General Board Meeting

Date: June 27, 2018
Location: United Medical Center
1310 Southern Ave., SE,
Conference Rooms 2-3
Washington, D.C. 20032

2018 BOARD OF DIRECTORS

LaRuby Z. May, *Chair*
Dr. Malika Fair, Vice-Chair
Matthew Hamilton, CEO

Girume Ashenafi
Jacqueline Bowens
Konrad Dawson, MD
Brenda Donald
Millicent Gorham
Angell Jacobs
Dennis Haghighat, MD
Sean Ponder
Velma Speight
Wayne Turnage
Mina Yacoub, MD

OUR MISSION

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

OUR VISION

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

UMC will employ innovative approaches that yield excellent experiences.

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

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

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

NFPHC Board of Directors General Meeting
Wednesday, June 27, 2018

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

Finance Committee – Wayne Turnage, Chair

Tab 1

Agenda

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, June 27, 2018.** 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
May 23, 2018

V. CONSENT AGENDA
A. Dr. Dennis Haghighat, Chief Medical Officer
B. Dr. Mina Yacoub, Medical Chief of Staff

VII. EXECUTIVE MANAGEMENT REPORT
Matthew Hamilton, Chief Executive Officer

VIII. COMMITTEE REPORTS
Patient Safety and Quality Committee
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).

Tab 2

Meeting Minutes

Not-For-Profit Hospital Corporation
GENERAL BOARD MEETING (Teleconference)
Wednesday, May 23, 2018

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

Agenda Item	Discussion	Action Item
Call to Order	Meeting called to order at 9:07 AM. Quorum determined by Michael Austin.	
	Meeting chaired by LaRuby May.	
Approval of the Agenda	Agenda approved as written.	
Discussion	**CHAIR MAY:** • Tribute to strong, African American attorney, Ms. Dovey Johnson Roundtree; who died at 104. • Acknowledged success of Board Retreat. Thank you to Director Donald and the Strategic Planning Committee for success. • Mazars Action Plan: establish timeline for accountability measures. Mazars must work with the Board and the hospital to ensure effective management. **STRATEGIC PLANNING COMMITTEE: BRENDA DONALD** • Mazars Report needed to brief Council's Health Committee on findings and	Chair May: appointed Directors Speight and Donald on Mazars accountability team to determine the oversight metrics.

recommendations of UMC Board.

- Discussion held in Finance Committee about performance oversight of Mazars accountability with support from DHCF and OCFO to ensure Board's expectation.
- Director Turnage: suggested the structure of meeting monthly: advised on historic process – operator — Mazars to provide its monthly action plan under the Open Meetings Act rules, then the full Board was notified of issues and documentation. OCFO must be involved. Board should give direction to Mazars on its expectations,
- Gap Closing Measures and Management Action Plan will be used each month to review Mazars performance.

Motion to accept report. Second. Motion accepted.

FINANCE COMMITTEE: Director Wayne Turnage

- Financial Summary of FY18—Income statement shows operating lost of $11.2 million; annualized VAT $19.3 million loss; UMC revenue down 10% of expected revenue.
- Matthew: census is 111—highest of the year.
- Lilian: Ten (10) indicators to assess UMC's performance—reading from a graph published in report.

Motion to accept report. Second. Motion accepted.

CHIEF MEDICAL OFFICER REPORT: Dr. Dennis Haghighat

- DC Department of Health visited in April and submitted a Plan of Correction.
- UMC is currently awaiting acceptance of Plan of Correction
- After acceptance another validation visit is expected to confirm implementation of Plan of Correction.
- Behavioral Health Unit: Two patients in custody escaped—problems attributed to both UMC and Metropolitan Police. Plans of Corrections in place for both areas.
- George Washington University Hospital Emergency Room Group started on

	April 01, 2018. Long-term goal is to have GW Group oversee ER and Hospitalist, which will start in July to improve metric. **CHIEF OF MEDICAL STAFF: Dr. Mina Yacoub** • Working closely with GW to ensure transfers out of UMC to improve performance and revenue. • Post discharge follow-up is important to outpatient volume. • Behavior Health Unit: working to develop process to streamline admission of patients from other psych units directly into UMC without the patient being admitted to through the ER. **EXECUTIVE MANAGEMENT REPORT: Mr. Matthew Hamilton** • SNF issues: Medicaid office wants $1 Million back; on April 27, $327K was taken back. June 1, 2018, $700K will be taken back. • HR: new generalists hired; Director, Marcia Nichols will start on June 04, 2018. • Pharmacy Cost is increasing. Need to research acuity and mortality. • Personnel questions to be discussed in "Closed Session". **Motion to accept reports. Second. Motion accepted.** *Roll Call to go into Closed Session:* Quorum Determined. *Roll Call Return to Open Session:* *Closed Session Minutes transcribed separately.* **May 2018 Board Meeting Adjourned at 11:07 AM by Chair May.**	Chair May requests that Mr. Hamilton provide the number of UMC employees who are DC residents. Chair May: UMC is the largest employer in the Ward and must include more DC residents.

Tab 3

Consent Agenda

General Board Meeting

Date: June 27, 2018

CMO REPORT

Presented by:

Dennis Haghighat, MD

Chief Medical Officer

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

Our Mission:

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

Our Vision:

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

Dennis P. Haghighat, M.D.

June 2018

Medical Staff Summary

Medical Staff Committee Meetings

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

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

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

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

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

Performance Improvement Committee, ***Committee Chairman***
The Performance Improvement Committee is comprised of 1-2 representatives from each department who report monthly on the activity of each department based on standards established by the Joint Commission, the Department of Health, and the Centers for Medicare and Medicaid Services (CMS).

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

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

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

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DEPARTMENT CHAIRPERSONS

Anesthesiology..*Dr. Amaechi Erondu*

Critical Care..*Dr. Mina Yacoub*

Emergency Medicine..*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

Dennis P. Haghighat, M.D.

June 2018

Chief Medical Officer Board Report

The Plan of Corrections that resulted from the Department of Health Annual visits in April of this year have been successfully submitted. The quality team and leadership teams at UMC are continuing to round daily to assure compliance with these plans. UMC anticipates a likely return visit by DOH and CMS in July of 2018 and expects that these bodies will find us in full compliance with the plan of correction at that time and going forward.

The number of visits to our ER and the number of resulting admissions to UMC continue to track at the projected 2018 budget levels. UMC is experiencing positive variances to budget in the number of ER visits resulting in admissions to observation status and in Medicare Case Mix Index compared to our 2018 budget levels. In the months of April and May the number of patients admitted to the Behavioral Health Unit (BHU) were 30% above historical levels. We have seen a drop off in BHU admissions in the early part of this month and we are monitoring this to see if this is just a temporary decrease or a trend.

The transition to the GW ER group continues at a smooth pace and UMC and GW leadership continue to meet on a weekly basis to assure that this trend continues. Weekly transition meetings with the GW hospitalist group started this month and orientation sessions for the new providers have been scheduled, and in some cases completed, and the remaining sessions will be completed by the end of this month.

My focus will now turn to improving the productivity and service to our community from the UMC primary care clinic. Meetings with the clinic leaders have taken place and meetings with individual providers will have been completed by the time of this month's Board meeting. The goal will be to significantly increase the number of Southeast Washington residents that we serve each month.

Anesthesiology Department
Amaechi Erondu, M.D., Chairman

PERFORMANCE SUMMARY

The overall cases for the month of April 2018 were 219.Total surgical cases were 97 while Endoscopy cases were 122.

We have substantially reduced late surgical cases (Elective) after 17:30 with the continued assistance of the surgical department.

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 have a procured a PYXIS ANESTHESIA CART that will become functional within the next few weeks. This is milestone, almost 3 years in making. This allows us to have a centralized medication management system in the operating rooms. It provides for medication waste management and appropriate utilization of resources.

We will reintroduce REGIONAL ANESTHESIA service to support the surgical orthopedic patient service. Our goal is to improve patient satisfaction, reduce overall opioid requirement for post-op pain control and reduce patients hospital length of stay.

EVIDENCE-BASED PRACTICE

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

SERVICE (HCAHPS) SATISFACTION

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

BILLING AND REVENUE CYCLE MANAGEMENT

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

Critical Care Department
Mina Yacoub, M.D., Chairman

PERFORMANCE SUMMARY

In May 2018, the Intensive Care Unit had 67 admissions, 67 discharges, and 289 Patient Days, with an Average Length of Stay (ALOS) of 4.3 days. The ICU managed 75 patients in May. Average ICU overnight census for May was 10.3 patients.

QUALITY OUTCOMES

Core Measures Performance

ICU continues to meet target goals for quality metrics. ICU is embarked on a sepsis initiative in collaboration with Quality Department.

Morbidity and Mortality Reviews

ICU Mortality

ICU had 8 deaths for 75 patients managed, with an overall ICU mortality rate of 10.7 % for May. Mortality review is conducted in June Critical Care Committee meeting with Quality Department.

Severe Sepsis and Septic Shock

ICU managed 20 patients with severe sepsis and septic shock in May. Three ICU deaths are directly attributable to severe sepsis and septic shock, with an ICU sepsis specific mortality rate of 15%. Quality Department under leadership of Ms. Tina Rein is working in a multidisciplinary effort with ICU, ED and Hospitalists to improve and monitor performance on sepsis measures, and we are beginning to see improving performance and outcome metrics. It is important to note we need to see a continued trend of improvement.

Infection Control Data

Infection control data for May is being compiled by Infection Control RN and will be presented to Critical Care Committee. 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).

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 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. May and June data would be presented in July meeting.

Care Coordination/Readmissions
In May, 75 patients were managed in the ICU. There was one readmission to the ICU within 48 hours of transfer out, and this was due to a new medical problem.

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. Infection Prevention team is monitoring performance.

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

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

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

Financials - We are requesting feedback on ICU financial performance.

Needed Steps to Improve Performance
Nursing staffing continues to be a challenge and we need more 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.

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

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

In our second month at UMC, we continued to invest time fostering a collaborative work environment in the ED and amongst the consultant and supportive services in the hospital.

The daily census and ambulance traffic was higher than previous months with most throughput measures remaining consistent in comparison to previous months.

We compared average and median throughput times for the month of May and noted that most times were similar with the exception of boarding times for admitted patients. The average boarding time for admitted patients is 267 minutes, which is markedly different from the median time of 30 minutes. This suggests that there is a cohort of patients who are boarding for extended periods of time. It would be important to note that most psychiatric admissions were omitted from this data set as that often is connected to longer boarding times.

One of our key areas for improvement remains throughput of patients through the ED. As we look ahead, we are starting to identify areas which may be leading to delays, some of which may be easily remedied while others will require more long-term process improvement.

ED Volume and Events 2018

	Jan	%	Feb	%	Mar	%	Apr	%
Total patients	5027		4656		4881		4783	
Daily Average Census	162		166		157		159	
Admit	452	9.0%	461	9.9%	461	9.4%	460	9.6%
Transfer	60	1.2%	55	1.2%	86	1.8%	90	1.9%
AMA	73	1.5%	55	1.2%	56	1.1%	49	1.0%
Eloped	36	0.7%	35	0.8%	45	0.9%	38	0.8%
LWBS	109	2.2%	79	1.7%	101	2.1%	107	2.2%
Left Prior to Triage	189	3.8%	168	3.6%	156	3.2%	235	4.9%
Ambulance Arrivals	1541	30.7%	1364	29.3%	1453	29.8%	1314	27.5%

ED Volume and Events 2018

	May	%
Total patients	5071	
Daily Average Census	169	
Admit	484	9.5%
Transfer	90	1.8%
AMA	40	0.8%
Eloped	45	0.9%
LWBS	148	2.9%
Left Prior to Triage	249	4.9%
Ambulance Arrivals	1468	

ED Throughput May 2018 (time in minutes)

	Median Times	Average Time
Admissions		

Door to triage	16	25
Door to room	29	60
Door to provider	29	60
Door to decision	262	297
Door to departure	292	564
Time to provider	0	0
Time to admit decision	233	237
Boarding time	30	267
Discharges		
Door to triage	24	33
Door to room	84	105
Door to provider	95	115
Door to decision	220	237
Door to departure	270	291
Time to provider	11	10
Time to discharge decision	125	122
Waiting to depart	50	54
Transfers		
Door to triage	14	24
Door to room	36	93
Door to provider	36	93
Door to decision	239	400
Time to provider	0	0
Time to transfer decision	203	307

ED Throughput 2018 (median times in minutes)

	Jan	Feb	Mar	Apr	May
Admissions					
Door to triage	17	16	16	18	**16**
Door to room	21	23	25	32	**29**
Door to provider	21	23	25	33	**29**
Door to decision	245	266	240	250	**262**
Door to departure	267	285	255	293	**292**
Time to provider	0	0	0	1	**0**

Time to admit decision	224	243	215	218	**233**
Boarding time	22	19	15	43	**30**
Discharges					
Door to triage	22	22	19	24	**24**
Door to room	63	65	51	81	**84**
Door to provider	75	78	67	92	**95**
Door to decision	187	188	180	229	**220**
Door to departure	233	234	222	276	**270**
Time to provider	12	13	16	11	**11**
Time to discharge decision	124	123	129	148	**125**
Waiting to depart	46	46	42	47	**50**
Transfers					
Door to triage	16	15	13	12	**14**
Door to room	24	22	22	26	**36**
Door to provider	24	28	26	29	**36**
Door to decision	266	267	291	221	**239**
Time to provider	0	6	4	3	**0**
Time to transfer decision	242	245	269	195	**203**

Internal Medicine Department

Musa Momah, M.D., Chairman

The Department of Medicine remains the major source of hospital admissions. For the month of May 2018,

Patient days-	Medicine	1534	57%
	Hospital	2698	
Observation Days-	Medicine	133	83%
	Hospital	160	
Admissions-	Medicine	261	57%
	Hospital	456	
Discharges-	Medicine	245	52%
	Hospital	467	
ALOS-	Medicine	6.26 days	
	Hospital	5.78 days	

Procedures

EGD	56
Colonoscopies	61
Bronchoscopies	4
ERCP	1

Announcements

- GWMFA Hospitalist begins July 1, 2018 at 7:00am
- Morbidity and Mortality Conference on June 20th, 2018 at 8:00AM in Foundation Board Room.

