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Monthly Board Meeting

Date: April 28, 2021

Location - Meeting link: https://unitedmedicaldc.webex.com/unitedmedicaldc/j.php?MTID=m5d00c0e612ad9277278535956d0d8848

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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 5:30pm on Wednesday, April 28, 2021. Due to the Coronavirus pandemic, the meeting will be held via WebEx.

Meeting link: https://unitedmedicaldc.webex.com/unitedmedicaldc/j.php?MTID=m5d00c0e612ad9277278535956d0d8848
Meeting number:132 681 0644 **Password:** AEeqmmmx352 **Via Phone:** +1-415-655-0001, **Access code:** 1326810644

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 - March 24, 2021

V. CONSENT AGENDA
- A. William Strudwick- Chief Medical Officer
- B. Dr. Gregory Morrow- Medical Chief of Staff
- C. Dr. Jacqueline Payne-Borden, Chief Nursing Officer

VI. EXECUTIVE MANAGEMENT REPORT
- A. Colene Daniel, Chief Executive Officer
- B. Brian Gradle, Chief Compliance Officer

VII. HUMAN RESOURCES REPORT
- A. Akia Embry, Employee Relations Specialist

VIII. CORPORATE SECRETARY REPORT
- A. Toya Carmichael, VP Public Relations/Corporate Secretary

IX. NFPHC COMMITTEE REPORTS

X. PUBLIC COMMENT

XI. OTHER BUSINESS
- A. Old Business
- B. New Business

XII. ANNOUNCEMENTS

XIII. ADJOURN

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)(1)(2)(4A)(5),(9), (10),(11),(14).

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General Board Meeting Date:

April 28, 2021

Reading and Approval of Minutes

Minutes Date:
March 24, 2021

Not-For-Profit Hospital Corporation
GENERAL BOARD MEETING
Wednesday, March 24, 2021 at 5:30pm
Held via WebEx

Absent:

Directors:
LaRuby May, Angell Jacobs, Velma Speight, Wayne Turnage, Dr. Konrad Dawson, Girume Ashenafi, CM Eydie Whittington, Dr. Malika Fair, William Sherman, Konrad Dawson, Millicent Gorham

UMC Staff: CEO Colene Daniel, Dr. Gregory Morrow, CMO, William Strudwick, CNO Dr. Jacqueline Payne-Borden, CFO Lillian Chukwuma, Corp. Sec. Toya Carmichael, CCO Brian Gradle, Derrick Lockhart

Mazars: Cheyenne Holland,

Other: Kai Blissett

Agenda Item	Discussion
Call to Order	By Chair May at 5:43pm. Quorum determined by Toya Carmichael Chair May acknowledged and spoke out against the violence against Asian Americans and asked that we take a moment of silence to remember the lives lost.
Approval of the Agenda	Motion to accept the agenda by Dir. Jacobs 2nd by Dir. Ashenafi, unanimous vote.
Approval of the Minutes	Motion by Dir. Speight 2nd by Dir. Ashenafi, unanimous vote.

Discussion	**CONSENT AGENDA** **CHIEF MEDICAL OFFICER REPORT: William Strudwick** • Chair May noted that we received a grant for diabetes treatment for twenty individuals and asked if we have identified the individuals and started their treatment yet? Dr. Strudwick noted that we have identified the individuals and we are now working on purchasing technology that our communities usually do not have access too. Chair May added to the extent that it is helpful to any of the patients that we are working with if it's helpful to the Senior Technology Officer for the city because the District is offering free Wi-Fi to seniors and students. **CHIEF OF MEDICAL STAFF REPORT: Dr. Gregory Morrow** • Chair May asked Dr. Morrow to speak to why our blood contamination levels are still high? Dr. Morrow stated that he has met with the ED and ICU and they have instituted a new process for certain patient blood draws to be administered by lab staff instead of ED staff. Right now there are not enough lab staff available to take blood draws for all the patients in the ED. Chair May asked if it is a staff issue from a manpower and competency standpoint? Dr. Morrow stated yes, the ED staff require additional training. • Dr. Fair asked about the letter from Dr. O'Connell to Dr. Strudwick regarding the ED. Dr. Strudwick said that he has had a discussion with Dr. O'Connell. Dr. Fair asked Dr. Strudwick to give an update on Walgreens' handling of the vaccination clinic. Dr. Strudwick provided a background as to why Walgreens was brought in and noted that the biggest change is that now all the appointments are being made through the DC portal except for UMC staff. The hours have also changed to Tues-Sunday and Walgreens is also charging an administration fee to a patient's insurance company. Dr. Fair asked about the charges. Dr. Strudwick stated they are charging insurance but if a patient does not have insurance they are not turned away. • CM Whittington noted that she is really concerned about the ED. It seems to her from her reading and attendance at these meetings, this being her second that the ED is not equipped to handle emergencies. Dr. Strudwick said that she should not have that impression, we are equipped to handle the type of emergencies that come into the hospital. We are not a trauma center so ambulances do not bring those patients here. The physicians in the ED are GW physicians.

- Chair May noted that in the future when the hospital engages a relationship with a new public facing provider in the hospital like Walgreens, the board should be notified. Chair May noted that she was not notified and received news that Walgreens is here from the public and received photos of seniors standing outside and complaints about the process.

CHIEF NURSING OFFICER: Dr. Jacqueline Payne-Border

- No questions or comments from the board.

Motion to accept the MCOS and CNO reports by Dir. Jacobs, 2nd by Dr. Fair. Unanimous vote.

EXECUTIVE MANAGEMENT REPORT: CEO Colene Daniel

- Colene apologized to the board for not notifying them about the Walgreens partnership. We have been focused on trying to make this work. Today, we asked DOH to come out and witness for themselves how things are going.
- Dr. Strudwick noted that our first priority is to maintain the good reputation we have established for our vaccine clinic. Tuesday was an anomaly because we started on Tuesday and everyone who had been scheduled for Monday came on Tuesday all at 9am. Today we went back to our normal cadence and we will not have a "Tuesday like" experience again.
  Chair May asked that we continue to figure out how folks in our community can make appointments via phone. We know there is a digital divide in our community so we must continue to work to make sure folks have access.
- Chair May asked for an update on the issues noted as high on the Safer Matrix. Colene stated that once the Joint Commission comes in and notes something as high, it will stay at high until it is inspected and approved by JC. We are moving really well and we will be more than ready for a revisit long before April 30th.
- Chair May asked how much we pay Indeed? Colene responded that she will email that information to Chair May tomorrow. Chair May noted that she has heard from community members that they have issues applying via Indeed so she wants to know if we are getting our money's worth.
- Dr. Fair asked about the increase in violence from certain patients that was reported out during the PI meeting? Colene noted yesterday there was a meeting with six hospitals including UMC on this issue because across the District hospitals are experiencing an increase in violence. There will be another meeting with…so we can identify steps to address this. We presented a report to the police department detailing the type of weapons, guns, knives, machetes etc. that patients

	are coming in with when brought in by MPD. We assumed MPD or the EMTs would search them. In asking DCHA to look into this, we learned that other hospitals are experiencing the same thing. Colene provided number of FD-12 related incidents in January and February. It takes 3 security officers to handle an FD-12 patient so we have worked to back fill security positions and Derrick has worked to get more off duty police officers in the hospital on every shift. • Dir. Bobb asked what an FD-12 patient is? Colene explained that an FD-12 is an involuntary mental health patient. They come in through the ED and after they are screened for COVID they are admitted to the BHU Unit. Dir. Bobb asked if the Dept. of Mental Health has been involved? Colene said yes, they were part of the meeting yesterday but CPAP is full and the city has an increase of FD-12 patients. • Chair May asked Colene to disclose how many hospitals in the District accept FD-12 patients. Colene noted only three hospitals in the District accept FD-12 patients. • Dr. Jacque noted that FD-12 means they are involuntary so these patients are usually combative right off the bat. • Dir Whittington asked what is our capacity for FD-12 patients. Colene noted that we have 3 rooms in the ED and 32 beds on BHU but because of COVID we can't use all the beds so our average is about 18. Chair May noted that CPAP is located by the DC jail so that is why we get more patients. • Dr. Jacque noted they are involuntary and likely a danger to themselves or others. Within 72 hours they can switch to voluntary. Clarified that how they come in varies sometimes MPD or ambulances but when family members bring them in, they have to go to CPAP for the FD-12 designation. • Chair May noted that we have improved tremendously but at one time we were not getting consideration from DOH because we had a number of FD-12 patients leaving when we are responsible for their care. So where it may seem extreme and costly to have 3 staff members treat an individual this cost is much better than the costs of them leaving and endangering themselves. • Dir. Jacobs noted that 40% of our staff have been vaccinated and asked if UMC has any programs in place to encourage more staff to get vaccinated. Dr. Strudwick noted the programs we have in place and now with Walgreens any staff member who wants to get vaccinated can just walk up and show their badge and get vaccinated. Chair May noted that DM Turnage had an idea for board members and their families to come and receive the vaccine to encourage staff to get vaccinated. Dr. Strudwick noted the nurses are on the low side and our physicians are on the higher side and then it varies with other groups. We have used influencers and walk and talk to people throughout the hospital but there is still resistance due to our history so at this point people still want to wait and see how the side effects impact those who have been vaccinated.

- Dir. Whittington shared her surprise that frontline healthcare workers are not mandated to receive the vaccine. Chair May asked if she could mandate the vaccine and was told that we cannot at this time because the vaccines have only been approved for emergency use.

CHIEF COMPLIANCE OFFICER – Brian Gradle

- No questions or comments from the board.

Motion to accept CEO and CCO reports by Dir. Speight, 2nd Dir Ashenafi. Unanimous vote.

HUMAN RESOURCES REPORT: Trenell Bradley

- Chair May asked for an update on the union negotiations.
  Akia Embry noted that Lillian and Roosevelt have been present at the last few meeting. We are down to 12 of the total 190 positions and we continue to try and get this contract done and signed. We understand and have explained to the union some of the financial constraints the hospital is experiencing currently.

Motion to accept by Dir. Jacobs, 2nd by Dir. Speight. Unanimous vote.

CORPORATE SECRETARY: Toya Carmichael

- No questions or comments from the board.

Motion to accept management report by Dir. Jacobs, 2nd by Dr Fair. Unanimous vote.

	COMMITTEE REPORTS **PERFORMANCE IMPROVEMENT: Dr. Fair** • Directed Board members' attention to page 106 of the board book to highlight the increase in positive feedback from patients. • Chair May asked if we are also capturing feedback from patients in the vaccination clinic. **FINANCE COMMITTEE: DM Turnage** • $7-8million dollar range. The CFO is also keeping us focused on what the hospital's cash needs are in April we may be in a situation where we have to get dollars from the Executive to meet payroll. DM Turnage and Dir. Jacobs are working on a way to do this that does not trigger a reconstitution of the board. So those are things we are focusing on as the Closure Committee is formed and while the operator continues to work on the reduction plan. What the committee needs this evening is a vote on the financials. Mot to accept the financial committee report including the by Dir. Bobb, 2nd by Dir. Ashenafi. **AUDIT COMMITTEE: Dir. Speight** • No items for open discussion. **GOVERNANCE COMMITTEE: Dr. Dawson** • No items for open discussion.
Public Comment	No public comment.

	.
Other Business	N/A
Closed Session	
Announcements	During closed session the board voted to approve the amendment to the bylaws committee as presented by the MEC adding mostly in part a Vice Chair designee and accepted credentials, change in status, reappointments, resignations, and recognition presented by the medical staff and voted to approve the contract for our operator Mazars.
Adjourned.	Motion to adjourn by Dir. Speight, 2nd by Dir. Jacobs. Unanimous vote meeting adjourned at 7:26pm.

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General Board Meeting

Date: April 28, 2021

Consent Agenda

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General Board Meeting

Date: April 28, 2021

CMO Report

Presented by:
Dr. William Strudwick
Chief Medical Officer

Not-For-Profit Hospital Corporation
CMO March 2021 Report & Accomplishments

Respectively submitted by William Strudwick, MD

During my fourth month as the NFPHC/UMC Chief Medical Officer, we have been solidifying our collaboration with Walgreens to create a daily high volume vaccination clinic here on our campus. Other important events include the on-boarding of our new Director of Case Management & Social Work, Paul Oriaifo, MD, and the resignation of our Director of Quality & Performance Improvement.

COVID-19 Vaccination:

- Because of the success of our clinic in vaccinating our community in Ward 7 and 8, we were approached by DC Health and the DCHA asking us to consider a collaboration with Walgreens to increase our weekly volume from approximately 700 vaccines to more than 2000 – in order to serve our community better. Walgreens would receive the vaccine allotments, provide supplies, administer the doses, and do the required reporting. We met with Miranda Cobbs who is the regional pharmacy manager for Walgreens, and we discussed the arrangement including reviving one of our previous plans to move the vaccine clinic to the old dialysis building. That building is now prepared and it will work to re-direct this high volume of traffic away from the hospital proper.
- We began this collaboration March 17th and we are gradually ramping up our numbers. Notable changes include that all of the appointments are made through the DC portal, assuring that our priority population actually are residents of Ward 7 and 8. Additionally any UMC employees with proper ID may walk in. The new schedule includes weekend hours Tuesday through Sunday 9am-5pm. Another big change is that Walgreens does collect insurance information and charges for the administration. The upcoming MOU will consider what portion of those dollars will be paid to UMC for the space, security, EVS, and administrative and medical oversight.
- The bottom line is that we will have a high output vaccination clinic on our campus without the financial and time burdens of personnel, supplies, scheduling, or reporting. Our high-level oversight will make sure that the quality of the service remains at the level that the community deserves.

Medical Staff Office/Physician Recruitment:

- The Medical Staff office continues to work with the MD-Stat software platform to create an automated process to perform timely OPPE.
- Two new Medical Staff members were oriented: Nicole Albertson, PA-C and James Phillips, MD.
- Quarterly Medical Staff meeting was held on March 10th; Mortality and Morbidity conference was presented by Caitlin Mingey, MD on March 17th; Grand Rounds was presented by Brian Gradle on March 17th – the topics were documentation compliance, fraud and abuse.
- Physician Contracts are being reviewed and appropriately updated considering community needs, productivity, and sustainability.

Quality & Performance Improvement/Infection Prevention & Control:

- With sudden resignation of the Director of Quality & Performance Improvement, the Quality Managers Leslie Rodney, and Tracy Follin have stepped up to seamlessly maintain Quality, Regulatory Compliance, Survey Readiness, Reporting, and performance Improvement.
- We continue to work closely with DC Health to prevent any further COVID-19 outbreaks among patients and staff on the med-surg units. Measures include surveillance testing, cohorting COVID -19 patients on 8W and ICU, handwashing, PPE compliance, and having dedicated staff, by shift, for COVID -19 patients.

Case Management:

- The Brundage Group outsourced contract that supported Case Management ended in March.
- We were fortunate to recruit an experienced Case Management leader, Paul Oriaifo, MD, as Director of Case Management & Social Work. We are also onboarding several new Case Managers and Social Workers.
- Case Manager and Social Work coverage was changed from Team based to Unit based to improve simplicity and consistency of coverage.
- The "Gatekeeper" review process is progressively improving to place patients in the appropriate status on admission. The goal is to eliminate denials from MCOs and other payers.

Patient Advocacy:

- March Press Ganey score for the Emergency Department is 39 which has decreased from the previous month of 54. Although the overall score for the Department decreased, the trend is still positive and the number of the respondents to the survey continues to increase. Focused improvement for the ED included wait times and communication with doctors and nurses.
- March Press Ganey score for inpatient is 50, which meets our set benchmark; however, decreased from the previous month of 64. Focused improvement for inpatient included hospital environment, communication regarding medications, and communication with nurses.

Other:

- Through a Medical Informatics grant, Ms. Cherrel Christian, Diabetic Educator, has begun distributing the Dexcom continuous glucose monitoring system to selected diabetics in the Primary Care Clinic – at no cost to the patients. Immediate positive outcomes for the patients have included better glucose control, improved food portion awareness, and significant weight loss.

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General Board Meeting Date:
April 28, 2021

Medical Chief of Staff Report

Presented by:
Dr. Gregory Morrow
Medical Chief of Staff

Amaechi Erondu, M.D., Chairman

MARCH 2021

PERFORMANCE SUMMARY:
Our total volume for all surgical cases for March 2021 was 133 while the February 2021 was 142.

QUALITY INITIATIVES AND OUTCOME:
SCIP protocols are ensured for all our patients with no fall-outs. Surgical and anesthesia time outs followed per protocol including preoperative antibiotics, temperature monitoring and all relevant quality metrics. All relevant quality metrics documented in the various anesthesia record for easy access and reference.

ANESTHESIA INFORMATION MANAGEMENT SYSTEM (AIMS)
The current Anesthesia documentation remains challenging. The Meditech upgrade does not include anesthesia documentation capability. We created Order sets for most the regular orders we provide. The Meditech does not have the capability for anesthesia documentations for Preoperative and IntraOperative documentation. We have gone through several cycles of AIMS acquisition.

Attached is the typical anesthesia document as archived by Medical Records. We photocopy these documents severally. As shown, the clarity of the documentation is quite questionable especially as a reference medical document.

VASCULAR ACCESS SERVICE:

	PIV	ACCUCATH/ POWERGLIDE	MIDLINE	PICC	TOTAL
2020 CENSUS					
JANUARY	162		11	3	176
FEBRUARY	168		12	3	183
MARCH	110	25	15	3	158
APRIL	115	35	10	4	164
MAY	102	28	30	3	163
JUNE	94	25	20	4	143
JULY	87	27	11	4	129
AUGUST	134	35	13	0	182
SEPTEMBER	92	23	4	1	120
OCTOBER	72	21	4	0	97
NOVEMBER	110	22	13	2	145
DECEMBER	91	25	17	4	137
TOTAL	**1337**	**266**	**164**	**31**	**1798**

PAIN MANAGEMENT SERVICE
We are facilitating the chronic pain management to ensure adequate service coverage for hospital inpatient.

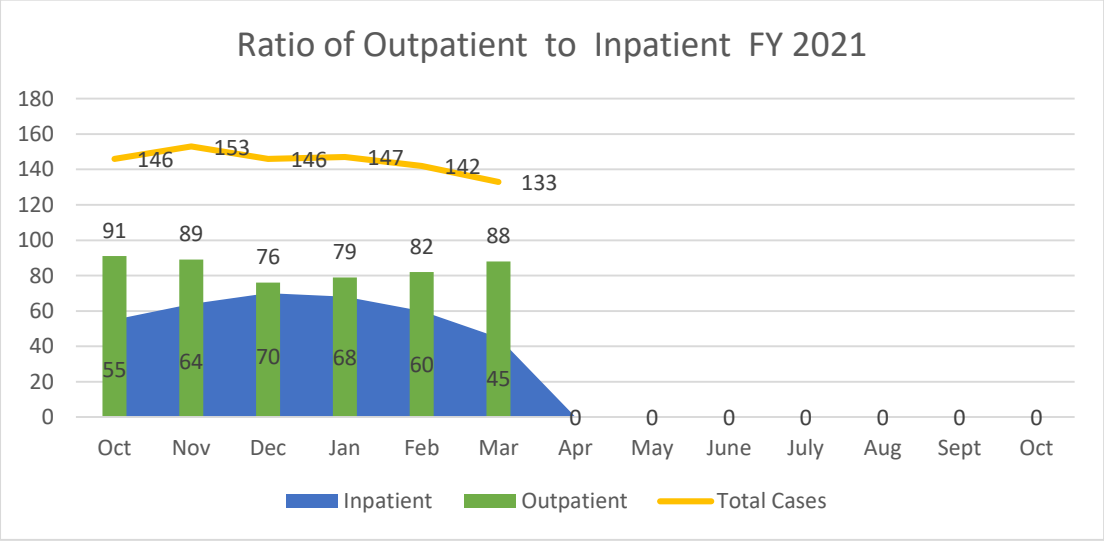
Interventional Pain Management service has recommenced service slowly and ramping up the volume. As shown in the chart below, *Pain management service provides the next highest OR volume and is among the top 3 high volume services*.
Radiofrequency ablation (RFA) has commenced as we increase awareness of the service in the region.

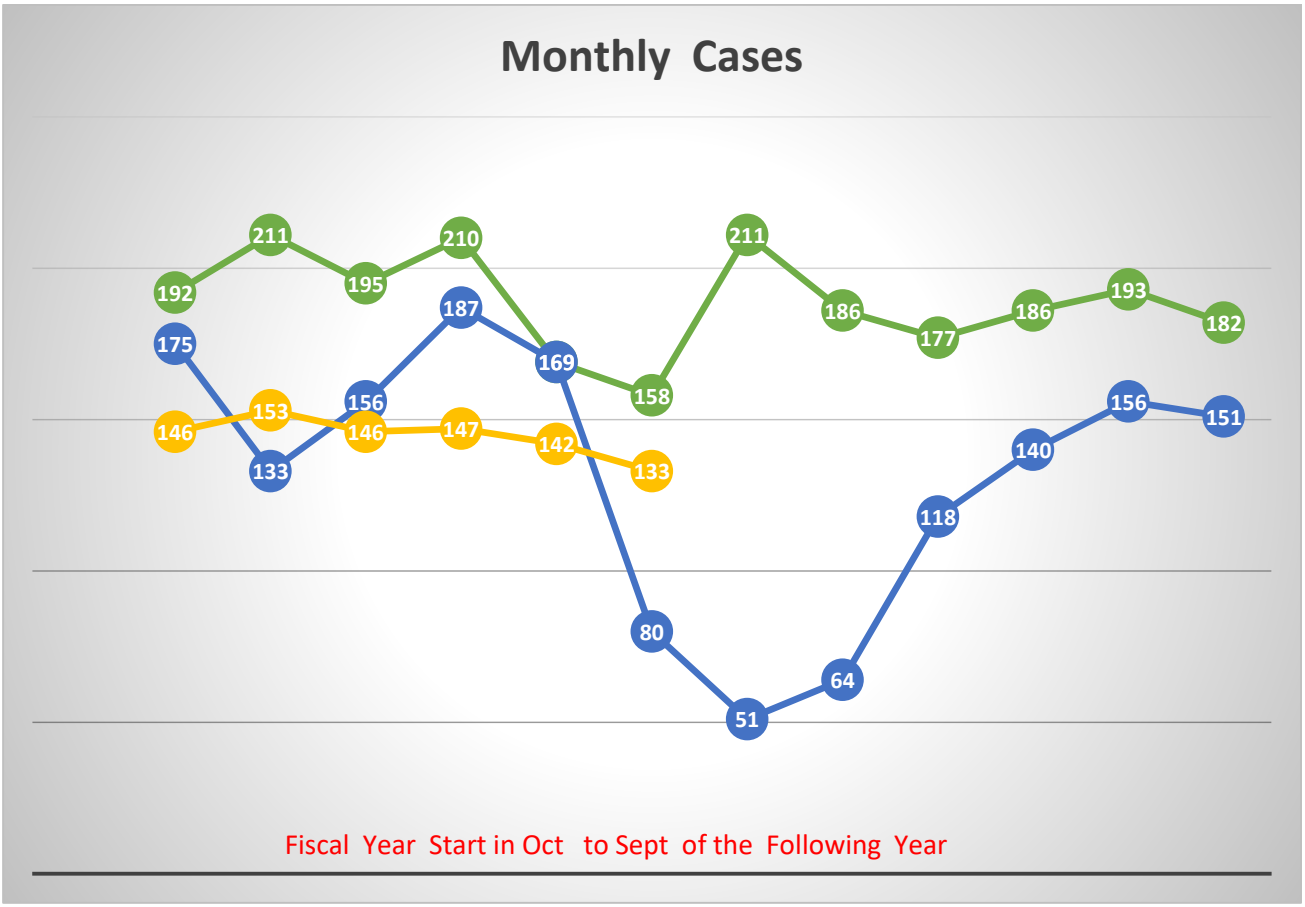
Spinal Cord Stimulation Trials: This a new service offered by the Pain management. It is important to note that, UMC is the only center that offers this service in the area. This will drive enormous revenue for the hospital as we increase the service.

OR UTILIZATION
Our current utilization has decreased due to low surgical volume. We accommodate cases to ensure appropriate staff utilization.

