wastestrategies.com.

March 2019 P&T Summary:

1. Formulary Removal – of special concern was Amphotericin B. It was confused with the **Liposomal** Amphotericin B. Dosing for both products is completely different and can severe reactions with mistakes. Liposomal Amp. B has a safer profile on kidney function

Pharmacy Formulary Removal

Removal	Alternative
1. Acetylcysteine 10% vial	Acetylcysteine 20% vial
2. Amphotericin B	Liposomal Amphotericin B
3. Carbamide Peroxide Antiseptic Oral Cleanser	Chlorhexidine Gluconate Mouthwash
4. Tenecteplase	Alteplase
5. Integrilin	
6. Cortisporin Otic Soln	Cortisporin Otic Suspension
7. Neosynephrine Nasal 0.25%, 1.0%	Neosynephrine Nasal 0.5%

Pharmacy Formulary Removal Cont'd

Removal	Alternative
8. Zostrix Capsaicin 0.025%, 0.075% Cream	Zostrix Capsaicin 0.033% Cream
9. Fluocinonide 0.05% Cream	Fluocinonide 0.05% Ointment
10. Nystatin 100,000 unit Cream	Nystatin 100,000 unit Ointment
11. Triamcinolone Acetonide Cream	Triamcinolone Acetonide Ointment
12. Gentamicin 1.0% Cream	Gentamicin 1.0% Ointment
13. Balanced Salt Soln for Opth.	

2. Formulary addition of Veltassa for dialysis patients (CKD) and CHF, with chronic hyperkalemia. Kayexalate will still be used for acute onset hyperkalemia. Better tolerated and more effective for chronic hyperkalemia. Reserved for use by Nephrologists.

Background

- **FDA Approval Date:** October 21, 2015
- **Generic Name:** Patiromer
- **Proprietary Name:** Veltassa®
- **Therapeutic Class:** Antidote; Potassium Binder
- **Indications:** Treatment of chronic hyperkalemia

3. Medication scanning now available in ED as of January 2019.

4. **Policies/Protocols:**

a) Removal of ED Dispensing of "Starter Doses of Drugs" Policy (ED-1001)
Policy indicated giving meds to patients to cover them over weekends, holidays, etc., we are not licensed to do this and the policy was unclear of what drugs and for how many, etc.

b) Restricted Antibiotic Policy approved
to ensure best practice of antimicrobial use in our patients
all restricted antibiotics must be written by an ID doc. One-time starter doses and weekend doses permitted until ID doc. Is available

c) Blood Borne Pathogen Exposure Policy
updated to included needlesticks should proceed to the ED immediately for follow-up
Pharmacy will provide HIV KIT for 3 days of therapy
Employee will follow-up with Occ. Health

5. Proposal for Pharmacy Tech in ED to increase Medication Reconciliation accuracy

Monday March 11, 2019

Quality Safety Huddle- DC Health Survey results departmental plans

- 8 West
  - Working with Diabetic Center on the blood glucose check training; Also, with Infection Prevention to address proper isolation sign to be posted on patient's room entrance. Working with staff on positive patient identification and patient care technician to teach a class to staff on proper usage of patient identification bands.
- 5 West
  - Surveillance of Nurse WOWs and ensuring sharps are not visible and locks work.
- Nursing Education
  - Currently working on ED triage training.
  - Working on wound care education with 8 West.
- ED
  - Working on Triage education with staff.
- Perioperative
  - Construction in progress due to flood.
- Rehab
  - Renovation is in progress, the department will be relocated
- Respiratory
  - Working on education of policy and treatment administration time. Staff will be reminded via messages on when-2-work. If the policy is not followed after staff review, disciplinary action will be taken.
- Wound Care
  - DC Health Exit Review sent to Allison and Aldene to review for findings.
  - Currently working on reeducation of wound care documentation.
- Case Management
  - D/C planning and D/C orders for patient going to home care. Case management is working with physicians to provide reminders that orders are needed.
- Infection Control
  - DOH concerns on water intrusion in multiple areas of the building, Infection Control is working with Facilities to address the findings, policy will be also written. Will work with areas on infection control signage outside of patient rooms.
- Pharmacy
  - DOH concern on IV room not in compliance with the USP standards, the area was tested (March 4th, 2019) the hood was assessed, waiting on report from vendor. The override issue was also addressed by implementing a process to control medication orders/ override.
- SPD
  - The department will restructure the supply control (PIC list training to come as well) for the OR
- Biomed
  - A vendor will come onsite 03/18/19 to assess equipment for a Preventative Maintenance management system. For now a written document is being kept in the department to track the PM recently updated.
- EVS
  - DOH concern on dirty vents, EVS will work with Facilities to clean the vents inner and outer parts.
- Facilities
  - Working with Children's on bathroom flood. DOH concern, will repaint patients' carts in nursing stations.
- IT
  - Will make rounds on the units to address the unlocked/broken WOWs. Will also work with Diabetic Center on the Lab having access to comments/notes related to diabetic test results. Diabetic Center recommends-nurses to have access to lab notes in patient's file.