Pathology Department

Eric Li, M.D., Chairman

Month	01	02	03	04	05	06	07
Reference Lab test – Urine Protein 90% 3 days	100% 40/40	58% 28/48	98% 52	98% 82	98% 90		
Reference Lab specimen Pickups 90% 3 daily/2 weekend/holiday	92% 66/72	93% 65/70	81% 13	70% 13	88% 14		
Review of Performed ABO Rh confirmation for Patient with no Transfusion History (Benchmark 90%)	100%	100%	100%	100%	100%		
Review of Satisfactory/Unsatisfactory Reagent QC Results (Benchmark 90%)	100%	100%	100%	100%	100%		
Review of Unacceptable Blood Bank specimen (Goal 90%)	98%	99%	98%	100%	100%		
Review of Daily Temperature Recording for Blood Bank Refrigerator/Freezer/Incubators (Benchmark <90%)	100%	100%	100%	100%	100%		
Utilization of Red Blood Cell Transfusion/ CT Ratio – 1.0 – 2.0	1.3	1.2	1.2	1.2	1.2		
Wasted/Expired Blood and Blood Products (Goal 0)	4	-0-	2	3	7		
Measure number of critical value called with documented Read Back 98 or >	100%	100%	100%	100%	100%		
Hematology Analytical PI Body Fluid	100% 13/13	100% 12/12	100% 6/6	100% 15/15	100% 10/10		
Sickle Cell	0/0	2/2	2/2	0/0	1/1		
ESR Control	100 19/19	100% 18/18	96% 22/23	100% 31/31	100% 27/27		
Delta Check Review	100% 162/162	99% 164/165	100% 186/186	100% 156/156	100% 195/195		

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.

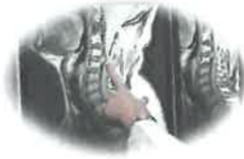
COMPLAINTS - Complaints are an important metric for evaluating the quality of our laboratory processes.

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

Psychiatry Department

Surendra Kandel ,M.D., Chairman

Referrals	May	YTD
Total Admissions	105	**530**
Admissions		
ALOS (Target<7 Days)	5.42	5.498
Voluntary Admissions	51	174
Involuntary Admissions	54	47
Total Admissions	105	430
Referral Sources		
CPED	15	123
UMC ED	89	354
GWU	0	4
Providence	0	4
Georgetown	0	7
Sibley	0	2
UMC Medical/Surgical Unit	1	77
Children Hospital	0	0
Howard	0	5
Laurel Regional Hospital	0	1
Washington Hospital Center	0	2
Suburban	0	0
PIW	0	0
Other/Not Listed	0	18
Total Referrals	**105**	**527**
Other Measures		
ED to Psych Admissions (Target: <2 hours)	2.7	3.64
Psychosocial Assessments (Target: 100%)	86%	89%
Treatment Planning (Target: 100%)	79%	76%
Discharge Appointments		
Discharged to medical unit	1	5
Transfer to St. Elizabeth's	1	12
Discharge Appointments for those D/C'ed>72 hours (Target: 100%)	**80%**	**94%**
Patients who went to court	1	5



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Radiology Department

Raymond Tu, M.D., Chairman

Performance Summary:

	INP		ER		OUT		TOTAL	
EXAM TYPE	EXAMS	UNITS	EXAMS	UNITS	EXAMS	UNITS	EXAMS	UNITS
CARDIAC CATH	4				3		7	
CT SCAN	100		560		196		856	
FLUORO	18		0		16		34	
MAMMOGRAPHY					149		149	
MAGNETIC RESONANCE ANGIO					3		3	
MAGNETIC RESONANCE IMAGING	26		9		51		86	
NUCLEAR MEDICINE	14				11		25	
SPECIAL PROCEDURES	31		0		5		36	
ULTRASOUND	94		218		213		525	
X-RAY	159		1000		893		1998	
CNMC CT SCAN			23				23	
CNMC XRAY			537				537	
GRAND TOTAL	446		2347		1540		4279	

Quality Initiatives, Outcomes, etc.

Core Measures Performance

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

Radiology staff and director are addressing requests for more after hour imaging studies. .

Morbidity and Mortality Reviews: There were no departmental deaths.

Code Blue/Rapid Response Teams ("RRTs") Outcomes: One rapid response during cardiology procedure and patient transferred.

Care Coordination/Readmissions: N/A
Evidence-Based Practice (Protocols/Guidelines) We continue to collaborate with clinical staff on clinical decision support.

Service (HCAHPS Performance/Doctor Communication)

The radiology department working well with the emergency department new staff.

Stewardship

Dr. Tu spoke at the National American College of Radiology Annual meeting in Washington, DC as Chairman of the Medicaid Network.

American College of Radiology
Medicaid Network Meeting
ACR Annual Meeting 2018
Monday, May 21st 12:00noon – 1:15pm
Marriott Wardman Park Hotel
Room - Wilson B
Dial-in: (877) 647-3411
Passcode: 431 355 3638 #

Agenda

I **Welcoming Remarks and Presentation - Raymond Tu, M.D. FACR, Chair, ACR Medicaid Network**

II **Insights from Keith Maccannon, Director of Marketing, Community Relations, and Outreach, AmeriHealth Caritas District of Columbia (DC)**

III **New Business**

UMC

UNITED
MEDICAL CENTER

Surgery Department

Gregory Morrow, M.D., Chairman

For the month of MAY 2018, the Surgery Department performed a total of 219 procedures. The chart below shows the annual and monthly trends over the last 6 calendar years:

	2013	2014	2015	2016	2017	2018
JAN	173	159	183	147	216	155
FEB	134	143	157	207	185	194
MAR	170	162	187	215	187	223
APRIL	157	194	180	166	183	182
MAY	174	151	160	176	211	219
JUNE	159	169	175	201	203	
JULY	164	172	193	192	189	
AUG	170	170	174	202	191	
SEP	177	168	166	172	171	
OCT	194	191	181	177	214	
NOV	137	157	150	196	152	
DEC	143	183	210	191	153	
TOTAL	1952	2019	2116	2242	2255	754

Over the last several months our surgical volumes have shown a steady rebound back to levels that are more in line with the consistency and growth we would expect. (Some of the current numbers may have changed from previous months reports and reflect corrections in how some procedures or sets of procedures were recorded). 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 Reoperation.

The OR Committee met in May 2018 with the following action items:

1. Updated policy for OR Needle, Sponge and Instrument counts was finalized and will be presented to the Policy and Procedures Committee for approval.
2. On-going evaluation of OR start times and room turnover times to determine where our processes can be made more efficient.
3. Continued monitoring of after-hours cases to determine the appropriateness and optimization of available resources.
4. On-going assessment of how best to utilize technology to improve our patient throughput and overall satisfaction across the entire perioperative spectrum.

For our vascular surgery services, we have updated some of the patient monitoring and safety standards and have made the necessary purchase requests to meet these guidelines. These efforts are designed not only to improve care and safety, but also to expand the types of procedures that we will be able to offer the community we serve.

The following projects that have been implemented 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.

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.

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

Chief of Medical Staff Report

Chief of Staff Report
June 15, 2018

During June, the Medical Staff and Medical Staff office are working to complete credentialing, and orientation processes for GW MFA Hospitalist providers who are scheduled to start on Sunday July 1st, 2018. Medical Staff Office Staff and leadership are meeting weekly with administration and GW MFA towards a smooth transitioning of GW MFA into in-patient services.

The Medical Staff continues to work with administration to ensure patients of our community continue to receive their services at UMC, when these services are available. It remains the mission of the Medical Staff to work with administration to increase patient volumes and activities in both the inpatient and outpatient settings at UMC.

A clinical initiative the Medical Staff is working on in close collaboration with Quality Improvement Department under leadership of Ms. Tina Rein is the establishment of Severe Sepsis protocols and pathways with a goal of decreasing mortality due to sepsis at UMC. This is a CMS quality measure tied to financial returns. Data from May 2018 and going into June show an improving trend in performance and outcomes. We are committed to the necessary consistent and ongoing effort, and continued collaboration with Quality Department, for improving and monitoring performance and outcomes of Severe Sepsis management.

Mina Yacoub, MD
Chief of Staff
United Medical Center

General Board Meeting

Date: June 27, 2018

Executive Management Report

Presented by:

Matthew Hamilton

Chief Executive Officer

United Medical Center
Executive Management Report
June 2018

Foundational Elements

- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPHPS)
- Correlation of Scores to Financial Performance
- DOH Follow-up Survey

Infrastructure Fundamentals

- ED Volume Demands
- Biomedical and Healthcare Informatics

Healthcare Delivery Priorities

- Hospitalist Transition on July 1

United Medical Center
Management Report
Operations Summary – June 2018

QUALITY

DEPARTMENT OF HEALTH - PLAN OF CORRECTION ACCEPTED

District of Colombia Department of Health survey was completed 4/11/18, findings include:

- Governance
- Infection Control and environmental oversight
- QAPI and oversight of Infection Control activities
- Pharmaceutical Services
- Physical environment

A plan of correction has been completed for the CMS Deemed Status Statement of Deficiencies and the DC DOH findings. The plan of correction addresses the immediate remediation of the findings and system and process improvements including capital projects, maintenance of the environment, software solutions, and enhanced quality oversight.

After June 25th a survey could take place at any time.

VALUE BASED PURCHASING MONTHLY VALUES

SAFETY SCORE:

1. CDI: Clostridium Difficile Infection
2. CAUTI: Catheter Associated Urinary Tract Infection,
3. CLABSI: Central Line-Associated Line Infection
4. MRSA: Methicillin-Resistant Staphylococcus Aureus Bacteremia
5. SSI: Surgical Site Infection Colon Surgery and Abdominal Hysterectomy

Safety of Care	Central Line Associated Bloodstream Infection (CLABSI)	0%	0%	1 CLABSI	0%	0%		2.1 CLABSI
	Catheter Associated Urinary tract infections (CAUTI)	0%	0%	0%	0%	0%		3.5 CAUTI
	Surgical Site Infections from colon surgery (SSI)	0%	1 SSI	0%	0%	0%		0.18 SSI
	MRSA			7 MRSA	3 Cases	3 cases		5.5 MRSA
	Hospital Acquired C-diff	0 cases	2 cases	3 cases	0 cases	2 cases		0.325 cases

Clinical Care 30 Day Death Rates:

1. Mortality Acute Myocardial Infection
2. Mortality Heart Failure
3. Mortality Pneumonia
4. Mortality Total knee and Hip Arthroplasty

	UNITED MEDICAL CENTER	NATIONAL RESULT
Death rate for COPD patients	No Different than the National Rate	8.0%[20]
Death rate for heart attack patients	No Different than the National Rate	13.6%[20]
Death rate for heart failure patients	No Different than the National Rate	11.9%[20]
Death rate for pneumonia patients	No Different than the National Rate	15.9%[20]
Death rate for stroke patients	No Different than the National Rate	14.6%[20]
Death rate for CABG surgery patients	Not Available[5]	3.2%[20]

The Leapfrog Survey

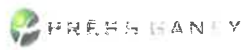
Every year, hospitals across the country demonstrate their commitment to transparency and quality improvement through the Leapfrog Hospital Survey. United Medical Center participated in 2016. The organization is completing the survey this year in a commitment to improve patient safety and accountability. The deadline is June 31, 2018.

Reducing Mortality

The organization is committed to improving systems and processes across the organization and has committed to a process improvement project to improve the care of patients experiencing Severe Sepsis and Septic Shock. Work to date includes reconvening the Severe Sepsis committee to improve the recognition of sepsis and successful resuscitation that saves lives in the organization.

UMC has reduced Severe Sepsis mortality from 36% in the first quarter of 2017 to 14% which aligns with National benchmarks.