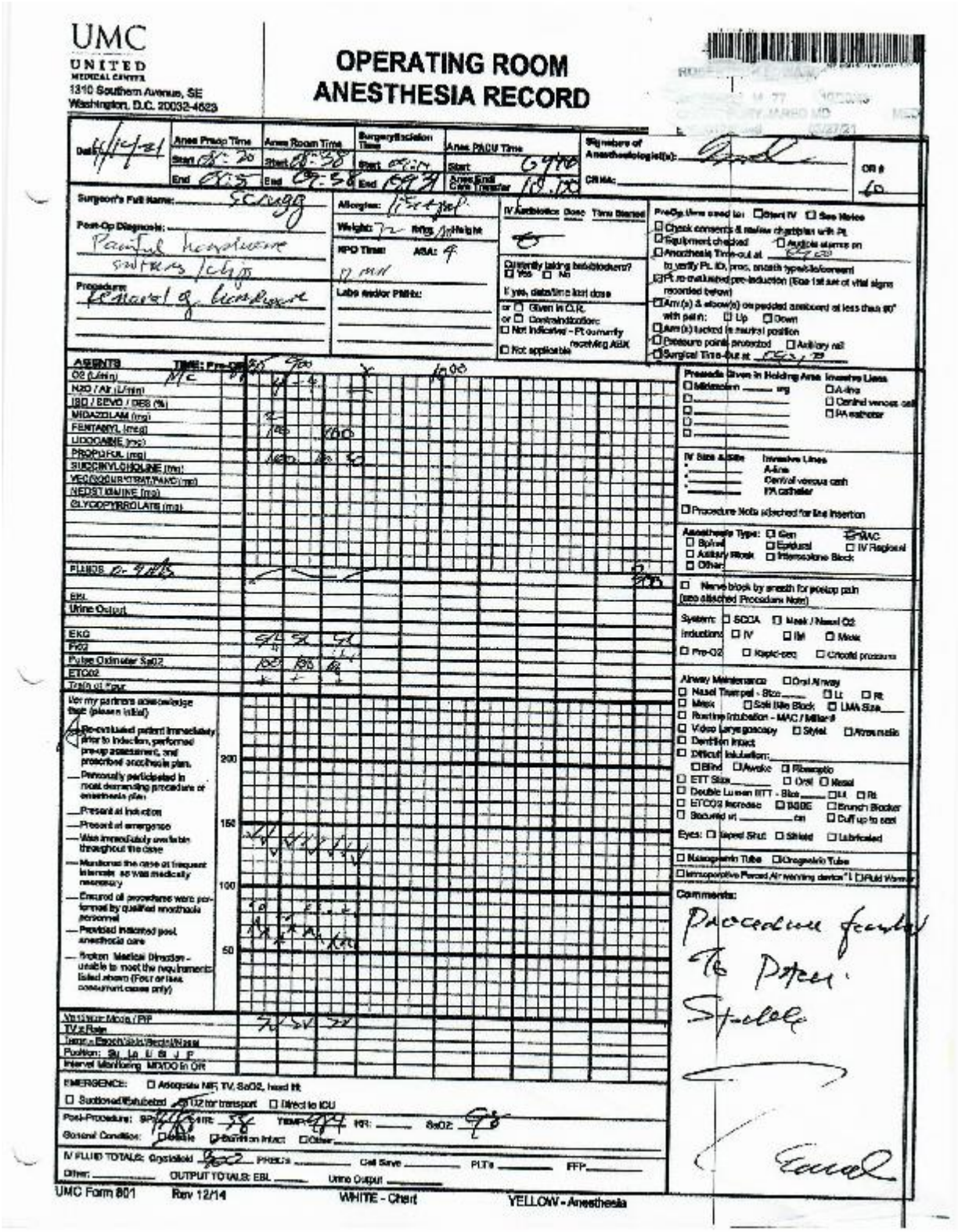
EVIDENCE-BASED PRACTICE AND PRACTICE MANAGEMENT.
Virtual **Mortality and Morbidity Conference** will continue. We are working on developing a Traumatic Brain Injury Protocol for the hospital.

MONTH	2018	2019	2020	2021
JAN	150	210	187	147
FEB	181	169	167	142
MARCH	204	158	80	133
APRIL	177	211	51	
MAY	219	186	64	
JUNE	213	177	118	
JULY	195	186	140	
AUG	203	193	156	
SEPT	191	182	151	
OCT	211	175	146	
NOV	195	133	153	
DEC	192	156	146	
TOTAL	2,331	2136	1559	





NAME	Oct	Nov	Dec	Jan	Feb	Mar	Total
Abdullah , L	0	3	0	0	1	2	5
Berkeblitt ,S.	7	3	2	4	3	1	20
Brownlee III, W	1	8	1	3	9	5	26
Byam .J	10	7	11	12	8	13	**61**
Cadieux,K	6	0	2	0	1	0	3
Craig, J	0	0	1	0	1	0	2
Frazier ,A	5	5	3	4	1	3	21
Khalilzadeh,J	3	9	1	12	5	8	38
Morrow ,G	21	12	18	13	13	12	**89**
Nedd , W	16	27	20	26	19	5	**113**
Nwachucku,A	22	17	16	18	13	24	**110**
Nwuju ,I	1	0	6	1	1	1	10
Oke ,Luc	2	4	1	3	2	1	13
Perez ,D .	1	1	1	1	0	0	4
Proctor ,S	2	6	2	3	3	3	19
Ramineni , S	0	1	0	1	1	0	3
Rezazadeh ,A	6	3	1	6	4	7	27
Scruggs ,M	3	2	6	2	2	1	16
Shaigany , A	48	54	47	38	53	42	**282**
Wilder , D	0	0	0	0	0	1	1



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1310 Southern Avenue, SE
Washington, D.C. 20032-4523

OPERATING ROOM ANESTHESIA RECORD

Date: 4/16/21 | Anes Preop Time: Start 0820 End 0835 | Anes Room Time: Start 0838 End 0958 | Surgery/Incision Time: Start 0917 End 0947 | Anes PACU Time: Start 0948 | Anes End / Care Transfer 1018 | Signatures of Anesthesiologist(s): | CRNAs: | OR # 40

Surgeon's Full Name: Scruggs
Post-Op Diagnosis: Painful hardware
Procedure: Removal of hardware

Allergies: Versed
Weight: 72 kg/lb Height
NPO Time: ASA: 4
17 min
Labs and/or PMHx:

IV Antibiotics: Dose: Time Started:
Currently taking beta-blockers? ☐ Yes ☐ No
If yes, date/time last dose
or ☐ Given in O.R.
or ☐ Contraindications:
☐ Not Indicated - Pt currently receiving ABX
☐ Not applicable

Pre-Op Urine used for: ☐ Start IV ☐ Sex Waiver
☐ Check consents & review chart/plan with Pt.
☐ Equipment checked ☐ Anesthesia alarms on
☐ Anesthesia Time-out at 0820
to verify Pt. ID, proc, anesth type/site/consent
☐ Pt re-evaluated pre-induction (See 1st set of vital signs recorded below)
☐ Arm(s) & elbow(s) on padded armboard at less than 90° with palm: ☐ Up ☐ Down
☐ Arm(s) tucked in neutral position
☐ Pressure points protected ☐ Axillary roll
☐ Surgical Time-Out at 0917

AGENTS — TIME: Pre-Op 0825 0900 1000
O2 (L/min) MC
N2O / Air (L/min)
ISO / SEVO / DES (%)
MIDAZOLAM (mg)
FENTANYL (mcg) 100 100
LIDOCAINE (mg)
PROPOFOL (mg) 100 50
SUCCINYLCHOLINE (mg)
VECURONIUM/ATRACURIUM (mg)
NEOSTIGMINE (mg)
GLYCOPYRROLATE (mg)
FLUIDS 0-900 900
EBL
Urine Output
EKG
P/O2
Pulse Oximeter SaO2 100 100 100
ETCO2
Train of Four

Presedex Given in Holding Area — Invasive Lines
☐ Midazolam ____ mg ☐ A-line
☐ ☐ Central venous cath
☐ ☐ PA catheter
☐ ☐

IV Size & Site — Invasive Lines
• ____ A-line
• ____ Central venous cath
• ____ PA catheter
☐ Procedure Note attached for line insertion

Anesthesia Type: ☐ Gen ☐ MAC ☐ Spinal ☐ Epidural ☐ IV Regional ☐ Axillary Block ☐ Interscalene Block ☐ Other:

☐ Nerve block by anesth for postop pain (see attached Procedure Note)

System: ☐ SGDA ☐ Mask / Nasal O2
Inductions: ☐ IV ☐ IM ☐ Mask
☐ Pre-O2 ☐ Rapid-seq ☐ Cricoid pressure

Airway Maintenance ☐ Oral Airway
☐ Nasal Trumpet - Size ____ ☐ Lt ☐ Rt
☐ Mask ☐ Soft Bite Block ☐ LMA Size ____
☐ Routine Intubation - MAC / Miller #
☐ Video Laryngoscopy ☐ Stylet ☐ Airtraq/Glidescope
☐ Dentition intact
☐ Difficult Intubation: ____
☐ Blind ☐ Awake ☐ Fiberoptic
☐ ETT Size ____ ☐ Oral ☐ Nasal
☐ Double Lumen ETT - Size ____ ☐ Lt ☐ Rt
☐ ETCO2 Increase ☐ BIS/BE ☐ Bronch Blocker
☐ Secured at ____ cm ☐ Cuff up to seal
Eyes: ☐ Taped Shut ☐ Shield ☐ Lubricated

☐ Nasogastric Tube ☐ Orogastric Tube
☐ Venoocclusive Pressure Air warming device* ☐ Fluid Warmer

Comments:
Procedure fourth
To Patient
Stable

Per my partners acknowledge that: (please initial)
☐ Pre-evaluated patient immediately prior to induction, performed pre-op assessment, and prescribed anesthesia plan.
☐ Personally participated in most demanding procedure or assessments plan
☐ Present at induction
☐ Present at emergence
☐ Was immediately available throughout the case
☐ Monitored the case at frequent intervals as was medically necessary
☐ Ensured all procedures were performed by qualified anesthesia personnel
☐ Provided indicated post anesthesia care
☐ Broken Medical Direction - unable to meet the requirements listed above (Four or less concurrent cases only)

Ventilator Mode / PIP
TV / Rate
Insp. n Breath Vitals / Rectal / Nasal
Position: Sp Le L R J F
Interval Monitoring: MD/DO in OR

EMERGENCE: ☐ Adequate MF, TV, SaO2, head lift
☐ Suctioned/Extubated ☐ O2 for transport ☐ Directly to ICU
Post-Procedure: BP 110/70 HR: 58 TEMP 97.4 HR: ____ SaO2: 98
General Condition: ☐ Stable ☐ Dentition Intact ☐ Other:

IV FLUID TOTALS: Crystalloid 900 PRBCs ____ Cell Save ____ PLTs ____ FFP ____
Other: ____ OUTPUT TOTALS: EBL ____ Urine Output ____

UMC Form 801 Rev 12/14 WHITE - Chart YELLOW - Anesthesia

Amaechi Erondu, M.D.
Chairman, Anesthesiology Department

Mina Yacoub, M.D., Chairman

MARCH 2021

UMC ICU COVID-19 DATA TO DATE

As of April 9th, 2021 the ICU managed 131 patients with Covid-19 infection, of whom 62 have died. The overall ICU mortality rate for Covid-19 patients to date is 47 %.

Since early March 2021, we have been experiencing a significant and sustained surge of admissions of Covid-19 cases to the ICU, similar to the summer months of 2020. It is difficult to identify if the admissions are due to Covid-19 variant strains or not as routine Covid-19 testing does not make the differentiation.

MARCH STATS

In March, the Intensive Care Unit had 56 admissions, 53 discharges, and 294 Patient Days. Average daily census was 10 patients. Average Length of Stay (ALOS) was 5.5 days, probably impacted again by the higher number of admissions of Covid-19 cases that are demonstrated to have longer and protracted ICU courses. ICU had 12 deaths for 53 discharges in March with a 22.6 % mortality rate and with a third of the deaths being due to Covid-19 infection. One patient was transferred to Tertiary Care Hospital for services not available at UMC. One patient was re-admitted to UMC within 48 hours of discharge. Patient outcome was good and patient was discharged home.

ICU INFECTION CONTROL DATA

In March, the ICU had 142 Ventilator days with no Ventilator Associated Pneumonias (VAPs), 90 Central Venous Catheter days with no Central Line Associated Blood Stream Infections (CLABSIs) and 209 Urinary Catheter days with no Catheter Associated Urinary Tract Infections (CAUTIs). ICU infection control performance remains well above national standard benchmarks and is reported regularly to the National Healthcare Safety Network (NHSN)

ICU SEPSIS DATA

In March, the ICU managed 37 cases of severe sepsis (including Covid-19 patients). Nine patients died due to severe sepsis, for an overall severe sepsis mortality rate of 24%. One third of ICU sepsis deaths in March were due to Covid-19 infection. Pre-Covid-19 ICU severe sepsis mortality was around 15% or less. The Quality Department compiles and reports on overall sepsis data for the ICU and Hospital.

BLOOD CULTURE CONTAMINATION

Contamination rates of blood culture specimens for ICU patients drawn on admission from ED continue to be unacceptably high. This continues to present challenges in clinical decision making and increases risk and cost. In March 2021, MEC recommended the Lab perform blood culture draws for ICU patients still present in the ED.

Rapid Response and Code Blue Teams

ICU continues to lead, monitor and manage the Rapid Response and Code Blue Teams at UMC. Reports are reviewed monthly in Critical Care Committee meeting with Nursing and Quality Department. Goal is to increase utilization of Rapid Response Teams in order to decrease cardiopulmonary arrest episodes on the medical floors, and improve patient outcomes. Code Blue and Intubation practices have been modified during the Covid-19 pandemic to help improve outcomes and to protect healthcare providers.

Mina Yacoub, MD,
Chair, Department of Critical Care Medicine
April 9th, 2021

Francis O'Connell, M.D., Chairman

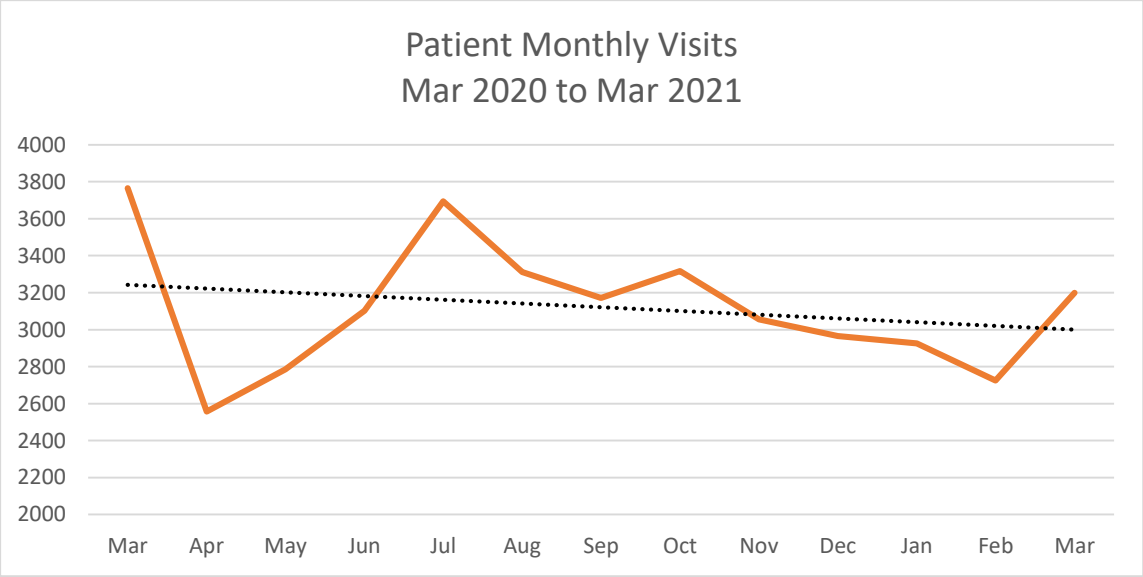
MARCH 2021

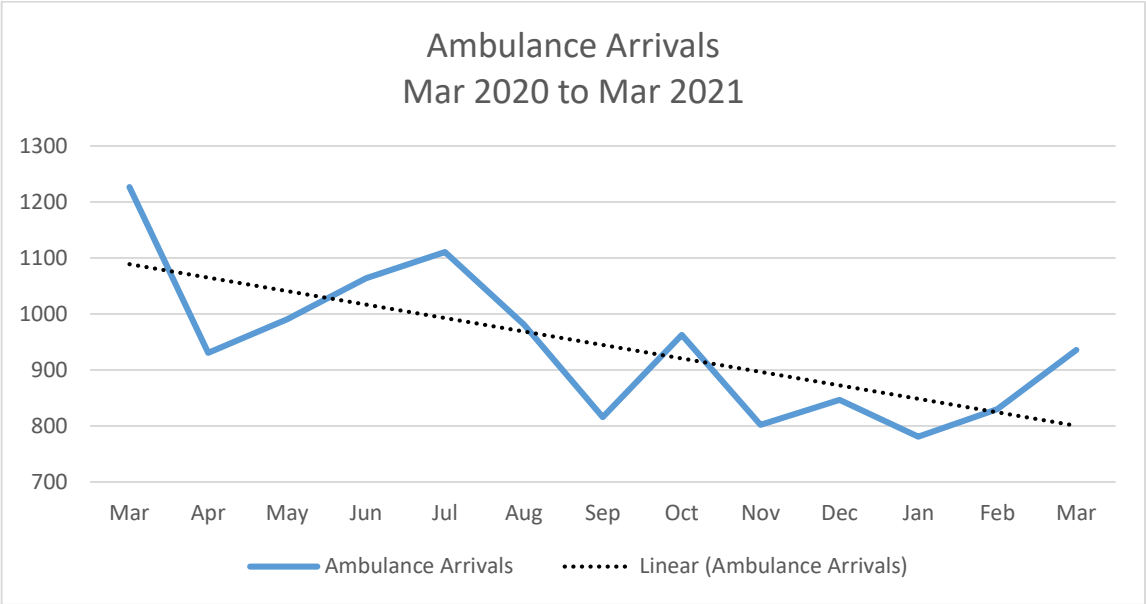
Enclosed is a summary of United Medical Center's (UMC) Emergency Department (ED) volume and key measures for March 2021. Also included are graphic tables to better highlight important data.

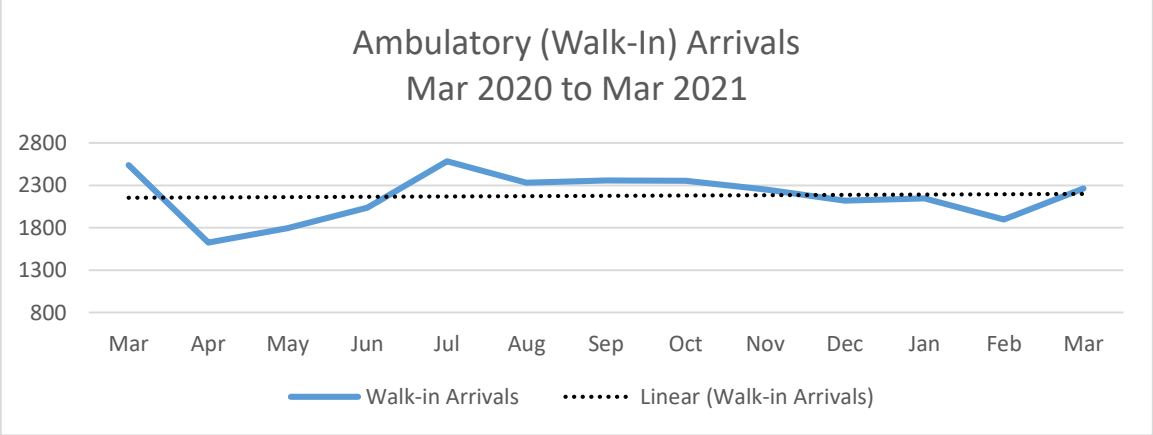
Data used for this and past ED reports was derived from Meditech (hospital EMR) raw data provided by hospital's IT department.

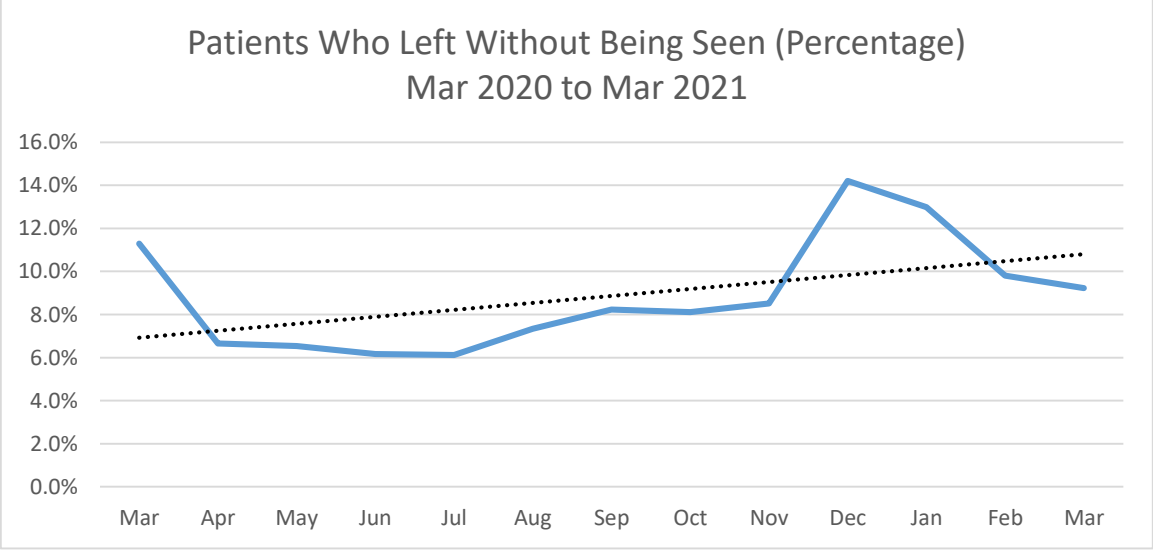
Definitions of the terms used in this report are as follows:

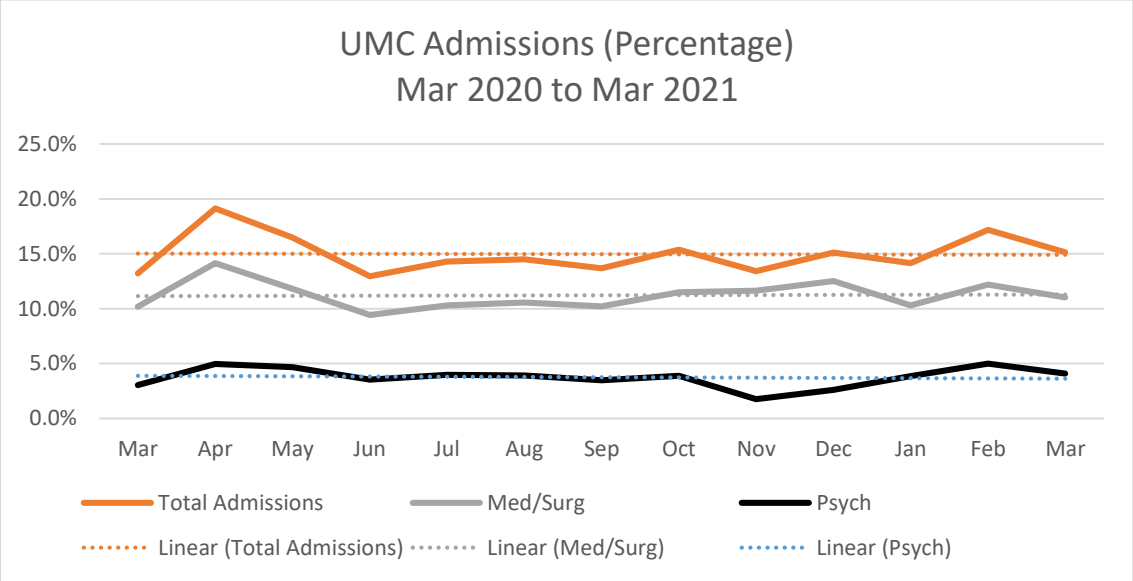
- **Total Patients**: number of patients who register for treatment in the ED
- **Daily Average Census:** total patients divided by days of the month
- **Ambulance Arrivals**: number of patients who arrive by ambulance
- **Admit**: number of admissions to UMC
    - **Med/Surg:** number of medical/surgical patients admitted (includes ICU admissions)
    - **Psych:** number of patients admitted to the behavioral health unit
- **LWBS:** Left without being seen rate is the number of patients who leave prior to seeing a provider and is made up of two categories: LAT and LPTT
- **Ambulance Admission Rate:** percentage of ambulance arrivals that are admitted
- **Walk-In Admission Rate:** percentage of walk-in patients that are admitted

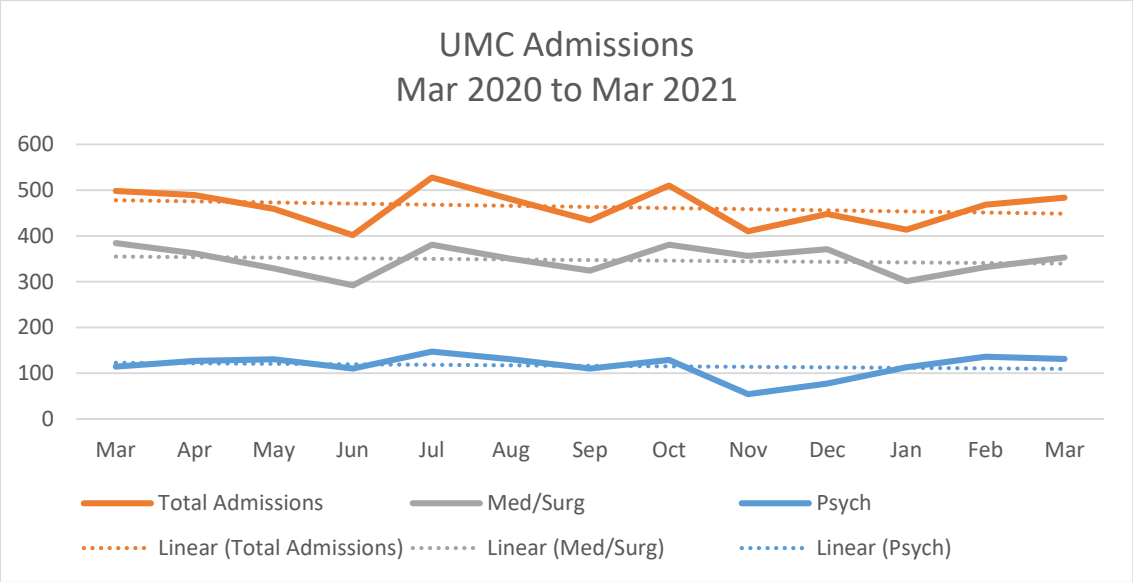



Ambulance Arrivals
Mar 2020 to Mar 2021
1300
1200
1100
1000
900
800
700
Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Ambulance Arrivals
Linear (Ambulance Arrivals)


Ambulatory (Walk-In) Arrivals
Mar 2020 to Mar 2021
2800
2300
1800
1300
800
Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Walk-in Arrivals
Linear (Walk-in Arrivals)


Patients Who Left Without Being Seen (Percentage)
Mar 2020 to Mar 2021
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar


UMC Admissions (Percentage)
Mar 2020 to Mar 2021
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Total Admissions
Med/Surg
Psych
Linear (Total Admissions)
Linear (Med/Surg)
Linear (Psych)


UMC Admissions
Mar 2020 to Mar 2021
600
500
400
300
200
100
0
Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Total Admissions
Med/Surg
Psych
Linear (Total Admissions)
Linear (Med/Surg)
Linear (Psych)

Data tables:

ED Volume and Events - January				
	Mar 2020	**%**	**Mar 2021**	**%**
Total patients	3766		3199	
Daily Avg Census	121		103	
Ambulance Arrivals	1227	32.6%	936	29.3%
Admit	498	13.2%	484	15.1%
• Med Surg	384	10.2%	353	11.0%
• Psych	114	3.0%	131	4.1%
LWBS	425	11.3%	295	9.2%
Ambulance Admission Rate	27.5%		32.6%	
Walk-In Admission Rate	6.3%		7.9%	

Analysis:

1. The monthly census for Mar 2021 increased slightly from the previous month and is down 15% from the previous year.

2. The total number of medicine admissions in Mar 2021 is less than that of 2020. The percentage of admissions of med/surg and psychiatric patients rose slightly from the previous year.

