UMC
UNITED
MEDICAL CENTER

General Board Meeting

Date: May 22, 2019
Location: United Medical Center
1310 Southern Ave., SE, Auditorium
Washington, DC 20032

2019 BOARD OF DIRECTORS

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

Dr. Malika Fair, Vice-Chair
Girume Ashenafi
Jacqueline Bowens
Dr. Dennis Haghighat, CMO
Brenda Donald
Millicent Gorham
Angell Jacobs
William Sherman
Lilian Chukwuma
Robert Bobb
Velma Speight
Wayne Turnage
Dr. Marilyn McPherson-Corder

UMC
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OUR MISSION

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

OUR VISION

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

UMC will employ innovative approaches that yield excellent experiences.

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

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

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

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NFPHC Board of Directors General Meeting
Wednesday, May 22, 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 a Roundtree Residences at 2515 Alabama Avenue, SE, Washington, DC, 20020 at **9:00 a.m. on Wednesday, May 22, 2019**. Any time change, or intent to have a closed meeting will be published in the D.C. Register, posted in the Hospital, and/or posted on the Not-For-Profit Hospital Corporation's website (www.united-medicalcenter.com).

DRAFT AGENDA

I. CALL TO ORDER

II. DETERMINATION OF A QUORUM

III. APPROVAL OF AGENDA

IV. READING AND APPROVAL OF MINUTES
April 24, 2019

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

VI. EXECUTIVE MANAGEMENT REPORT
Matthew Hamilton. Chief Executive Officer

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

IX. PUBLIC COMMENT

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

XI. ANNOUNCEMENTS

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

Not-For-Profit Hospital Corporation
GENERAL BOARD MEETING
Wednesday, April 24, 2019

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

Agenda Item	Discussion	Action Item
Call to Order	Meeting called to order at 9:19 AM. Quorum determined by Michael Austin.	
	Meeting chaired by LaRuby May.	
Approval of the Agenda	Motion. Second. Agenda approved as written.	
Approval of the Minutes	Motion. Second. Minutes approved as written.	
Discussion	**CONSENT AGENDA** **CHIEF OF MEDICAL STAFF REPORT: Dr. Haghighat** • A rise in surgical case volumes that was seen early in the year was reversed in recent months. ER volumes rose in March relative to the same month in 2018, reversing a recent downward trend and this trend reversal has continued thus far into the early days of April	

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

	• UMC has our Spring Cleaning initiative ongoing to declutter and organize clinical and administrative areas. • HR has created an electronic HR shared drive to better organize contracts, meeting minutes, union documents, and recruits. • UMC continues with the Performance Improvement Committee meetings. In March, eight departments presented information for performance improvement projects. • Diabetes Center is currently focusing on improving insulin administration. • UMC Quality Department is revamping the Quality Dashboard. **COMMITTEE REPORTS** **PATIENT SAFETY AND QUALITY: Dr. Fair** • PSQ met on March 21, 2019. • PSQ received a tracker for ICU remodeling so the Committee can track progress. • ICU continues to be in a temporary space. The current ICU is on the fourth floor and has 14 beds and given the damage a total renovation is needed for the old ICU. • 0 deliveries in the ED for February 2019. • Length of Stay is averaging 5.3 days. And a new ambulatory transportation company is in use for non-emergencies. • Transfer policy for Children's and the ED is currently with Children's Legal Team. • UMC will have a Mock Survey. The CNO will take the lead.	

FINANCE COMMITTEE: Deputy Mayor Turnage

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

BOARD GOVERNANCE REFRESHER

	• Chair May launched a refresher course for Board members that will span several Board meetings. The goal is to become more effective at serving the community. Topics included: Board composition, good governance methods, Board skills and qualifications, attendance, Board roles, By-law review, Board Accountability. • Next meeting will focus on effective Board oversight and ways to improve systems for the Board's duties. • The Board also participated in a pop quiz to test their knowledge of various Board governance duties and responsibilities. **Vote to return to Enter Closed Session:** Roll Call: Quorum determined to enter closed session. **Voter Return to Open Session:** Roll Call: Quorum determined to exit closed session. *Closed Session Minutes transcribed separately.* **Public Comment** Union representatives spoke regarding the new hospital and the need for continued partnership with the UMC Board. **Other Business** n/a **Announcements** **April 2019 Board Meeting Adjourned after 3 hours and 5 mins by Chair May.**	

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General Board Meeting

Date: May 22, 2019

CMO REPORT

Presented by:
Dennis Haghighat, MD
Chief Medical Officer

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

Our Mission:

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

Our Vision:

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

Dennis P. Haghighat, M.D.

May 2019

Medical Staff Summary

Medical Staff Committee Meetings

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

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

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

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

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

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

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

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

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

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

DEPARTMENT CHAIRPERSONS

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

May 2019 CMO Board Report

Update on construction/remediation projects:

ICU- Lead abatement completed. Architects met with UMC leadership to review construction plans. An open house for local (Wards 7 and 8) contactors is planned for this month. Estimated date for the 4th floor ICU to reopen is currently January of 2020.

MRI- We continue to be on track for resumption of MRI services by the end of July 2019.