HCAHPS ((Hospital Consumer Assessment of Healthcare Providers and Systems)

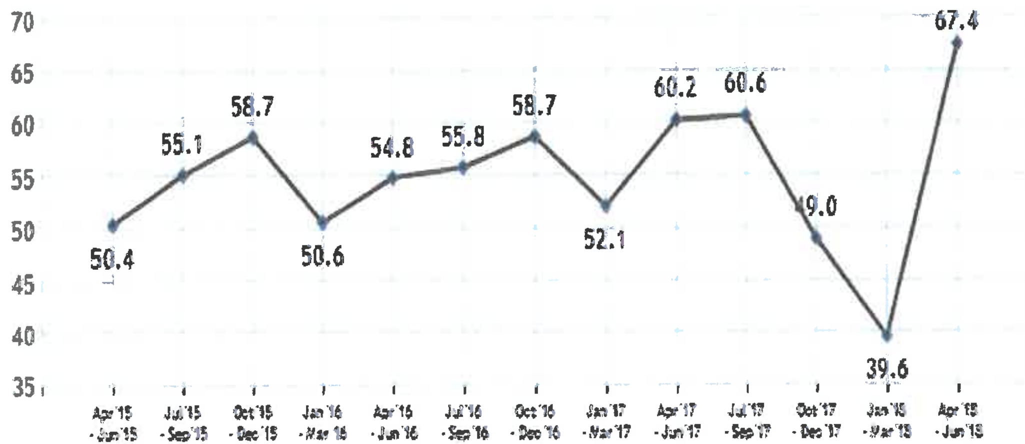


Top Box Trends

Inpatient

United Medical Center

Section - CAHPS - Hospital Environment

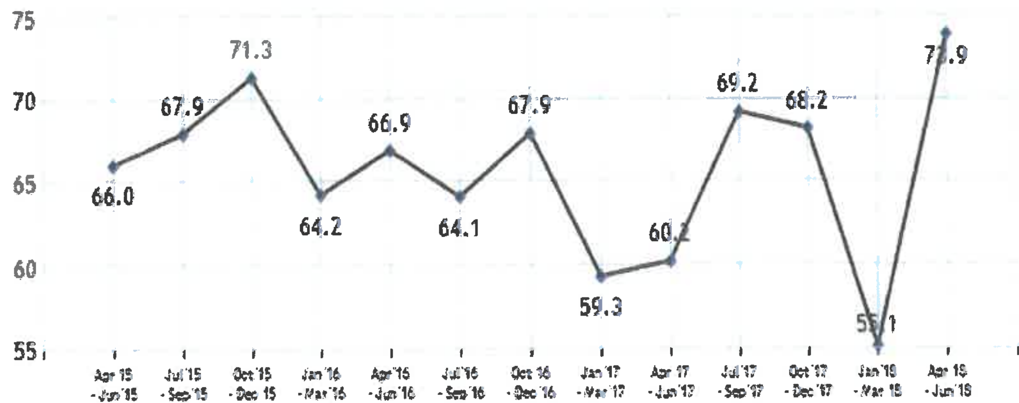


Top Box Trends

Inpatient

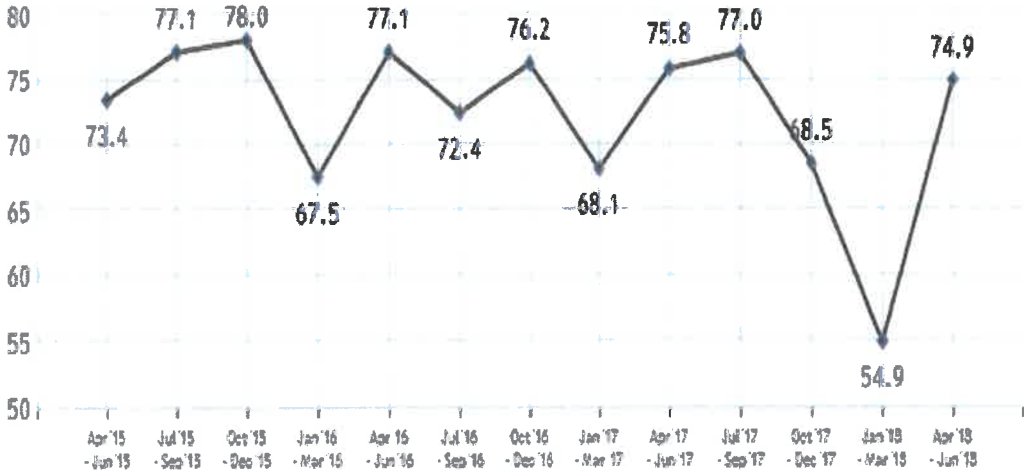
United Medical Center

Section - CAHPS - Comm w/ Nurses



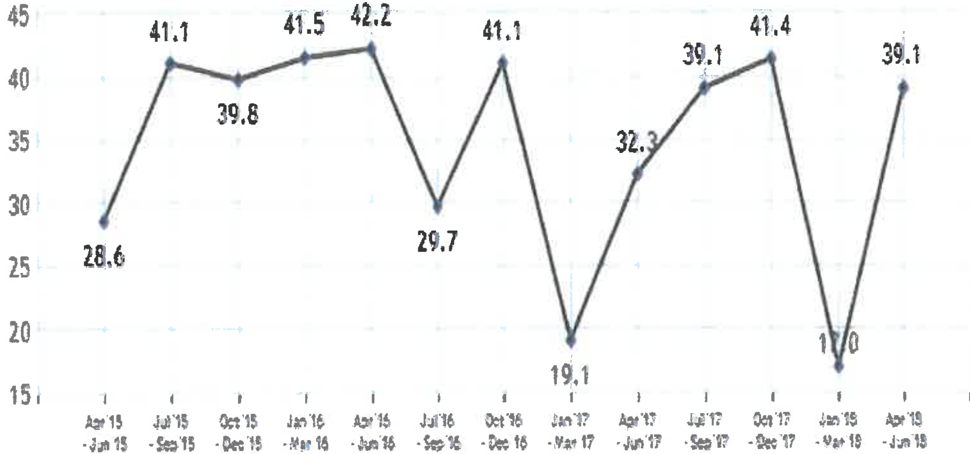
United Medical Center

Section - CAHPS - Comm w/ Doctors



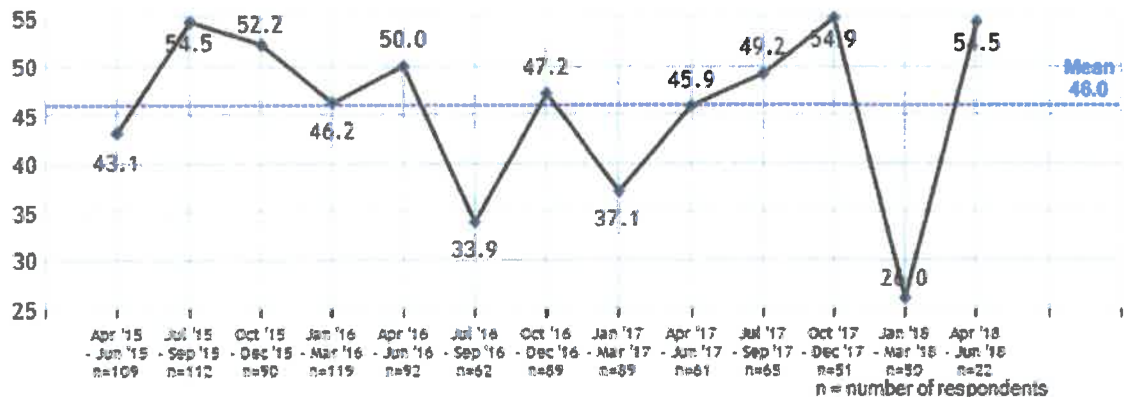
United Medical Center

Question - CAHPS - Recommend the hospital



United Medical Center

Question - Overall rating of care given



PATIENT CARE SERVICES

SERVICE/PATIENT EXPERIENCE

- **ICU** – Ongoing patient and family rounding addressing ICU needs and concerns. Met with **45** families. The experience has been mostly positive. Families appreciated the care board as means of POC communication.
- **5W/8W** – Ongoing patient and family rounding (**834** patients/families were rounded) addressing the cleanliness of the environment, delayed assistance with ADLs, variety of diet menu and adequate pain control continue to be the theme for this month. Patient complaints have also gone down as a result of daily rounding.
- **BHU** – "This place looks better than it did the last time I was here" (a comment from a patient which becomes the theme of the overall patient/family's comments).
- **ED** – Rounded on **21** patients - received compliments on the quick staff response and overall cleanliness of the environment. Security presence in the lobby 24/7 with MPD addition were also appreciated by the patients and families – sense of feeling safe. Complaints continue to have gone down but noise and pain management were identified as most concerning. Staffing was increased (8-9RNs and 5-6 Techs) to improve patient throughput.
- **Respiratory** – Patient complaints about delay in nebs treatment were addressed and resulted in service recovery.
- **Wound** – 3 patients/week rounded with 100% satisfaction with care – they will refer our services to friends and the community.
- **Radiology** – Service recovery performed for longer stay in the Radiology Department.
- **Lab** – Continue with rounding and service recovery.
- **SNF** – Patient concerns about the laundry service were addressed and monitored.

QUALITY

The UMC Patient Care Services (PCS) made significant gains in a number of safety and quality measures. Nurse-led initiatives were behind many of the improvements made in the beginning of

this year. PCS is committed in working with the Quality Department in addressing DOH Plan of Correction (POC).

The ***Nursing – Sensitive Quality Indicators*** continue to provide evidence that quality and patient safety is at the heart of every nurse practicing at UMC. Measures that are being tracked are: Indwelling Urinary Catheter Infections (CAUTI), Central Lines Infections (CLABSI), Ventilator-Acquired Event (VAE), Surgical Care Improvement Project (SCIP) and Hospital Acquired Pressure Ulcers (HAPU). **Overall, there were no infections identified for the month of May (zero infection rate). Sepsis education is underway.**

PHARMACY:

- Progress has been made to continue working on the DOH POC
- Pyxis ES training is underway (with IT and Nursing)
- Continue addressing antibiotic stewardship and handling of narcotics

RESPIRATORY:

- 100% compliant with CAP requirements
- Medication Administration education specific to nebs treatment in place

LABORATORY:

- Lab turnaround time with ER will be measured and monitored (mini PDCA)
- Insulin/Accu check education – 100% completed

PEOPLE/STAFF ENGAGEMENT:

- Daily leader rounding continues to be a practice in the ED and inpatient units asking the staff what is working well and what they need to do their job. Adequate staffing in ED (RNs, TECHS, UC) ICU, and lab remain a concern. Handheld phones have arrived and are ready for distribution to facilitate communication of the unit staff. Daily huddles with the staff were identified as useful to improve communication. AIDET (Acknowledge, Introduce, Duration, Explain and Thank You) is reinforced as a template for communication with the patient.
- For SNF, Ambassadorship program was initiated where nursing leadership is assigned to different rooms to perform follow-up assessments and ensure resident satisfaction and quality care are provided consistently.
- PCS continue to maintain a good relationship with the District of Columbia Nurses' Association (DCNA) while addressing labor and staffing issues. Through the Nursing Practice Committee, issues and concerns in clinical practice are being addressed by the members of the committee and making recommendations to change or improve clinical practice. The biggest accomplishment of PCS is the improvement of exceeding the goal of >80% (achieving 93% in ICU) with regards to nurse-to-staffing ratios in all nursing departments. This report is most welcomed by the nursing staff as positive in improving nurse-patient ratio.
- Staff recognition on each unit is being implemented.
- The new Rehab Director will begin work on June 18, 2018.

Finance and Growth

- Control of overtime remains a challenge especially in the Emergency Room (8 FTEs over). With GWMFA joining UMC ED, the need to increase RN FTE (goal is 9 RNs per shift and 5-6 Techs) is needed to accomplish the ED metrics identified. The total FTEs needed to meet this goal is 10.8 and the use of agency and RN travelers cannot be avoided. Aggressive hiring is in place and with the new staff recruited, patient throughput is expected to improve.
- There is currently in place a monitoring process for incremental OT. Any incremental OT needs the Supervisor's approval with reasons for staying over. The managers are looking at the KRONOS daily and addressing the incremental OT in real time.
- On April 15, 2018 BHU implemented a Virtual Intake Process in the ER with the purpose of reducing ER disposition time for Psych patients. ED RNs and MDs were trained about the new process with the steep learning curve. Staff were re in-serviced on how to do Mini Mental status Exams.
- Dialysis – 228 performed in May
- Radiology – 252(XR); 525(US); 856 (CT Scan); 7(Cardiac Cath); 34(Fluoro)

	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Census	5073	5133	5044	4760	5087
Daily Census	160	174	168	164.3	182
LWBS	109	90	116	132	148
LWBS %	2.15	1.94	2.1	2.7	2.9
Left prior triage	265	277	284	255	289
Left prior triage %	5.6	5.4	5.9	5.35	5.67
Admissions	410	421	433	512	552
Admission Rate	9.7	9.3	9.5	10.7	10.85
Ambulance arrivals	1560	1534	1588	1324	1468
Ambulance arrivals %	30.75	32.1	34.6	27.8%	28.85%
Elopements	44	61	57	68	57
Triage	21	27	23	25	22
Room	59	67	56	98	85
Provider	69	68	66	112	97
Disposition DC	177	226	155	241	265
Disposition Admit	203	292	233	355	333
LOS DC	239	175	189	270	277
LOS Admit	312	292	370	475	564
Dispo to leave (DC)	24	31	34	29	24
Dispo to leave (Admit)	263	189	270	210	321

Telemetry - Goal: 5:1; ADC: 45							
	Less than 5	5	6	7	8	ADC	% ratio met - Goal 80%
January	32%	56%	11%	0%	0%	53.7	88%
February	20%	73%	5%	2%	0%	46.2	93%
March	39%	52%	5%	5%	0%	46.7	91%
April	52%	38%	7%	3%	0%	43.4	90%
May	39%	52%	5%	2%	3%	47	91%

Medical/Surgical - Goal: 6:1; ADC: 35							
	Less than 6	6	7	8	9	ADC	% ratio met - Goal 80%
January	92%	8%	0%	0%	0%	13.3	100%
February	75%	23%	2%	0%	0%	18.7	98%
March							
April	52%	40%	5%	3%	0%	12.5	92%
May	76%	15%	6%	2%	2%	19	91%

ICU - Goal 2:1; ADC: 12						
	Less than 2	2	3	4	ADC	% ratio met - Goal 80%
January	13%	82%	5%	0%	9.70	95%
February	4%	93%	4%	0%	9.90	97%
March	10%	90%	0%	0%	9.10	100%
April	5%	93%	2%	0%	9.35	98%
May	8%	85%	6%	0%	9.80	93%

Emergency Room - Goal: 7-8							
	6 and below	7	8	9	10	Average Staffing	% ratio met - Goal 80%
Jan-18	10%	61%	24%	3%	2%	7.6	90%
Feb-18	5%	29%	64%	0%	2%	7.53	95%
Mar-18	6%	34%	56%	4%	0%	7.5	94%
Apr-18	18%	42%	33%	7%	0%	6.94	82%
May-18	3%	35%	37%	21%	3%	7.5	96%

	17-Oct	17-Nov	Dec-17	18-Jan	18-Feb	18-Mar	18-Apr	18-May
ENDO PROCEDURE	88	125	117	103	88	125	104	122
SURGERY PROCEDURE	69	69	106	79	69	69	79	97
Total Procedure	157	194	223	182	157	194	182	219

	Oct-17	Nov-17	DEC	Jan-18	Feb-18	Mar	April	May
TOTAL CASE	209	148	151	150	181	204	177	202
TOTAL PROCEDURE	224	157	161	155	194	223	193	219
IP	88	68	79	76	68	78	68	90
OP	121	80	72	74	113	126	109	129

	OCT	NOC	DEC	18-Jan	18-Feb	Mar	April	May
EGD	43	37	48	38	43	60	47	56
COLONOSCOPY	68	38	36	49	70	56	52	61
BRONCHOSCOPY	3	4	0	1	2	2	0	4
ERCP	2	0	1	0	0	0	0	1
Total	116	79	85	88	115	118	99	122

	OCT	NOV	DEC	18-Jan	18-Feb	18-Mar	18-Apr	18-May
ADD ON				41	19	45	32	44
CX				35	13	42	41	48

HUMAN RESOURCES

ANNOUNCEMENT

Please join us in welcoming our new Human Resources Director to UMC. She joined the HR Team on Monday, June 4, 2018:

- Marcia Nicholson, Director, Human Resources - Ms. Nicholson comes to UMC with many years of Human Resources experience, most recently from the Office of the Chief Financial Officer (OCFO). She has strategic leadership skills in talent acquisition, employee and labor relations, records management, employee onboarding and retention, training and development and a host of other talents we are excited to employ here at UMC. Ms. Nicholson also brings with her a strong background in process/policy development and is an active member of the Society of Human Resources Management (SHRM).