3. The percentage of patients who left without seeing a provider (LWBS) is elevated and declined slightly from the previous month.

4. The total number of ambulances coming to UMC increased from the previous month but is 23% down from the previous year.

5. Ambulance visits remains a large contributor to ED volume and admissions as more than one-third of patients who arrive by ambulance are admitted.

The pieces of data that are most significant are the small rise in ambulance traffic from the previous month and the slight improvement in LWBS from the previous month, though both remain areas of concern and focus.

The rise in both ambulance and walk-in visits is reassuring; however, these data points do not yet suggest a clear trend. As noted in previous letters, most of the hospital admissions and approximately a third of the ED census are derived from ambulance traffic.

The bolstering of the nursing workforce with traveler and agency nurses continues to aid in decreasing boarding and the LWBS. Despite these efforts, of which we are very appreciative, there continues to be shortages in nurses, techs and sitters.

Ambulances are still queuing, though to slightly lesser degree, which subsequently led to a slight rise in ambulance traffic. Likely, DC and PG Fire & EMS are not having to reroute as many ambulances away from UMC. It is important that efforts to decrease disruptions to ambulance traffic continue. Disruptions to ambulance traffic are due to ambulance queueing and excessive boarding in the Emergency Department.

Hospital-wide nursing, tech and sitter staffing shortfalls remain an area of concern as shortfalls contribute to extended boarding periods, extended waiting room times, decreased ambulance traffic which all affect patient safety and satisfaction.

Preliminary analysis of data from the electronic medical record (EMR) is in early stages with the goal to better quantify, identify and comprehend the areas in most need of improvement in the ED. At this point, we can only comment on noted trends and make broad, rather than targeted interventions to address the elevated LWBS and efforts to promote increased ambulance and walk-in patient visits.

We continue to support the efforts related to COVID-specific patient visits.

Francis O'Connell M.D.
Chair, Emergency Medicine

Musa Momoh, M.D., Chairman

MARCH 2021

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

ACTIVITY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	TOTAL
ADMISSIONS													
OBSERVATION													**264**
MEDICINE	70	74	120										**264**
HOSPITAL	70	74	120										**100%**
PERCENTAGE	**100%**	**100%**	**100%**										
REGULAR													
MEDICINE	239	261	243										**746**
HOSPITAL	354	400	385										**1139**
PERCENTAGE	**68%**	**65%**	**63%**										**65%**
DISCHARGES													
OBSERVATION													
MEDICINE	74	70	117										**261**
HOSPITAL	74	70	117										**261**
PERCENTAGE	**100%**	**100%**	**100%**										**100%**
REGULAR													
MEDICINE	180	207	194										**581**
HOSPITAL	280	349	337										**966**
PERCENTAGE	**64%**	**59%**	**58%**										**60%**
PROCEDURES													
HEMODIALYSIS	176	140	154										**470**
EGD'S	22	29	24										**75**
COLONOSCOPY	23	30	24										**77**
ERCP	0	0	0										**0**
BRONCHOSCOPY	0	1	0										**1**
QUALITY													
Cases Referred to Peer Review	0	0	0										**0**
Cases Reviewed	0	0	0										**0**
Cases Closed	0	0	0										**0**

Department of Medicine met on March 10, 2021.
The next meeting is June 9, 2021.

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

Eric Li, M.D., Chairman

MARCH 2021

Month	01	02	03						
Reference Lab test – Urine Eosinophil (2day TAT) 90%	100% 11	100% 7	100% 10						
Reference Lab specimen Pickups 90% 3 daily/2 weekend/holiday	94% 15/16	88% 14/16	100% 16/16						
Review of Performed ABO Rh confirmation for Patient with no Transfusion History. Benchmark 90%	100%	100%	100%						
Review of Satisfactory/Unsatisfactory Reagent QC Results Benchmark 90%	100%	100%	100%						
Review of Unacceptable Blood Bank specimen Goal 90%	99%	99%	99%						
Review of Daily Temperature Recording for Blood Bank Refrigerator/Freezer/incubators Benchmark <90%	100%	100%	100%						
Utilization of Red Blood Cell Transfusion/ CT Ratio – 1.0 – 2.0	1.2	1.2	1.2						
Wasted/Expired Blood and Blood Products Goal 0	2	3	3						
Measure number of critical value called with documented Read Back 98 or >	100%	100%	100%						
Hematology Analytical PI Body Fluid	100% 17/13	100% 10/8	100% 8/7						
Sickle Cell	0/0	0/1	0/2						
ESR Control	100% 73/29	100% 59/25	100% 69/30						
Delta Check Review	100% 230/230	100% 259/259	100% 170/170						
Blood Culture Contamination – Benchmark 90%	94.2% ER Holding 82.6% ER 93.9% ICU	100% ER Holding 91.2% ER 93.9% ICU	93% ER Holding 88% ER 90.5% ICU						
STAT turnaround for ER and Laboratory Draws <60 min Benchmark 80%	91% ER 93% Lab	95% ER 94% Lab	92% ER 94% Lab						
Pathology Peer Review Discrepancies	0/0 Frozen vs Permanent 0/2 In house vs consultation	0/0 Frozen vs Permanent 0/1 In house vs consultation	0/0 Frozen vs Permanent 0/1 In house vs consultation						

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

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

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

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

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

Eric Li, M.D.
Pathology Department

Shanique Cartwright, M.D., Chairwoman

MARCH 2021

UMC Behavioral Health Unit March 2021 Board Report

Description		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Admissions													
	ALOS (Target <7 Days)	4.63	3.94	3.8									
	Voluntary Admissions	31	30	40									
	Involuntary Admissions = FD12	83	109	100									
	Total Admissions	114	139	140									
	Average Daily Census	17	21	19									
Other Measures	Average Throughput (Target: <2 hrs)	4.2	2.9	4.9									
	# TeleCourt Meetings (Pt Hearings)	0	0	0									
	# Psych Consultations	94	170	243									
	Psychosocial Assessments (Target: 80%)	44%	62%	65% *									
Discharge													
	Discharges	102	147	143									

Key - TBA - Data to be provided by Access.

Shanique Cartwright, M.D.
Department of Psychiatry

Riad Charafeddine, M.D., Chairman

MARCH 2021

Exam Type	Exams (INP)	Units (INP)	Exams (ER)	Units (ER)	Exams (OUT)	Units (OUT)	Exams (TOTAL)	Units (TOTAL)
Cardiac Cath								
CT Scan	97		655		163		915	
Fluoro	5		0		26		31	
Mammography					141		141	
Magnetic Resonance Angio								
Magnetic Resonance Imaging								
Nuclear Medicine	12		2		7		21	
Special Procedures	16		0		8		24	
Ultrasound	76		214		189		479	
X-ray	189		975		608		1772	
Echo	79		1		32		112	
CNMC CT Scan			26				26	
CNMC X-ray			265				265	
Grand Total	474		2138		1174		3786	

Volumes have progressed in March 2021 relative to January and February by more than 25%.

Quality Initiatives, Outcomes:

1. **Core Measures Performance**
   100% extracranial carotid reporting using NASCET criteria
   100% fluoroscopic time reporting
   100% presence or absence hemorrhage, infarct, mass.
   100% reporting <10% BI RADS

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

3. **Code Blue/Rapid Response Teams ("RRTs") Outcomes:** No code.

4. **Evidence-Based Practice (Protocols/Guidelines):**
   Staff attention and PPE procedures for COVID -19 is regular.

IT and PACS administrator are in the process of merging Radiology data images in CRISP application.

Radiology protocols are being reviewed and optimized to reduce the need for repeat procedures if patients are transferred to other facilities.

Services:
MRI: The new uMR 570 United 1.5T magnet is here and set-up. The MRI services to be fully functional pending remaining MRI trailer permit from DCRA, in progress.

Fluoroscopy Philips bariatric table room completion is pending a dedicated humidifier. This is tailored to general diagnostic Barium exams mainly GI (gastrointestinal) applications, fluoroscopic radiological procedures, with added standing Chest Xray/exams options.

Nuclear Medicine: GE Discovery dual head camera provides wide range of exams, including cardiac software and SPECT applications is readily available.

Active Steps to Improve Performance: The active review of staff performance and history to be provided for radiologic interpretation continues.

Riad Charafeddine, Chairman
Department of Radiology

Gregory Morrow, M.D., Chairman

MARCH 2021

For the month of March 2021, the Surgery Department performed a total of 133 procedures.
The chart and graft below show the annual and monthly trends over the last 9 calendar years:

	2013	2014	2015	2016	2017	2018	2019	2020	2021
JAN	173	159	183	147	216	155	210	195	147
FEB	134	143	157	207	185	194	180	167	153
MAR	170	162	187	215	187	223	158	82	133
APRIL	157	194	180	166	183	182	211	57	
MAY	174	151	160	176	211	219	186	74	
JUNE	159	169	175	201	203	213	177	126	
JULY	164	172	193	192	189	195	186	140	
AUG	170	170	174	202	191	203	193	161	
SEP	177	168	166	172	171	191	182	162	
OCT	194	191	181	177	214	211	175	146	
NOV	137	157	150	196	152	196	138	156	
DEC	143	183	210	191	153	192	156	146	

This month our volumes were decreased by 13% compared to last month but up by 62% compared to this time last year. The Covid-19 pandemic continues to linger, but to a lesser extent. Our outpatient procedures have begun to show a steady rise in relation to the total volume of cases for Q1, 53%, 57%, 66%, respectively.
We will continue to monitor trends related to the Covid-19 pandemic and resurgence and institute additional measures, as necessary. We currently test all elective patients for Covid-19 on or within 72hrs prior to the day of surgery.

We continue to meet or exceed the monthly quality measures benchmarks outlined for the Surgery Department.

MEASURE	UMC	NAT'L AVG
1) Selection of Prophylactic Antibiotics	100%	92%
2) VTE Prophylaxis	100%	95%
3) Anastomotic Leak Interventions	0%	2.2%
4) Unplanned Reoperations	0%	3.5%
5) Surgical Site Infection	0%	4.8%

We will continue assess the data and make improvements where possible.

We are developing surgery specialty specific measures to support OPPE and the regularity with which these evaluations will be performed and reported.

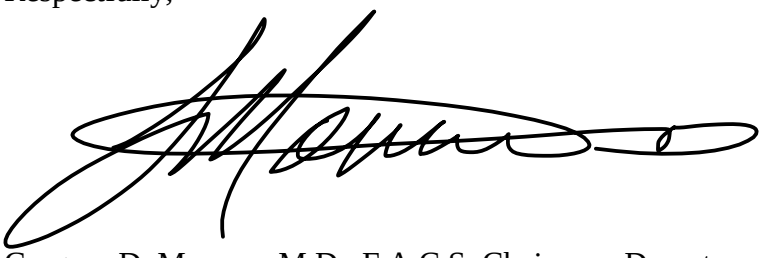
All educational conferences within the department continue to be held by Zoom conferencing and focused on Covid-19 updates and procedures for UMC.

Surgery and Perioperative services continue to evaluate how best to utilize our resources to respond to the anticipated surge of hospitalized patients in response to the Covid-19 pandemic and will continue to collaborate with other departments to formulate a comprehensive strategic plan.

Our reopening plan for the operating rooms for elective procedures has worked well and there have been no identified problems noted. We will continue to make modifications as information is updated. We continue to evaluate and modify how we manage Covid-positive patients to minimize exposure to the staff in all areas of the hospital.

We are currently working with administration to review, plan and realign our surgical services to make sure that we are focusing our resources in the areas that are most in need by the community. This means that we will be enhancing and complimenting some service lines, whereas others may be eliminated. We are evaluating and proposing revisions of the current physician contracts within the department.

Respectfully,



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

UMC
UNITED
MEDICAL CENTER

General Board
Meeting Date: **April 28, 2021**

CNO Report

Presented by:
Jacqueline Payne-Borden
Chief Nursing Officer

Nursing: Board Report
March 2021

The Not-For-Profit Hospital Corporation's FY 2021 Goals are grounded by the Quadruple Aims of Better Outcomes, Improved Patient Experience, Reduced Care Cost and Satisfied Providers. As such, the Nursing Administration/Patient Care Services report is guided by those principles and the hospital's mission, vision and values.

Nursing Administration/Patient Care Services

I. Better Outcomes

- During the month of March, nurses and nursing personnel cared for over 3203patients via Emergency Department visits, 492 admissions: of that 131were behavioral health admissions. There were 131 behavioral health admissions; however, a total of 141 patients were admitted or transferred to the behavioral health unit; 100 (71%) patients were involuntary/FD12 status. A patient with a FD12 status, at a minimum initially requires additional support such as a Sitter, Security, and more frequent nursing assessment. Overall there were 158 dialysis treatment performed.
  *Note: The numbers in Table 1 does not reflect potential interhospital unit transfers.

Table 1. Number of Admissions Dec.20 - Mar. 2021

UNIT	Dec. 2020 Admissions	Jan. 2021 Admissions	Feb.2021 Admissions	Mar.2021 Admissions
8W- Med/Surg/Telemetry	246	159	176	191
5W – Med/Surg	99	115	124	131
4E & 4W- Behavioral Health	81	114	137	131
ICU/Critical Care	18	15	20	39
Total	**444**	**403**	**457**	**492**

Data provided by UMC Analytics.

- Staffing issues were intermittent throughout the hospital units; however, the ED has marked improvement in nurse staffing due to supplemental staffing provided by two agencies.
- There are currently 21 supplemental agency nurses- 17 travelers and 6 Per Diem status. Supplemental staff are performing duties in the ED, ICU, Telemetry and Behavioral Health.
- The hospital continues to attempt to recruit experienced and competent staff for hard to fill areas such as the ED, ICU and Telemetry; this includes Medical/Surgical and Monitor Technicians. This month the following staff were on-boarded: RN-0.9, Sitter- 1.0 and Unit Secretary- 0.6. Human Resources are exploring additional sources to advertise for hospital staff.

Emergency Department

- The Emergency Department (ED) continues to be the natural hub of activities for the hospital. Over the past month throughput within the ED such as door to triage remained

within the 30-minute goal. There was improvement from door to room and door to provider times; however, the aim is to meet "goals in minutes". *See Table 3.

- Executive Team including Nurse leadership, and Medical Director of ED continues to meet to find strategies to improve ED throughput and provide patient centered care. A small but significant change in practice was implemented after last meeting. Patients who are in the ED for an extended stay (period) and was admitted but cannot be taken to the unit due to varying reasons are transferred from ED gurney to an actual hospital bed. These patients are designated as ESAP – Extended Stay Admitted Patients. This change in practice should improve the patient comfort level and decrease the possibility of skin breakdown in at risk patients.

Table 2. Emergency Dept. Metrics FY21

ED Metrics Empower Data	Dec	Jan	Feb	Mar
Visits	2968	2925	2726	3203
Change from Prior Year (Visits)	4425	4451	3863	3765
% Growth	-49.09	-52.17	-41.71	-17.55
LWBS	12	19	11	18
Ambulance Arrivals	849	781	830	936
Ambulance Admissions	305	281	327	325
Ambulance Patients Admission Conversion	0.36	0.36	0.39	0.35
% of ED Patients arrived by Ambulance	0.29	0.27	.30	0.29
% of Ambulance Patients Admitted	0.36	0.36	.39	0.35
Reroute + Diversion Hours	141	75	0	12.20

Data provided by UMC Analytics

Table 3. Emergency Dept. Metrics FY21

ED Metrics Empower Data	*Goal in Mins	Dec	Jan	Feb	Mar
Door to triage	30	33	35	28	28
Door to room	45	96	95	90	74
Door to provider	60	98	100	82	78
Door to departure	150	234	230	216	216
Decision to admit to floor	240	335	345	315	339

Data provided by UMC Analytics

*The goals in minutes are a national standard by the Emergency Medical Service (EMS)

Skin and Wound Care

- Recruited and on-boarded a Wound Care Tech who replaced the Tech who resigned in December 2020.
- Despite the number of patients that are admitted with existing wounds, the overall goal is for patients not to develop any Hospital Acquired Pressure Injury (HAPI) while in our care.

- The Certified Wound Care Nurse continues to provide staff development and reinforcement of appropriate documentation, utilization of prevention equipment, supplies, and techniques.
- The Champions for Change initiative continues to promote additional staff development, this month namely in the 5th and the 8th Floor, selected staff members shadowed the Wound Care Nurse for a total of 6 hours.

Table 4. Patients with pressure injury, HAPI and unit.

	# Patients	# Pressure Injuries	# HAPIs
ICU/CCU	7	32	0
BHU	0	0	0
5 W	8	19	1
8W	17	67	2
Total	**32**	**118**	**3**

Data provided by Wound Care Specialist

Diabetes Center

- Diabetes Center Manager/Educator continues to provide a range of services for patients and staff education. On an average, over 50% of our hospitalized patients have a Diabetes Mellitus (DM) as a primary or co-morbid diagnosis.

Table. 5. Percentage patients with DM

	Dec-20	Jan-21	Feb-21	Mar-21	Average
Per Month % patients with Diabetes	63.54	63.84	56.61	58.40	60.59

Data provided by Diabetes Center Manager/Educator

Table 6. Diabetes Metrics

	Dec-20	Jan-21	Feb-21	Mar-21	Total
Average # DM patients per work day	47	56	52	47	202
Total DM patient days per month	840	1057	878	990	3765
Number patients with DM per month	237	226	227	226	916
Total Hospital Census	373	354	401	387	1515

Data provided by Diabetes Center Manager/Educator

- Insulin drips is insulin given through an intravenous route to decrease high blood glucose levels quickly and safely. A total of 194 insulin drips were administered during calendar year 2020.

- Continuous Glucose Monitoring (CGM) Project – IT received a grant that will allow for up to 20 patients in the medicine clinic to try CGM for 3 months. This will be at no cost to the participant. The goal is to improve glucose control, increase patient and provider satisfaction, and to increase patient ability to make decisions about their diabetes. The Diabetes Educator will provide training for the patients and monitor them during the program. Information will be reported to Dr. Namitra Sodhi. This project will begin in April.

Respiratory Department

- The Respiratory Department has made incremental improvements in documentation but does not meet the benchmark of 95%. It was discovered in review that scanning medication for the MAR directly correlated to the documentation deficiencies and will be added to this PI monitor going forward.

- There is also the "March Madness" Education Kick-off that will focus on Oxygen Therapy, Hi-Flo oxygen equipment and practices, and Chest Physiotherapy equipment and practices. These educational sessions were progressive in nature, building on these concepts each week, and ending with best practice strategies. Approximately 50% of staff participated. The Respiratory Dept. Manager will continue with this education initiative through daily huddles until all staff receive this training.
- Nebulizer treatments administered audits continue with 90% compliance

Occupational Health

- Occupational Health performed 34 more Covid-19 tests this month compared to last month. UMC worked closely with DC Health, Epidemiology team to ensure staff and patients are tested per their guidance; this will limit any potential covid-19 cluster outbreaks.

Table 7. Occupational Health Activities Dec. 2020-Mar. 2021

Month	Flu Vaccine	Pre-Employment Physicals	Annual Physical	COVID Testing	Back to Work Clearances	FIT Tests	Other Activities	Total
Dec.	89	12	7	473	18	21	7	627
January	18	21	5	241	25	37	14	361
February	17	12	26	127	19	56	19	276
March	12	20	134	161	6	160	20	359

Culture of Safety

- The hospital's Management Council which includes nursing services continues its proactive daily morning safety huddles. Potential safety risks are discussed in real time, are transparent, and provide timely follow up and solutions.
- Information on the Covid-19 vaccine is provided during the daily safety huddles. In addition, leaders from the Quality Department provided easy to follow information on the 2021 National Patient Safety Goals. Videos for example, on the "proper technique to wash hands" was presented as another mode of imparting knowledge.
- Nursing Administration/Patient Care Services continues a twice a day and as needed, throughput huddles to determine safe and effective movement of patients from admission, hospital stay and discharge. The Case Management Department works closely with nursing on these efforts.
- Members of the Executive Team including the CEO, DC Hospital Association, Department of Behavioral Health and Metropolitan Police Department and other city-wide hospital members met remotely to further discuss and bring solutions to concerns with violent patients, health care worker assaults and the increasing number of weapons being transported with patients.
- DCHA will be convening a meeting with MPD and Fire and EMS to address the issues discussed on the remote meeting long with a timetable for resolution. Additional information will be forthcoming and shared when available.

Education/Training/Competency

- The Director, Education and Training has provided Accu-Chek glucometer recertification for 5W, ICU and Administrative Nursing Supervisors. The Diabetes Manager/Educator provided recertification training for the other units.

- Two Telemetry Monitor (TTM) tech candidates received telemetry exam/assessment and were very successful.
- Crisis Prevention Intervention training was accomplished- this training is mandatory for Security, Behavioral Health Staff and Emergency Department staff.
- Target Temperature Management training module was uploaded into the learning system management platform Relias to be accomplished by for ICU, ICU, ER, OR/PACU nursing staff and Administrative Nursing Supervisors.
- Recertification through the American Nurses Credentialing Center process continues. This needs to be accomplished in order for UMC to have the ability to provide continuing education units to our nurses when we provide educational offerings. Continuing education units are mandatory for nursing license renewals.
- Each department has unit specific annual training or several spontaneous trainings depending on the needs.

II. Improve Patient and Customer Experience

- Directors and Managers continue to provide real time service recovery to any patient who voiced a concern. The Patient Advocate as always is available if needed.

III. Reduced Care Cost

- Members of the nursing and respiratory teams remain active participants in Revenue Cycle and Initiatives Monitoring meetings to explore ways to accurately and timely capture deserved revenue and explore cost savings and effective initiatives.
- Participation in daily Multi-Disciplinary Rounds facilitated by Case Management to improve care, ensure appropriate discharge and limit patient hours in observation status amongst other patient centered activities.

IV. Satisfied Providers

- Routine ED Throughput meeting continue for collaboration, insight and solutions to issues ranging from staffing, IT and supplies.
- City-wide member hospital representatives met with several leaders from the Metropolitan Police Department to discuss concerns with violent patients, health care worker assaults and the increasing number of weapons being transported with patients by MPD and Fire and EMS. The member hospitals provided MPD with new perspectives and had an impact not seen in previous meeting with MPD. Aiming for a win: win for all stake holders; bottom line safety for all.
- Joined in celebrating our medical doctors on National Doctor's Day 2021 on March 30th. Nursing is appreciative of the positive comradery between nursing and physicians; hoping this comradery will be enhanced even more as we proudly served the community.