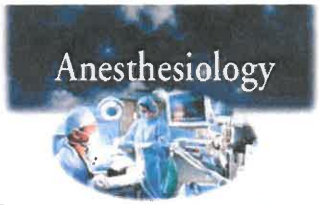
Both CT scans rooms (and their HVAC systems)will be remediated by June 19th 2019 which should eliminate the possibility of CT scan services not being available to the UMC ER in the future.

ER volumes continue their downward trend in a year to year comparison. The number of patients who have been left without being seen appears to be as high as 10% and appears to have increased in comparison to calendar year 2017 and the early part of 2018. Many factors appear to be contributory including staffing challenges, ancillary delays (lab and x ray for which staffing also appears to be contributory), flow to the inpatient units and possibly provider related factors. The UMC and GW MFA ER leadership continue to meet weekly on this topic and are now exploring different models that would allow increased throughput despite our current existing constraints.

The upward trend in the use of our OR(surgical volume) continues with the increase in April largely due to an increase in the number of endoscopy (GI) cases that were performed in the OR.

Our hospital acquired infection rates continue to be exceptionally low both in absolute numbers and in comparison to national benchmarks.

UMC leadership and staff are diligently working to assure that all elements of the Plan of Correction that were submitted to DC Health have been completed in anticipation of a repeat visit as early as the end of this month.



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

April

PERFORMANCE SUMMARY:

The overall cases for the month of April 2019 were 211 and increase from 158 in March 2019. This is an increase of 25% in overall surgical volume, GI contributed to most of the volume increase.

QUALITY INITIATIVES AND OUTCOME:

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

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

OR UTILIZATION

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

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.

EVIDENCE-BASED PRACTICE:

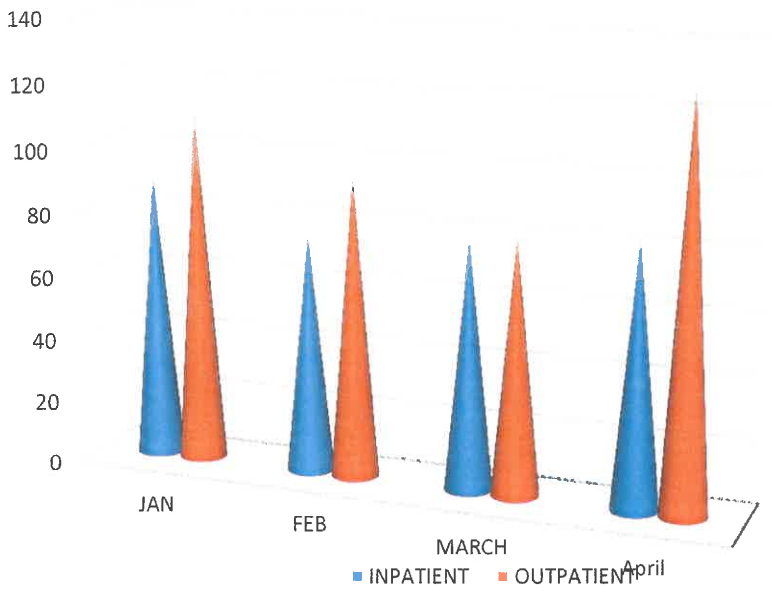
We are working with the **orthopedic group** to develop a system throughput for the patients including a Pain management protocol.
The **Mortality and Morbidity Conference** continues with increasing interest among the Provider community.

SERVICE (HCAHPS) SATISFACTION:

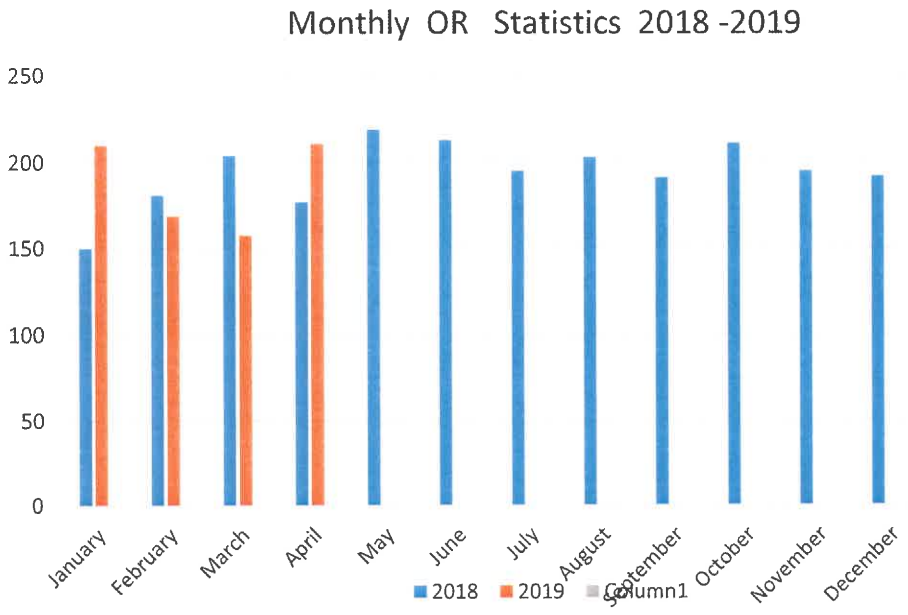
The Anesthesia Providers continue to provide quality service to our patients. We continue to provide real-time performance assessment of the anesthesia providers. We provide standardized service that ensures patient satisfaction.