HUMAN RESOURCES INITIATIVE PROGRESS UPDATE:

- Members of the Human Resources team had the kick-off meeting to discuss new and improved employee benefits.
- Human Resources leadership welcomed our new Risk Management Director, Ceceila Davis who joined UMC on May 21, 2018.

INFORMATION TECHNOLOGY

15-Jun-18

Initiative	START DATE	END DATE	Status	Comments
Create and Maintain Appropriate IT Governance Structure	Apr-18	May-19		
Establish IT Governance structure / Steering Committee		Apr-18		Note: Committee established in April as per schedule. However, its May meeting was postponed; to convene when COO brought on board to accept charimanship.
Develop and implement formal IT Security Program		May-19		In progress. Security Officer hired. Remediation of last two remaining "notice of Findings" from most recent security audit are underway
Develop and update all IT policies and procedures		Jul-18		Process underway
Institute Project Management processes		Apr-19		Continuing progress
Update and Expand Applications	Apr-18	Jun-20		
Upgrade Meditech Magic to current release level		Nov-18		Slated to be completed by December, 2018.
Select / purchase / implement replacement for Meditech Magic		Jun-20		Determination of future partnership for the UMC institution will have significant effect on selection of replacement Hospital Information System. Finalists, pending that determination, are Meditech Expanse and Cerner
Complete implementation of owned systems (timing TBD by Steering Committee)				
- CareFusion Pyxis Medication Distribution		Jul-18		On track for June 2018 go-live
- CareFusion MedMined Infection Control & Medication Stewardship		Jun-18		Completed. Live date 6/7/18.
- 3M360 Coding		Jun-18		Live date adjusted from June to August, due to training availablity of vendor
- Interface Meditech to eClinical Works outpatient system		Sep-18		On track for September 2018 go-live
Curaspan - Post Acute Patient Management		Oct-18		Contracting phase.
Point Click Care - SNF				Priority / dates TBD by IT Steering Committee
Meditech Magic ED Medication Scanning				Priority / dates TBD by IT Steering Committee
Meditech Magic HR module				Priority / dates TBD by IT Steering Committee
Obtain Meaningful Use compliance and maximize MACRA scores		Mar-19		Regulatory changes being proposed. Schedule to be determined accordingly.
Purchase and implement systems as necessary				To be determined by IT Steering Committee.
- Medisolv Quality Measures reporting				To be determined by IT Steering Committee. May be impacted by proposed changes to regulations.
- CareSelect Clinical Decision Support				To be determined by IT Steering Committee. May be impacted by proposed changes to regulations.
Patient data reports for downtime periods		Jun-18		Reports developed, hardware purchased. On track for June go-live
Refurbish Infrastructure	Apr-18	May-19		
Overhaul cable plant and wiring/communications closets		May-19		Supplemental detail being obtained to increase specificity of RFP
Develop and maintain Business Continuity / Disaster Recovery plan and processes, including annual testing		Aug-18		Planning for disaster recovery test is underway, being scheduled for September/October, pending confirmation of dates by vendor.
Implement appropriate IT security tools/controls as identified in annual testing		May-19		Per Risk Analysis - results TBD
Upgrade data center environmentals, including power availability for servers		Oct-18		To be combined with plant facilities projects.
Replacement of printer/copier vendor - cost savings		Jun-18		On track for replacement of 70 printers/copiers
Wireless communication for nursing		Jun-18		On track for full implementation in June
Revamp IT Organization	Apr-18	Aug-18		
Restructure IT organization		May-18		Realignment of IT department completed.
Fill critical IT vacancies		Jul-18		Security Officer and Director of Biomedical and Clinical Informatics hired. Recruitment underway for HelpDesk and Clinical Analyst positions.
Implement internal processes, such as formal change management		Jul-18		Underway
Expand service to include support of all key applications, such as PACS, eClinicalWorks, etc.		Aug-18		Training in eClinicalWorks underway.

Color Key	
(green)	On Track
(yellow)	Behind Schedule
(red)	Project at Risk

Tab 5

Committee Reports

General Board Meeting

Date: June 27, 2018

Patient Safety & Quality Committee

Dr. Malika Fair, Chair

Not-For-Profit Hospital Corporation
Patient Safety & Quality Committee Meeting Minutes
APRIL 19, 2018

Present: Chair, Dr. Malika Fair, Director Girume Ashenafi, Director Millicent Gorham, Matthew Hamilton, Tina Rein, Sylvia Clagon, Allea Parker, Dr. Dennis Haghighat, Dr. Mina Yacoub

Absent: N/A

Agenda Item	Discussion	Action Item
Call to Order	Meeting called to order at 4:37P.M. Quorum determined by Michael Austin.	
Approval of the Agenda	Agenda approved as written.	
Discussion	Previous meeting minutes approved.	
Meeting Discussion	**Ms. Tina Rein:** • Infection Control Plan not approved as of yet. Still under review and must be approved for Board with understanding that the plan will be modified following most recent survey. **Ms. Sylvia Clagon:** • Infection Control Plan: Risk assessed using grid and the highest-number identifies high-risk problems for the year.	

	• Patients are identified as high-risk through medical records and persons that have multi-drug resistance; potential TB patients from nursing home or correctional facility are flagged because they are at risk; every patient is screened for MRSA as well as all nursing-home patients for BRE. Any patient with positive Multi-drug resistance organism is flagged in the computer and upon return such patient is put on contact precaution. • Disparities in hospital should be considered to look for differences in treatment. • UMÇ is delivering safe care as reflected in the Infection Control measures. CLABSI, CAUTI, SSE, are a component of the Value Based Purchasing reimbursement model. Poor performance results in fines from CMS. UMC has not received a fine. **REGULATIONS: TINA REIN** • EMTALA Plan of Correction finding from March 2018: CMS Federal Level accepted formally, but CMA State Level is not yet accepted formally: the correction included immediate education for EMTALA, compliance, nursing--charge nurse, patient access. Developing education to include monthly case study and 100% of pediatric patient population transfer---mostly 15-18 year olds but also includes ages near 2 years and concerns in audits is elevated in real-time. Last day of plan of correction was April 15th. • Reviewing 20% of adult patients to include OB patients that are transferred as part of plan of correction. In April an increase of OB patients that requires transfers out—more education needed in the community about PR that L&D are not accepted at UMC, which is a high risk for EMTALA. • Dr. Haghighat advised that staff are in place to deliver if a mother presents. • One delivery at UMC and was crowning via private vehicle and not by ambulance.	Dr. Fair: instructed Michael to include all attachments in the Infection Control Plan in the Board Book as per regulation.

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<td>SERIOUS EVENT:
Dr. Fair: update Board in Closed Session on serious events. The Committee will also continue to discuss

Bronchoscopy Update:
Bronchoscopy Update came from Joint Commission Survey. Temporary space and fix allowed by DOH; procedure to be done in negative pressure room/isolation room. Identified through CDC to use a HEPA Filter. Discussion ongoing for long-term solution relating to facility.
Skilled Nursing Facility (SNIF):
High-risk patients in SNF; proactively reached to DOH and Ombudsman to successfully discharge patients; one patient discharged.
New Urgent Care/Fast Track:
New ER group started on April 01, 2018. Urgent Care may require a certificate of need--Primary Care Clinic may be best solution in the interim hence the need for expansion.
No call no shows – 65 to 66 appointments – 30% no show rate…
Dr. Fair advised Dr. Haghighat to review the DC Hospital Association an excellent tool for Best Practice; look at FQHCs in the area.
ER Security:
Card reader needed to enter ER is active.
Panic buttons installed.
Ability to lockdown/and allowed to leave the ER a major concern of ER group.</td>
<td>Dr. Fair: Michael should add the LeapFrog Survey material in Board Book.</td>
</tr>
</table>

	DOH Survey: • Annual survey was July 2017 and DOH came in early. • 8 surveyors: SNF not included. • 10 business days to provide report. • DOH applauded the building of systems to improve. • Clinical findings: reporting and responsiveness; ensuring Med-Surg versus Critical Care. Challenges around physician orders; education and new hire competencies; medication administration; HR portfolio competencies; staffing in Lab position and reduces turn-around time for labs---some hiring done. Infection control findings in Pharmacy; Radiology was cited for Fluoroscopy and must be addressed because UMC cannot offer to all patients as per the license. Behavioral Health also cited about painting and dusting; Life-safety is pending and the Fire Marshall. 10 days to write the plan, which began immediately. Repeat areas: Insulin, Cutting-boards in Kitchen; Fluoroscopy. **Meeting adjourned at 5:32 PM.**	

Infection Control Environmental Oversight

<table>
<tr><th colspan="2">Infection Control</th></tr>
<tr><th>Background</th><th>Future State and Countermeasures</th></tr>
<tr><td>- Air Sample testing in the medication preparation area collected in March positive for pathogenic fungus.
- Infection Control unaware of the result
- Infection Control Environmental reports were not reported to Performance Improvement.
- Finding required immediate action and organizational plan</td><td>1) Research Director of Pharmacy job description; responsibilities for the compounding and distribution of IV medications (Completed)
2) Air and Surface reporting results are currently sent to the Director of Pharmacy, Infection Control, and the Director of Quality
3) A test result will be sent to the new recipients to verify action complete.
4) Research additional resources for air and surface testing.
5) Infection Control Established EOC reporting for high risk areas in the organization. (Completed)</td></tr>
<tr><th>Current State</th><th>Impact</th></tr>
<tr><td>System reporting of high risk testing and result reporting
▪ Environmental testing is completed in high risk areas.
▪ Content experts are not aware of the testing and resulting processes
▪ Results are not communicated to the governance structure</td><td>1) Two samples with in normal limits
2) Additional results reported as a standing item on the P and T minutes, IC committee, And PI Committee
3) Job Description completed and reviewed with the Director of Pharmacy</td></tr>
<tr><th>Objective</th><th>Follow up</th></tr>
</table>

Infection Control Environmental Oversight

Create and maintain a reporting mechanism to meet Infection Control standards in the environment of care.	Governance • Pharmacy and Therapeutics/6 months • Infection Control Committee for 6 months • QAPI (Performance Improvement Committee) for 3 months and quarterly
Root Cause Analysis	**Team Members**
1) Pharmacist unaware of the testing and results requiring additional action 2) Support staff were receiving the results without a back-up or reporting to the Director of Pharmacy 3) Environmental Infection Control Surveillance had not been identified as an infection control requirement in the organization 4) The current vendor did not call the "highly pathogenic" result to the organizational identified leader.	1) Director of Pharmacy 2) Director of Quality 3) Infection Control Preventionist.

Infection Control Schedule Reports

Departments	Monthly	Bi-yearly	Annually	
Bio-Med Services				
Negative Pressure Rooms	X			
Negative Pressure Room by contractor			X	
Laminar Flow Hoods Pharmacy / Lab - by contractor		X		
OR Room pressure Monitoring / SPD	X			
Dialysis				
Water Culture	X			
Dialysate Culture Report	X			
Pharmacy				
Laminar Flow Hood Cleaning	X			
Air Surface Monitoring By Contractor		X		
SPD				
Autoclave Monitoring	X			
Washer / Decontaminate Machine	X			
OR				
AER Scope Washer	X			
Temperature / Humidity monitor	X			
Other				
Facilities				
Water Tower Testing	X	During summer		
Pre- filter (hepa) change in pharmacy	X			
Environment of Care Services				
Terminally clean – OR, Pharmacy, SPD	X			
Food Services				
Refrigerator / Freezer monitor	X			
Ice machine monitor	X			
Employee Health				
Needle Sticks / PPD conversions	X			
Physical Exams				

The above departments should provide monitoring reports to the Infection Control Department as scheduled by the 5th day of the month during your reporting period.