- Food and Nutrition
    - The inspections needed for this department for the Hood/Vent will be every 6 months. Recommendations to custom make a ceiling vent. The temperature check log was added to the inspection list.

UMC

UNITED
MEDICAL CENTER

General Board Meeting

Date: March 27, 2019

Location: Conference Rooms 2/3

Audit Committee

Director Speight, Chair

Fiscal Year 2018 Financial Highlights

- The Medical Center's total assets exceed its liabilities as of September 30, 2018 and 2017, by $94.5 million and $105.4 million, respectively.
- The Medical Center's change in net position was ($10.9) million and $7.0 million for the years ended September 30, 2018 and 2017, respectively. The decrease in net position was primarily due to 10.1% reduction in operating revenues and a 11.3% increase in total operating expenses.
- The Medical Center's operating loss increase includes $11.7 million and $9.1 million of depreciation expense for the years ended September 30, 2018 and 2017, respectively.
- The Medical Center's operating loss increased by $27.7 million primarily as a result of increases in various expense categories and reduction in operating revenues due to lower activities.
- The Medical Center received $25.8 million and $16.0 million subsidy from the District of Columbia (the District) in fiscal years 2018 and 2017, respectively.
    - During fiscal year 2018, $8.8 million of the subsidy received was for capital related costs and $17.0 million was for continued operating support.
    - During fiscal year 2017, $16.0 million of the subsidy received was for capital related costs.
- The Medical Center's total liabilities increased from $29.1 million to $31.8 million during fiscal year 2018. This was primarily attributed to an increase of $4.2 million in current liabilities.
- The Medical Center's net working capital (current assets minus current liabilities) decreased from $32.5 million to $27.9 million during fiscal year 2018. The decrease was attributed to the increase in current liabilities of $4.2 million resulting from timing of vendor payables.