BILLING AND REVENUE CYCLE MANAGEMENT

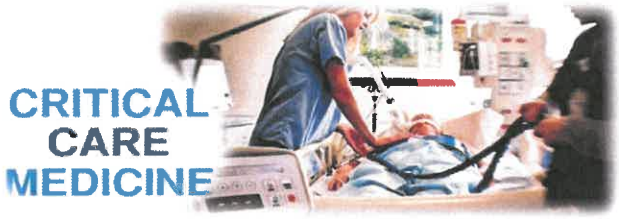
We have ensured that our providers are oriented to the ICD 10 requirements for both the anesthesia and hospital billing portions. We monitor closely documents and chart by our providers to ensure chart completion at the appropriate time.



ENDOSCOPY	Oct	Nov	Dec	Jan	Feb	Mar	Apr
EGD	59	36	48	54	40	29	23
COLONOSCOPY	52	54	47	58	40	26	51
ERCP	2	0	1	0	0	0	1
BRONCHOSCOPY	2	3	1	5	1	4	3



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



Mina Yacoub, M.D., Chairman

April

In April, the Intensive Care Unit had 64 admissions, 63 discharges, and 246 Patient Days, with an Average Length of Stay (ALOS) of 3.9 days. ICU managed 71 patients in April with 6 deaths. Overall ICU mortality rate for April was 9.5 %. ICU managed 22 patients with severe sepsis and septic shock in April with 4 deaths attributed to severe sepsis/septic shock. Sepsis specific ICU mortality rate was 18 %. One patient was transferred to GW University Hospital for needed higher level of care. There were three readmissions to ICU within 48 hours of transfer. Contamination of blood culture specimens drawn for ICU patient remains above acceptable national benchmarks and continues to be a challenge affecting clinical decision making and increasing risk and cost for patients. Consideration would be to require blood culture draws in the ED to be performed by phlebotomy team rather than ED staff.

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 6 deaths for 63 discharges, with an overall ICU mortality rate of 9.5 % for April. Mortality review is conducted in monthly Critical Care Committee meeting with Quality Department.

2. **Severe Sepsis and Septic Shock**

   ICU managed 22 patients with severe sepsis and septic shock in April. Four ICU deaths were directly attributable to severe sepsis and septic shock, with an ICU sepsis specific mortality rate of 18 %. The UMC Sepsis committee has been reconvened under directorship of Quality Department for continued support and monitoring of performance.

3. **Infection Control Data**

For April, the ICU had 102 ventilator days with no Ventilator Associated Pneumonias (VAP), 101 Central Line device days with no Central Line Associated Blood Stream Infections (CLABSI) and 167 Urinary Indwelling Catheter days with no Catheter Associated Urinary Tract Infections (CAUTI). ICU infection rates continue to be much lower than national averages. ICU infection rate data is reported regularly to the National Healthcare Safety Network (NHSN). ICU Hand Hygiene compliance was 90 % in April.

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

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

5. **Care Coordination/Readmissions**

In April, 71 patients were managed in the ICU. There were three readmissions to the ICU within 48 hours of transfer out. One was for worsening of original pneumonia process, one was for a newly developed medical condition, and one patient had signed out against medical advice and returned with worsening of the original medical condition. . In April, one patient was transferred from UMC ICU to GW University ICU for higher level of care for services not provided at UMC.

Evidence-Based Practice (Protocols/Guidelines)

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

Growth/Volumes

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

Stewardship

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

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

Financials We are requesting feedback on ICU financial performance.

Needed Steps to Improve Performance

Nursing staffing continues to be a challenge and we need more effective critical care nurse recruitment, and importantly, nurse retention. Goal is to continue to provide safe and high quality patient care, caring for patients with increased illness acuity, providing best evidence based practice, all while keeping ALOS low and preventing Hospital Acquired infections and complications. Working closely with Quality Department and Infection preventionist to ensure we continue to meet benchmarks. Ten patients out of 71 patients managed had contaminated blood culture specimens drawn. Consideration would be to require blood culture draws in the ED to be performed by phlebotomy team rather than ED staff.

Mina Yacoub, MD
Chairman, Department of Critical Care Medicine

Musa Momoh, M.D., Chairman

April

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

- Admissions:
  - Observation admissions: Medicine 102; Hospital 102; Percentage: 100%
  - Regular admissions: Medicine 247; Hospital 347; Percentage: 74%
- Discharges:
  - Observation discharges: Medicine 97; Hospital 97; Percentage: 100%
  - Regular discharges: Medicine 193; Hospital 272; Percentage: 71%
- Procedures
  - Hemodialysis 171
  - EGD's 49
  - Colonoscopy 49
  - ERCP 1
  - Bronchoscopy 3
- Quality
  - Cases referred to peer review: 0
  - Cases reviewed: 0

Department of Medicine met on March 13, 2019.
The next meeting is on June 12, 2019.
Morbidity and Mortality is scheduled for May 15th, 2019.