Please provide email reports to Sylvia Clagon – Infection Preventionist – sclagon@united-medicalcenter.com

Contact number (cell) (202) 557-4619 or (office) (202 – 574-7177

Title:	Pharmacy Infection Control	Page: 1 of 7		
Policy No:	IC 8D-22	Effective 6/2008	Review 12/2011 11/2014	Revised 11/2016, 06/2018

OBJECTIVE:
To promote effective infection Control measures in the pharmacy

SCOPE:
Pharmacy Department

POLICY:
The Department of Pharmacy constitutes a vital part in infection control because its products are potentially disseminated to all patients. Contamination of medications, or other pharmacy products, whether caused by faulty manufacturing, handling, storage, or compounding can have disastrous effects on many patients throughout the hospital. Therefore, the department shall establish and assure strict infection control procedures for all compounding and handling of sterile and non-sterile products.

PROVISIONS:

General Information

All pharmacy personnel shall follow the policies and procedures of Occupational Health.

Food and beverages are permitted in non-compounding and non-IV areas of the pharmacy only. Food and beverages are not to be stored in refrigerators used to store medications.

All drugs shall be stored under clean, safe environmental conditions on shelves or plastic palettes.

Refrigerators shall be maintained at a temperature range of 36°F - 46°F and cleaned once per month by pharmacy personnel.

Opened multi-dose vials returned to the pharmacy shall be discarded and not returned to stock. All medication packaged in ampoules is intended for one time use only and the unused portion shall be discarded once opened. Routine inspections should be performed to ensure that expired medications are removed and disposed of properly.

Personnel shall wash hands frequently during the day to prevent contamination to other drugs as well as themselves. Hands are thoroughly washed before dispensing medications. Waterless hand hygiene products may be used as adjunct to soap and water.

IV ***Admixture Area***

Definitions

Large Volume Parenteral (LVP)

A sterile solution of 250ml or more, intended for injection, and used in the diagnosis, Cure, mitigation, or treatment of disease or modification of physiological functions in Human beings, excluding blood.

Intravenous Admixture

Intravenous piggyback (IVPB) or mini-bag (a sterile solution of 50 to 249ml, intended for injection) to which one or more additional drug products have been added in the hospital.

Receiving and Storage

The containers of large volume parenteral (LVPs) shall be inspected for water marks indicating container breakage and signs of excessive abuse in handling (e.g. carton contents, such as cracking of glass containers). Damaged cartons shall be separated from the rest of the shipment for closer inspection and replacement, if necessary.

Precaution shall also be taken when removing LVPs and related products from their shipping cartons to detect defects that were not initially apparent (e.g. crystals on outside of containers, cracks, dents, incomplete products, visible turbidity, mold growth, improper labeling, or outdated products). If a problem is found, the product shall be removed.

Products shall be stored exercising proper handling techniques, including protection from excessive heat or cold, and rotation of inventory.

IV Preparation Room (Compounding)

- Will be cleaned with a USP 797 approved sporicidal cleaner, mixed with sterile water that is applied with micro fiber cloths and a micro fiber mop.
- Terminal cleaning will be completed monthly and will include pharmacy responsibilities, pharmacy will be responsible for cleaning the laminar flow hood, table top and shelving. Environmental Services will be responsible for cleaning the floors, ceiling, and walls.
- Counters and easily cleanable work surfaces are cleaned daily
- Floors are cleaned daily
- Environmental Services will assign IV room specific cleaning buckets, mops, and micro-fiber cloths for the IV room and pharmacy
- A tacky mat will be placed at the entrance through the ante room to decrease contamination.
- A medication storage refrigerator will be relocated outside of the medication preparation room for decrease entry into the preparation room.

- Air and laminar flow hood testing by an outside vendor will be completed every six months and test results notification will be provided to the Director of Pharmacy, Director of Quality and Infection Control
- No food or drinks are permitted into the ante-area or buffer area of the pharmacy.

A clean work area with adequate lighting, isolated from heavy traffic, and separated from contaminated supplies shall be available for compounding sterile supplies.

Floors shall be maintained by environmental services on a daily basis, using hospital approved detergent/disinfectant.

All non-recessed hanging light fixtures shall be cleaned on a routine basis.

Work surfaces, bench tops, and countertops shall be cleaned daily with hospital approved detergent/disinfectant and weekly with a sporicidal agent.

Drugs, packaging supplies, and drug containers shall be stored in a clean, dry, dust-free area not in direct contact with the floor. Storage shelves shall be cleaned routinely not in direct contact with the floor. Storage shelves shall be cleaned routinely

Drugs and pharmaceutical supplies shall not be stored under sinks.

Compounding of sterile products shall be performed under Laminar Flow Hoods. This includes any manipulation that could introduce contaminants into an IV solution, eye drops, etc.

Laminar Flow Hoods

Laminar Flow Hoods (LFHs) shall be cleaned at least once each shift at the beginning of each shift hospital approved disinfectant, then wiped with sterile 70% isopropyl alcohol and germicidal wipe. All items shall be removed from the hood before proceeding.

Pre-filters of LFHs shall be changed the first of each month. The date and initials of the individual changing the filter shall be on a Periodic Maintenance record in Building Services. The grill shall be wiped with hospital approved disinfectant when the pre-filter is changed.

The HEPA filters shall be changed when the air flow drops below 70 feet per minute and cannot be corrected by increasing the blower speed.

The operational efficiency of each hood shall be inspected and certified by an outside independent contractor every 6 months. Notification of test results will be provided to the Director of Pharmacy, Director of Quality and Infection Control. The results will also be

presented to the Pharmacy and Therapeutics Committee and the Prevention and Control of Infections Committee.

Ideally, the LFH should run 24 hours a day. If a hood has been turned off, at least a 30 minute warm-up plus a thorough cleaning shall be performed prior to use.

Personnel shall work at least six inches within the LFH to avoid turbulence, which could introduce contaminated air into the hood.

Only equipment necessary for each procedure shall be placed in the hood.

Arrange articles and work flow in LFH in such a manner that clean air does not flow over dirty articles and contaminate other articles that must remain sterile.

To assure unimpeded air flow, place large articles toward outside LFH.

Personnel shall not laugh, cough, talk, or sneeze into LFH.

Personnel with upper respiratory infections shall not be involved in the preparation of sterile products.

Personnel shall exercise strict aseptic techniques when compounding or manipulating all sterile products.

A distinctive supplementary label shall be attached to each IV admixture stating: The solution, the additives, and their expiration notice, administration rate, patient name, patient room number, and the initials of the pharmacist and technician.

After checking the solution, additives, labels, and compounding accuracy of supportive personnel, the pharmacist shall initial the designated area of each IV admixture label.

Distribution

Appropriate IV admixtures shall be refrigerated following the compounding process until time to be delivered to the nursing units.

Nursing personnel shall assume responsibility for IV admixture storage on the nursing units prior to time of administration.

Personnel

Non-pharmacy personnel are not permitted in the IV admixture area during times when IV's are being admixed.

- Compounding personnel shall remove personal outer garments (e.g bandannas, coats, hats, jackets, scarves, sweaters, vest; all cosmetics, because they shed flakes and particles
- Remove all hand, wrist, and other visible jewelry or piercings (e.g. earrings, lip or eyebrow piercings) that can interfere with the effectiveness of personal protective equipment (PPE) (fit of gloves and cuffs of sleeves)
- The wearing of artificial nails or extenders is prohibited while working in the sterile compounding environment. Natural nails shall be kept neat and trimmed.
- Personnel shall don the following PPE in an order that proceeds from those activities considered the dirtiest to those considered the cleanest. Garbing activities considered the dirtiest include donning of dedicated shoes or shoe covers, head and facial hair covers (e.g., beard covers in addition to face mask), and face mask/eye shields. Eye shields are optional unless working with irritants such as germicidal disinfecting agents or when preparing hazardous drugs.
- Perform hand sanitation then don a nonshedding gown with sleeves that fit snugly around wrist and enclosed at the neck
- Once inside the compounding area and prior to donning sterile powder-free gloves, perform hand hygiene.
  Handwashing facilities shall be located in close proximity to all work areas used for preparation and dispensing of pharmaceuticals.

Hands shall be thoroughly washed with the hospital approved antimicrobial solution at least each shift and after each interruption which would grossly contaminate the hands.

Gloves are to be replaced after each shift, and after each interruption which would grossly contaminate the hands.

Education

Technical personnel who compound IV admixtures shall be rigidly trained and adequately checked and supervised by licensed pharmacy personnel.

The Technician Training Program shall include life demonstration, video/audio tapes, and/or readings on:

- Routes and administration of medication and dosage forms.
- Drug nomenclature.
- Abbreviations
- Weights, measures, and pharmaceutical calculations Medication orders.

- Aseptic techniques.

Quality Assurance

All pharmacy personnel that work in the IV admixture areas shall be evaluated annually for competency in aseptic technique and pharmaceutical calculations.

Periodic departmental service audits shall be conducted in the IV admixture areas to assure compliance with established policies and procedures.

In cooperation with the Pharmacy & Therapeutics and the Infection Control Committees, the Pharmacy shall participate in the hospital-wide antibiotic drug utilization review efforts by providing data on antibiotic usage patterns.

Suspected Drug Contamination

If a drug is suspected of being contaminated (bacterial, fungal, etc.) the Director of Pharmacy or Designee, shall be contacted. The Infection Control Department shall also be notified of the problem and its possible extent. A sample(s) of the suspected product shall be sent to the Microbiology Laboratory for culturing and/or analysis of contents.

All dispensing areas and pharmacy stores shall be contacted and asked to locate and quarantine all of the suspected drug product with the same lot number.

If the Microbiology Report is positive for growth, then an additional sample with the same lot number shall be sent to the Microbiology Laboratory for confirmation.

If the second sample confirms the initial Microbiology Report, then:

- All dispensing areas shall return their supply to pharmacy stores, where it shall be quarantined pending further action.

- All non-pharmacy areas which may have a supply of the affected item shall be inspected for the product.

- The manufacturer and the appropriate governmental agencies shall be notified and return procedures shall be initiated.

Reference:

797 Pharmaceutical Compounding – Sterile Preparations Guidelines

Infection Control: A Practical Guide for Health Care Facilities 2016 by George Allen, PhD, CIC, CNOR; Cathy Frye, Contributing Editor

General Best Practice Guidelines for immunization Best Practices of the Advisory Committee on Immunization Practices (ACIP) March 9, 2017

The ISMP Guidelines for Safe Preparation of Compounded Sterile Preparation of Compounded Sterile Preparations (September 19, 2016)
Drug Distribution and Control Preparations and handling – Guidelines (June 2, 2014)

ASPOH Guidelines on Compounding Sterile Preparations AM J Health System Pharm 2014:71:145-66

Next Review Due Date

June 2021

<table>
<tr><th colspan="2">Severe Sepsis/Septic Shock</th></tr>
<tr><th>Background</th><th>Future State and Countermeasures</th></tr>
<tr><td>

Severe Sepsis is a Life-threatening organ dysfunction caused by a systemic infection
Septic Shock is a Subset of sepsis with circulatory and cellular/metabolic dysfunction associated with higher risk of mortality

Severe Sepsis and Septic shock can occur in any of our patient care departments and the early identification and treatment of severe Sepsis and septic shock are directly related to positive outcomes.
</td><td>
Quality Improvement Principles and Methodologies
- Sepsis FMEA – A3 Methodology
Sharing Knowledge

Reconvene Sepsis Committee Meetings
Review Sepsis Mortality Data and cases
Develop and track PI projects to improve sepsis care and decrease mortality
Sepsis cases will be discussed at ED and Inpatient staff meetings
Engaging Key Stake Holders

Tools and resources

Sepsis screening of all patients to be completed not only by RNs at ED Triage but also on Inpatient units at every shift, Quality will monitor compliance (95% compliance)

Providers will be notified of patients with new SIRS criteria, Quality will monitor

Lactate greater than 2 has been placed into the Global Trigger tool for daily staff notification of potential severe sepsis and septic shock (Done)

Lactate over 2 has been classified as a critical lab requiring telephone notification of primary nurse (Done)

Severe Sepsis care pathway will be developed and implemented, paper format (Kathy Prestige)

Review and develop Sepsis Protocol Forms and Flowsheets on ED intranet with sepsis criteria (Nursing leadership, IT)

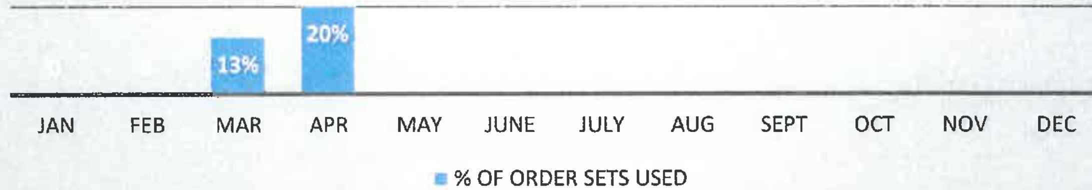
ED Tracking Board that includes alerts for patients with positive sepsis screens and lactate values greater than 2mmol/L (Can this be done?) (Nursing leadership and IT)
</td></tr>
</table>

	▪ Update severe sepsis policy to include sepsis screening at triage and on Inpatient units every shift to improve recognition of patients with sepsis **(Done)** ▪ Education for RNs on sepsis screening and provider notification **(Nurse Educator with Nursing Leadership)** ▪ Add provider notification to SIRS screening in the EHR **(Quality and IT)** ▪ Sepsis education for current and new providers **(CMO)** ▪ Create Sepsis specific documentation (Alert Event and Reassessment Notes) **(Quality and IT)** ▪ - Provider interventions documented ▪ - Non-sepsis patients with abnormal vital signs ruled out
April 2017	**Impact/March 2018**
Beginning state; United Medical Center's mortality from Severe Sepsis and Septic Shock 3 times the national rates. UMC failing the Severe Sepsis/Septic Shock Bundles in the 3 hour bundle. Greater than 50% of failures related to initial lactate, repeat lactate, and administration of crystalloids 30ml/kilo. 60% of UMC ICU mortality related to severe sepsis/septic shock. Less than 10% of UMC severe sepsis/septic shock is identified in the ER.	See graphs.
Objective	**Follow up**