Respectfully submitted,
Jacqueline A. Payne-Borden, PhD, RN, NEA-BC
Chief Nursing Officer

UMC
UNITED
MEDICAL CENTER

General Board Meeting Date:
April 28, 2021

Executive Management Report

Presented by:
Colene Y. Daniel
Chief Executive Officer

Not-for-Profit Hospital Corporation
Executive Management Report & Accomplishments

April 28, 2021

Respectfully Submitted: Colene Y. Daniel

"Of all the forms of inequality, injustice in health is the most shocking and inhumane."
The Rev. Dr. Martin Luther King Jr.

In the 55 years since Dr. Martin Luther King Jr. spoke those words, our nation has made some progress to ensure all individuals have an equal opportunity to reach their healthiest life — but we still have a long way to go. United Medical Center's mission is dedicated to the health and well-being of individuals and communities entrusted in our care. We are dedicated to achieve health equity for our community.

March's Accomplishments

As stated in February's report, the hospital is facing a critical time and we must provide our services differently. The NFPHC-UMC is privileged to serve our residents. We in Leadership must continue to serve and improve the health outcomes for our community; as well as ensure the financial sustainability of the hospital.

The Board Chair has announced a Hospital Closure Committee (HCC) – chaired by Dr. Malika Fair. The Board shall articulate the immediate expectations to be achieved by the entire hospital. Most important, the core services essential for our community including shall include:

- 24/7 Emergency Services
- Intensive Care Unit Services
- Perioperative Services
- Medical/Surgical Services
- Behavioral Health Services

The hospital is continuing to strive to become a High Reliable Organization that meets the Quadruple Aim:

- Ensure Better Outcomes
- Improve Patient Satisfaction & the Patient Experience
- Increase the Provider & Staff Engagement
- Achieve the Financial Sustainability – Lower Care Cost

The Budget Reduction Financial/Operations Plan focuses on attaining excellence consistent with each of the Quadruple Aim. With the leadership of the HCC, the hospital must reconfigure itself to be ready for the transition over the next three to four years, and the final closure. Therefore, the entire hospital must collaborate to develop action plans to consolidate, reduce, or close services; and we must reorganize our work to become more efficient.

Simultaneously, the hospital team must continue to address the mission and vision of the hospital – and continue to exceed regulatory compliance. For example, there are numerous items to complete over the next several months for patient safety and for regulatory compliance: refurbishment of the HVAC Systems (due to the arrival of warm weather), replacement of the plumbing systems (water intrusion), the replacement of chillers and old generators (power surge), and the need to always meet new fire safety regulations.

Regarding the enhancement of services and equipment, in 2020 the Intensive Care Unit was refurbished, and in 2021 the Emergency Department, as well as, the third and fifth floors will be fully telemetry accessible. UMC now has state-of-the-art Nuclear Medicine, Fluoroscopy, CT Scan, MRI, and Laboratory equipment.

Lastly, the hospital team must safely close the 6th, 7th and 8th floors, inventory equipment and furniture, and begin appropriating supplies, pharmaceuticals, bio-medical equipment & furniture to the new model of the hospital.

To ensure that all that is required is achieved timely, the Executive Management Committee and the Medical Executive Committee will serve on teams to achieve the directions of the HCC and the Board. The Reduction Financial/Operations Teams are to carry out the approved actions of the HCC and Board in a timely and orderly matter. A detail of the plan is in development and once approved by the HCC, shall be distributed to the EMC and MEC.

Chief Medical Officer

The Chief Medical Officer report is submitted separately by Dr. William Strudwick.

Chief Nursing Officer

The Chief Nursing Officer report is submitted separately by Dr. Jaqueline Payne-Borden

Children's National Medical Center

Children's National Lease & Purchased Services Agreement:

1. 3 remaining items:
    i. Fair Market Value (FMV) – Completed.
    ii. Charge Data Master (CDM) review – Finance, Laboratory & Radiology to review CDM file and answer some of the questions related to rates – submitted final file to Children's for review.
    iii. Security purchased service amount – we had agreed upon the monthly rate for providing security services and they have come back with a new request. Under review with Security & Support Services staff.

Compliance

Regulatory Compliance: BEGA Conflicts of Interest and Financial Disclosures

- Prepare and submit to the DC Board of Ethics and Government Accountability (BEGA) all public (65 identified) and confidential (52 identified). Financial Disclosure Statement (FDS) Filers for CY 2020 DC Financial Disclosure Program.
- Commence confidential filer notification process, include scheduling of filer-designation appeals and counseling regarding appropriate completion of forms. Note: BEGA handles public disclosure process.

Patient Neglect, Abuse, Safety and Satisfaction

- The Patient Safety/Abuse Review Board is meeting weekly and is now comprised of members of the hospital's Public Relations/Governance, Legal, Employee Relations, Patient Advocacy, Risk Management and Compliance departments. Work includes the following:
    - Eighteen (18) *"See Something, Say Something"* posters were designed, printed, and posted (with "in-house" resources) throughout the hospital and MOB, using the current Hotline number as the point of contact.
    - The Chief Compliance Officer is instructing new employees, contractors, and students regarding identifying and reporting patient safety issues during weekly New Employee Orientation.
    - The Chief Compliance Officer and Patient Advocate will be presenting in-person to the Nursing Leadership meeting in April on this and related topics (e.g., bias in care).

- Risk Management and Legal are reviewing current policies and will be presenting to the Executive Management Committee in April.

- Regular, on-going collaboration with Patient Advocate fielding and resolving patient complaints and concerns.

Achieving Quadruple Aim and Becoming a High Reliability Organization

- Conduct weekly, in-person training sessions in UMC auditorium in Leadership Formation Program (LFP) regarding *Commitment to Resilience, Derek Redmond and the 92 Olympics*. This is the 2nd of 18 programs in the program. This program now includes information regarding EAP resources.

COVID-19 Vaccination Program – Education and Communication

- Prepare and circulate (anonymous) Vaccine Survey to Management Council and Safety Huddle regarding vaccination status and reasons for any vaccination hesitancy, to inform Education and Communication efforts.
- Provide daily education and updates regarding vaccine program, vaccine hesitancy among hospital workers, and expansion of eligibility within DC, Maryland, and Virginia, at morning Safety Huddle.
- Conduct periodic rounding on floors to provide education and training to staff regarding vaccination program, including conversations with staff, contractors, and student work force.

Enterprise Risk Management

- Prepare and distribute Enterprise Risk Management Survey to Board, Medical Executive Committee, and Executive Management Committee.

Compliance Program Assessment and Development

- Prepare and present Grand Rounds to medical staff regarding healthcare Fraud and Abuse and documentation requirements.

Improving the Patient Experience: Continuous Glucose Monitoring Program

- In collaboration with hospital diabetes center and Information Technology leadership, worked with Dexcom Company to resolve outstanding issues regarding Continuous Glucose Monitoring (CGM) program. Prepared Patient Acknowledgement and Consent to enable go-live of CGM program.

Contracts & Procurement

Procurement along with Legal department presented the Procurement Compliance presentation for the monthly Management Council meeting. This was a great collaboration of both departments to educate staff on all Procurement principles to assure everyone is knowledgeable of procurement process and abide by all applicable laws and regulations. We discussed equitable inclusion, sole source, emergency requests, RFQ/RFP, purchase order/contract thresholds and the required documents to process contracts and purchase requisitions. We started weekly meetings to streamline the processes and create workflows to assist with assuring UMC will comply going forward. One of our goals is to reduce the usage of purchase

orders for spend that is over $100K, we are starting with implementing MSA agreements for categorized services. The listing of current MSA's are: general electric service, plumbing, medical malpractice, general construction, water restoration, HVAC and recruitment agency. These services will all be competitively bided, and a bench of suppliers will be selected to do business with UMC.

Our department spearheaded the start of Cintas scrub machine program across the hospital. There were two (2) scrub machines installed which will provide clean and sanitized scrubs according to CDC guidelines for Nurses, OR and other staff. We will be able to monitor usage by each employee and department going forward.

Monthly Procurement Tracking:
PPE prices are still increasing due to COVID. We will continue to streamline fulfillment processes and enhancement to our PAR levels across organization.

PPE PRICE COMPARISON

	DISTRIBUTOR PRICING (PRE-COVID)	COMPETITOR PRICING	MARKUP
ISOLATION GOWN	$ 0.51	$ 5.95	1067%
N95	$ 1.80	$ 4.70	161%
SURGICAL MASK	$ 0.20	$ 0.80	300%
SURGICAL GOWN	$ 0.44	$ 6.89	1466%
SHOE COVER	$ 0.06	$ 0.50	733%
HEAD CAP	$ 0.10	$ 0.52	420%
STETHOSCOPE	$ 1.95	$ 3.36	72%
FACESHIELD	$ 1.36	$ 4.75	249%

Due to our continuous training and commitment to increase CBE/SBE and DC based business across all category spend, we are starting to see the supplier diversity spend diversify and increase across the board.

The hospital spend increased by $126K from last month to a total spend of $2.6M YTD for end of March.

Procurement was able to reduce the supply spend for by ~$40,000 from the previous year for March. The tracking of inventory spend is tracked monthly as a KPI to measure team and individual performance of Materials Mgmt. and Procurement.

- Procurement Savings
- CBE/Diversity Spend
- Procurement Dashboard

Facilities & Support Services

Environment of Care Key Initiatives:

1. Fire drill matrix inspection - Compliant
2. Fire door repairs – 85% complete
3. Ice Machine Weekly inspection – Compliant
4. Revised Exit Light Monthly Documentation- Compliant
5. H-Cylinder Storage Inspection Log- Compliant
6. Fire Door Functional Inspections – Compliant
7. IT Closet Floor Penetration Inspections – Compliant
8. ICU Depicted as a Suite on LS Drawings – Compliant

9. NO Exit signs posted - Compliant
10. Storage rooms door functional test – Compliant
11. Missing Ceiling Tile Inspections - Compliant
12. Storage less than 18 inches to sprinkler head – Compliant
13. Escutcheon Plate Inspections – Compliant
14. Hydrocollator Water Change Inspection – Compliant
15. Ceiling inspections – Compliant
16. BHU EVS Room Inspections – Compliant
17. BHU thermostat covers Inspections - Compliant

Grants

1. Grant Program Oversight & operations
    a. UMC Mobile Health Clinic is fully operational providing primary and preventive health care screenings, health literacy, and COVID-19 testing; the Mobile Health Clinic is collaborating with DC Housing Authority (twice a week), Faunteroy Community Enrichment Center (once a week):
        i. HIV Screening
        ii. HIV Testing
        iii. COVID19 Testing
        iv. Added additional point of care testing
    b. **Wellness on Wheels Campaign**: The UMC mobile team continues to expand mobile vaccination administration to seniors in Ward 7 & 8 at housing communities.
        i. IT created new scheduling capability for mobile clinic vaccinations
        ii. On boarded and trained Medical Assistant to assist with administration of vaccine & documentation to include Meditech training for clinical documentation.
        iii. Developing plans for our mobile & community based programs to support the work we do in HIV/AIDS treatment and prevention.
        iv. Expand partnership with DC Home Health Association to vaccinate home health workers
        v. Expand community outreach program with The Roundtree Residences senior community.

Human Resources

The Human Resource Report is submitted separately by Akia Embry. (Closed Report)

Information Technology

Applications

- Upgraded MERGE (Radiology PACS) application to new version
- Assisted Legal and Risk Manager with vendor issues and downtime procedures for hospital users due to the Navex Ethics Point outage
- Supported COVID vaccination teams
- Applied software updates for 3M and IMO applications
- Submitted electronic filing for ACA
- Provided reports for ED throughput project

- Implemented new Meditech – Vizient file automation routine
- Completed set-up for Continuous Glucose Monitoring –Dexcom Project
- Implemented patient and client detail data automation for Finance/ Premier
- Successfully serviced 102 Help Desk/Service tickets in March 2021

Infrastructure

- Implemented new hardware, desktop client and related infrastructure components for the new MERGE application upgrade
- Provided support for the COVID vaccination team using the mobile van
- Enabled phone lines for fire alarm in former 'Fresenius' building
- Replaced dish and controllers as part of upgrade for patient TV services
- Completed new cabling and moved Case Management devices to a new office
- Installed new network connections and enabled the activation of the Cintas Scrub devices
- Reinstalled the repaired, special phone in Behavioral Health
- Addressed an emergency patching need for Microsoft Exchange; worked with Mazars Cybersecurity team to evaluate and confirm it was safe to bring up new, patched Microsoft Exchange system
- Performed weekly termination audits with HRIS records to appropriately adjust end-user access rights
- Maintained the 3rd floor disaster recovery replication of PACs, Exchange, and Pyxis systems
- Continued 24/7 network monitoring tools and services with Mazars' team
- Regularly monitored network and user traffic for potential security issues/attacks
- Updated/decommissioned several servers with unsupported operating systems
- Successfully completed upgrade of vCenter and ESXi to 6.7
- Successfully added new drives for backup copy job offsite rotation
- Successfully completed the Domain Controller project; all domain controllers are now at current versions
- Troubleshooting of, and fixed, Veeam's backup copy jobs, which were failing due to a configuration issue
- Deployed Tiger Connect (texting solution) to the case management and GW users
- Replaced failed memory DIMM on host ESXi01
- Successfully serviced 512 Help Desk/Service tickets in March 2021

Operations

1. COVID19 Vaccination Clinic fully operational:
    a. Planning & coordination with DC Health & DCHA (include delivery, reporting & tracking of vaccine vials) for transition to Walgreens/UMC vaccination partnership
    b. Revamp clinic operation activities to incorporate Walgreens vaccinators, registration staff and pharmacists.
    c. Daily Reporting to HHS, DC Health, DCHA & HSEMA

2. Community Relations:
    a. Represented UMC at SE Tennis & Learning Center "Don't Miss your Shot" Vaccination event for Ward 8 Residents

FY2021YTD Activity:

COVID-19 PCR tests	Flu Vaccines	HIV tests	Rapid COVID-19 tests	Moderna COVID Vaccines
406	110	112	236	382

3. Food & Nutrition Services:
    a. DC Health Survey for Food Services on 3/25/2021:
        i. Noted 5 observations, 3 of which were corrected on site. The remaining 2 are to conduct in-service for the cold holding procedure and plumbing issue to be shared with Facilities. No requirement for resurvey.
        ii. Planning for reduction in retail café services
            1. Closing weekends and cut hours on weekdays
            2. Reduction in catering

4. Radiology:
    a. American College of Radiology (ACR) – ACR complete for Nuclear Medicine & CT Scanner #2; ACR completed for CT #1. ***Achieved reaccreditation – Triennial Survey***
    b. MRI & Fluoroscopy operations preparations (including staffing onboarding); applications preparation; ***Received DCRA approval & DC Health approval***, DCFEMS is pending approval.
    c. Registration/scheduling/billing setup.
    d. Performance Improvement – Improve monitoring of Patients in holding area – installed 2 additional Nurse call buttons in holding area.

5. Human Resources:
    a. Leadership oversight during both Director & Manager absences
    b. Negotiated lower rates with existing staffing agency to provide ED, ICU & Med/Surg Telemetry nurses
    c. Weekly meetings with HR & nursing leaders to track recruiting/onboarding of nurses and nursing staff.
    d. Instituting new recruitment efforts through nurse's associations, adding job postings to website, UMC intranet site; planning for virtual nursing job fair
    e. Preparations for upcoming audits & upcoming regulatory surveys: ACA submittal, PlanSource electronic submission.

f. Prepared calendar of financial & wellness events for April 2021:
   - April 1: Banking Basics
   - April 8: Banking Services
   - April 15: Personal Credit (Credit Scores and Reports)
   - April 22: Budgeting
   - April 29: Identity Theft

g. Thursday weekly workshops:
   i. Lydia's House Financial workshops

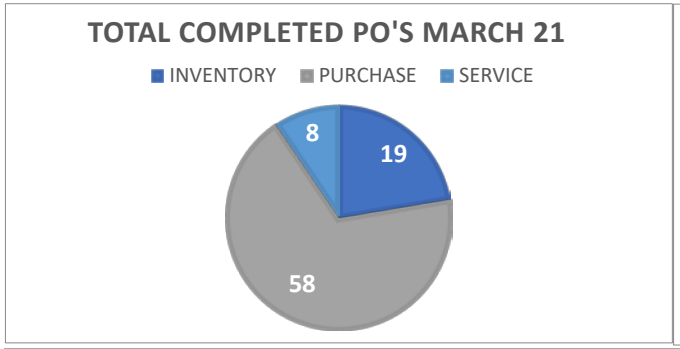
h. Communicate with all staff information on our Employee Assistant Program (EAP) – Daily safety huddles, Newsletter, emails.

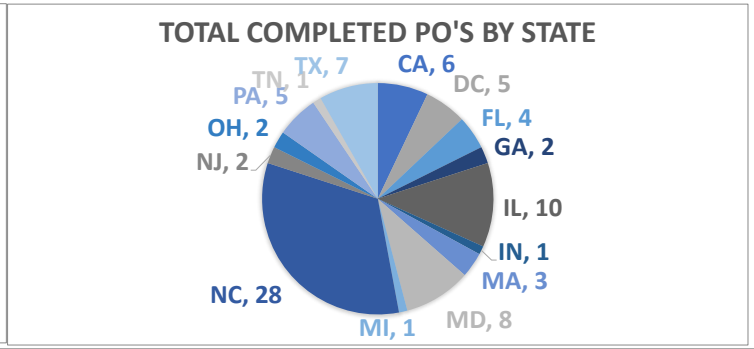
i. Planning for HRIS (KUG – Kronos) implementation: Time & Attendance & Compensation Management

6. Linen Services:
   a. We are putting into place some additional savings opportunities.
   b. Continue to meet with unit managers to address soiled linen

7. Screener Program:
   a. Exploring opportunity to partner with *DOES Project Enrichment* to provide screener resources
      i. Legal & HR to review program, agreement and onboarding process

PROCUREMENT COMPLETED PO DASHBOARD -MARCH 2021





VENDOR NAME	AMOUNT	VENDOR NAME	AMOUNT	VENDOR NAME	AMOUNT
ABBOTT DIAGNOSTICS	$ 13,352.60	FISHER & PAYKEL HEALTHCARE	$ 20,095.80	SERVICEPRO FORMERLY HELPSTAR	$ 5,924.79
ABBOTT LABORATORIES FORMERLY	$ 12,200.00	FRESENIUS USA MARKETING	$ 7,930.80	SHERWIN WILLIAMS	$ 869.40
ACELL INC.	$ 4,264.00	GE HEALTHCARE (FORMERLY NYCOMED	$ 5,346.60	SMITH & NEPHEW ORTHOPEDICS	$ 7,113.00
AIRGAS EAST	$ 237.31	HEALTH CARE LOGISTICS	$ 34.16	STRYKER ENDOSCOPY	$ 559.86
ARGON MEDICAL DEVICES	$ 2,538.26	ICU MEDICAL, INC.	$ 12,250.81	STRYKER INSTRUMENT DIVISON	$ 380.00
ARTHREX INC.,	$ 4,272.00	NIHON KOHDEN	$ 650.00	SURGICAL DIRECT INC	$ 2,375.00
BARD ACCESS SYSTEMS INC	$ 4,508.30	OLYMPUS CORPORATION OF AMERICA	$ 41,224.60	SW MED-SOURCE, INC	$ 223.00
BENJI HOLDINGS LLC (DC)	$ 40,000.00	ORTHO CLINICAL DIAGNOSTIC	$ 14,233.58	TELEFLEX MEDICAL, INC	$ 275.38
BIO-RAD LABORATORIES, INC.,	$ 3,552.00	PARTS SOURCE INC.	$ 957.84	U.S. OFFICE SOLUTIONS (SBE)	$ 53.76
BOSTON SCIENTIFIC CORPORATION	$ 2,466.29	PC CONNECTION SALES CORP.	$ 21,582.71	ULINE	$ 11,325.00
CARDINAL HEALTH/MEDICAL PRODUCTS	$ 26,707.40	PERFORMANCEHEALTH.COM	$ 91.95		
CAREFUSION 2200, INC.	$ 74.70	RESPITECH	$ 897.00	**Grand Total**	**$ 289,899.24**
COOK MEDICAL INCORPORATED	$ 5,532.00	RIVENDELL INTERNATIONAL INC (DC)	$ 4,500.00		
DAYCON PRODUCTS COMPANY INC	$ 7,443.01	ROCHE DIAGNOSTICS CORPORATION	$ 46.00		
DEROYAL INDUSTRIES	$ 178.56	S. FREEDMAN & SONS	$ 3,631.77		

VENDOR NAME	VENDOR STATE	PO NUMBER	PO TYPE	ORDER DATE	PO VALUE
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61088	PURCHASE	3/1/2021	$ 388.28
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61094	INVENTORY	3/2/2021	$ 325.18
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61114	PURCHASE	3/8/2021	$ 2,266.77
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61120	PURCHASE	3/8/2021	$ 48.45
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61122	PURCHASE	3/9/2021	$ 636.80
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61123	PURCHASE	3/9/2021	$ 2,956.14
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61131	PURCHASE	3/9/2021	$ 2,476.26
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61132	PURCHASE	3/9/2021	$ 100.06
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61133	PURCHASE	3/9/2021	$ 200.40
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61134	PURCHASE	3/9/2021	$ 624.94
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61137	PURCHASE	3/9/2021	$ 1,590.77
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61144	INVENTORY	3/11/2021	$ 180.34
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61147	INVENTORY	3/11/2021	$ 900.00
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61153	PURCHASE	3/11/2021	$ 161.50
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61158	PURCHASE	3/11/2021	$ 799.96

VENDOR NAME	VENDOR STATE	PO NUMBER	PO TYPE	ORDER DATE	PO VALUE
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61165	PURCHASE	3/12/2021	$ 883.98
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61169	PURCHASE	3/15/2021	$ 1,911.33
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61174	INVENTORY	3/16/2021	$ 4,572.59
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61184	PURCHASE	3/17/2021	$ 1,183.36
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61205	PURCHASE	3/22/2021	$ 340.00
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61212	INVENTORY	3/23/2021	$ 475.14
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61227	PURCHASE	3/26/2021	$ 3,194.15
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61233	PURCHASE	3/29/2021	$ 77.00
CARDINAL HEALTH/MEDICAL PRODUCTS	NC	61240	INVENTORY	3/30/2021	$ 414.00
BOSTON SCIENTIFIC CORPORATION	MA	61139	PURCHASE	3/9/2021	$ 1,954.34
BOSTON SCIENTIFIC CORPORATION	MA	61208	PURCHASE	3/22/2021	$ 511.95
SMITH & NEPHEW ORTHOPEDICS	NC	61130	SERVICE	3/9/2021	$ 7,113.00
AIRGAS EAST	IL	61164	PURCHASE	3/12/2021	$ 237.31
ROCHE DIAGNOSTICS CORPORATION	GA	61171	INVENTORY	3/15/2021	$ 46.00
FRESENIUS USA MARKETING	MA	61161	INVENTORY	3/12/2021	$ 7,930.80
ABBOTT LABORATORIES FORMERLY	IL	61167	SERVICE	3/12/2021	$ 6,100.00
ABBOTT LABORATORIES FORMERLY	IL	61210	SERVICE	3/23/2021	$ 6,100.00
STRYKER ENDOSCOPY	CA	61152	PURCHASE	3/11/2021	$ 559.86
COOK MEDICAL INCORPORATED	IN	61107	INVENTORY	3/4/2021	$ 5,532.00
BARD ACCESS SYSTEMS INC	NC	61115	PURCHASE	3/8/2021	$ 2,070.80
BARD ACCESS SYSTEMS INC	NC	61145	PURCHASE	3/11/2021	$ 2,437.50
ICU MEDICAL, INC.	CA	61187	INVENTORY	3/18/2021	$ 12,250.81
GE HEALTHCARE (FORMERLY NYCOMED	NJ	61110	INVENTORY	3/5/2021	$ 2,673.30
GE HEALTHCARE (FORMERLY NYCOMED	NJ	61231	INVENTORY	3/29/2021	$ 2,673.30
OLYMPUS CORPORATION OF AMERICA	TX	61126	SERVICE	3/9/2021	$ 30,000.00
OLYMPUS CORPORATION OF AMERICA	TX	61127	SERVICE	3/9/2021	$ 8,000.00
OLYMPUS CORPORATION OF AMERICA	TX	61166	PURCHASE	3/12/2021	$ 429.60
OLYMPUS CORPORATION OF AMERICA	TX	61206	PURCHASE	3/22/2021	$ 420.00
OLYMPUS CORPORATION OF AMERICA	TX	61209	PURCHASE	3/22/2021	$ 2,375.00
ORTHO CLINICAL DIAGNOSTIC	IL	61183	PURCHASE	3/17/2021	$ 11,719.55
ORTHO CLINICAL DIAGNOSTIC	IL	61223	PURCHASE	3/26/2021	$ 2,514.03
PC CONNECTION SALES CORP.	PA	61093	PURCHASE	3/2/2021	$ 21,082.59
PC CONNECTION SALES CORP.	PA	61101	PURCHASE	3/2/2021	$ 221.70
PC CONNECTION SALES CORP.	PA	61224	PURCHASE	3/26/2021	$ 278.42
NIHON KOHDEN	CA	61188	PURCHASE	3/18/2021	$ 650.00
ARTHREX INC.,	FL	61143	SERVICE	3/11/2021	$ 4,272.00
BIO-RAD LABORATORIES, INC.,	CA	61092	PURCHASE	3/2/2021	$ 3,552.00
ABBOTT DIAGNOSTICS	GA	61218	PURCHASE	3/25/2021	$ 13,352.60
STRYKER INSTRUMENT DIVISON	MI	61129	PURCHASE	3/9/2021	$ 380.00
HEALTH CARE LOGISTICS	OH	61232	PURCHASE	3/29/2021	$ 34.16
RESPITECH	PA	61238	INVENTORY	3/30/2021	$ 897.00
ULINE	IL	61159	INVENTORY	3/12/2021	$ 10,440.00
ULINE	IL	61211	INVENTORY	3/23/2021	$ 700.00
ULINE	IL	61230	INVENTORY	3/29/2021	$ 185.00
PERFORMANCEHEALTH.COM	IL	61200	PURCHASE	3/22/2021	$ 91.95
FISHER & PAYKEL HEALTHCARE	CA	61204	PURCHASE	3/22/2021	$ 20,095.80
PARTS SOURCE INC.	OH	61156	PURCHASE	3/11/2021	$ 957.84
S. FREEDMAN & SONS	MD	61096	INVENTORY	3/2/2021	$ 975.00