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

Eric Li, M.D., Chairman

MONTH	JAN	FEB	MAR	APR	MAY	JUN
Reference Lab Test – Intake PTH 90% 2 days	100% 21	97% 30	96% 28	87% 23		
Reference Lab specimen Pickups 90% 3 daily/2 weekend/holiday	100% 16/16	100% 16/16	100% 20/20	88% 15/16		
Review of Performed ABO Rh confirmation for Patient with no Transfusion History. Benchmark 90%	100%	100%	100%	100%		
Review of Satisfactory/Unsatisfactory Reagent QC Results Benchmark 90%	100%	100%	100%	100%		
Review of Unacceptable Blood Bank specimen Goal 90%	97%	100%	100%	99%		
Review of Daily Temperature Recording for Blood Bank Refrigerator/Freezer/incubators Benchmark <90%	100%	100%	100%	100%		
Utilization of Red Blood Cell Transfusion/ CT Ratio 1.0 – 2.0	1.2	1.3	1.4	1.5		
Wasted/Expired Blood and Blood Products Goal 0	1	5	10	2		
Measure number of critical value called with documented Read Back 98 or >	100%	100%	100%	100%		
Hematology Analytical PI Body Fluid	100% 15/15	100% 16/16	100% 12/12	100% 16/16		
Sickle Cell	0/0	0/0	1/1	0/0		
ESR Control	100% 26/26	100% 28/28	100% 70/31	100% 68/27		
Delta Check Review	100% 202/208	99% 170/171	99% 184/185	100% 184/184		
Blood Culture Contamination – Benchmark 90%	92%	100%	94%	100%		
ER HOLDING	98%	90%	89%	87%		
ICU	92%	91%	95%	100%		
STAT turnaround for ER and Laboratory Draws <60 min Benchmark 80%						
ER	83%	84%	82%	82%		
LAB	80%	85%	87%	86%		

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

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

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

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

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

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

Psychiatry

Surendra Kandel, M.D., Chairman

DESCRIPTION	01	02	03	04	05	06	YTD
ADMISSIONS							
ALOS (Target <7 days)	6.26	5.67	5.70	4.98			5.6
Voluntary Admissions	22	33	41	54			150
Involuntary Admissions	47	52	54	60			213
Total Admissions	**69**	**85**	**95**	**114**			**363**
REFERRAL SOURCES							
CPEP	22	11	22	28			83
UMC ED	66	74	72	84			296
GWU	2	0	0	1			3
Providence	1	0	0	0			1
Georgetown	0	0	0	0			0
Sibley	1	0	0	0			1
UMC Medical/Surgical Unit	3	0	1	2			6
Children's Hospital	0	0	0	0			0
Howard	2	0	0	0			2
Laurel Regional Hospital	0	0	0	0			0
Washington Hospital Center	0	0	0	0			0
Suburban	0	0	0	0			0
PIW	0	0	0	0			0
Washington Adventist Hospital	0	0	0	0			0
Holy Cross Hospital	0	0	0	1			1
OTHER MEASURES							
Average Throughput Target: <2 hours	3.8	3.1	3.8	4.5			3.8
Psychological Assessments (Target: 100%)	95%	98%	90%	85%			96.5%
DISCHARGE APPOINTMENTS							
Discharge Appointments for those d/c > 24 hours	68	74	87	83.3			324
Discharged to home without appointments/No discharge appointment information provided	5	3 (AMA)	5	3			16
Discharge Appointments for those d/c > 24 hours (Target: 100%)	**93%**	**87%**	**91.5%**	**92%**			**90%**
OTHER							
Patients who went to Court	3	0	0	0			3

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

Department of RADIOLOGY
Raymond Tu, M.D., [illegible]n

April

MONTHLY DEPARTMENT CHAIR REPORT

Performance Summary:

	INP		ER		OUT		TOTAL	
EXAM TYPE	EXAMS	UNITS	EXAMS	UNITS	EXAMS	UNITS	EXAMS	UNITS
CARDIAC CATH	3		0		0		3	
CT SCAN	117		570		157		844	
FLUORO	28		2		20		50	
MAMMOGRAPHY			1		133		134	
MAGNETIC RESONANCE ANGIO							0	
MAGNETIC RESONANCE IMAGING							0	
NUCLEAR MEDICINE	16		1		4		21	
SPECIAL PROCEDURES	39		0		5		44	
ULTRASOUND	97		209		214		520	
X-RAY	202		1037		721		1960	
ECHO								
CNMC CT SCAN			29				29	
CNMC XRAY			441				441	
GRAND TOTAL	502		2290		1254		4046	

Quality Initiatives, Outcomes, etc.

6. **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 MRI system itself remains closed with ongoing selection of a mobile unit solution.

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

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

9. **Care Coordination/Readmissions:** Memorandum of understanding for transfer of patients from UMC to Howard University was executed.

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

Service (HCAHPS Performance/Doctor Communication) Stewardship:

Dr. Tu was recognized at the National Hispanic Medical Association for work with the Spanish speaking community access to care, radiology screening studies with the United States Preventive Services Task Force and access of the underserved on April 13, 2019.