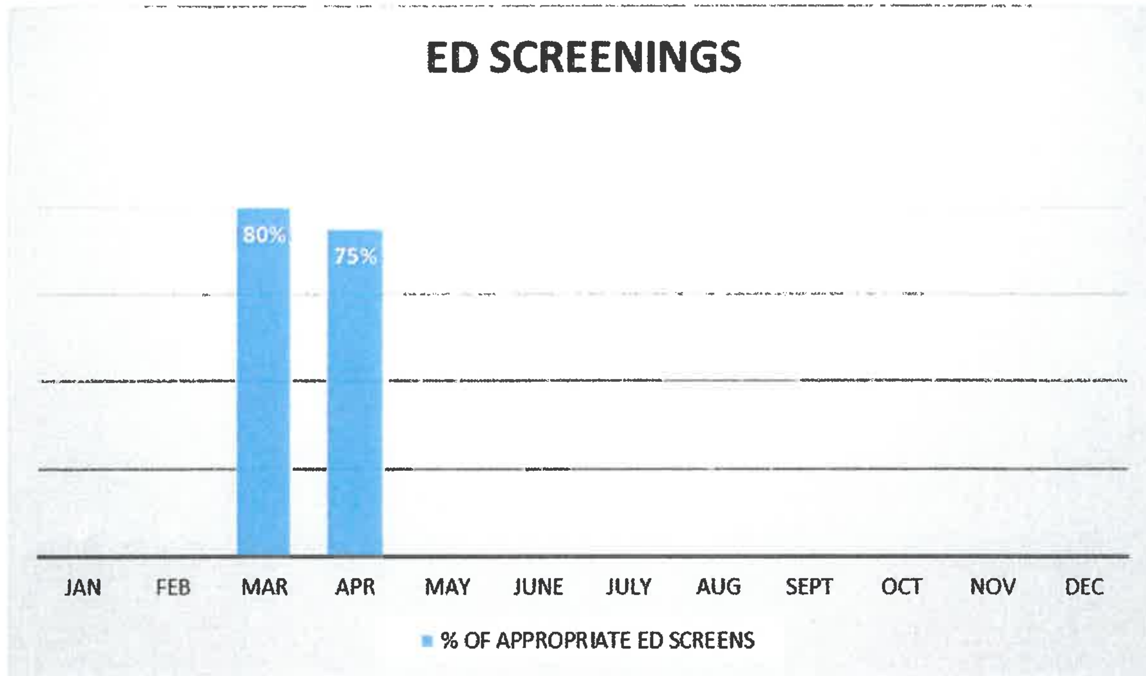
• Improve by 25% severe sepsis and septic shock provision of care and documentation to meet the 3 and 6 hour bundle within 3 months. • Reduce the mortality related to severe sepsis and septic shock by 25% in 2018. **Recognition- Early Goal Directed Therapy** • SIRS screening will occur in the ED at triage and at every shift inpatient • When Severe Sepsis/Septic shock criteria is met in the ED it will be placed on the tracking board for the physician and the nurse in the ED • When SIRS criteria plus organ dysfunction and suspected infection occurs inpatient outside if the ICU and ER, Rapid Reponses are called.	• Review each case to provide follow up to team members. • On-going staff education • Each unit to trend chart reviews on patients who arrests.
Root Cause Analysis	**Team Members**
• Electronic Health Record does not provide alerts • Care Pathways are not built into the Electronic Health Record • Documentation of provider notification and action not documented • Handoff of patients enrolled in the sepsis protocol from the ED to Inpatient units not in place • Inconsistent use of the severe sepsis order set • Sepsis policy not reflective of best practice • Knowledge deficit of the Severe Sepsis policy	. **Established Sepsis team;** • Tina Rein RN-C, BSN- Director of Quality, chair • Leslie N. Rodney, RN BSN,PI Coordinator, co-chair • Dennis Haghighat- Chief Medical Officer • Mina Yacoub MD- Chief of Staff • CNO • Jordan Warchol, MD- Emergency Services • Chief of Hospitalist • Doris Onyima RN, Assistant Director of Nursing Medical Surgical • Majeed Sanori RN, Clinical Supervisor Critical Care

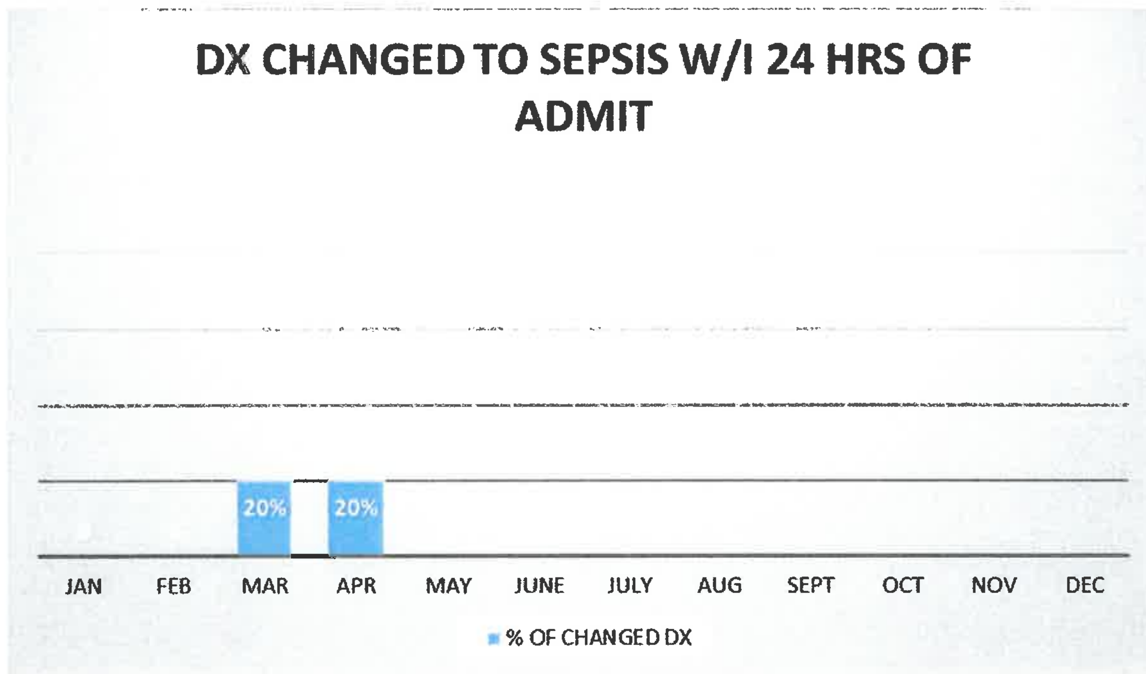
• Communication to providers when SIRS criteria met inconsistent • Best practice according Surviving Sepsis Guidelines is inconsistently being followed. • Delay in labs in the ED when SIRS criteria met • Lactate labs cancelled as duplication	• Fernando Calalin RN, Clinical Supervisor ER

ED ORDER SETS USED



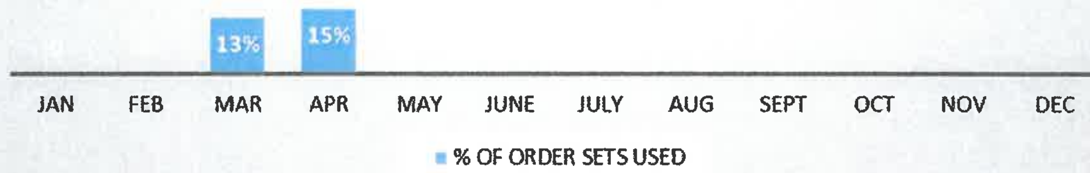
May 2018



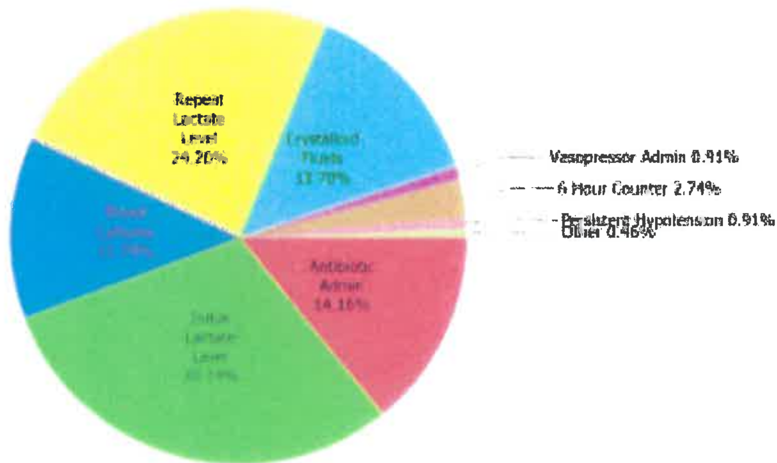


May 2018

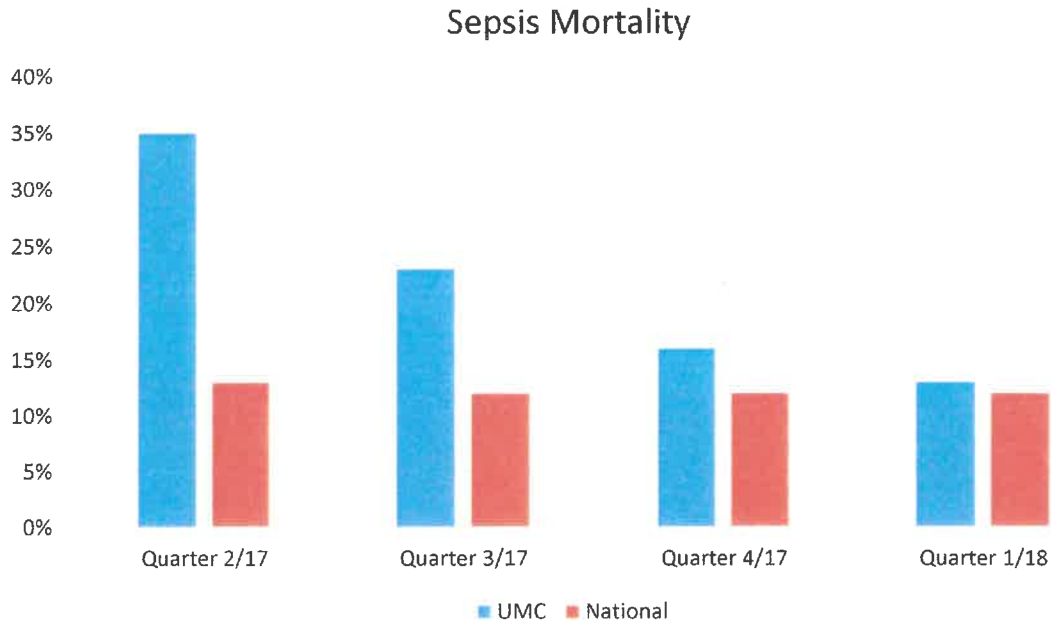
INPT ORDER SET USED



Sepsis Reasons for Failure



May 2018



Next Steps

- Nursing and Provider Education on the changes to the policy and use of Rapid Response for Resuscitation
- Develop a Severe Sepsis competency for annual review and orientation
- Developing a Bundle checklist for frontline staff to meet the 3 and 6-hour bundle
- ED Medical Director to review ED severe sepsis and septic shock cases
- A Quality nurse will be assigned to ED, Med surg, and ICU to partner with nursing leadership to Champion meeting the bundles

General Board Meeting
Date: June 27, 2018

Finance Committee Report

Wayne Turnage, Chair

UNITED
MEDICAL CENTER

Not For Profit Hospital Corporation
United Medical Center

Board of Directors Meeting
Preliminary Financial Report Summary
For the eight months ending May 31, 2018

Table of Contents

1. Gap Measures
2. Key Financial Information Summary
3. Key Indicators with graphs
4. Income Statement with Prior Year Numbers
5. Income Statement with Forecast Variances
6. Balance Sheet
7. Cash Flow

Gap Measures Tracking

Not-For-Profit Hospital Corporation
FY 2018 Actual Gap Measures
As of May 2018

	FY 2018 Original Gap Measures Gain/(Loss)	Adjustments	Realized	Balance	Percent Accomplished
May 2018 Annualized Net Income (Loss) from Operations:				($13,575,000)	
Add: Initiatives to be Realized					
Revenue Cycle:					
A. Documentation Enhancements/AR Review	$3,000,000	$0	$2,474,069	$525,931	82.5%
B. Charge Capturing (Infusion/Therapy)	$625,000	$0	$0	$625,000	0.0%
C. Hospital Based Clinics Charges	$816,000	($398,656)	$0	$417,344	0.0%
GWUMFA Professional Fees Collection	$1,225,000	$0	$161,420	$1,063,580	13.2%
GWUMFA Additional Cost	($2,700,000)	$0	$1,468,000	($1,232,000)	54.4%
Psych Volume Growth	$375,000	$0	$140,000	$235,000	37.3%
ER Admits Volume Increase	$1,225,000	$0	$100,389	$1,124,611	8.2%
Supply Chain Management	$3,010,000	$0	$190,000	2,820,000	6.3%
Overtime And Outside Agency Costs	$500,000	$0	$0	$500,000	0.0%
Length Of Stay Reduction	$200,000	$0	$0	$200,000	0.0%
FTE Reduction Of 20	$500,000	$0	$0	$500,000	0.0%
District Subsidy (Proposed)	$10,000,000	$0	$2,000,000	$8,000,000	20.0%
Adjusted Net Income (Loss) from Operations:	**$18,776,000**	**($398,656)**	**$6,533,878**	**$1,204,466**	**32.7%**

Key Financial Information Summary

- ❑ Comparative financials have been presented based on original forecast run-rate annualized and adjusted for gap measure initiatives which were originally slated to start in April 2018.
- ❑ Cash on Hand at the end of May 2018 was 17.31 days, excluding capital funds.
- ❑ The Month of May 2018 shows an operating gain of $1.9M which is a result of the $2.0M operational subsidy recognized.
- ❑ May 2018 year to date net operating loss totals $9.0M. The year to date loss annualized is $13.6M and can be attributed to Key Initiatives not yet realized. Below are updated on key areas of interest.