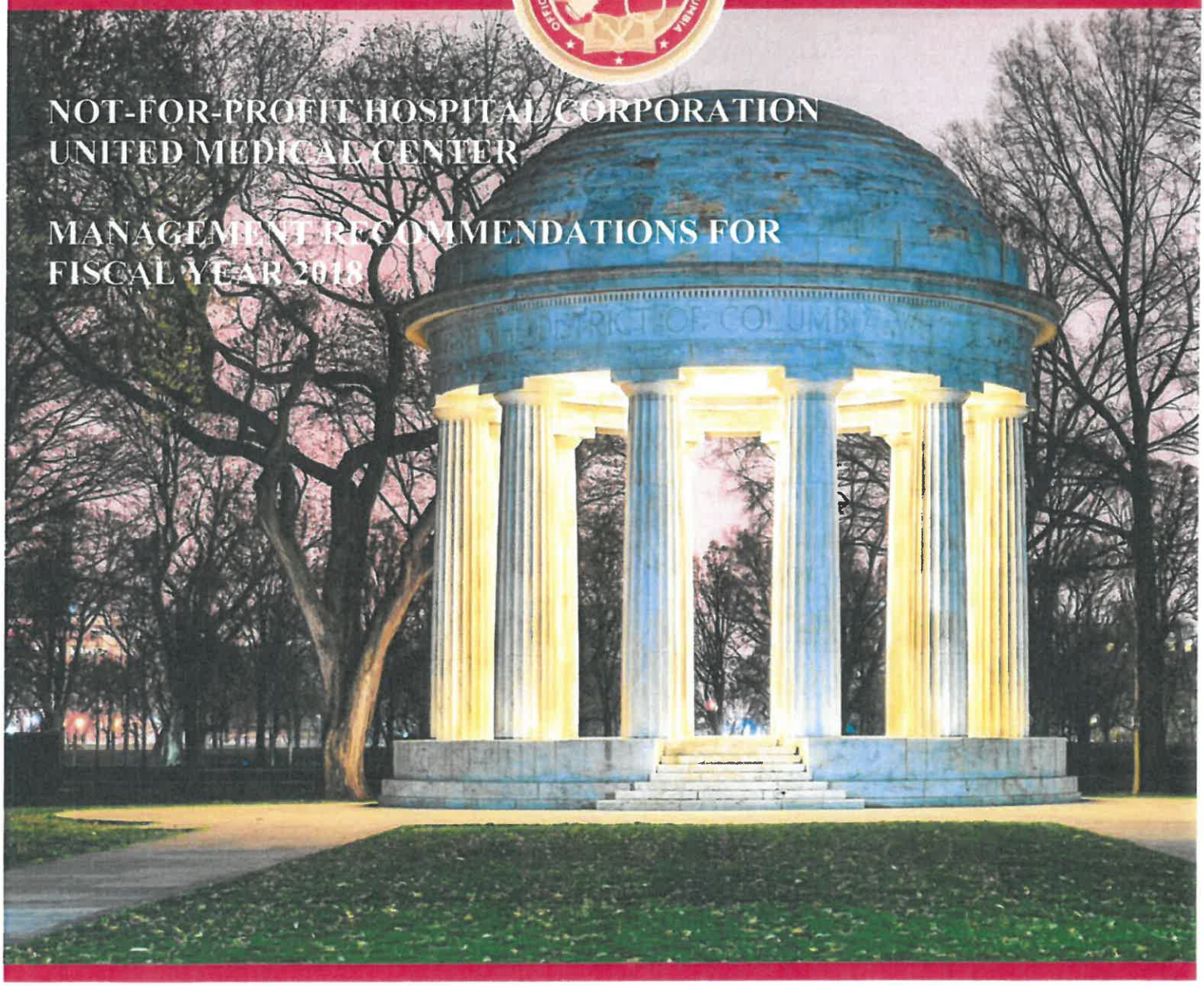
DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL

OIG Project No. 19-1-25HW

March 2019

NOT-FOR-PROFIT HOSPITAL CORPORATION UNITED MEDICAL CENTER

MANAGEMENT RECOMMENDATIONS FOR FISCAL YEAR 2018



Guiding Principles

*Workforce Engagement * Stakeholders Engagement * Process-oriented * Innovation * Accountability * Professionalism * Objectivity and Independence * Communication * Collaboration * Diversity * Measurement * Continuous Improvement*

Mission

Our mission is to independently audit, inspect, and investigate matters pertaining to the District of Columbia government in order to:

- prevent and detect corruption, mismanagement, waste, fraud, and abuse;
- promote economy, efficiency, effectiveness, and accountability;
- inform stakeholders about issues relating to District programs and operations; and
- recommend and track the implementation of corrective actions.

Vision

Our vision is to be a world-class Office of the Inspector General that is customer-focused, and sets the standard for oversight excellence!

Core Values

Excellence * Integrity * Respect * Creativity * Ownership * Transparency * Empowerment * Courage * Passion * Leadership

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General

OIG

March 11, 2019

The Honorable Muriel Bowser
Mayor
District of Columbia
Mayor' s Correspondence Unit, Suite 316
1350 Pennsylvania Avenue, N.W.
Washington, D.C. 20004

Jeffrey S. DeWitt
Chief Financial Officer
Office of the Chief Financial Officer
John A. Wilson Building
1350 Pennsylvania Avenue, N.W., Suite 203
Washington, D.C. 20004

The Honorable Phil Mendelson
Chairman
Council of the District of Columbia
John A. Wilson Building
1350 Pennsylvania Avenue, N.W., Suite 504
Washington, D.C. 20004

Dear Mayor Bowser, Chairman Mendelson, and Chief Financial Officer DeWitt:

Enclosed is the Not-for-Profit Hospital Corporation United Medical Center Management Recommendations report SB & Company, LLC (SB&C) issued for fiscal year (FY) 2018 (OIG No. 19-1-25HW). SB&C submitted this report as part of our overall contract for the audit of the District of Columbia's general-purpose financial statements for FY 2018.