Dr. Tu participated as District of Columbia Medicare advisor to Novitas, the District's Medicare Administrative Contractor at the April Carrier Advisor's meeting on April 23, 2019.

Novitas Contractor Advisory Committee (CAC) Meeting

April 23, 2019

Baltimore Convention Center, Rooms 327-328
1 W Pratt St., Baltimore, MD 21201

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

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

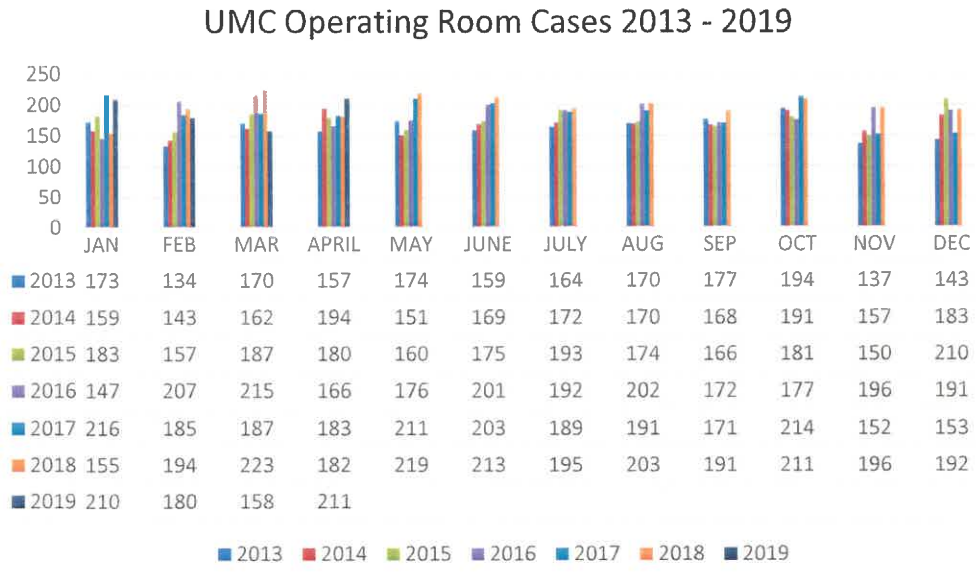
Gregory Morrow, **M.D.**, Chairman

April

For the month of March 2019, the Surgery Department performed a total of 211 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	158
APRIL	157	194	180	166	183	182	211
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 APRIL 2019

We started 2019 relatively strong, however, the volume of cases over the last 2 months of the first quarter experienced a precipitous fall. Despite that, the first quarter outperformed all prior year's Q1. This month, however, has been the strongest this year showing a 25% increase from March and a 16% increase from this same time last year.
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 April 15, 2019.

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

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

The ultimate goals being:

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

Our current Peri-Operative Performance Improvement activities include:

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

We were in the final stages of completing the agreements for the joint educational venture with the Howard University Surgery Department regarding reinstitution a surgery residency "Major Participating Site" program here at UMC. However, this process has been placed on HOLD for undisclosed reasons. We are waiting for further details regarding this process. This is another in a series of steps to make our surgical program more robust and attractive to more community physicians and enhance the services that we provide to our patients.

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

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General Board Meeting

Date: May 22, 2019

Medical Chief of Staff

Presented by:
Dr. Maryilyn McPhereson-Corder, Medical Chief of Staff

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

MARCH

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

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

APRIL

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

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

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

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General Board Meeting

Date: May 22, 2019

Executive Report

Presented by:
Matthew Hamilton, CEO

UMC

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General Board Meeting

Date: May 22, 2019

Patient Safety and Quality Committee

Presented by:
Dr. Malika Fair, Chair

Not-For-Profit Hospital Corporation
Patient Safety & Quality Committee Meeting Minutes
May 14, 2019

Present:
Absent:

Agenda Item	Discussion	Action Item
Call to Order		
Approval of the Agenda		
Discussion		
Meeting Discussion	Patient elopement review DOH visits/notifications **Standing Reports** - Executive Quality Dashboard **Regulations & Accreditation** - ED/Children's Transfer policy - ED Staffing - Committee Updates	

	○ Pharmacy ○ Infection Control ○ Safety/EOC ○ Patient Safety - Joint Commission Mock Survey **Other Topics**	

Not-For-Profit Hospital Corporation
Patient Safety & Quality Committee Meeting Minutes
April 16, 2019

Present: Dr. Fair, Director Ashenafi, Director Gorham, Dr. Shephard, Dr. Payne-Borden, Regina Kim, Shirlitta Cropper, Dr. Dennis Haghighat

Absent:

Agenda Item	Discussion	Action Item
Call to Order	Meeting was called to order at 4:35 PM. Quorum determined by Mike Austin	
Approval of the Agenda	Agenda approved with addition as noted below	
Discussion	Previous meeting minutes approved	
Meeting Discussion	**Patient elopement** - **DOH and police have been notified. Internal team have met to discuss modifications to door in BHU** **DOH visits/notifications** - SNF Visit Regarding HIPPA Complaints – 2567 was received. Plan of Correction was submitted. No other residents were impacted by this incident. MOUs are now being signed with SNF employees that no phones, tablets, or other electronics are to be used.	