INITIATIVE WATCH:

- ❑ Revenue Cycle:
  - Clinical Documentation effort and extensive work on AR has contributed $2.5M year to date to net revenue due to the reprocessing of claims, to contract review and updates by management, and extensive AR work. Management is confident that it will accomplish the original projection of $3.0M.
  - Charge Capturing (Infusion/Therapy) has been reanalyzed and the $625K will be realized by year-end.
  - Hospital Based Clinic revenue projection of $816K has being re-analyzed based on current clinic volumes and this has resulted in a shortfall of $399K. Outside of the interface between E-Clinical Works (ECW) and Meditech, continued analysis will be performed to ensure that all regulatory requirements are being met and the projection will be reviewed and updated.
- ❑ Psych Volume Growth
  - Admission for the month of May exceeded the average admissions for the past seven months by 7 admissions and has contributed approximately $140K to the net patient revenues. This has been reflected in the gap volume increase initiative.
- ❑ ER Admits Volume Increase:
  - Admission for the month of May exceeded the average admissions for the past seven months by 37 admissions and has contributed approximately $100K to the net patient revenues. This has been reflected in the gap volume increase initiative.
- ❑ Supply Chain Management:
  - An analysis of Supply Chain Management is forthcoming.
- ❑ Overtime and Outside Agency Costs Reduction:
  - Overtime continues to be a challenge due to hard to fill positions.
- ❑ FTE Reduction:
  - FTE reduction related to OB overhead is ongoing until realized.
- ❑ District Subsidy:
  - For the Month of May $2.0M in other revenue is reflected as part of the $10.0M pledge for FY 2018.

Key Indicators

Key Performance Indicators	Calculation	Year to Date 05/31/2018				DC Hospitals	National Standard
		Prior Month	Actual	Forecast	FY 2017		
VOLUME INDICATORS:							
Admissions (Consolidated)	Actual Admissions	2,960	3,420	3,355	4,727	-	-
Inpatient/Outpatient Surgeries	Actual Surgeries	1,206	1,440	1,368	1,715	-	-
Emergency Room Visits	Actual Visits	32,886	37,927	38,072	39,357	-	-
PRODUCTIVITY & EFFICIENCY INDICATORS:							
Number of FTEs	Total Hours Paid/Total Hours YTD	842	842	839	839	-	-
Case Mix Index	Total DRG Weights/Discharges	1.32	1.32	1.07	1.14	1.04	1.04
Salaries/Wages and Benefits as a % of Total Expenses	Total Salaries, Wages, and Benefits /Total Operating Expenses	55.6%	55.2%	55.5%	58.1%	58.0%	58.2%
PROFITABILITY & LIQUIDITY INDICATORS:							
Net Account Receivable (AR) Days	Net Patient Receivables/Average Daily Net Patient Revenues	45	51	43	26	48	48
Net Account Receivable (AR) Days Inc. Unbilled*	Net Patient Receivables/Average Daily Net Patient Revenues	82	90	76	63	-	-
Cash Collection as a % of Net Revenue	Total Cash Collected/ Net Revenue	90.1%	90.5%	98.0%	99.0%	95.8%	95.8%
Days Cash on hand	Total Cash /(Operating Expenses less Depreciation/Days)	22	17	45	48	212	212
Operating Margin % (Gain or Loss)	Net Opearting Income/Total Operating Expenses	-17.6%	-12.7%	-3.6%	-2.2%	3.4%	3.4%

***Note:** Unbilled: Unbilled included in the Net AR days represents claims for in-house patients who are not yet discharged as well as discharged patients within the bill-hold review days.

Total Admissions (Consolidated)

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
FY 2018	482	420	397	435	426	399	401	460
Forecast 18	482	420	397	406	426	358	433	424
FY 2017	558	582	660	634	610	564	565	554

Less Nursery and OB for FY 2017

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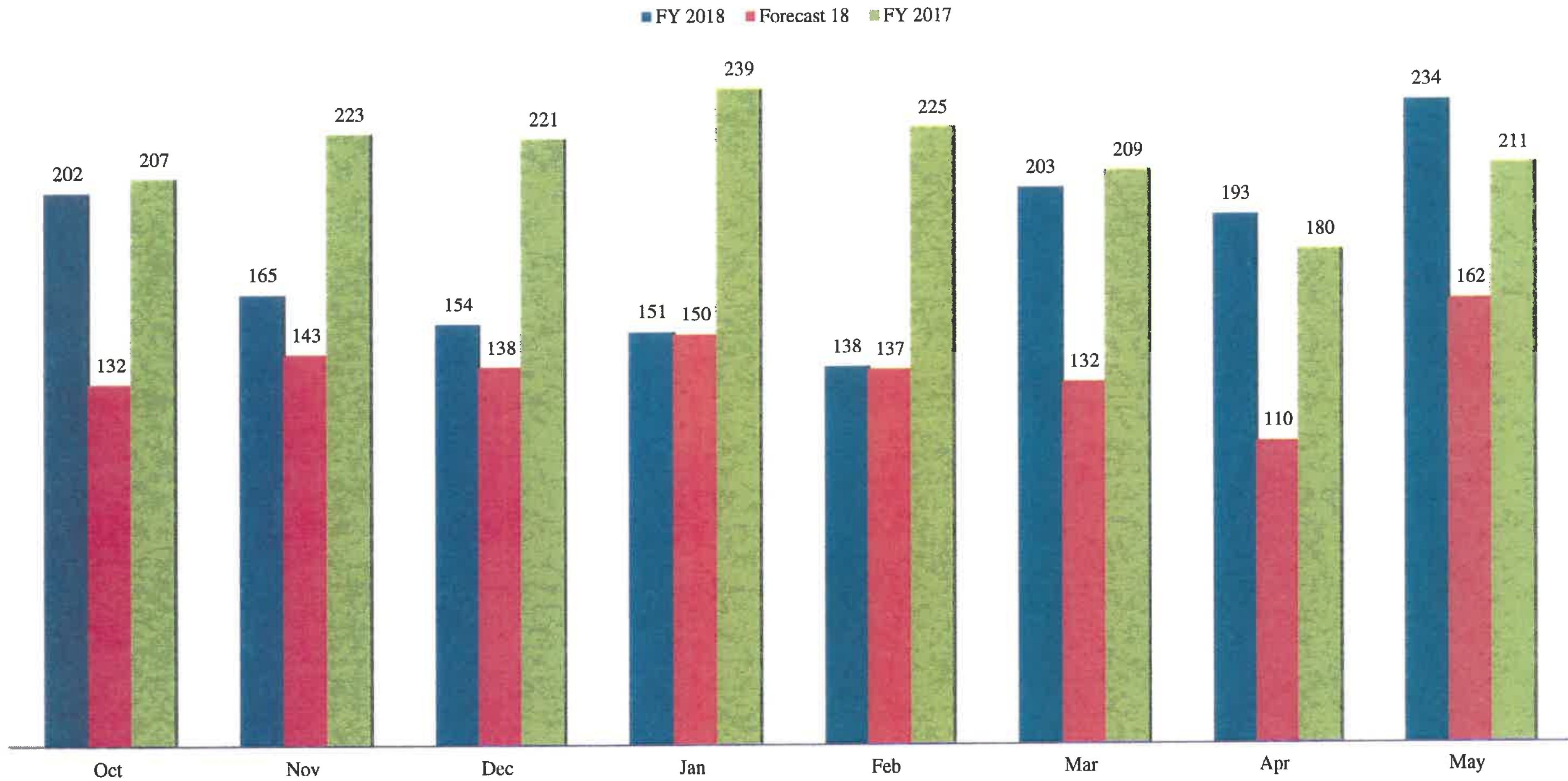
Inpatient/Outpatient Surgeries



Total Emergency Room Visits

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
FY 2018	4,881	4,576	4,624	4,884	4,496	4,722	4,703	5,041
Forecast 18	4,881	4,576	4,624	4,884	4,496	4,722	4,703	5,186
FY 2017	4,861	4,727	4,943	4,847	4,729	5,167	4,923	5,160

Number of FTEs

	FY 2018	Forecast 18	FY 2017
FTEs	842	840	837

Case Mix Index

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
FY 2018	1.2700	1.4000	1.3900	1.2800	1.3400	1.4300	1.3000	1.1600
Forecast 18	1.0700	1.0700	1.0700	1.0700	1.0700	1.0700	1.0700	1.0700
FY 2017	1.1400	1.0600	1.1300	1.1090	1.1600	1.1600	1.1600	1.2100

Salaries/Wages & Benefits as a % of Total Operating Expenses

54.4%
54.2%
54.0%
53.8%
53.6%
53.4%
53.2%
53.0%
52.8%

54.3%
54.1%
53.3%

FY 2018
Forecast 18
FY 2017

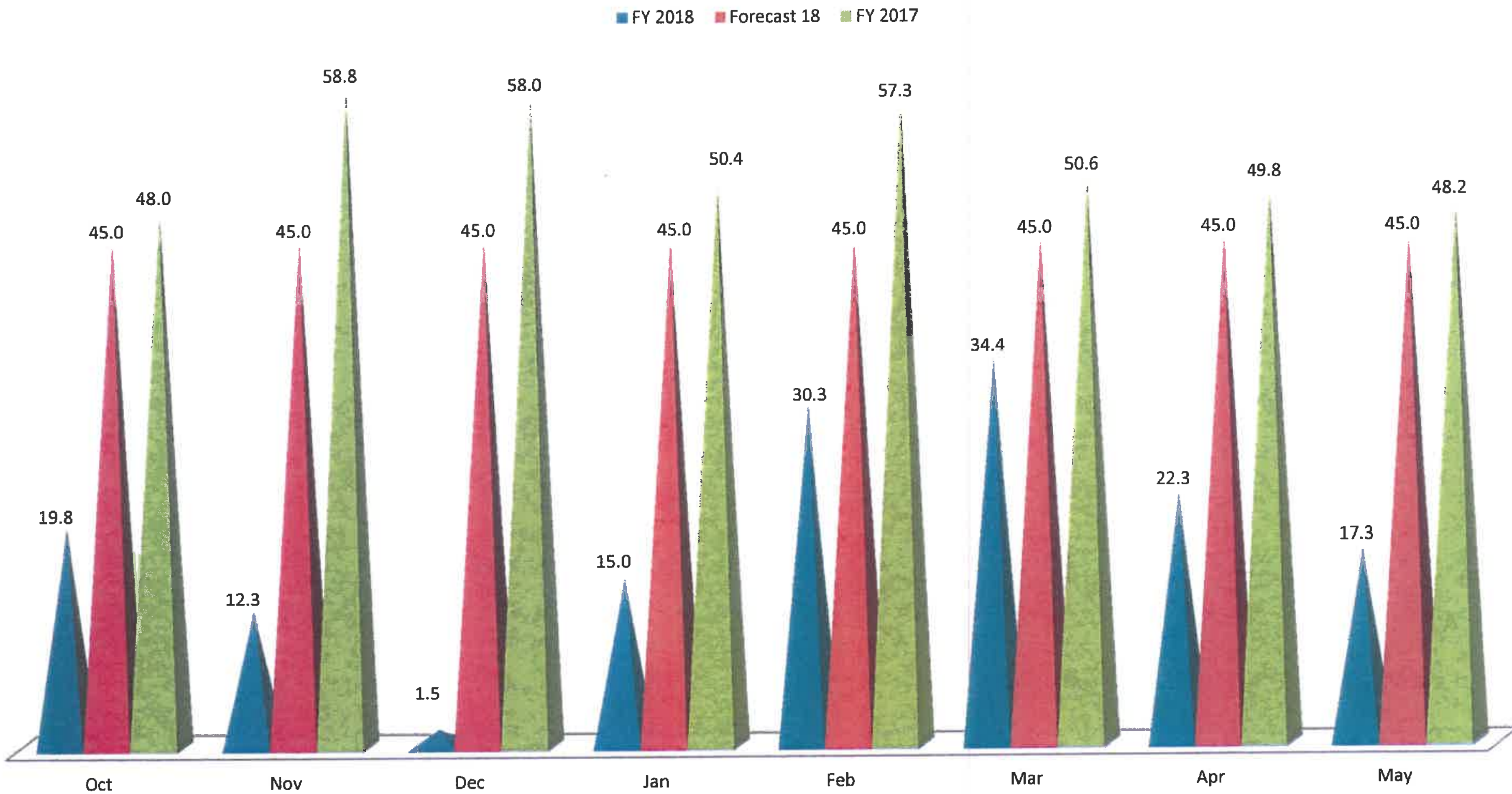
FY 2018
Forecast 18
FY 2017

Net Accounts Receivable (AR) Days With & Without Unbilled

Cash Collection as a % of Net Revenues

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
FY 2018	90%	86%	85%	86%	87%	88%	90%	91%
Forecast 18	83%	79%	90%	76%	81%	87%	84%	96%
FY 2017	97%	98%	97%	97%	100%	103%	101%	98%