VENDOR NAME	VENDOR STATE	PO NUMBER	PO TYPE	ORDER DATE	PO VALUE
S. FREEDMAN & SONS	MD	61113	PURCHASE	3/8/2021	$ 842.59
S. FREEDMAN & SONS	MD	61216	INVENTORY	3/25/2021	$ 890.00
S. FREEDMAN & SONS	MD	61221	PURCHASE	3/25/2021	$ 924.18
TELEFLEX MEDICAL, INC	NC	61140	PURCHASE	3/9/2021	$ 275.38
CAREFUSION 2200, INC.	IL	61179	PURCHASE	3/17/2021	$ 74.70
SHERWIN WILLIAMS	DC	61097	PURCHASE	3/2/2021	$ 869.40
SERVICEPRO FORMERLY HELPSTAR	FL	61117	SERVICE	3/8/2021	$ 5,924.79
U.S. OFFICE SOLUTIONS (SBE)	DC	61102	PURCHASE	3/2/2021	$ 23.18
U.S. OFFICE SOLUTIONS (SBE)	DC	61104	PURCHASE	3/4/2021	$ 30.58
ARGON MEDICAL DEVICES	TX	61239	PURCHASE	3/30/2021	$ 2,538.26
ACELL INC.	PA	61182	PURCHASE	3/17/2021	$ 4,264.00
SW MED-SOURCE, INC	TX	61138	PURCHASE	3/9/2021	$ 223.00
SURGICAL DIRECT INC	FL	61089	PURCHASE	3/2/2021	$ 780.00
SURGICAL DIRECT INC	FL	61189	PURCHASE	3/19/2021	$ 1,595.00
DAYCON PRODUCTS COMPANY INC	MD	61112	PURCHASE	3/8/2021	$ 2,751.84
DAYCON PRODUCTS COMPANY INC	MD	61124	PURCHASE	3/9/2021	$ 541.80
DAYCON PRODUCTS COMPANY INC	MD	61220	PURCHASE	3/25/2021	$ 4,149.37
DEROYAL INDUSTRIES	TN	61128	PURCHASE	3/9/2021	$ 178.56
BENJI HOLDINGS LLC (DC)	DC	61154	INVENTORY	3/11/2021	$ 40,000.00
RIVENDELL INTERNATIONAL INC (DC)	DC	C61093	SERVICE	3/1/2021	$ 4,500.00

MARCH CBE/DIVERSITY SPEND YTD FY21

CBE SPEND

VENDOR #	CBE	SERVICE	WARD	AP SPEND YTD
M01856	U.S. OFFICE SOLUTIONS	OFFICE SUPPLIES	5	$ 51,214.98
M02509	RSC ELECTRICAL & MECHANICAL	ELECTRICAL/HVAC	7	$ 171,500.00
M00561	MEDICAL SUPPLY SYSTEMS	MEDICAL/SURGICAL EQUIPMENT	4	$ 51,227.80
M02574	E-LOGIC, INC	INFORMATION TECHNOLOGY	2	$ 80,400.00
M02644	COLUMBIA ENTERPRISE	GENERAL CONTRACTING	6	$ 14,344.50
M02730	RIVENDELL INTERNATIONAL INC	CONSULTING & DIGITAL SERVICE	3	$ 4,500.00
M02261	RATH ENTERPRISES	CONSTRUCTION/ASBESTOS	5	$ 95,910.00
M02612	NATIONAL SERVICE CONTRACTORS	CONSTRUCTION/FACILITY SERVICE	8	$ 45,368.54
M02624	WALDON STUDIO ARCHITECTS & PLANNERS	ARCHITECTURAL DESIGN	2	$ 131,168.29
M02647	GLOBAL PRINT MASTER	MARKETING/BRANDING	5	$ 260.00
M02692	NETWORKING FOR FUTURE INC	INFORMATION TECHNOLOGY	2	$ 379,749.63
M02597	AL'S TWIN AIR, LLC	HVAC	6	$ 144,698.39
M01157	COAST TO COAST HOSPITALITY LLC	SIGN LANGUAGE	8	$ 23,103.50
	TOTAL CBE SPEND YTD 3/31/21			**$ 1,193,446**

DC BASED BUSINESS

VENDOR #	DC BASED BUSINESS	SERVICE	WARD	AP SPEND YTD
M02270	BONNER KIERNAN TREEBACH CROCIATA LLP	LAW FIRM	2	$ 142,911.13
M02680	IM SO DC	DC CLOTHING APPAREL	8	$ 3,890.00
M02691	NOVA MEDICAL LLC	TERMINAL CLEANING	2	$ 264,849.00
M02710	NOW MARKETING SOLUTIONS	CUSTOM PRINT	7	$ 78,881.99
M02709	DILIGENT CORPORATION	SOFTWARE	2	$ 8,769.60
M02706	PACT PRO LLC	ASSET SECUTIRY MGMT	6	$ 179,858.00
M02682	WAYNE ENTERPRISES LLC	CONSULTING	8	$ 30,500.00
M02705	BENJI HOLDINGS LLC	MEDICAL SUPPLIES	1	$ 28,200.00
M02657	PITT ELECTRIC INC & CONSTRUCTION	ELECTRIC CONTRACTOR	8	$ 99,872.00
M02693	JH CONTRACTORS LLC	CONSTRUCTION	5	$ 435,250.00
	TOTAL SPEND YTD 3/31/21			**$ 1,272,982**

VIZIENT (GPO) SUPPIER DIVERSITY TIER 2 DISTRIBUTION SPEND

SUPPLIER NAME	VETERAN DISTRIBUTION	MINORITY DISTRIBUTION	WOMAN DISTRIBUTION	TOTAL
ABOBOTT LABORATORIES	$ 50.14	$ 176.30	$ 257.86	$ 484.30
ALLERGEN USA	$ 554.81	$ 3,881.34	$ 9,126.87	$ 13,563.02
DEROYAL INDUSTRIES	$ -	$ -	$ -	$ -
FRESENIUS-KABI USA, INC	$ 162.35	$ 713.06	$ 2,093.49	$ 2,968.90
GETINGE USA, INC	$ 8.89	$ 18.99	$ 23.81	$ 51.69
O&M HALYARD, INC	$ 17.16	$ 201.59	$ 94.81	$ 313.56
MEDTRONIC	$ 3,071.25	$ 6,442.87	$ 4,040.26	$ 13,554.38
PHILIPS NORTH AMERICA LLC	$ 14,578.72	$ 7,427.98	$ 17,560.23	$ 39,566.93
RR DONNELLEY & SONS COMPANY		$ 3.55	$ 34.59	$ 38.14
MORRISON MANAGEMENT SPECIALISTS	$ 4,705.10	$ 2,271.26	$ 10,657.35	$ 17,633.71
UPSHER-SMITH LABORATORIES, INC.	$ 25.11	$ -	$ 71.55	$ 96.66
HEALTHMARK INDUSTRIES CO INC		$ 86.18	$ 16,314.31	$ 16,400.49
VERIZON WIRELESS	$ 33.04	$ 490.72	$ 200.63	$ 724.38
TOTAL SPEND YTD 3/31/21				**$ 105,396**

** start date for tracking supplier diversity 9/1/20

TOTAL CBE/DIVERSITY SPEND YTD FY21 **$ 2,571,824**

PROCUREMENT

Savings Identified	Date Submitted	Annual Savings Identified	Status
Office of General Council			
Switching Cell Phone Service to AT&T from Verizon (Monthly)	01-09-2020	$105,000	Budget Officer Responded 02/14/2020 Analysis Completed & Sent to CFO/Controller for Review. CFO asked from more clarity which was provided on 3/2/2020. Procurement followed up with CIO on 3-9-2020. Followed up with OCFO 4/27/2020 No response. Uploaded into Contracts Guardian per new process on 5/6/2020. 6-4-2020 No response from Legal or OCFO office on this savings contract. Re did analysis and submitted to internal teams 8-6-2020 Budget stated they would review new analysis. Sent new analysis to Budget office 9/1/2020. In Legal office as of 10/30/2020. Sent updated follow up 1/5/2021. Status unknown procurement has followed up with Legal numerous time.
Joining Z5 Inventory Network of Local Hospitals to Sell UMC Obsolete Inventory & Buy Excess Inventory at Discounted Pricing from Local Hospitals (Monthly)	02/11/2020	Provides Ability to Purchase Certain Products at 40%-50% off Supplier Pricing from Local Hospitals	Budget Asked a Few Additional Questions on 02/14/20. In Legal as of 3/5/2020. Uploaded to Contract Guardian 5/1/2020 per new process. Final contract signed by Vendor 5-28-2020 waiting on Legal and fiscal signatures to execute. Budget office has additional questions for Legal 7/1/2020. Legal stated they would work out the details with Budget office. With Budget Office as of 7/31/2020 for review with OCFO. Legal working with Vendor. Submitted new business case docs for participation agreement.9/4/2020. In Legal office 10/30/2020. Followed up 1/4/2021 Megan is reviewing. No updated provide from Legal Jan 21

PROCUREMENT

Battelle Decontamination Services. This service is of zero cost to UMC and will provide decontamination services of our N95 masks to preserve supply. Current burn rate 275 masks per day (Monthly) May slow down due to lack of surge.	4/23/2020	$300,000	Business Case Signed by CEO/CMO on 4/23/2020. Sent Service Agreement and signed business case to Legal 4/23/2020 and uploaded to Contracts Guardian per new process. 6-4-2020 Procurement provided Legal with DC contact to see if we can utilize program under their contract. No update provided. No update. Followed up 1/4/2020 Megan is reviewing. No response from Legal on status of contract. Jan 2021
Air Products Bulk Oxygen price renegotiation (Monthly)	11/7/2019	$8,000	Legal Sent Contract Edits to Vendor 01/24/2020. Vendor disputed and Legal. Legal never followed up with Vendor. We are still using these services. 6/30/2020 no new updated. Reengaged vendor on 8-3-2020 awaiting COTR and Legal Involvement Followed up 1/4/2020 Megan is reviewing. Vendor wants multiple year contract to provide discounts.
Renegotiated Konica Minolta Printer Agreement (Monthly)	11/08/2019	$22,000	Approved by Budget Now in Legal Department to Process No Edits Sent to Vendor as of 2/11/2020. 6-4-2020 No edits sent to Vendor that Procurement has visibility to. Followed up 1/4/2021 Megan is reviewing. Met with Vendor and IT to understand requirements and new SLA's to benefit the hospital
Cardinal Supply Assurance Exam Gloves	11/30/2020	Prevents off contract spend	Program that will lock Cardinal in to an annual committed amount of gloves to distribute to UMC. This program will prevent us needing to purchase off contract exam gloves. Sent to legal for review and signature. Contract signed and implemented Jan 21
Ramco Pandemic Control Solution Proof of Concept Trial Contracts Guardian	9/30/2020	Prevents human contact temperature processing with entering the building the cost savings here will be employee labor and reduction ~$488,000	Ramco's Pandemic Control Solution services to perform "safe entry, prescreening, and facial recognition processing for employees and guests of UMC. Contract with Legal after vendor provide updates. Awaiting Legal, OCFO, and vendor signatures. 1/4/2020. Contract signed Jan2021 facilities has not implemented.

PROCUREMENT

Office of CFO			
Lucrotec AP card payment processing	10/15/2020	$500,000+	Initial analysis and presentation provided to Budget Office and Controller 10/20/2020. Meeting with UMC Team and vendor on 11/03/2020, went very well. Presentation sent to OCFO, CEO and Controller awaiting OFCO feedback. Sent follow up 12-1-2020 no response. No response 2/26/2021
Road Runner Recycling Program for waste management	08/13/2020	$27,000	Business case and documents sent to Budget office 8/13/2020 and uploaded to Contracts Guardian. No response as of 9/4/2020. Awaiting feedback from OCFO Sent follow up on 12/1/2020 no response. Budget office approved Jan21 Legal worked with vendor had all signatures then budget office denied contract Feb 19, 2021
Implement Records Retention Policy & Destroy Records 10 years & Older Per AHIMA Guidelines That Are in A GRM Warehouse	11/19/2019	$15,000	OCFO Denied Plan to Move Forward Reason Not Provided 11/25/2019.
Procurement			
Finalizing Cardinal Contract to Complete Product Conversions with ICU Medical Supplies, Incontinence Pads, and Lead Wires, Electrodes (Monthly)	11/15/2019	$118,000	Contract with Legal Spend Over 3 Million Needs to Go to Board. Costing us 2-3 times more per supply products purchasing outside of contract. Sent to Legal and had meeting with Legal on 6/29/2020 to move forward. Procurement Manager working on implementing Product Review Committee 1/4/2020

***** 2/04/2021 Annual Total Identified Not Fully Realized Projected $1,583,000 *****

***** If All Above Initiatives Are Executed by Feb 1st, 2021 Projected 9-month FY2021 Savings $1,055,333**

***** If All Above Initiatives Are Executed by Feb 1st, 2021 Projected 3-month FY2022 Savings $527,667**

Savings Captured	Date	FY 2020 Projected Savings	FY 2021 Projected Savings	Annualized Savings
Notable Procurement Wins				

PROCUREMENT

Ramco	01/15/2021	$0	N/A	N/A
Cardinal Glove Supplier Assurance Program	01/12/2021	$0	$32,000	$27,000
Cardinal Blood Pressure Cuffs	12/23/2020	$0	$50,000	$50,000
Cardinal OptiFreight Logistics	12/16/2020	$73,980	$98,640	$98,640
Vizient GPO Rebates (Q2 2020) (One Time)	10/30/2020	$0	$59,422	$59,422
ICU Medical Contract	10/27/2020	$0	$90,750	$99,000
ConvaTec Wound Care Product Conversion	9/24/2020	$0	$28,000	$28,000
Cardinal SCD Contract (Monthly)	7/23/2020	$37,500	$187,500	$225,000
Vizient GPO Rebates (Q1 2020) (One Time)	7/1/2020	$63,530.91	$0	$63,530.91
Vizient GPO Achieve Program Contract (Monthly)	4/13/2020	$33,333.33	$46,667	$80,000
Vizient GPO Rebates (Q4 2019) (One Time)	4/1/2020	$42,854	$0	$42,854
Cardinal product conversion on Wipes from qty. 8 pack to qty. 64 (Monthly)	3/11/2020	$20,000	$20,000	$40,000
Switching Elevator Service Providers to ThyssenKrupp from Otis (Monthly)	3/16/2019	$22,500	$22,500	$45,000
Patient Band Product Conversion to Typnex (Monthly)	3/1/2020	$7,500	$7,500	$15,000
Renegotiated Ortho Contract (Monthly)	1/29/2020	$78,000	$39,000	$117,000
Renegotiated DCPA Licenses (Monthly)	1/2/2020	$16,000	$0	$16,000
Vizient GPO Rebates (Q3 2019) (One Time)	1/26/2020	$48,561	$0	$48,561
Renegotiated Morrison Dietary Services Contract (Monthly)	1/2/1/2019	$219,000	$73,000	$292,000
Renegotiated Kronos Time Clock to include GSA pricing (One Time)	11/7/2019	$23,000	$0	$23,000
Renegotiated Quest Diagnostics Contract (Monthly)	7/1/2019	$65,000	$0	$65,000

HUMAN RESOURCES BOARD REPORT

April 6th, 2021

STAFF COMPOSITION – MARCH 2021

Employee Data				
Employee Data by Group	**# of EEs**	**DC**	**Ward 7**	**Ward 8**
Total FTE	707	173	57	87
Total Active Employees (Full-time, Part-time, and relief staff)	845	188	58	94
Total Union (Active EEs)	525	122	37	60
Total Non-Union (Active EEs)	320	66	21	34

Employee Demographics								
Age (Average)	50 Years Old	Race	African American 85%	Gender	Female - 70%	Male – 30%	Average Tenure	10 Years

Union Data				
Total Active Union EE by Group	**# of EEs**	**DC**	**Ward 7**	**Ward 8**
Total Active Union EEs DCNA	199	15	2	7
Total Active Union EEs SEIU	288	93	31	47
Total Active Union EEs UFSO	28	11	4	5

UMC Annual Turnover (YTD)			
	UMC Rates	NE Region	National Average
Hospital Turnover	8.5% *	16.2%	17.8%
RN Turnover Rate	16.39% (5.51% Mar)	13.8%	15.9%

The Hospital FY20 turnover rate is significantly below the national and northeast region averages according to the 2020 Nursing Solutions National Health Care Retention & RN Staffing Report. A study in the 2020 National Healthcare Retention & RN Staffing Report indicated that the national hospital turnover rate was 17.8%. Alarmingly, the average hospital turned over 89% of its workforce since 2015.

*Due to the SNF Closure that took place at the end of the year, the Hospital turnover rate has increased to 8.5% from 6.9%.

New Hire Positions March 2021

TALENT ACQUISITION/RECRUITING

New Hires (Year to Date)												
Department Name	Oct 20	**Nov 20**	**Dec 20**	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21
4W Psych Unit		1	-	-	2	3	-	-	-	-	-	-
5W Med/Surg.		2	-	1	2	2	-	-	-	-	-	-
8W Telemetry		1		1	3	2						
ER Admission (OCFO)		1	-	-	-	-	-	-	-	-	-	-
Care Management		-	3	-	-	.1	-	-	-	-	-	-
Clinical Lab		2	1	1	-	-	-	-	-	-	-	-
Critical Care Unit	1	1	-	-	2	.1	-	-	-	-	-	-
Emergency Dept.	4	5	1	.8	3	-	-	-	-	-	-	-
Hospital Admin		-	-	.1	-	-	-	-	-	-	-	-
Linen Department		-	-	-	1	-	-	-	-	-	-	-
Medical Affairs		1	-	-	-	-	-	-	-	-	-	-
Nursing Admin		-	-	-	2	.1	-	-	-	-	-	-
Office of the CFO	2	-	-	-	-	-	-	-	-	-	-	-
Patient Care Center		1	-	-	-	-	-	-	-	-	-	-
Pharmacy		-	-	1	-	-	-	-	-	-	-	-
Radiology/MRI/Cat		3	1	-	2	-	-	-	-	-	-	-
Respiratory Therapy	1	-	-	1	-	.1	-	-	-	-	-	-
Risk Management					1							
Security		-	-	1	-	.1	-	-	-	-	-	-
Surgery				1	2							
Telecom		-	1	-	-	-	-	-	-	-	-	-
Totals	8	18	7	16	20	12	-	-	-	-	-	-

New Hire Positions – MARCH 2021		
Critical Care Unit	Clinical Nurse	1
4W Psych Unit	Psych Nurse	1
4W Psych Unit	Psych Tech	2
8W Telemetry	RN	2
5W Med/Surge	Patient Sitter	1
5W Med/Surge	Unit Secretary	1
Nursing Admin	Wound Care Tech	1
Case Management	Director of Case Mgt	1
Respiratory	Respiratory Specialist	1
Security	Special Police Officer	1
	Total	**12**

March 2021 UMC New Hire Residence	
Residence	Number
Washington, DC	**2**
Washington, DC Ward 7	**0**
Washington, DC Ward 8	**0**
Maryland	**8**
Virginia	**2**
Totals	**12**

SEPARATIONS

Voluntary Separations (Year to Date)												
Department Name	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21
CCU/ICU		-	-	-	-	1	-	-	-	-	-	-
4W Psych Unit		1	-	.1	-	1	-	-	-	-	-	-
5W Med/Surg		1	-	-	2	2	-	-	-	-	-	-
8W Tele/Med		-	-	.1	-	-	-	-	-	-	-	-
Emergency Dept	2	-	1	-	1		-	-	-	-	-	-
Clinical Lab		-	-	-	1	-	-	-	-	-	-	-
Office of CFO				1								
Centralized Sched (OCFO)		-	1	-	-	-	-	-	-	-	-	-
Respiratory Therapy	1	-	-	-	-	-	-	-	-	-	-	-
Risk Mgt		1	-	-	-	-	-	-	-	-	-	-
Human Resources		-	1	-	-	-	-	-	-	-	-	-
Bio Medical Eng		1	-	-	-	-	-	-	-	-	-	-
Skilled Nursing Facility	2			-	-	-	-	-	-	-	-	-
Special Police						1						
Totals	5	4	3	3	4	5	-	-	-	-	-	-

Involuntary Separations (Year to Date)												
Department Name	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21
Environmental Services	-	-	-	-	-	-	-	-	-	-	-	-
Emergency Dept.	-	-	-	-	-	1	-	-	-	-	-	-
Primary Care (MOB)	-	-	-	-	-	-	-	-	-	-	-	-
ICU	-	-	-	-	-	1	-	-	-	-	-	-
8W Med/Surg	-	-	-	-	-	2	-	-	-	-	-	-
5W Med/Surg	-	-	-	-	-	2	-	-	-	-	-	-
Resp. Therapy	-	-	-	-	-	-	-	-	-	-	-	-
Skilled Nursing Facility	-	1	78	-	-	2		-	-	-	-	-
Medical Lab	-	-	-	-	-	-	-	-	-	-	-	-
Special Police	-	-	-	-	-		-	-	-	-	-	-
Patient Care Center						1						
Pharmacy	-	-	-	-	-	-	-	-	-	-	-	-
Office of General Counsel						1						
Nursing Administration	-	-	-	-	-	4	-	-	-	-	-	-
Communications	-	-	-	-	-	-	-	-	-	-	-	-
4W BHU	-	1	-	-	-	1	-	-	-	-	-	-
Radiology	-	-	-	-	-	-	-	-	-	-	-	-
Totals	-	2	78	-	-	15	-	-	-	-	-	-

REDUCTION
WARN NOTICES
MARCH 17, 2021

DEPARTMENTS

-OUTPATIENT SERVICES
10 POSITIONS AFFECTED
MARCH 17, 2021

-PHYSICIANS
2 PHYSICIANS AFFECT
MARCH 17, 2021

NOTICES:
-SENT TO SEIU & DCNA ON MARCH 17-18, 2021
-IN-PERSON MEETINGS MARCH 17-18, 2021
3 POSITIONS IN OUTPATIENT SERVICES WILL CONTINUE TO WORK UNTIL MAY 17, 2021

UMC

UNITED
MEDICAL CENTER

General Board Meeting

Date: April 28, 2021

Corporate Secretary Report

Toya Carmichael

UMC
UNITED
MEDICAL CENTER

NOT-FOR-PROFIT HOSPITAL CORPORATION

CORPORATE SECRETARY REPORT

TO: NFPHC Board of Directors

FROM: Toya Carmichael
Corporate Secretary / Special Counsel

DATE: April 1, 2021

GENERAL UPDATE

During the month of March, the PR team supported WILL Interactive a local film company that creates training videos. WILL Interactive rented space from UMC for the second time in less than 12 months generating revenue for both the hospital and the Cafe.

PUBLIC RELATIONS

Weekly Newsletter – Distributed bi-weekly on Friday via all staff email and included on UMC website. During the month of March, the UMC Newsletter celebrated Women's History Month and Women and Girls HIV/AIDS Awareness Day provided tips on saving for retirement and maintaining a healthy lifestyle. As the PR Department has been shut down, the newsletter has accordingly been discontinued.