	- DC Health Survey Results (received on March 29, 2019) – Plan of Correction was timely submitted last week. All senior leadership was involved in crafting the plan. Currently waiting on DC Health approval. - Facilities Projects – Document attached outlining each project. Waiting on certificate that lead dust is clear from the old ICU. - Water Intrusion – Policy will be approved through the Policy and Procedures Committee. The goal is to streamline tracking for facilities that will involve looking at infrastructure for any indication of water intrusion. - IV room not USP compliant – Included on facilities projects attachment and in progress. - **Standing Reports** - Executive Quality Dashboard (including core measures, sepsis, and SSE) – Template dashboard is finished. It will be sent to PSQ Committee by next week and populated by May 1, 2019. Currently exploring at national goals to include in the dashboard. Additional reports will be in the CMO Board book report this month. No serious safety events. - Deliveries in ED – 0 deliveries; 46 visits; 4 transfers. - Length of Stay – 5.3 days. UMC is working to increase case management in the ED, currently we have more social workers but we still need to fill a gap from 11pm – 7am **Regulations & Accreditation** (Updates on Plans of Correction Items) - ED/Children's Transfer policy – Policy currently with Children's legal team	• If an employee is going to miss the PSQ meeting, they need to submit their reports in writing prior to the PSQ meeting.

	- ED (Staffing, Peds/OB Mock Drills) – 2 traveling nurses were on-boarded along with other agency nurses. Currently exploring a UMC-sponsored program to offer additional training to CNAs. - Mock Drill: On March 29, 2019 at 10am, UMC had a mock drill, the recommendations based on that drill are as follows: According to evidence based practice, positive outcomes are more likely to occur when the patient has an assessment and intervention completed within the first 5 minutes of arrival to ER. In the event of multiple emergencies simultaneously and the code bay nurse is occupied, the charge nurse should have another allocated area available and ready for use. Have ultrasound machine readily available to assess fetus. Nursing staff need to be quicker in obtaining vital signs on expectant mother. Upon entrance to room, immediately undress and apply monitor to patient. Have a pre-packaged OB pack in designated area containing heplock insertion & blood draw supplies along with IV tubing and commonly used IV fluids. - Committee Updates (Pharmacy, Infection Control, Safety/EOC, Patient Safety) – Flu rates are going down. UMC has 99% compliance for hand hygiene. No hospital acquired infections were reported. MRSA Screen rate was 100% for Mach 2019. New Pharmacy is opening soon and the gift shop is currently open. Patient Safety Meeting was held with the PI and Quality Director to review plan for upcoming meetings. Patient safety is reviewing the National patient safety goals. The Culture of Safety Survey is being reviewed as a first step of analyzing the staff's feel towards reporting safety concerns. This survey will align with Leap Frog. UMC is working on ways to encourage staff to be recognized for bringing safety concerns forward.	

	- Joint Commission Mock Survey- awaiting for two additional vendors for comparison prior to making the decision on a vendor.. **Other Topics** **Meeting adjourned at 5:21pm**	

PROJECT NAME

1. KITCHEN REFRIGERATION Replacement – In Progress
2. IT Closets Renovations: IT Closet Cabling & HVAC (Phase 1 &2) – Pre-Bid Meeting 5/7/2019

DESCRIPTION	DATE
RFP ISSUED:	April 29, 2019
INTENT TO PARTICIPATE (Mandatory):	May 6, 2019 (5:00 EST)
PRE-PROPOSAL CONFERENCE (See Section E)	May 7, 2019
DEADLINE FOR BIDDER QUESTIONS (must be in writing by letter or email to the RFP Coordinators listed in Section G). Please note that bidder questions and NFPHC's responses to them will be shared with all bidders and will NOT be considered confidential.	May 9, 2019
NFPHC RESPONSE TO BIDDER QUESTIONS	May 13, 2019
PROPOSAL DUE:	May 15, 2019 No later than 5:00pm EST
EVALUATION PERIOD:	May 17 through May 23, 2019
NOTICE OF INTENT TO AWARD:	On or about May 24, 2019
PROPOSED COMMENCEMENT DATE:	Begin as soon as practicable but no later than May 29, 2019

3. Renovations for Mobile MRI, Surgical Suite Demolition and Minor Renovations and Renovations to Fluoroscopy Rooms 3 &4: MRI Modular Demo/Abatement (Modular & MRI); Radiology FLOURO 3 & 4; OR Decomission/Abatement/Demo. Pre-Bid Meeting on 5/7/2019

DESCRIPTION	DATE
RFP ISSUED:	April 29, 2019
INTENT TO PARTICIPATE (Mandatory):	May 6, 2019 (EST 5:00)
PRE-PROPOSAL CONFERENCE (See Section E) (MANDATORY)	May 7, 2019
DEADLINE FOR BIDDER QUESTIONS (must be in writing by letter or email to the RFP Coordinators listed in Section G). Please note that bidder questions and NFPHC's responses to them will be shared with all bidders and will NOT be considered confidential.	May 9 2019
NFPHC RESPONSE TO BIDDER QUESTIONS	May 13, 2019
PROPOSAL DUE:	May 15, 2019 No later than 5:00pm EST
EVALUATION PERIOD:	May 17 through May 23, 2019
NOTICE OF INTENT TO AWARD:	On or about May 24, 2019