This report sets forth SB&C's comments and recommendations intended to improve internal controls or result in other operating efficiencies in the Not-for-Profit Hospital Corporation United Medical Center. The report also includes SB&C's summary of FY 2017 management recommendations and the corresponding implementation status.

If you have any questions concerning this report, please contact me or Benjamin Huddle, Assistant Inspector General for Audits, at (202) 727-2540.

Sincerely,

Daniel W. Lucas
Inspector General

DWL/ws

Enclosure

cc: See Distribution List

DISTRIBUTION:

Mr. Rashad M. Young, City Administrator, District of Columbia (via email)
Mr. Barry Kreiswirth, General Counsel, City Administrator, District of Columbia (via email)
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The Honorable Anita Bonds, Chairperson, Committee on Housing and Neighborhood Development, Council of the District of Columbia (via email)
The Honorable Mary M. Cheh, Chairperson, Committee on Transportation and the Environment, Council of the District of Columbia (via email)
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The Honorable Kathy Patterson, D.C. Auditor, Office of the D.C. Auditor, Attention: Cathy Patten (via email)
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Ms. Berri Davis, Director, FMA, GAO, (via email)
Mr. Graylin (Gray) Smith, Partner, SB & Company, LLC (via email)

NOT-FOR-PROFIT HOSPITAL CORPORATION
UNITED MEDICAL CENTER
(A Blended Component Unit of the District of Columbia)

Management Recommendations

For the Year Ended September 30, 2018

SB & COMPANY, LLC
KNOWLEDGE • QUALITY • CLIENT SERVICE

The Mayor and the Council of the Government of the District of Columbia Inspector General of the Government of the District of Columbia The Board of Directors of Not-For-Profit Hospital Corporation:

In planning and performing our audit of the financial statements of the Not-For-Profit Hospital Corporation, commonly known as United Medical Center (the Medical Center or the Hospital), a blended component unit of the Government of the District of Columbia as of and for the year ended September 30, 2018, in accordance with auditing standards generally accepted in the United States of America, we considered the Medical Center's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances, for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we do not express an opinion on the effectiveness of the Medical Center's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect, and correct misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected, and corrected on a timely basis.

Our consideration of internal control was for the limited purpose described in the first paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

During our audit, we noted a certain matter involving the internal control, and other operational matters that are presented for your consideration. This letter does not affect our report on the financial statements of the Medical Center. We will review the status of these comments during our next audit engagement. Our comments and recommendations, all of which have been discussed with appropriate members of management, are intended to improve the internal control or result in other operating efficiencies. We will be pleased to discuss these comments in further detail at your convenience, perform any additional study of these matters, or assist you in implementing the recommendations. Our comments are summarized as follows:

1. Resolve Issue with Employee Pay Rate Changes

There was inadequate documentation to support employee's identified for testing for base pay and shift differential rates used in the processing of payroll. There are several union contracts that must be adhered to in order to ensure that union members' records are accurate. We identified instances where employees were compensated using different base pay and shift differential rates based on their job titles as defined in the most current signed union agreement on file. In all instances, the base pay and shift differential rates were greater than the approved amount set forth in the union agreement. The union contracts are in the process of being finalized.

Recommendation

We recommend that the Human Resources Department supervisors review all changes in an employee's pay, indicated with appropriate sign-offs, to ensure those amounts are in accordance with the signed union contract or other supporting documentation (i.e. raise letter), before this information may be entered into the HR system. Additionally, Human Resources should perform a review of all pay rates in the system to ensure the correct rates are loaded for all employees. In instances where one-time changes are needed, the Hospital should implement a process to document these changes within a reasonable timeframe.

Management's Response

- All union contract rates have been reviewed and updated in Meditech to ensure accuracy in accordance with the available Collective Bargaining Agreement (CBA) and will be updated with any future CBA.
- No future instant rate changes without written authorization and signature of Human Resources Director that will be processed through Human Resources.
- All Personnel Action Requests (PARs) now include the rate by hour, in accordance with existing Union CBAs. All appropriate signatures are obtained by Human Resources including fiscal sufficiency before implementation.
- HR and Finance will continue to work effectively and collaboratively to ensure timely documentation is submitted on rate changes within 72 hours and documented and filed accordingly in Human Resources and within the employee records.
- Monthly rate audit to ensure proper checks and balances is required by Human Resources.