News Media– The PR team continues to track news articles and social media mentions which are now listed in the bi-weekly newsletter. UMC appeared in one news article in the month of March.

UMC
UNITED
MEDICAL CENTER

General Board Meeting Date:
April 28, 2021

Performance Improvement Committee Report

Presented by:
Dir. Girume Ashenafi

NFPHC Performance Improvement Committee
(Quality and Safety)
April 20, 2021 | 4:00 – 5:30 pm| Conference Call & Zoom Meeting

AGENDA ITEMS

1. Call Meeting to Order

2. Approval of the Minutes (March 16, 2021)

New Business – Hospital-Wide Programs

3. Chief Medical Officer Report – Dr. William Strudwick

4. Emergency Department Report – Dr. Francis O'Connell and Teka Henderson

5. Provisions of Care, Treatment & Services Report – Dr. Jacqueline Payne-Borden
   - Improvements with Patient Care (Attachment 1)
   - Staffing and Recruitment Updates

6. The Final Joint Commission Report – Ken Blackwell (Attachment 2)

7. DC Health Food Establishment Inspection Report – Marcela Maamari (Attachment 3)

COVID-19 Reports

8. COVID-19 Vaccination Report – Dr. William Strudwick & Marcela Maamari (Attachment 4)

9. DC Health COVID-19 Report – Sylvia Clagon (Attachment 5)

Standing Reports – Standing Reports have been updated and are attached for your perusal and the Team is ready to address questions.

10. Compliance Report – Brian Gradle (Attachment 6)

11. DC Health Hospital Survey Readiness Update – Tracy Follin & Leslie N. Rodney
    - Action Plan for the upcoming hospital survey (Window begins February onwards)

12. Quality Assessment Performance Improvement (QAPI) Department Reports and Quality Dashboards (Attachment 7)
    - March Report – Tracy Follin & Leslie N. Rodney

13. Pharmacy – Maxine Lawson (Attachment 8)

14. Patient Experience/Patient Advocacy – Denise Vernon
    - Press Ganey Report (Attachment 9)
    - Management Council March Presentation

15. Environment of Care Key Initiatives: March 2021 – Ken Blackwell
    - Fire drill matrix inspection - Compliant
    - Fire door repairs – 85% complete
    - Ice Machine Weekly inspection – Compliant
    - Revised Exit Light Monthly Documentation- Compliant
    - H-Cylinder Storage Inspection Log- Compliant
    - Fire Door Functional Inspections – Compliant
    - IT Closet Floor Penetration Inspections – Compliant
    - ICU Depicted as a Suite on LS Drawings – Compliant
    - NO Exit signs posted - Compliant
    - Storage rooms door functional test – Compliant
    - Missing Ceiling Tile Inspections - Compliant
    - Storage less than 18 inches to sprinkler head – Compliant
    - Escutcheon Plate Inspections – Compliant
    - Hydrocollator Water Change Inspection – Compliant
    - Ceiling inspections – Compliant
    - BHU EVS Room Inspections – Compliant
    - BHU thermostat covers Inspections – Compliant

16. Facilities & Support Services – Ken Blackwell
    - Utility Report – Ken Blackwell (Attachment 10)

Facilities: March 2021 Project Updates

Project	Status	Targeted Completion Date
IT Closets	80 % complete. The project is progressing as planned. Two additional closets were added which increased the targeted completion date.	May 31, 2021
MRI	75% complete. The project is moving as planned. The mobile unit was delivered. However, we've had to amend the current permit to include the required work within the mobile unit. Amended permit submitted, awaiting a response from DCHA.	May 31, 2021
Pharmacy	Certificate of Occupancy Received. Punch list Created.	May 31, 2021
Fluoroscopy	98% Completed. Application for the Certificate of Occupancy is in preparation.	May 31, 2021
Data Center	90% of the FM 200 unit Suppression unit has installed.	May 15, 2021
Fire Door Repairs	85 % completed which includes all fire doors on floors 8 – Ground.	April 30, 2021
Chiller #1 Replacement	New chiller was ordered in November with a 20 lead time.	Completed
1 North Air Handler Unit	Approved by the NFPHC	TBD

Project	Broad. Awaiting DC Council Approval	
Upgrade Equipment Management System Project.	Approved by NFPHC Board. Awaiting DC Council Approval	May 31,2021
8 Air Handler Unit Replacements	Award was issued on 6/19. Upon final approval by DC Council, we anticipate the project to last 7 to 8 month.	TBD
3rd Floor Reopening	Telemetry Equipment Installation	Completed
5th Floor	Telemetry Equipment Installation	• Week of May 10 Equipment Arrival • Week of May 17 Install and Training • Week of May 24 Go Live
Kitchen Cart Wash	Assigned To Architect preparing to reapply for DCRA permit.	TBD
Materials Management	Design phase completed. New shelfing was installed as a part of the Pharmacy project	TBD

17. Information Technology: Key Performance Improvement Initiatives – David Parry

Expansion of information to patients and providers

- We are currently providing all available 'patient portal' information from Meditech, in compliance with the Cures Act to ensure patients have access to their medical record information
- Meditech has released an update that will enable additional clinical information to be provided on the patient portal; more than a dozen new additional items will be available, including History and Physical, Consultation notes, Lab reports and Progress notes; we expect to complete the necessary work for the additional clinical information to be available to patients by June 30, 2021
- PACS - We are working with the regional HIE (CRISP) to enable the availability of UMC patient reports and images to providers through the CRISP portal; a tentative go-live date is July 31, 2021

- ADT notification to providers – we have completed this work with the regional HIE (CRISP) to be in compliance with the CMS Cures Act

Clinical documentation and workflow enhancements

- Insulin Non-DKA Protocol (Targeted go-live is June 30, 2021)
  - In Meditech, enable order sets and protocol guidelines for the physician to order the medications/orders and nursing to document the insulin titrations via the eMAR; will be available for critical care and ED to improve patient outcomes/safety; will be presented at P&T and then MEC for approval to be implemented in Meditech
- Therapeutic Hypothermia Protocol (Targeted go-live is May 15, 2021)
  - In Meditech, enable electronic order sets to be implemented within the ED and Critical Care environments; reviewed Nursing/Lab/Rad and Medication Orders to be initiated by providers in ED and Critical Care environments; to enhance patient outcomes and safety
- Hyperkalemia Guideline (Targeted go-live is April 22, 2021)
  - In Meditech, enable the pharmacy initiative written policy through an electronic build of one order set to be shared within the ED and Critical Care environments to allow consistent patient standard of care; reviewed best practices and rationales for treatment of hyperkalemia with medication treatment protocols; order set is to be initiated by providers in ED and Critical Care; increased patient safety - orders/guidelines in one place

Pharmacy Drug Database – We have completed the initial clean-up and updates, and have implemented procedures to keep the database current in Meditech

Authorized IT system access by end-users

- We are performing quarterly validations with all managers to ensure only authorized users have access to UMC electronic systems; we successfully completed our first quarter validation in March, 2021; we have started our second quarter validation and expect to have this completed by the end of May, 2021
- We are working with Human Resources to develop additional procedures for enhanced communications of employee status changes that require system access modifications; more information on this initiative will be provided at upcoming meetings

Patient and family video conferencing tablets

- Enabled for ICU
- We have additional devices to deploy if needed

18. The Joint Commission – Ken Blackwell, Sylvia Clagon, Dr. Jaqueline Payne-Borden, and Dr. William Strudwick (Attachment 11)
    The SAFER Matrix Monitoring Sheet and monthly monitoring is to ensure all corrections are in compliance.

19. Safety & Security Report and Fire Drill Matrix Report – Derrick Lockhart (Attachment 12)

20. Updates: Hospital Licensure/Survey/Accreditation Activities for 2021 (Attachment 13)

Closed Session

21. Risk Management Report – Wendy Faulkner

22. Adjournment

NFPHC Performance Improvement Committee
(Quality and Safety)
March 16, 2021 | 4:00 – 5:30 pm| Conference Call & Zoom Meeting

AGENDA ITEMS

Dirs: Dir. Gorham, Dr. Fair, Dir. Bobb, Dir. Ashenafi

UMC Staff: Ken Blackwell, David Perry, Wendy Faulkner, Denise Vernon, Mike Austin, Toya Carmichael, Dr. Faye Goode Vaddy, Brain Gradle.

1. Call Meeting to Order

2. Approval of the Minutes (February 16, 2021) Mot to approve by Dir. Gorham, 2nd by Dir. Ashenafi, unanimous vote.

New Business – Hospital-Wide Programs

3. Provisions of Care, Treatment & Services Report – Dr. Faye Goode-Vaddy

    - The nursing department continues educating the staff.
    - Feb had 2 patients hapi and in March we have had 1 thus far.
    - Still experiencing staffing challenges and supplementing with agency nurses and actively recruiting.
    - At the time the report was submitted we were 99% compliant with the flu vaccine but now we are 100%.
    - Dr. Fair asked if we had to terminate any staff who did not get vaccinated? No, we did not have to terminate any staff due to the flu vaccine requirement and received one waiver yesterday which is how we got to 100%.

4. The Safety Culture Action Plan & Training & Education – Tracy Follin & Leslie N. Rodney
    - Leslie noted that Dr. Shepard conducted the education and she is not sure where we are with the plan.

5. Compliance Report – Brian Gradle (Attachment 2)
    - Discussed the patient safety and review board and noted that it includes Wendy Faulkner, Akia Embry, Mike Austin, Brian Gradle, and Denise Vernon now meeting on a daily basis each day after the safety huddle. The first task we are taking on is publicizing the “see something say something” message to staff regarding patient safety. We have also been providing training for all new employees, contractors, and students to report that if they see a patient safety issue they have a duty to report it.
    - Dr. Fair asked if the internal policies have been completed and communicated to staff on what the policies are and how to report an incident? Have we been receiving reports?

Brian stated we already have internal policies and we are working on posters to communicate where to report. The reports do come in and they come in via security or through the compliance line.

- Dr. Fair asked about the composition of the review board and if there is or a thought about a community member serving on the panel.
  Denise Vernon stated that Brian Gradle came up with a list of people he wanted to serve on the review board.
  Colene added that no member of the public is on the review board panel because it would require them to be vetted by HR and legal and sign confidentiality agreements.

6. DC Health Hospital Survey Readiness – Tracy Follin & Leslie N. Rodney
   - Leslie stated that the plan is to increase education to clinical and non-clinical units in the hospital. Working with nursing department to make sure we are ready.

COVID-19 Reports

7. COVID-19 Vaccination Report – Dr. William Strudwick & Marcela Maamari (Attachment 3)
   - 6400 doses provided to date.
   - Today started a collaboration with Walgreens Pharmacy to expand the good work we started in the community. The partnership will allow us to grow to 400 vaccinations per day. There will be more to be said as we go forward.
   - The most common zip code is 20020 and 20032 and 20019. Approximately 40% of staff are fully vaccinated and 60% of the people we have vaccinated identify as Black or African American.
   - We will be moving the vaccination clinic from the hospital to the old dialysis building.
   - Colene noted that we will continue to manage the scheduling by doing it on paper and then Walgreens will add it to their system because we know our residents especially the seniors have a hard time with the citywide portal. The purpose of the call with DC health was to work out the details of the partnership.

Standing Reports – Standing Reports have been updated and are attached for your perusal and the Team is ready to address questions.

8. Quality Assessment Performance Improvement (QAPI) Department Reports and Quality Dashboards February Reports – Tracy Follin & Leslie N. Rodney
   - Dashboard remains largely unchanged since the beginning of the year. We have had improvement with two nurses signing transfusion tags. As of February we are at 99%.
   - Hand hygiene compliance is 99% which exceeds our threshold
   - Bottom of page 7 and top of page 8, medication safety, we still do well with scanning patients we are at 94% for February but we were 83% for medication scans in February and January. About the same for medication conciliation in the ED and inpatient. We have some strategies to implement in the emergency room and we hope to recognize some improvement in our compliance there. On page 9, when we look at the % of patients who recommend UMC and our overall rating we have seen drastic improvements. In February we were at 50% and 64% for those who would recommend the hospital which is above our goal of 50%.
   - We reconfigured the pressure ulcer data, if you look we had .5% of happied rate, of the two incidents one was reportable. On page 11, case management length of stay has gone up just a bit from 2020 and we do have some room to improve.

- Dr. Fair asked what we are doing to address the scanning issue?
  Dr. Lawson responded worked with nursing to determine what can't be scanned so when we have a medication that can't be scanned we create our own barcode so they can be safely scanned.

9. Pharmacy – Maxine Lawson (Attachment 4)
   - No new formularies or protocols to review at last PNT.
   - Are in the window for our annual survey preparedness and we are focusing on the first 5 things they usually check for like making sure all pharmacists have done their fingertips test results and IV room results. 15 of the 18 staff have received their results and have been successful. Licensures were due February 28th but they have all been renewed. We have been doing methadone overrides weekly, and some are done daily.

10. Patient Experience/Patient Advocacy – Denise Vernon
    - Press Ganey Report (Attachment 5)
    - Noted that emergency room received 85% positive comments and we did improve in score and rank amongst all the hospitals that participate in Press Ganey. The ED response rate continues to decline however, those patients who are returning the survey are giving us 9s and 10s.
    - The main areas of improvement for the 5th floor in January they scored 32%, they exceeded expectations regarding Dr. communication. Overall ratings were lower with fewer participants. Areas of improvement were staff responsiveness and hospital environment. Scores did increase in February.
    - Dr. Fair congratulated the hospital on the improving patient experience scores.

11. Environment of Care Key Initiatives: February 2021 – Ken Blackwell
    - Provided update on the projects listed in the table.

Facilities: January 2021 Project Updates

Project	Status	Targeted Completion Date
IT Closets	80 % complete. The project is progressing as planned. Two additional closets were added which increased the targeted completion date.	April 30, 2021
MRI	75% complete. The project is moving as planned. The mobile unit was delivered. However, we've had to amend the current permit to include the required work within the mobile unit. Amended permit submitted, awaiting a response from DCHA.	April 30, 2021
Pharmacy	Certificate of Occupancy Received. Punch list Created.	April 30, 2021
Fluoroscopy	98% Completed. Application	April 30, 2021

	for the Certificate of Occupancy is in preparation.	
Data Center	90% of the FM 200 unit Suppression unit has installed.	April 30, 2021
Fire Door Repairs (TJC Waiver)	85 % completed which includes all fire doors on floors 8 – Ground.	April 30, 2021
Chiller #1 Replacement	New chiller was ordered in November with a 20 lead time.	March 31, 2021
1 North Air Handler Unit Project	Approved by the NFPHC Broad. Awaiting DC Council Approval	TBD
Upgrade Equipment Management System Project.	Approved by NFPHC Board. Awaiting DC Council Approval	TBD
8 Air Handler Unit Replacements	Award was issued on 6/19. Upon final approval by DC Council, we anticipate the project to last 7 to 8 month.	TBD
3rd Floor Reopening	Telemetry Equipment Installation	Completed
5th Floor	Telemetry Equipment Installation	April 30, 2021
Kitchen Cart Wash	Assigned To Architect preparing to reapply for DCRA permit.	TBD
Materials Management	Design phase completed. New shelfing was installed as a part of the Pharmacy project	TBD

12. Information Technology: Key Performance Improvement Initiatives – David Parry

- Expansion of clinical information on patient portal
  - We are on target to complete the expansion of available Meditech information by the original target date of April 5, 2021
  - Meditech will be releasing an update later this year (currently targeted for 2nd quarter of calendar year 2021) that will allow us to further expand the available data set; we will establish a target date once the release and pre-requisites are communicated by Meditech
- ADT notification to providers (May 1, 2021)
  - We are working with the regional HIE to complete and expect to be done by the required target date
  - Working with HIE for PAX images and reports to their database which would make that information available to providers outside of UMC.
- Authorized end-user audits – quarterly validations to ensure only authorized users have UMC system access (initial - March 1, 2021)
  - We completed our first quarter audit on time
  - We will be performing audits every quarter going forward

- Next audit will begin next month to make sure we are only enabling authorized users to our applications and we find it very useful.

- Pharmacy Drug Database Upgrade to improve charges and clinical interaction checks (April 1 2021)
  - We are on target to complete our initial update and then will initiate the plan to keep the database current and we will continue to work with Dr. Lawson's team to remain in compliance.
- Patient and family video conferencing – Enable for ICU patients (March 1 2021)
  - We successfully deployed an initial device; the device is fully in use
  - We have received 3 other tablets and are in process of configuring them for additional use through the ICU and/or the facility for patients who would like to communicate with family while we are still restricting visitors.
  - Dr. Fair asked if she missed something about our system as she recalled a previous report that our Meditech system could not be updated.
    David said no there are some regulatory requirements and updates that need to be made and we can do those through Meditech magic. We have also worked with Meditech to tailor system functionality when there is an opportunity to add additional work flows and screens for nurses and departments throughout the hospital. It is an older system and not always pretty to look at but you can do some updates to make it better.

13. The Joint Commission – Ken Blackwell, Sylvia Clagon, and Dr. William Strudwick (Attachment 6)
    The SAFER Matrix Monitoring Sheet and monthly monitoring is to ensure all corrections are in compliance.
    - Ken Blackwell started by going back to the UMC initiatives which are directly related to our success. The safer matrix is based on the findings we had during our JC visit. We are 100% across the board with the exception of our fire doors. We are in the window for their return and we look forward to their return so we can receive our gold seal.
    - Ms. Clagon added that one of the items discovered was that they wanted the staff to talk about how they handle soiled reusable surgical instruments and we now have in place a training and process and materials where they can put those materials in puncture resistant containers on each unit and have been doing rounds and talking to staff. Staff are now able to talk through the process.
    - Dr. Strudwick added that we had some gaps with credentials and we have put in place a process so we don't have those gaps. So now we are documenting why there are gaps where they exist and documented the rules and how to get those submitted on time. The second gap was credentialing so we are now using Med Staff which prompts us when credentials are due.

14. Safety & Security Report and Fire Drill Matrix Report – Derrick Lockhart (Attachment 7)
    - There was a significant increase in all of our areas with the exception of gunshot wounds. All of the increases were due to the increase of FD12s and the type of FD12 patients we receive especially when other facilities go on diversion. Our FD12 patients tend to be those who were recently released from an institution and are still under monitors with ankle bracelets. Reviewed the statistics. BHU combative patients went from 18 to 30 and some of these incidents resulted in full out assaults, bites, and strikes and one security officer who received very serious injuries including a concussion, stitches in the face, etc. There are several days in February that has continued through March were we have had to have 3-4 security guards on the BHU unit so staff could do their work safely.
    - We are in compliance with all the fire drills.
    - Dir. Bobb asked if the individuals with behavioral health issues brought to the hospital by a District agency, the police department or did they come in on their own?

Derrick responded that it is a mix but a lot of them are brought by CPAP and MPD. One patient came into the ED under the influence of drugs and the patient became combative and we had to take the patient down and recovered a glock which was turned over to the police department. Colene added that we have met with the emergency room department and security. Wendy Faulkner has created a report which we sent to DCHA who is going to meet with staff and we are also having a meeting with the police department and first responders to discuss the fact that they are too often bringing in patient who have weapons. Another meeting will occur with CPAP to come up with another alternative when CPAP is full because we are not equipped to handle those types of patients.

15. Emergency Department Report – Dr. Francis O'Connell and Teka Henderson
    - Overall things have been stable in the emergency room. The bigger take aways are in Dr. O'Connell's letter to the board.
    - Acknowledged that hospital administration and nursing administration has dedicated quite a bit of time bringing in agency and traveling nurses and gave kudos to Teka who has interviewed and brought in a number of new staff who make the unit safer and more productive. Hope this will remain constant. We have talked about making more beds available and moving patients faster which will allow ambulances to stop passing by UMC because we are full.

16. Facilities & Support Services – Ken Blackwell
    - Utility Report – Ken Blackwell (Attachment 8)
    - Went through the utilities monitored. Our critical areas are our OR and rooms 3 and 4 in the emergency room. If the rooms are designed to be negative, we want the air right in the corridor…this ties into infection control. We also test to make sure our water is healthy. Had one steam utility failure in February. We have old air handlers and we are doing everything we can to maintain the ones we do have and for our patient care areas we are going to take a different approach and refurbish our air handlers which take less time than it does to replace them. We did not have any power outages or interruption in the month of February. No water intrusions in February but we do have a leak on the penthouse floor. What we tried to do with the air handlers or example we are trying to show the actual labor costs which are going down. But on a monthly basis we have to reach out to our contractors when issues occur so this number will likely be a constant. We are not totally manned the way we need to be to meet certain benchmarks so that often requires we use overtime to fix the issues.

17. Hospital Licensure/Survey/Accreditation Activities for 2021 (Attachment 9)
    - Colene noted we are focusing on our waiver for the fire doors so JC can come back in and verify that we have met all the requirements for a conditional level.
    - JC has given notice to the hospitals that they will not give a heads up of future visits. We are also putting in a plan for the DC Hospital survey so we are going to move things up because our window is April – July for this visit.

Closed Session

- Mike Austin read the justification. Roll Call vote by Toya Carmichael unanimous vote.
- Mot to end closed session by Dir. Gorham, 2nd by Dir Ashenafi, unanimous roll call vote by Toya Carmichael.

18. Adjournment at 5:33pm.

NFPHC Performance Improvement Committee

Patient Care Services

Provision of Care, Treatment & Service Report for March 2021

- Improvement with Patient Care:
  - A small but significant change in practice was implemented. Patients who are in the ED for an extended stay, (not to exceed 8 hours), and was admitted but cannot be taken to the unit due to varying reasons are transferred from the ED gurney to an actual hospital bed. These patients are designated as ESAP – Extended Stay Admitted Patients. This change in practice should improve the patient comfort level and decrease the possibility of skin breakdown in at risk patients.
  - The current practice of using cooling blankets to regulate the temperature of post cardiac arrest patients will be replaced by the Arctic Sun Temperature Management System. This is a non-invasive targeted temperature management system used to regulate patients who meet certain inclusion criteria post cardiac arrest. Temperature regulation should be started as soon as possible after the return of spontaneous circulation (ROSC). It is more accurate and user friendly than cooling blankets. The Administrative Nursing Supervisors, ED, OR, ICU leaders and staff accomplished both didactic, and hands on training with the actual Artic Sun machine. The order set and documentation workflow was built in Meditech by IT; providers and nurses are practicing ordering and documentation in Meditech. A tentative go-live date is planned for the end of April.

  - <u>Recruitment and Onboarding by Unit</u>
    - Recruitment efforts continues for all units. While we await outcome of recruitment efforts we continue to utilize supplemental staff for the Intensive Unit, Emergency Department, 8W- Telemetry, and BHU. At present there are 22 supplemental staff.
    - 7 Per Diem RNs – 3 BHU, 2 ED, 2 ICU
    - 15 Traveler RNs
      - 3 ICU – day
      - 3 ICU - night
      - 2 ED - day
      - 4 ED – night
      - 3 Telemetry – night
- Staffing and Recruitment Updates:
  - The major focus at present is providing adequate and consistent staffing. There are steady increases with the gaps in staffing which proves challenging. Reasons for gaps include vacancies, terminations, resignations, and illnesses. * **See table.**

Unit	Covid-19	FMLA	Other Illnesses	Termination	Retirement	Resignation	On Boarded
BHU	0	0	0	0	Sec. 0.6	0	0
ICU/CCU	0	RN 2.3	*3.9 (14 days)	0	0	0	0
5W	0	RN 1.0 Sitter 1.0	0	0	0	RN 1.6 MST 3.0	Sitter 1.0 USec.0.6
8W/Tele	0	RN 0.6	0	0	0	RN 0.9 MST 0.9	
ED	0	RN 1.5 Unit Cord. 1.8	0	0	0	0	0
OR/PACU	0	0	0	0	0	0	0
DIALYSIS	0	RN 0.9	0	0	0	0	0

***Combined absence of 14 days amongst the 3.9 RN FTEs**

Respectfully Submitted,

April 14, 2021

Jacqueline A. Payne- Borden, PhD, RN, NEA-BC

Chief Nurse Officer

April 14, 2021

Colene Daniel
CEO
Not-for-Profit Hospital Corporation
1310 Southern Ave. SE
Washington, DC 20032

Joint Commission ID #: 472805
Program: Hospital Accreditation
Accreditation Activity: Unannounced Medicare Deficiency Survey
Accreditation Activity Completed : 4/9/2021

Dear Ms. Daniel:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Hospital

This accreditation cycle is effective beginning November 14, 2020 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer and Chief Nurse Executive
Division of Accreditation and Certification Operations

The Joint Commission

April 14, 2021

Colene Daniel
CEO
Not-for-Profit Hospital Corporation
1310 Southern Ave. SE
Washington, DC 20032

Re: # 472805
CCN: # 090008
Deemed Program: Hospital
Accreditation Expiration Date: November 14, 2023

Dear Ms. Daniel:

This letter confirms that your November 10, 2020 - November 13, 2020 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on January 22, 2021 and the successful unannounced Medicare Deficiency follow-up event conducted on April 9, 2021, the area of deficiency listed below have been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of November 14, 2020. We congratulate you on your effective resolution of these deficiencies.