PROPOSED COMMENCEMENT DATE:	Begin as soon as practicable but no later than May 28, 2019

4. Radiology AHU Replacement – In Progress
5. Radiology CT Rooms A/C Units:

Phase I: begins on 5/10/19 with Prep of CT Room #1 (Protect all equipment in room)
5/13 – 5/15: Removal of ceiling tiles, equipment above ceiling etc.
5/14 – 5/24: Install of new system, ceiling grid, new grilles and new ceiling tiles
5/25 – 5/27: Touch up Patching/Paint; Terminally clean room

Phase II: begins on 5/28 with Prep of CT Room #2 (Protect all equipment in room)
5/28 – 5/30: Removal of ceiling tiles, equipment above ceiling etc.
5/30 – 6/10: Install of new system, ceiling grid, new grilles and new ceiling tiles
6/11: Touch up Patching/Paint; Terminally clean room

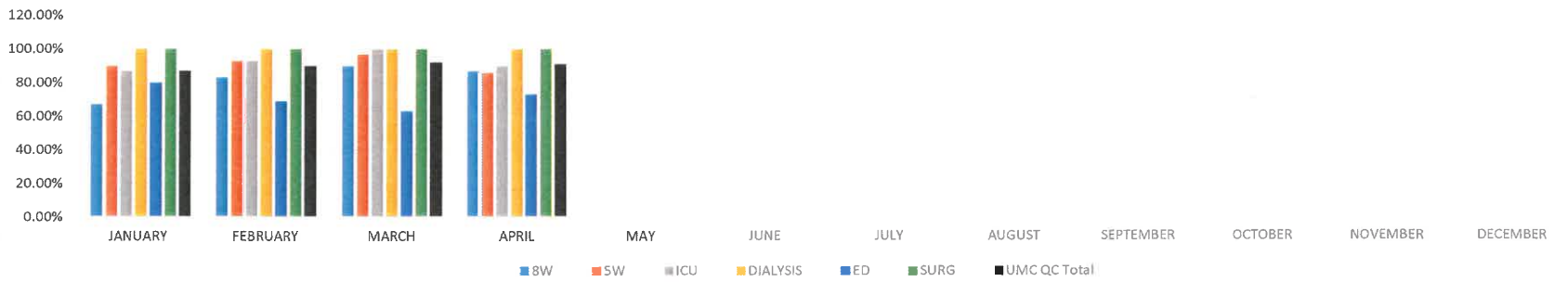
Phase III: begins on 6/11 with Prep of CT Control Room – timelines provides additional time & flexibility (work commences at 3:00am each day)
6/12: Removal of ceiling tiles/grilles/grid & supply ductwork
6/13 – 6/14: Install of new duct, insulate supply duct,etc
6/17: System start up; Install of ceiling grid, grilles and ceiling tiles
6/17 – 6/18: Touch up Patching/Paint; Terminally clean room

6. Pharmacy (USP 797/800) - RFP Preparation to start on 5/10/19.
7. Outpatient Rehab: PT/OT - RFP Preparation to start on 5/10/19.
8. KITCHEN CART STORAGE
9. ICU Restoration/Renovation (Post ServPro work)
10. . Flooding (Jan 2019)

- HIM – In Progress
- Kitchen/Café - Completed
- L &D, NICU, OR on 3rd – In Progress

11. BHU Flooding related Renovation – TBD (possibly June/July)
12. IT Suite (Leak/Mold Remediation) – In Progress
13. Chillers & Cooling Towers Repairs – In Progress
14. Roofing Repairs – Starts 5/20/19
15. HVAC Repairs – In Progress
16. ICU Siding/Panel Replacements – In Progress
17. Emergency Department Renovation – Reduced Scope

UMC Hand Hygiene Compliance CY-2019



	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
8W	67%	83%	90%	87%								
5W	90%	93%	97%	86%								
ICU	87%	93%	100%	90%								
DIALYSIS	100%	100%	100%	100%								
ED	80%	69%	63%	73%								
SURG	100%	100%	100%	100%								
UMC QC Total	87%	90%	92%	91%								

United Medical Center
Infection Control Report - Critical Care Committee minutes
May 09, 2019

Dr. Woldebeagzi, Shirlitta Warren Cropper, Missi Sylvain, Amaro Keith,, Eftu Negash, Ray Farmer, Maryetta McCullough