2. Business Recommendations

A. Need for enterprise risk assessment:

We recommend that the Medical Center continue to actively work to develop a plan of action that address risks in a variety of areas, to include strategic initiatives, risk management, staffing analysis, operational efficiency, technology, and compliance. An effective enterprise risk assessment process can help the Medical Center identify and take action on risks that may be affecting the achievement of its core strategic objectives. Additionally, we recommend that the Medical Center implement procedures to review operational policies on a periodic basis.

Management's Response

The Medical Center currently has a written risk management plan to identify, prevent or reduce, modify and control conditions that cause loss hospital-wide. Additionally, through its insurance carrier, the Medical Center is assigned a consultant who works closely with the Director, Risk Management and the Corporate Compliance Officer. The consultant conducts at least three audits per year of hospital-wide functions to include risk management, staffing analysis, operational efficiency, technology and compliance. These audits conclude with a final risk assessment report identifying areas in need of improvement. In addition to having its ongoing audits, the Medical Center will conduct its first risk management committee meeting during the month of April 2019. This meeting will be interdisciplinary and will address issues identified by the consultant and continue to focus on improving hospital-wide operations.

Additionally, the Medical Center currently has a policy and procedure committee in place facilitated by the Medical Center 's quality management department. The committee is interdisciplinary and meets at least monthly to review hospital-wide policies and procedures, inclusive of operational policies. Policies are revised when practice and/or regulatory changes occur or as frequently as necessary, but no less frequently than every three (3) years. Medical Center policies and procedures are also reviewed by an outside consultant provided through the Medical Center's insurance carrier. In addition to the Policy and Procedure Committee, the Medical Center has a Health Information Management (HIM) Committee facilitated by the Health and Information Manager. This committee reviews forms that are attachments to a policy and stand-alone forms.

B. Financial sustainability:

The Medical Center has experienced significant operating losses over the past few years. Most recently, the operating loss in fiscal year 2018 grew significantly over fiscal year 2017. This was mainly attributed to a decrease in operating revenues due to a decrease in patient volume, as well as significant expense growth. Continuation of this situation will diminish the Medical Center's ability to be self-sustaining and will continue to rely on the subsidies and grants from the Government of the District of Columbia. We recommend that management consider implementing broad-based cost management techniques that eliminate any unnecessary costs and waste while improving overall efficiency including using appropriate technology. Management should create both short term and strategic cost cutting plans that should demonstrate how the individual cost items on the statement of operations would be reduced while not reducing the level of patient care.

Management's Response:

Management is embarking on the following broad based techniques to eliminate any unnecessary costs and waste:

- Requiring mandatory pre-approval of any overtime.
- Re-designing the time keeping system to eliminate incremental overtime.
- Evaluating and analyzing reasons for excessive turnover.
- Implementation of an updated Kronos system for nurse scheduling, time reporting, and human resource systems.
- Cost structure alignment to revenue.
- Timely union negotiations and market-based analysis for all employees.
- Appropriately flexing staffing in response to volume changes.

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Management is also monitoring the following short term cost cutting measures to show how the individual cost items on the statement of operations would be reduced:

- Enhancement in Revenue Cycle and increase in psychiatric volume.
- Reduction in Supply Chain, Length of Stay, Overtime Costs, and excessive staffing.

Status of Prior Year Recommendations

The following chart outlines the status of prior year management recommendations that had not been implemented as of October 1, 2017.

Year	Finding	Status
2017	Finding 2017-001: Use Appropriate Encryption Levels to Protect Data in Storage at the Cloud Service Provider (Recommendation)	Implemented
2017	Finding 2017-002: Enhance Controls over Domain Administrator Accounts (Recommendation)	Implemented

This communication is intended solely for the information and use of management, Board of Directors, others within the organization, the Mayor and the Council of the Government of the District of Columbia and the Inspector General of the Government of the District of Columbia, and is not intended to be, and should not be, used by anyone other than these specified parties.

Washington, D.C.
January 4, 2019

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