§482.41 Physical Environment

The Joint Commission is also recommending your organization for continued Medicare certification effective November 14, 2020. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following location(s):

Not-for-Profit Hospital Corporation
1310 Southern Ave. SE, Washington, DC, 20032

Not-For-Profit Hospital Corporation
d/b/a United Medical Center
1328 Southern Avenue SE, Suite 216, Washington, DC, 20032

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and

The Joint Commission

current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark G. Pelletier, RN, MS
Chief Operating Officer and Chief Nurse Executive
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 3 /Survey and Certification Staff

DC HEALTH

Food Establishment Inspection Report

Pursuant to Title 25-A of the District of Columbia Municipal Regulations

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Health Regulation and Licensing Administration • Food Safety & Hygiene Inspection Services Division • 899 North Capitol Street, NE • Washington, DC 20002

http://doh.dc.gov/service/food-safety email: food.safety@dc.gov

Establishment Name UNITED MEDICAL CENTER CAFETERIA

Address 1310 SOUTHERN AVE SE

City/State/Zip Code Washington, DC 20032

Telephone (202) 574-6818 E-mail address Elijahconstant@iammorrison.com

Date of Inspection 03 / 25 / 2021 Time In 11 : 04 AM Time Out 01 : 25 PM

License Holder Morrison Management Specialists Inc

License/Customer No. 09313xxxx-11003473

License Period 06 / 01 / 2019 - 05 / 31 / 2021 Type of Inspection Routine

Establishment Type: Restaurant Total Risk Category 1☐ 2☐ 3☐ 4■ 5☐

Priority Violations	1	**COS**	1	**R**	0
Priority Foundation Violations	0	**COS**	0	**R**	0
Core Violations	4	**COS**	2	**R**	0

Certified Food Protection Manager (CFPM)
LLOYD WYNN

CFPM #: FS-91744

CFPM Expiration Date: 11/07/2023

D.C. licensed trash or solid waste contractor:
Building

D.C. licensed sewage & liquid waste transport contractor:
Filta Fry

D.C. licensed pesticide operator/contractor:
Orkin

D.C. licensed ventilation hood system cleaning contractor:
PM Hood Service

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Compliance Status		COS	R
	Supervision		
IN OUT	1. Person in charge present, demonstrates knowledge, and performs duties	☐	☐
IN OUT	2. Certified Food Protection Manager	☐	☐
	Employee Health		
IN OUT	3. Management, food employee, and conditional employee; knowledge, responsibilities, and reporting	☐	☐
IN OUT	4. Proper use of restriction and exclusion	☐	☐
IN OUT	5. Procedures for responding to vomiting and diarrheal events	☐	☐
	Good Hygienic Practices		
IN OUT N/O	6. Proper eating, tasting, drinking, or tobacco use	☐	☐
IN OUT N/O	7. No discharge from eyes, nose, and mouth	☐	☐
	Control of Hands as a Vehicle of Contamination		
IN OUT N/O	8. Hands clean and properly washed	☐	☐
IN OUT N/A N/O	9. No bare hand contact with RTE foods or a pre-approved alternate procedure properly allowed	☐	☐
IN OUT	10. Adequate handwashing sinks properly supplied and accessible	☐	☐
	Approved Source		
IN OUT	11. Food obtained from approved source	☐	☐
IN OUT N/A N/O	12. Food received at proper temperature	☐	☐
IN OUT	13. Food in good condition, safe, and unadulterated	☐	☐
IN OUT N/A N/O	14. Required records available: shellstock tags, parasite destruction	☐	☐
	Protection from Contamination		
IN OUT N/A	15. Food separated and protected	☐	☐
IN OUT N/A	16. Food-contact surfaces: cleaned and sanitized	☐	☐
IN OUT	17. Proper disposition of returned, previously served, reconditioned, and unsafe food	☐	☐
	Potentially Hazardous Food (Time/Temperature Control for Safety Food)		
IN OUT N/A N/O	18. Proper cooking time and temperatures	☐	☐
IN OUT N/A N/O	19. Proper reheating procedures for hot holding	☐	☐
IN OUT N/A N/O	20. Proper cooling time and temperature	☐	☐
IN OUT N/A N/O	21. Proper hot holding temperatures	☐	☐
IN OUT N/A	22. Proper cold holding temperatures	■	☐
IN OUT N/A N/O	23. Proper date marking and disposition	☐	☐
IN OUT N/A N/O	24. Time as a public health control: procedures and records	☐	☐
	Consumer Advisory		
IN OUT N/A	25. Consumer advisory provided for raw or undercooked foods	☐	☐
	Highly Susceptible Populations		
IN OUT N/A	26. Pasteurized foods used; prohibited foods not offered	☐	☐
	Chemical		
IN OUT N/A	27. Food additives: approved and properly used	☐	☐
IN OUT N/A	28. Toxic substances properly identified, stored, and used	☐	☐
	Conformance with Approved Procedures		
IN OUT N/A	29. Compliance with variance, specialized process, and HACCP plan	☐	☐

GOOD RETAIL PRACTICES

Compliance Status		COS	R
	Safe Food and Water		
IN OUT N/A	30. Pasteurized eggs used where required	☐	☐
IN OUT	31. Water and ice from approved source	☐	☐
IN OUT N/A	32. Variance obtained for specialized processing methods	☐	☐
	Food Temperature Control		
IN OUT	33. Proper cooling methods used; adequate equipment for temperature control	☐	☐
IN OUT N/A N/O	34. Plant food properly cooked for hot holding	☐	☐
IN OUT N/A N/O	35. Approved thawing methods used	☐	☐
IN OUT	36. Thermometers provided and accurate	☐	☐
	Food Identification		
IN OUT	37. Food properly labeled; original container	☐	☐
	Prevention of Food Contamination		
IN OUT	38. Insects, rodents, and animals not present	☐	☐
IN OUT	39. Contamination prevented during food preparation, storage, and display	☐	☐
IN OUT N/A	40. Personal cleanliness	☐	☐
IN OUT	41. Wiping cloths: properly used and stored	☐	☐
IN OUT N/A N/O	42. Washing fruits and vegetables	☐	☐
	Proper Use of Utensils		
IN OUT	43. In-use utensils: properly stored	☐	☐
IN OUT	44. Utensils, equipment and linens: properly stored, dried, and handled	■	☐
IN OUT	45. Single-use/single-service articles: properly stored and used	☐	☐
IN OUT N/A	46. Gloves used properly	☐	☐
	Utensils, Equipment, and Vending		
IN OUT	47. Food and nonfood-contact surfaces cleanable, properly designed, constructed, and used	☐	☐
IN OUT	48. Warewashing facilities: installed, maintained, and used; test strips	☐	☐
IN OUT	49. Nonfood-contact surfaces clean	☐	☐
	Physical Facilities		
IN OUT	50. Hot and cold water available; adequate pressure	☐	☐
IN OUT	51. Plumbing installed; proper backflow devices	☐	☐
IN OUT	52. Sewage and waste water properly disposed	☐	☐
IN OUT	53. Toilet facilities: properly constructed, supplied, and cleaned	☐	☐
IN OUT	54. Garbage and refuse properly disposed; facilities maintained	■	☐
IN OUT	55. Physical facilities installed, maintained, and clean	☐	☐
IN OUT	56. Adequate ventilation and lighting; designated areas used	☐	☐

IN = in compliance OUT = not in compliance N/O = not observed
N/A = not applicable COS = corrected on-site R = repeat violation

Establishment Name UNITED MEDICAL CENTER CAFETERIA Establishment Address 1310 SOUTHERN AVE SE

OBSERVATIONS	25 DCMR	CORRECTIVE ACTIONS
22. - Temperature control for safety foods were observed improperly cold holding in the pizza prep refrigerator on the service line. COS, items were removed or placed in ice bath. (Corrected On Site)	1005.1	Except during preparation, cooking, or cooling, or when time is used as the public health control as specified in Section 1009, potentially hazardous food (time/ temperature control for safety food) shall be maintained: (b) At five degrees Celsius (5 degrees C) (forty-one degrees Fahrenheit (41 degrees F)) or less. P
33. - Observed food items cooling with tightly sealed plastic wrap (salads, sandwiches). (CORRECT VIOLATION WITHIN 14 CALENDAR DAYS)	1004.2	When placed in cooling or cold holding equipment, food containers in which food is being cooled shall be: (a) Arranged in the equipment to provide maximum heat transfer through the container walls; and (b) Loosely covered or uncovered if protected from overhead contamination as specified in Section 816.1(b), during the cooling period to facilitate heat transfer from the surface of the food.
44. - Observed utensils stored near handwashing sink. COS (Corrected On Site)	2203.1	Cleaned equipment and utensils, laundered linens, and single-service and single-use articles, except as specified in Section 2203.4, shall be stored: (a) In a clean, dry location; (b) Where they are not exposed to splash, dust, or other contamination; and (c) At least fifteen centimeters (15 cm) or six inches (6 in.) above the floor.
51. - Observed a small leak from handwashing sink on service line near hot food items. (CORRECT VIOLATION WITHIN 14 CALENDAR DAYS)	2418.1	A plumbing system shall be: (a) Repaired according to the D.C. Plumbing Code (2008) incorporating the International Plumbing Code 2006, as amended by the D.C. Plumbing Code Supplement (subtitle F of 12 DCMR); and (b) Maintained in good repair.
54. - There was no waste (trash) receptacle at the handwashing sink. COS (Corrected On Site)	2706.3	If disposable towels are used at handwashing sinks, a waste receptacle shall be located at each sink or group of adjacent sinks.

Sanitizer: Quaternary Ammonium, 400 ppm, 0.0 pH, 121.0°F
Sanitizer: Quaternary Ammonium, 400 ppm, 0.0 pH, 101.0°F
Sanitizer: Quaternary Ammonium, 400 ppm, 0.0 pH, 123.0°F
Sanitizer: Quaternary Ammonium, 400 ppm, 0.0 pH, 104.0°F

Temperatures

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
Hot Water (Handwashing Sink)	101.0F	Hot Water (Handwashing Sink)	124.0F	(Deli display)	33.0F	Egg Salad (Deli display) (Cold Holding)	38.0F
Turkey (Reach-in Refrigerator) (Cold Holding)	41.0F	Turkey (Reach-in Refrigerator) (Cold Holding)	39.0F	Tuna Salad (Sandwich Prep Refrigerator) (Cold Holding)	39.0F	Chicken salad (Sandwich Prep Refrigerator) (Cold Holding)	39.0F
Ham (Sandwich Prep Refrigerator) (Cold Holding)	40.0F	Turkey (Sandwich Prep Refrigerator) (Cold Holding)	39.0F	Lettuce (Sandwich Prep Refrigerator) (Cold Holding)	41.0F	Tomatoes sliced (Sandwich Prep Refrigerator) (Cold Holding)	40.0F
Onions raw (Sandwich Prep Refrigerator) (Cold Holding)	41.0F	Cucumbers (Sandwich Prep Refrigerator) (Cold Holding)	41.0F	Pepperoni (Refrigerator - pizza prep unit) (Cold Holding)	46.0F	Cheese (Refrigerator - pizza prep unit) (Cold Holding)	51.0F
Turkey Diced (Service Line) (Hot Holding)	148.0F	Chicken baked (Service Line) (Hot Holding)	146.0F	Chicken Wings (Service Line) (Hot Holding)	151.0F	Greens (Service Line) (Hot Holding)	165.0F
Corn Chowder (Service Line) (Hot Holding)	146.0F	Chicken (Refrigerator - sandwich prep unit) (Cold Holding)	36.0F	salsa (Refrigerator - sandwich prep unit) (Cooling)	42.0F	Cheese (Service Line) (Hot Holding)	137.0F
Fruit - cut or sliced (Open Display Refrigerator) (Cold Holding)	39.0F	Yogurt (Open Display Refrigerator) (Cold Holding)	39.0F	Salad (Open Display Refrigerator) (Cold Holding)	35.0F	Hot Water (Handwashing Sink (kitchen))	103.0F
(Dishwashing Machine - Final Rinse Cycle)	182.0F	(Dishwashing Machine - Wash Cycle)	158.0F	Hot Water (3-compartment sink)	136.0F	Spinach (Walk-in Refrigerator) (Cold Holding)	41.0F
Vegetable Products (Walk-in Refrigerator) (Cold Holding)	39.0F	Eggs (Walk-in Refrigerator) (Cold Holding)	34.0F	Fruit - cut or sliced (Walk-in Refrigerator) (Cold Holding)	39.0F	Chicken raw (Walk-in Refrigerator) (Cold Holding)	35.0F
Turkey Sandwich (Walk-in Refrigerator) (Cooling)	46.0F	Yogurt (Walk-in Refrigerator) (Cold Holding)	38.0F	Lasagna (Walk-in Refrigerator) (Cold Holding)	33.0F	(Walk-in Freezer)	-11.0F
(Reach-in Freezer)	18.0F	(Reach-in Freezer)	1.0F	Cheese (Sandwich Prep Refrigerator) (Cooling)	38.0F	Meatballs (Hot Bar) (Hot Holding)	163.0F
pureed noddles (Hot Bar) (Hot Holding)	157.0F	pureed carrots (Hot Bar) (Hot Holding)	171.0F	pureed meat (Hot Bar) (Hot Holding)	165.0F	Rice steamed (Hot Bar) (Hot Holding)	157.0F
Chicken Chop (Hot Bar) (Hot Holding)	151.0F	Green Beans (Hot Bar) (Hot Holding)	141.0F				

Inspector Comments:
Correct cited violations in 14 calendar-days. For questions please contact area supervisor at food.safety@dc.gov for efficient response.

DC Health does not assign a grade, percentage, or rating for establishment inspection reports. We perform a pass-fail inspection. The amount of Priority, Priority Foundation, and Core violations are tallied at the top of each inspection report. DC Health also performs follow up inspections to ensure the violations which were cited on the initial report have been corrected. To view an establishment's inspection report, follow this link: https://dc.healthinspections.us.

Person-in-Charge (Signature) | Lloyd Wynn (Print) | 03/25/2021 Date

Inspector (Signature) | Lanita Carpenter (Print) | 014 Badge # | 03/25/2021 Date

UMC
UNITED
MEDICAL CENTER

NOT-FOR-PROFIT HOSPITAL CORPORATION

Not For Profit Hospital Corporation (UMC) Vaccination Clinic Daily Numbers 4-14-2021

Submitted by: William Strudwick, MD & Marcela Maamari

December
16th – **60** Pfizer #1
17th – **64** Pfizer #1
18th – **105** Pfizer #1
21st – **54** Pfizer #1
23rd – **60** Moderna #1
28th – **70** Moderna #1
29th – **70** Moderna #1
30th – **110** Moderna #1

January
5th – **96** Pfizer #2
6th – **10** Moderna #1 / **48** Pfizer #2 (**58**)
7th – **54** Pfizer #2
8th – **30** Pfizer #2
11th –**27** Pfizer #1 / **45** Pfizer #2 (**72**)
12th – **120** Moderna #1
13th – **120** Moderna #1
14th - **130** Moderna #1
15th – **146** Moderna #1 / **3** Moderna #2 (**149**)
19th – **81** Moderna #1 / **40** Moderna #2 (**121**)
20th – **106** Moderna #1 / **15** Moderna #2 (**121**)
21st – **84** Moderna #1 / **56** Moderna #2 (**140**)
22nd – **84** Moderna #1 / **46** Moderna #2 (**130**)
25th – **38** Moderna #1 / **93** Moderna #2 (**131**)
26th – **101** Moderna #1 / **29** Moderna #2 (**130**)
27th – **107** Moderna #1 / **13** Moderna #2 (**120**)
28th – **99** Moderna #1 / **1** Moderna #2 (**100**)
29th – **70** Moderna #1

February
1st – **25** Pfizer #2 / **11** Moderna #2 (**36**)
2nd – **65** Moderna #1 / **6** Moderna #2 (**71**)
3rd – **66** Moderna #1 / **4** Moderna #2 (**70**)
4th – **118** Moderna #1 / **2** Moderna #2 (**120**)
5th – **35** Moderna #1 / **100** Moderna #2 (**135**)
8th – **154** Moderna #2
9th – **99** Moderna #2
10th – **58** Moderna #1 / **74** Moderna #2 (**132**)

11th – **69** Moderna #1 / **30** Moderna #2 (**99**)
12th – **99** Moderna #1 / **76** Moderna #2 (**175**)
15th – **11** Moderna #1 / **163** Moderna #2 (**174**)
16th – **59** Moderna #1 / **83** Moderna #2 / **40** Moderna #1 – Mobile {Knox Hill} (**182**)
17th – **92** Moderna #1 / **51** Moderna #2 (**143**)
19th – **22** Moderna #1 / **110** Moderna #2 (**132**)
22nd – **7** Moderna #1 / **102** Moderna #2 (**109**)
23rd – **70** Moderna #1 / **95** Moderna #2 (**165**)
24th – **34** Moderna #1 / **87** Moderna #2 (**121**)
25th – **66** Moderna #1 / **33** Moderna #2 / **56** Moderna #1 – Mobile {Roundtree} (**155**)
26th – **100** Moderna #1 / **21** Moderna #2 (**121**)

March 1st – **11** Moderna #1 / **154** Moderna #2 (**165**)
2nd – **67** Moderna #1 / **54** Moderna #2 / **40** Moderna #1 – Mobile {Kentucky Courts} (**161**)
3rd – **86** Moderna #1 / **2** Moderna #2 (**88**)
4th – **95** Moderna #1 / **5** Moderna #2 (**100**)
5th – **108** Moderna #1 / **2** Moderna #2 (**110**)
8th – **133** Moderna #1 / **12** Moderna #2 (**145**)
9th – **51** Moderna #1 / **69** Moderna #2 / **30** Moderna #1 – Mobile (Carroll Apartments) (**150**)
10th – **116** Moderna #1 / **4** Moderna #2 (**120**)
11th – **127** Moderna #1 / **13** Moderna #2 / **40** Moderna #1- Mobile (Roundtree) (**180**)
12th – **125** Moderna #1 / **49** Moderna #2 (**174**)
15th – **64** Modena #1 / **86** Moderna #2 (**150**)
16th – **119** Moderna #1 / **21** Moderna #2 / **2** Moderna #1 and **38** Moderna #2 - Mobile (Knox Hill) (**180**)

17th – **Walgreen's first day** **117** Moderna #1 / **3** Moderna #2 (**120**)
18th – **119** Moderna #1 / **15** Moderna #2 / **50** Moderna #1 – Mobile (Langston Terrace) (**184**)
19th – **97** Moderna #1 / **69** Moderna #2 (**166**)

Totals: **310** Pfizer #1 doses; **298** Pfizer #2 doses; **4270** Moderna #1 doses; **2193** Moderna #2 doses / **7171** total doses of vaccine.

UMC/Walgreens Collaboration

date	dose 1	dose 2
16-Mar		
17-Mar	117	3
18-Mar	119	15
19-Mar	96	68
20-Mar		
21-Mar		
23-Mar	145	126
24-Mar	118	18
25-Mar	95	28
26-Mar	170	93
27-Mar	188	2
28-Mar	171	0
29-Mar		
30-Mar	15	142
31-Mar	139	70
1-Apr	189	24
2-Apr	160	57
3-Apr	157	2
4-Apr	170	
5-Apr		
6-Apr	161	51
7-Apr	110	101
8-Apr	107	102
9-Apr	101	106
10-Apr	67	5
11-Apr	105	106
12-Apr		
13-Apr	22	108

Totals: **2722** Moderna #1 doses; **1227** Moderna #2 doses / **3949** total doses of UMC-Walgreens collaborative.

DC Health – COVID-19 Report

Submitted by: Sylvia Clagon – Infection Preventionist

Several patients who initially tested negative for COVID 19 on admission were retested during the discharge planning process and were found to be COVID 19 positive.

Infection Control conducted an outbreak investigation and implemented control measures. The DOH was notified and responded with recommendations. Surveillance COVID 19 testing revealed 2 additional patients and 3 staff who were not aware of being COVID 19 positive. All patients were placed on droplet/contact precautions. COVID 19 positive staff were quarantined at home.

The DOH reports they are considering the COVID 19 outbreak at UMC resolved, because no new patients or staff have tested positive for at least 14 days from the last positive result.

Going forward the DOH recommends UMC **stop outbreak surveillance testing for patients and staff.**

- Continue to cohort confirm cases, exposed patients and unexposed cases on each unit.
- Continue to assign staff in accordance with cohorted groups
- Test newly admitted/transferred patients before admitting to the unit. Put these patients in private rooms when possible; to minimize potential exposures; don't room admitted/transferred patients with those who were already on the unit.
- The wearing of appropriate PPE for all employees must be enforced to include eye protection. Universal eye protection must be used on the unit, not just in-patient care areas.
- Continue to dedicate patient care equipment when possible. If unable to provide dedicated equipment, clean and disinfect equipment between uses according to manufacturer's instructions.
- Maintain good hand hygiene

April 14, 2021

To: NFPHC/UMF Performance Improvement Committee
From: Brian D. Gradle, Chief Compliance Officer
Subject: Compliance Report

I. Performance Improvement: The Patient Safety/Abuse Review Board.

In response to a recognized need to enhance the safety and quality of patient-centered care, and to ensure that any deviations from such standards of care by the staff of the Not-for-Profit Hospital Corporation (NFPHC)/United Medical Center (UMC) are expeditiously identified and addressed, the Patient Safety/Abuse Review Board has been constituted and is meeting weekly with representatives from the following departments:

- Public Relations
- Risk Management
- Human Resources/Employee Relations
- Legal
- Patient Relations
- Compliance

As has been previously noted to this Committee, the work conducted by the Review Board in this area is intended to supplement, and not supplant, any and all related work that is currently underway at NFPHC/UMC.

A. Raising Awareness: "See Something/Say Something."

The Review Board identified early-on that some within the UMC workforce as well as UMC patients may not recognize the "Compliance Hotline" can also be used as a point of contact for patient safety/abuse matters.

To address that concern, eighteen (18) "See Something/Say Something" posters have been designed, printed, and posted throughout the hospital and the Medical Office Building.

The posters identify the same toll-free phone number (844-810-9526) as the Compliance Hotline. However, in order to avoid confusion with the hotline, the number is not identified as such.

B. Training of New Employees, New Students, and New Contractors

This expanded training focusing on patient safety, abuse, and the neglect, and the duty to report, is provided in-person on a weekly basis by the Chief Compliance Officer as part of New Employee Orientation (NEO). The enhanced training commenced on 2/10/2021 and will be ongoing.

All NEO training is conducted in-person at UMC and is required prior to any member of the work force starting work. Particular emphasis is placed on the obligation to report concerns under the Code of Conduct and the hospital's strict non-retaliation policy.

C. Expansion of Training of Managers: Nursing Leadership.

Review Board members Denise Vernon (Patient Advocate) and Brian Gradle will be meeting with the UMC Nursing Leadership on April 21st to discern their concerns and get their recommendations for the proper identification, investigation, and resolution of patient safety/abuse/neglect concerns. Their discussion will also include a consideration of "implicit bias" and how that "shows up" in the rendering of care.

D. Review and Revision of Existing Policies

The Review Board has undertaken a review and revision of all patient safety/abuse policies and procedures, which includes its substantive involvement in any and all discussions and decisions regarding disciplinary actions involving actual or alleged patient safety/abuse matters.

II. Performance Improvement: Achieving the Quadruple Aim and Becoming a High Reliability Organization through UMC Leadership Formation Program

As part of the hospital's efforts to achieve the *Quadruple Aim of Healthcare* (improve population health, reduce costs, improve patient care, enhance the health and well-being of the hospital's workforce) and to become *a High Reliability Organization*, the *UMC Leadership Formation Program* commenced in January and since that time has provided weekly, in-person programs open to all staff and all departments on a "walk-in" basis:

- The initial module *"Empathy: The Human Connection to Patient Care,"* ran for 10 consecutive Fridays and attracted over 75 participants from over 20 departments.

- The second module (which is in week 3 of 10) is *"Accountability: Commitment to Resiliency,"* and has been well-received as well.

- The UMC Leadership Formation Program curriculum includes a total of 18 in-person modules, and its curriculum covers each aspect of the Quadruple Aim and HROs.