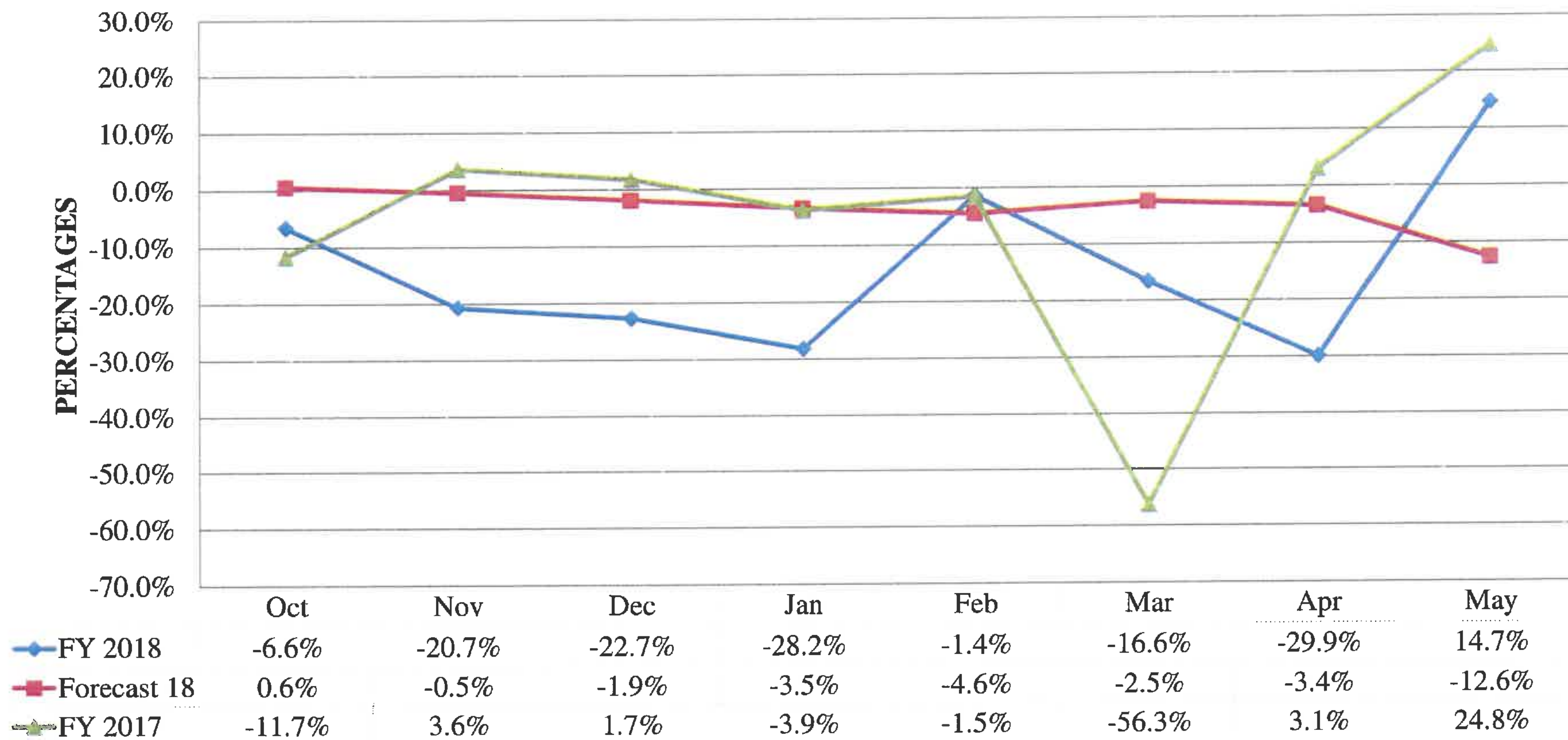
Days Cash On Hand



UNITED MEDICAL CENTER

UNITED
MEDICAL CENTER

Operating Margin % (Gain or Loss)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
FY 2018	-6.6%	-20.7%	-22.7%	-28.2%	-1.4%	-16.6%	-29.9%	14.7%
Forecast 18	0.6%	-0.5%	-1.9%	-3.5%	-4.6%	-2.5%	-3.4%	-12.6%
FY 2017	-11.7%	3.6%	1.7%	-3.9%	-1.5%	-56.3%	3.1%	24.8%

UNITED MEDICAL CENTER

Income Statement

FY18 Operating Period Ending May 31, 2018

	Month of May			Variance				2018 Year To Date			Variance			
	Actual	Forecast	Prior	Actual/Forecast		Actual/Prior		Actual	Forecast	Prior	Actual/Forecast		Actual/Prior	
Statistics														
Admission	460	424	554	36	8%	(94)	-17%	3,420	3,355	4,727	65	2%	(1,307)	-28%
Patient Days	5,825	6,240	6,537	(415)	-7%	(712)	-11%	47,224	47,639	52,401	(415)	-1%	(5,177)	-10%
Emergency Room Visits	5,041	5,186	5,160	(145)	-3%	(119)	-2%	37,927	38,072	39,357	(145)	0%	(1,430)	-4%
Clinic Visits	1,572	1,413	1,672	159	11%	(100)	-6%	12,223	13,119	13,120	(896)	-7%	(897)	-7%
IP Surgeries	117	71	114	46	65%	3	3%	671	634	813	37	6%	(142)	-17%
OP Surgeries	117	122	97	(5)	-4%	20	21%	769	734	902	35	5%	(133)	-15%
Radiology Visits	1,067	835	1,117	232	28%	(50)	-4%	7,740	7,508	8,860	232	3%	(1,120)	-13%
Revenues														
Net Patient Service Revenue	9,843	9,347	11,399	496	5%	(1,556)	-14%	56,249	55,755	67,652	494	1%	(11,403)	-17%
DSH	-	-	320	-	0%	(320)	0%	-		3,353	-	0%	(3,353)	0%
CNMC Revenue	231	269	270	(38)	-14%	(39)	-14%	1,870	1,908	1,816	(38)	-2%	54	3%
Other Revenue	3,255	1,430	877	1,825	128%	2,378	271%	19,553	17,413	6,573	2,140	12%	12,980	197%
Total Operating Revenue	**13,329**	**11,046**	**12,866**	**2,283**	**20.7%**	**463**	**3.6%**	**77,672**	**75,076**	**79,394**	**2,596**	**3.5%**	**(1,722)**	**-2.2%**
Expenses														
Salaries and Wages	4,797	5,294	4,695	(497)	-9%	102	2%	37,888	38,379	37,272	(491)	-1%	616	2%
Employee benefits	1,178	1,518	1,147	(340)	-22%	31	3%	9,988	10,327	9,864	(339)	-3%	124	1%
Contract labor	252	383	532	(131)	-34%	(280)	-53%	2,457	2,587	3,626	(130)	-5%	(1,169)	-32%
Professional fees	628	1,006	625	(378)	-38%	3	0%	6,007	6,385	5,946	(378)	-6%	61	1%
Supplies	955	901	881	54	6%	74	8%	7,553	7,231	7,193	322	4%	360	5%
Pharmaceuticals	316	546	267	(230)	-42%	49	18%	2,503	2,999	2,452	(496)	-17%	51	2%
Purchased services	2,648	2,011	1,254	637	32%	1,394	111%	14,469	13,831	9,281	638	5%	5,188	56%
Other	630	780	564	(150)	-19%	66	12%	5,857	5,998	5,483	(141)	-2%	374	7%
Total Operating Expenses	**11,404**	**12,439**	**9,965**	**(1,035)**	**-8.3%**	**1,439**	**14%**	**86,722**	**87,737**	**81,117**	**(1,015)**	**-1.2%**	**5,605**	**6.9%**
Operating Gain /(Loss)	**1,925**	**(1,393)**	**2,901**	**3,318**	**238%**	**(976)**	**-34%**	**(9,050)**	**(12,661)**	**(1,723)**	**3,611**	**29%**	**(7,327)**	**-425%**

May 2018 Income Statement with Forecast and Budget

	MAY 2018 YTD Actual	MAY 2018 YTD Forecast	MAY 18 YTD Actual /Forecast Var	YTD Variance %	Original 2018 Approved Budget	Adjusted 2018 Forecast Based on JAN 18
STATISTICS						
Admissions	3,420	3,355	65	2%	6,302	5,199
Patient Days	47,224	47,639	(415)	-1%	78,404	75,256
Emergency Room Visits	37,927	38,072	(145)	0%	57,529	62,707
Clinic Visits	12,223	13,119	(896)	-7%	18,619	18,546
IP Surgical Visits	671	634	37	6%	990	975
OP Surgeries	769	734	35	5%	1,006	994
OPERATING REVENUE						
Net Patient service revenue	$ 56,249	$ 55,755	494	1%	$ 115,972	$ 107,409
CNMC Revenue	1,870	1,908	(38)	-2%	3,023	2,902
Other Revenue	19,553	17,413	2,140	12%	6,436	29,734
Total Operating Revenue	**$ 77,672**	**$ 75,076**	**$ 2,596**	**3%**	**$ 125,431**	**$ 140,045**
OPERATING EXPENSE						
Salaries & Wages	$ 37,881	$ 38,379	$ (498)	-1%	$ 58,016	$ 58,785
Employee Benefits	9,988	10,327	(339)	-3%	14,476	16,797
Contract Labor	2,457	2,587	(130)	-5%	2,560	4,585
Professional Fees	6,007	6,385	(378)	-6%	8,473	11,027
Supplies	8,177	7,231	946	13%	9,938	10,327
Pharmaceuticals	1,885	2,999	(1,114)	-37%	3,381	2,451
Purchased Services	14,469	13,831	638	5%	18,857	24,720
Other	5,857	5,998	(141)	-2%	8,455	9,564
Total Operating Expense	**$ 86,722**	**$ 87,737**	**$ (1,015)**	**-1%**	**$ 124,156**	**$ 138,256**
Operating Gain / (Loss)	**$ (9,050)**	**$ (12,661)**	**$ 3,611**	**-29%**	**$ 1,275**	**$ 1,789**

Balance Sheet

As of the month ending May 31, 2018

May-18	Apr-18	MTD Change		Sep-17	YTD Change
			Current Assets:		
$ 29,241	$ 31,494	$ (2,253)	Cash and equivalents	$ 25,855	$ 3,386
20,218	17,886	2,332	Net accounts receivable	24,240	(4,022)
2,143	2,109	34	Inventories	1,904	239
5,998	3,561	2,437	Prepaid and other assets	2,898	3,100
57,600	55,050	2,550	Total current assets	54,897	2,703
			Long-Term Assets:		
235	235	-	Estimated third-party payor settlements	235	0
74,579	75,262	(683)	Capital assets	79,387	(4,808)
74,815	75,497	(683)	Total long term assets	79,622	(4,807)
$ 132,415	$ 130,547	$ 1,867	Total assets	$ 134,519	$ (2,104)
			Current Liabilities:		
$ -	$ 5	(5)	Current portion, capital lease obligation	$ 36	$ (36)
12,058	10,791	1,267	Trade payables	10,259	1,799
7,501	7,103	398	Accrued salaries and benefits	8,808	(1,307)
1,887	1,887	-	Other liabilities	1,979	(92)
21,446	19,786	1,660	Total current liabilities	21,082	364
			Long-Term Liabilities:		
7,374	8,443	(1,069)	Unearned grant revenue	1,328	6,046
3,534	3,522	12	Estimated third-party payor settlements	4,683	(1,149)
2,491	2,416	75	Contingent & other liabilities	2,016	475
13,399	14,381	(982)	Total long term liabilities	8,027	5,372
			Net Position:		
97,570	96,380	1,190	Unrestricted	105,410	(7,840)
97,570	96,380	1,190	Total net position	105,410	(7,840)
$ 132,415	$ 130,547	$ 1,868	Total liabilities and net position	$ 134,519	$ (2,104)

Statement of Cash Flow
As of the month ending May 31, 2018

Dollars in Thousands

Month of May Actual	Month of May Prior Year		Year-to-Date Actual	Year-to-Date Prior Year
		Cash flows from operating activities:		
$ 7,556	$ 11,042	Receipts from and on behalf of patients	$ 59,155	$ 71,225
(6,607)	(5,549)	Payments to suppliers and contractors	(41,049)	(36,858)
(5,577)	(5,302)	Payments to employees and fringe benefits	(49,176)	(45,666)
2,730	874	Other receipts and payments, net	6,193	11,254
(1,898)	1,065	Net cash provided by (used in) operating activities	(24,877)	(45)
		Cash flows from investing activities:		
		Proceeds from sales of investments		
		Purchases of investments		
-	-	Receipts of interest	-	-
-	-	Net cash provided by (used in) investing activities	-	-
		Cash flows from noncapital financing activities:		
-	-	Repayment of notes payable	-	-
-	-	Receipts (payments) from/(to) District of Columbia	21,248	-
-	-	Net cash provided by noncapital financing activities	21,248	-
		Cash flows from capital and related financing activities:		
(5)	(15)	Repayment of capital lease obligations	(36)	(73)
-	0	Receipts (payments) from/(to) District of Columbia	8,827	5,096
(350)	(1,631)	Change in capital assets	(1,776)	(13,206)
(355)	(1,646)	Net cash (used in) capital and related financing activ	7,015	(8,183)
(2,253)	(581)	Net increase (decrease) in cash and cash equivalent	3,386	(8,228)
31,494	**29,964**	**Cash and equivalents, beginning of period**	**25,855**	**37,611**
$ 29,241	**$ 29,383**	**Cash and equivalents, end of period**	**$ 29,241**	**$ 29,383**