Agenda Item	Discussion	Action Taken	Person Responsible	Due Date
Call to order	Called to order at 12:39 pm		Infection Control	
Approval of Minutes	Minutes approved at 12:39	Minutes were approved with no additions or corrections	Infection Control	
MEC Report	Water Intrusion Policy	Pending Approval	Infection Control	Pending approval
Statistical Report Ventilator Associated Event	April - 2019 102 – Ventilator days with 0 infections For a total of 2037 days without VAP Infection rate = 0	Continue to implement all elements of the ventilator bundle (VAP) and promptly monitor patients for extubation when mechanical ventilation is no longer needed.	ICU Staff Infection Preventionist	On-going
Central Line Associated Blood Stream Infection	April - 2019 101 – Central line device days with 0 infections Infection rate = 0	The vascular insertion process will continue with use of maximum barriers and limited use of the femoral site. Central line Insertion Practices (CLIP) data is currently submitted to National Healthcare Safety Network (NHSN)	ICU Staff Infection Preventionist	On-going
Catheter Associated Urinary Tract Infection	April - 2019 167 – Urinary indwelling catheter device days With 0 infections &The infection rate =0.	Only insert indwelling urinary catheter when indicated as identified in the Management of Urinary device policy. Continue to remove urinary devices when they are no longer needed. Data is submitted into National Healthcare Safety Network (NHSN)	ICU Staff Infection Preventionist	On-going
DOH finding and remediation started	Finding in Infection Control was Hand Hygiene and Remediation process. Isolation Room and Signage with orders	Educational Remediation will be started on 5/6 and continue throughout the month. Direct Observation has been started with immediate remediation in real time. Education with Isolation /signage will be also 5/6	Infection Preventionist	On going

United Medical Center
Infection Control Report - Critical Care Committee minutes
May 09, 2019

Agenda Item	Discussion	Action Taken	Person Responsible	Due Date
MRSA	April - 2019 MRSA in the blood is monitored hospital-wide and reported into NHSN. Admissions are screened for MRSA. There were 5 cases of MRSA hospital wide that was present on admission 1 had ICU visit. **5** MRSA in the blood that was not hospital acquired.	Persons with positive MRSA results are placed on Contact Precautions. Continue to promote good hand hygiene. MRSA screen rate for April 2019 was 100%	Infection Preventionist	On-going
C Difficile	April -2019 There were 1 cases of C difficile hospital wide. **1** C. Difficile Toxin that was hospital Acquired	Persons identified with C Difficile are placed on Contact Precautions and the information is shared with pharmacy. Strict hand hygiene is enforced. Data is submitted into NHSN	Infection Preventionist	On-going
VRE	April -2019 VRE is screened upon admission for nursing home patients. 7 screens for VRE were identified to be positive upon admission and 4 had an ICU visit. There were No cases of VRE HAI hospital wide.	Persons identified with VRE are placed on Contact Precautions. Staff is made aware of isolations.	Infection Preventionist	On-going
Hand Hygiene	April- 2019 ICU compliance rate was 90% for Hand Hygiene Hospital-wide there were 160 observations with a Hand Hygiene compliance of 91%	The data will be shared with the staff and will be reported in the Prevention and Control of Infections Committee meeting.	UMC Staff Infection Control	On-going

United Medical Center
Infection Control Report - Critical Care Committee minutes
May 09, 2019

		Hand hygiene compliance rate in **ICU decrease** to 90%. From 100%		
CT Scan 1& 2	CT Scan project will start on 5/10/19 to go thru 6/18/19 for new HVAC system	Demolition will begin on 5/10 and one CT Scan will be available as we go thru 3 phases to provide a safe environment for our staff and patient population.	Facilities and Infection Control	pending
OR # 5	Old OR area will be having demolition and reconstruction to remove water damage area and add Negative pressure room for Bronchoscopy	Area is currently has a containment area and is under Neg. pressure at this time.	Infection Control and Facilities	pending
Pharmacy IV Room	Certification process took place this month.	Biohazard hood for IV being assessed.	Pharmacy	
EVS	Working on hospital wide biohazard waste and Terminal cleaning process	Updating current process and paperwork.	EVS director	
DC health Alert	Increase case reporting in legionnaire's Disease(LD) has increased by **5x** since 2000	The key to prevention of Legionella bacteria is maintenance of building water systems to reduce the risk of Legionella growth and spread by implementing a **water management program.**	Facilities and Infection Control	

Report submitted by – Shirlitta Warren-Cropper Infection Control

Shirlitta- spoke about hand hygiene and Direct Observation and remediation of staff.
Ray (Pharmacy) – spoke about the clinical pharmacist (Frank) going to Mad ID Program that help with our Antibiotic Stewardship Program.
Dr. Woldebeagzi – spoke about the Antibiotic Stewardship Program and which antibiotic should be restricted- Meropenum being one of the already restricted antibiotics. Being able to reduce our use of antibiotics and monitor for correct usage.
Shirlitta- spoke about SPD Project to remove asbestos from the old linoleum flooring (DOH finding/ flooring is cracked) work to be started with Rath on May 13, 2019.
Amaro- spoke on streamlining the red bag (hazardous waste) to small bags on wall and getting rid of red trash bins. Leaving a big red bags in the soiled utility room for oversize trash and c.diff. Currently waiting for small red bags to come in.
Shirlitta -spoke on DC Health alert and Legionella disease and our testing pending for legionella and preventative treatment of water tower. Also, spoke of leak in Children's that is leaking into Facilities office.

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General Board Meeting

Date: May 22, 2019

Finance Committee

Presented by:
Depty Mayor Wayne Turnage, Chair