UMC QUALITY DASHBOARD					AT OR EXCEEDS TARGET			WITHIN 10% OF TARGET			TARGET NOT MET			AMENDED				
2021	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
Patient days		2575	2429	2475														
BLOOD PRODUCT MANAGEMENT																		
BLOOD TRANSFUSION REACTIONS																		
# of transfusion reactions		0	0	1										1				1
Allergic		0	0	0										0				0
Febrile		0	0	0										0				0
Hemolytic		0	0	0										0				0
Non-specific		0	0	1										1				1
BLOOD TRANSFUSION RECORD REVIEW																		
Transfusions		149	126	162										437				
Cryoprecipitate transfusions		1	0	1										2				
Fresh frozen plasma transfusions		18	10	25										53				
Platelet transfusions		7	1	5										13				

UMC QUALITY DASHBOARD					AT OR EXCEEDS TARGET			WITHIN 10% OF TARGET			TARGET NOT MET			AMENDED				
2021	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
Covid-19 convalescent plasma		8	7	8										23				
RH immune globulin (RhIG)		1	3	1										5				
Total red blood cell (RBC) units transfused		114	114	122										350				
Total RBC units crossmatched		139	136	141										416				
Crossmatch/ transfusion ratio *threshold < 2		1.2	1.2	1.2	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	1.2				1.185
BLOOD TRANSFUSION JUSTIFICATION																		
# of times O neg blood transfused to non O neg patient		3	5	3										11				11
BLOOD TRANSFUSION DOCUMENTATION								THRESHOLD = 100%										
MD order confirmed		100%	100%	100%										100%				100%
Consent signed		100%	100%	100%										100%				100%
2 RN signatures		98%	99%	99%										99%				99%
FALL PREVENTION																		
ED		0	0	0										0				
Outpatient		0	0	0										0				
Inpatient		3	7	5										15				
Visitor		0	0	0										0				
Total # of falls		3	10	5										18				
# of falls w/ injury		0	1	0										1				
Inpatient fall rate		0.00	0.00	0.00	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.0024				0.002

UMC QUALITY DASHBOARD					AT OR EXCEEDS TARGET			WITHIN 10% OF TARGET			TARGET NOT MET			AMENDED				
2021	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
INFECTION CONTROL AND PREVENTION																		
CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTION (CLABSI)								**THRESHOLD < 1/YR**										
Med/surg CLABSI		0	0	0										0				
Med/surg rate		0	0	0										0				0
Telemetry CLABSI		0	0	0										0				
Telemetry rate		0	0	0										0				0
Critical Care Unit (CCU) CLABSI		0	0	0										0				
CCU rate		0	0	0										0				0
CATHETER ASSOCIATED URINARY TRACT INFECTION (CAUTI)								**THRESHOLD < 1/YR**										
Med/surg CAUTI		0	0	0										0				
Med/surg rate		0	0	0										0				0
Telemetry CAUTI		0	0	0										0				
Telemetry rate		0	0	0										0				0
Critical Care Unit (CCU) CAUTI		0	0	0										0				
CCU rate		0	0	0										0				0
VENTILATOR ASSOCIATED EVENTS								**THRESHOLD < 1/YR**										
Ventilator associated conditions (VAC)		0	0	0										0				
VAC rate		0	0	0										0				0
MULTI DRUG RESISTANT ORGANISMS (MDRO)								**THRESHOLD < 1/YR**										
MRSA HAI (hospital acquired infection)		0	1	0										1				
MRSA rate		0	0.412	0	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.1				0.137
CLOSTRIDIUM DIFFICILE (C-DIFF)								**THRESHOLD < 1/YR**										
C-diff HAI		0	0	0										0				0
C- diff rate		0	0	0										0				0
VANCOMYCIN RESISTANT ENTEROCOCCUS (VRE)								**THRESHOLD <1/YR**										

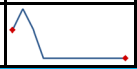
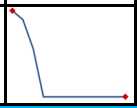
UMC QUALITY DASHBOARD					AT OR EXCEEDS TARGET			WITHIN 10% OF TARGET			TARGET NOT MET			AMENDED				
2021	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
VRE HAI		2	0	1										3				3
VRE rate		0.777	0	0.404										0.4				0.4
INFECTION SURVEILLANCE: SURGICAL SITE INFECTIONS (SSI)														THRESHOLD < 4/YR				
# of colon surgeries		0	0	0										0				0
# of colon surgery SSIs		0	0	0										0				0
# of major orthopedic surgeries		0	0	0										0				0
# of orthopedic surgery SSIs		0	0	0										0				0
DEVICE UTILIZATION RATE (DUR)																		
Med/surg patient days		516	560	626										1702				1702
Telemetry patient days		1173	1008	1150										3331				3331
CCU patient days		316	276	319										911				911
Total # of patient days		2005	1844	2095	0	0	0	0	0	0	0	0	0	5944				5944
FOLEY DUR														THRESHOLD < 1/YR				
# of foley days - M/S		22	47	35										104				104
FOLEY DUR - M/S		0.04	0.08	0.1	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.1				0.1
# of foley days - Tele		268	226	281										775				775
FOLEY DUR - TELE		0.2	0.2	0.2	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.2				0.2
# of foley days - CCU		221	207	209										637				637
FOLEY DUR - CCU		0.7	0.8	0.7	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.7015				0.702
Total # of foley days		511	480	525	0	0	0	0	0	0	0	0	0	1516				1516
CENTRAL LINE DUR														THRESHOLD < 1/YR				
M/S central line days		15	11	5										31				31

UMC QUALITY DASHBOARD					AT OR EXCEEDS TARGET			WITHIN 10% OF TARGET			TARGET NOT MET			AMENDED				
2021	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
M/S central DUR		0.0	0.0	0.0	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.0				0.0
Tele central line days		94	28	15										137				137
Tele central DUR		0.08	0.03	0.013	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.0				0.0
CCU central line days		184	81	90										355				355
CCU central DUR		0.58	0.29	0.28	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.4				0.4
TOTAL central line days		293	120	110	0	0	0	0	0	0	0	0	0	523				523
VENTILATOR DUR														THRESHOLD < 1/YR				
CCU ventilator days		184	128	142										454				454
CCU ventilator DUR		0.58	0.46	0.45	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.4971				0.497
TRANSMISSION BASED PRECAUTIONS																		
Airborne - M/S, tele		0	0	3										3				3
Airborne - CCU		0	0	0										0				0
Total		0	0	3	0	0	0	0	0	0	0	0	0	3				
Droplet - M/S, tele		0	0	0										0				0
Droplet Covid - M/S, tele		141	140	208										489				489
Droplet - CCU		3	0	0										3				3
Droplet Covid - CCU		58	34	95										187				187
Total		202	174	303	0	0	0	0	0	0	0	0	0	679				
Contact - M/S, tele		113		129										242				242
Contact - CCU		35		39										74				74
Total		148	0	168	0	0	0	0	0	0	0	0	0	316				
Contact enteric - M/S, tele		21	27	21										69				69

UMC QUALITY DASHBOARD					AT OR EXCEEDS TARGET			WITHIN 10% OF TARGET			TARGET NOT MET			AMENDED				
2021	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
Contact enteric - CCU		0	14	0										14				14
Total		21	41	21	0	0	0	0	0	0	0	0	0	83				
Neutropenic - M/S, tele		4	0	0										4				4
Neutropenic - CCU		0	0	0										0				0
Total		4	0	0	0	0	0	0	0	0	0	0	0	4				
HAND HYGIENE COMPLIANCE								THRESHOLD > 90%										
# of compliant observations		223	202	234										659				659
Total # of observations		223	212	237										672				672
Organizational compliance		100%	95%	99%	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	98%				98%
HAND HYGIENE COMPLIANCE (BY ROLE)								THRESHOLD > 90%										
# of compliant observations (non provider)		187	190	201										578				578
Total # of observations (non provider)		187	180	198										565				565
Non provider rate		100%	95%	99%	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	98%				98%
# of compliant observations (provider)		36	22	36										94				94
Total # of observations (provider)		36	22	36										94				94
Provider rate		100%	100%	100%	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	100%				100%
HAND HYGIENE COMPLIANCE (BY DEPT)								THRESHOLD > 90%										
# of compliant observations (ED)		11	40	32										83				83
Total # of observations (ED)		11	38	31										80				80
ED rate		100%	95%	97%	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	97%				97%

UMC QUALITY DASHBOARD					AT OR EXCEEDS TARGET			WITHIN 10% OF TARGET			TARGET NOT MET			AMENDED				
2021	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
# of compliant observations (Peri Op)		30	30	30										90				90
Total # of observations (Peri Op)		30	30	30										90				90
Peri Op rate		100%	100%	100%	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	100%				100%
# of compliant observations (Med/Surg, Tele)		116	80	74										270				270
Total # of observations (Med/Surg, Tele)		116	75	72										263				263
Med/Surg, Tele rate		100%	94%	97%	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	97%				97%
# of compliant observations (CCU)		54	40	51										145				145
Total # of observations (CCU)		54	38	51										143				143
CCU rate		100%	95%	100%	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	98%				98%
MEDICATION SAFETY																		
BARCODE MEDICATION ADMINISTRATION (BCMA)							THRESHOLD > 95%											
ICU		100%	100%	99%										100%				100%
BHU		100%	100%	100%										100%				100%
5W		100%	99%	100%										100%				100%
8W		100%	100%	100%										100%				100%
ED		99%	98%	96%										98%				98%
% of patients scanned		100%	99%	99%	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	99%				99%
ICU		85%	85%	81%										84%				84%
BHU		90%	92%	92%										91%				91%
5W		91%	88%	87%										89%				89%
8W		89%	87%	86%										87%				87%
ED		60%	61%	56%										59%				59%

UMC QUALITY DASHBOARD					AT OR EXCEEDS TARGET			WITHIN 10% OF TARGET			TARGET NOT MET			AMENDED				
2021	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
% of medications scanned		83%	83%	80%	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	82%				82%
MEDICATION RECONCILIATION														THRESHOLD > 95%				
# of patient records reviewed (ED)		2728	2557	2935										8220				8220
# of med recs completed		2245	2175	2437										6857				6857
Med rec compliance (ED)		82%	85%	83%										83%				83%
# of patient records reviewed (inpatient)		341	391	341										1073				1073
# of med recs completed		306	353	310										969				969
Med rec compliance (inpatient)		90%	90%	91%	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	90%				90%
MEDICATION ERRORS																		
# of errors reported		3	2	0										5				5
MEDICATION ERROR TYPE																		
Med given in spite of documented allergy		0	0	0										0				0
Med delay		0	0	0										0				0
Omission		0	0	0										0				0
Unordered med		0	1	0										1				1
Other		1	1	0										2				2
Wrong dose		0	0	0										0				0
Wrong med		1	0	0										1				1
Wrong patient		1	0	0										1				1
Wrong rate		0	0	0										0				0
Wrong time		0	0	0										0				0
PATIENT SATISFACTION/PERCEPTION OF CARE																		

UMC QUALITY DASHBOARD					AT OR EXCEEDS TARGET			WITHIN 10% OF TARGET			TARGET NOT MET			AMENDED				
2021	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
# of grievances/complaints		8	15	12										35				35
Recommend UMC Target 50%		33%	50%	40%										41%				41%
Overall hospital rating Target 50%		17%	64%	50%										44%				44%
Star rating		2	2	2														
CLINICAL OUTCOMES																		
CODE BLUE																		
Med/surg		0	0	1														
Tele		2	5	2														
BHU		0	0	0														
Dialysis		0	0	0														
OR		1	0	0														
PACU		0	0	0														
Radiology		0	0	0														
# of code blue events		3	5	3	0	0	0	0	0	0	0	0	0	11				11
Code blue rates		1.2	2.1	1.2	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	1.5				1.5
RAPID RESPONSE																		
Med/surg		1	2	0														
Tele		12	5	4														
BHU		0	3	1														
Dialysis		0	1	2														
OR		0	0	0														
PACU		0	0	0														
Radiology		0	0	0														
# of rapid response events		13	11	7	0	0	0	0	0	0	0	0	0	31				31
Rapid response rates		5.0	4.5	2.8283	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	10.333				10.3
COVID-19																		

UMC QUALITY DASHBOARD					AT OR EXCEEDS TARGET			WITHIN 10% OF TARGET			TARGET NOT MET			AMENDED				
2021	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
COVID-19 related deaths		8	6	6										20				20
VTE PROPHYLAXIS																		
VTE prophylaxis compliance- med/surg/ tele		92%	94%	91%										92%				92%
VTE prophylaxis compliance - CCU		100%	100%	100%										100%				100%
CLINICAL SAFETY INDICATORS																		
Number of restraint hours - BHU		0	0.08	0										0.0277				0.028
Restraint rate - BHU		0	0.14	0										0.05				0.047
ED deliveries		0	0	0										0				0
Insulin administration compliance benchmark - 95%		98%	98%	100%										99%				99%
PRESSURE ULCERS																		
# of hospital acquired pressure injuries (HAPI)		6	2	3										11				11
Total # of admissions		354	400	385										1139				1139
Incidence rate		1.69	0.5	0.7792	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.9914				0.99
# of reportable HAPIs		4	1	0										5				5
OCCURRENCE REPORTS																		
# of occurrence reports		67	115	98										280				280

UMC QUALITY DASHBOARD					AT OR EXCEEDS TARGET			WITHIN 10% OF TARGET			TARGET NOT MET			AMENDED				
2021	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
AMA/ Elopement		9	13	10										32				32
Equipment		0	0	0										0				0
Falls		3	10	5										18				18
Medication		2	1	0										3				3
Other		53	91	83										227				227
# of near misses		0	0	0										0				0
# of sentinel events		0	0	0										0				0
SEPSIS MEASURES																		
Sepsis (principal diagnosis) 30 day readmit		0	1	0										1				1
Simple severe sepsis w/ shock		18	17	15										50				50
Sepsis patients observed mortality (APR DRG 720)		2	4	0										6				6
Sepsis patient volumes (APR DRG 720)		21	26	29										76				76
CASE MANAGEMENT							THRESHOLD < 5.5											
Average length of stay		6.7	6.05	6.02										6.2567				6.257
FD12 PATIENT ADMISSIONS/ELOPEMENT TRACKING							THRESHOLD = 100%											
FD12 admissions		68	107	92										267				267
FD12 elopements		0	0	0										0				0
FD12 compliance		100%	100%	100%										100%				100%
BLOOD CONTAMINATION RATES							THRESHOLD > 90%											
ER holding		94%	100%	93%										96%				96%
ER general		83%	91%	88%										87%				87%

UMC QUALITY DASHBOARD					AT OR EXCEEDS TARGET			WITHIN 10% OF TARGET			TARGET NOT MET			AMENDED				
2021	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
CCU		94%	95%	90%										93%				93%

UMC REGEN-COV™ (casirivimab with imdevimab) Criteria

1. COVID (+): ☐ Yes ☐ No – patient does not qualify

2. Date of COVID (+) test result: _____

3. Patient is ≥ 12 yo AND ≥ 40 kg: ☐ Yes ☐ No – patient does not qualify

4. Mild to moderate symptoms for 10 days or less ☐ Yes ☐ No – patient does not qualify

5. High Risk Inclusion Criteria: Must meet at least 1 criteria

Overall criteria	Age ≥ 55 yo AND	Age 12-17 yo AND
☐ BMI ≥ 35	☐ Cardiovascular disease	☐ BMI ≥ 85th percentile for age/gender
☐ Chronic Kidney Disease	☐ Hypertension	☐ Sickle Cell Disease
☐ Diabetes	☐ Chronic obstructive pulmonary disease/other chronic respiratory disease	☐ Congenital or acquired heart disease
☐ Immunosuppressive disease		☐ Neurodevelopmental disorder (i.e. cerebral palsy)
☐ Receiving immunosuppressive treatment		☐ Medical-related technological dependence (i.e. tracheostomy, gastrostomy, positive pressure ventilation not related to COVID)
☐ Age ≥ 65		☐ Asthma, reactive airway or other chronic respiratory disease that requires daily medication for control

6. If patient meets criteria, give the patient the Fact Sheet for Patients, Parents and Caregivers Emergency Use Authorization (EUA) of REGEN-COV for Coronavirus Disease 2019 (COVID-19), document that the patient has **received the Fact Sheet and consented to receiving the medication in the chart.**

7. Administer REGEN-COV™ (1200mg casirivimab and 1200mg imdevimab) IVPB over 1 hour using 0.22 micron filter. Prime line with solution, administer, and flush line after infusion to ensure all medication has been administered.

8. Observe patient for 1 hour after end of administration. Patients treated with bamlanivimab should continue to self-isolate and use infection control measures (e.g., wear mask, isolate, social distance, avoid sharing personal items, clean and disinfect “high touch” surfaces, and frequent handwashing) according to CDC guidelines.

United Medical Center Not-for-Profit Hospital Corporation Emergency Department Press Ganey Survey

BY

TEKA HENDERSON, MSN, RN

EMERGENCY DEPARTMENT NURSING DIRECTOR

Press Ganey
What is Press Ganey?

- Global organization dedicated to improving patient experiences in healthcare facilities
- Mission has been to support health care providers in understanding and improving patient
- Dedicated **scoring** system which shows how hospitals are dedicated to enhancing a patient's experience
- Begins the moment a patient enters a healthcare facility until long after they leave
- >35 years old developed by Irwin Press & Rod Ganey with scientific data of patient's perceptions of the care they received in the hospital

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Press Ganey
How is it used?

- Measures Perception & Quality of Care in the emergency department
- Patient Perception of Care
- Understand the Perception
- Hospitals use the data to improve care
- Focus on how well patients needs are met
- CMS Reimbursement
- Comparisons
- Press Ganey Business Model

Press Ganey Data?

- Variables (sample size (30)
- Critically Ill Patients
- Excessive Wait Times
- Admitted Patients
- Transferred Patients
- Low Acuity Bias
- 90 days
- Memory, knowledge, Motivation & Communication

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Press Ganey Nurses Questionnaire?

- **Regarding Your Care from Nurses**

- During this hospital stay, how often did nurses treat you with courtesy and respect?
- During this hospital stay, how often did nurses listen carefully to you?
- During this hospital stay, how often did nurses explain things in a way you could understand?
- During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?

Press Ganey Provider Questionnaire?

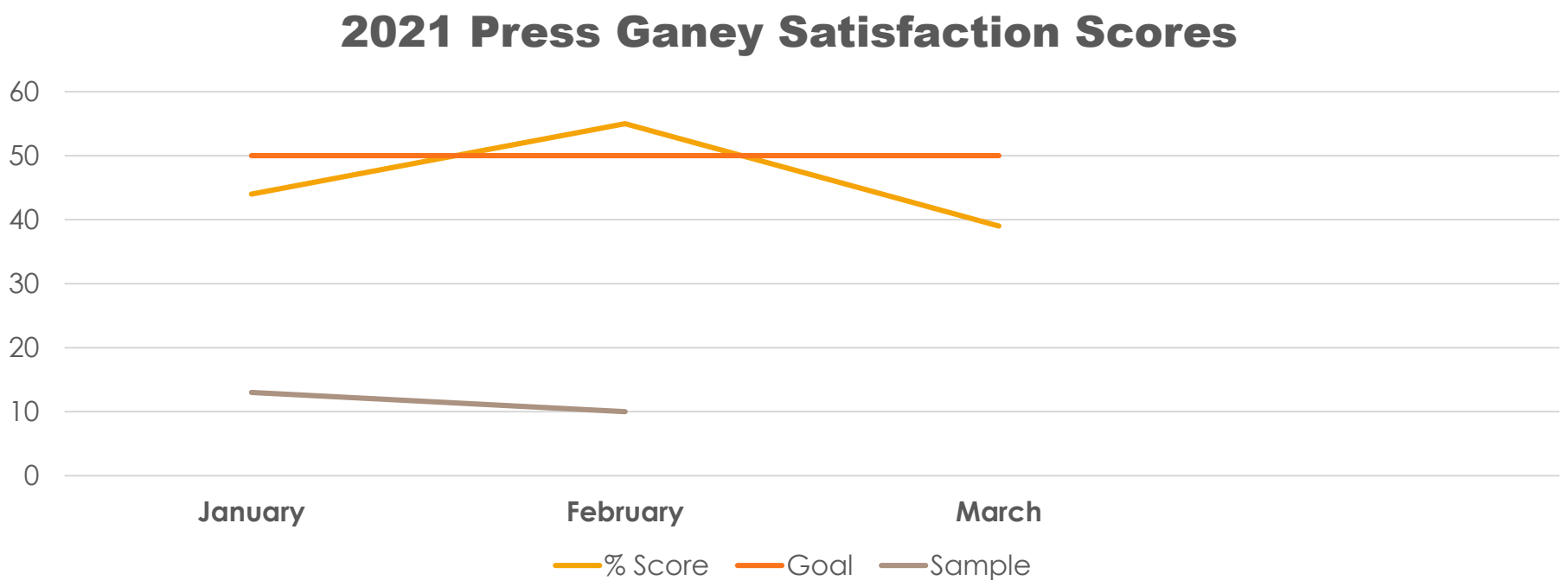
CARE PROVIDER	Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
During your visit, your care was provided primarily by a doctor, physician assistant (pa), nurse practitioner (np), or midwife. Please answer the following questions with that health care provider in mind.					
1) Friendliness/courtesy of the care provider	○	○	○	○	○
2) Explanations the care provider gave you about your problem or condition	○	○	○	○	○
3) Concern the care provider showed for your questions or worries	○	○	○	○	○
4) Care provider's efforts to include you in decisions about your treatment	○	○	○	○	○
5) Information the care provider gave you about medications (if any)	○	○	○	○	○
6) Instructions the care provider gave you about follow-up care (if any)	○	○	○	○	○
7) Degree to which care provider talked with you using words you could understand	○	○	○	○	○
8) Amount of time the care provider spent with you	○	○	○	○	○
9) Your confidence in this care provider	○	○	○	○	○
10) Likelihood of your recommending this care provider to others	○	○	○	○	○

11) Comments (describe good or bad experience):

United Medical Center
Not-for-Profit Hospital Corporation
Press Ganey 2021 Results

Time Period	January 2021	February 2021	March 2021
(Goal 50th Percentile)			
Sample Size (n)	13	10	23
Top Box Score	44.05%	54.09%	38.79%

United Medical Center
Not-for-Profit Hospital Corporation
Press Ganey 2021 Results



Areas of Improvement?

- Focus on patient wait times
- Listening
- Answering calls/hourly rounding
- Empathy
- Communication

AIDET

Acknowledge/Introduce/Duration/Explanation/Thank you☺

What we are doing well?

- TJC/DOH Accreditation
- Staffing
- Nurse/Patient Ratio 1:4 vs 1:5
- Zero Elopements/FD-12
- Restraint Documentation
- RN Medication Reconciliation
- Performance Improvement/Audits (random/monthly)

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Future Plan(s)

- Educate Staff
- Increase Leadership Rounding – low acuity patients
- Communication/Feedback on direct care
- Internal Survey
- Follow Up

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Questions???

We are committed to United Medical Center:

- Mission
- Vision
- Values
- Quadruple Aim
- High Reliable Organization

UNITED MEDICAL CENTER

Monthly Report Performance Improvement Committee
(April 2021)
(Patient Experience)

Accomplishments

Emergency Department:

- Number of responses (n) = 46, consistent with the last four quarters – overall top box score increased 2.8 points over the previous quarter.
- Significant increase of (14.46%) in the discharge question "information about home care" and (10.40%) "staff cared about you as a person."
- 55% of ED comments were positive:
  - ❖ "The nurses were very professional and helpful"
  - ❖ "Nurses are capable care/concerned overall

Inpatient:

- Significant increase of (16.19%) in care transitions question "good understanding of managing health" (24.61%) increase for "understood purpose of taking meds", and (13.24%) increase for discharge question "staff talked to you about help when you left".

Challenges and Current Action Plan

Emergency Department:

- Overall rating of "Good" represent 36.9%, again showing the largest opportunity for improvement.

Inpatient:

- Number of responses (n) decreased from previous quarters to 30, with a top box score increase of nearly 6 points over the previous quarter.
- Ratings of 7's and 8's represent 36.7%, showing the largest opportunity for improvement.

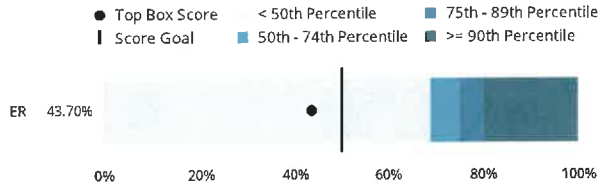
Regulatory/Corrective Action Follow-up

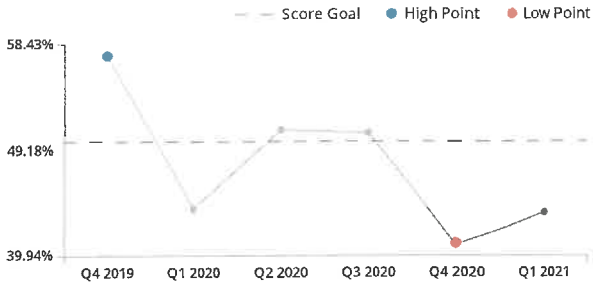
- N/A

Dashboard Name: Facility Scorecard | System Name: United Medical Center - System | System ID: 1410 | Facility Name: United Medical Center | Facility ID: 1410 | Service Line: Emergency Department | Measure: PG Overall | Metric: Top Box Score | Date Type: Received Date | Time Frame Last Quarter | Peer Group: All PG Database | Priority Index - Survey Type: PG | Priority Index View: External | Current Benchmarking Period: 12/01/2020 - 02/28/2021 | Fiscal Start Month: 01 | Download Date & Time: Apr 9, 2021 2:54 pm EDT

Service Line Performance

PG Overall





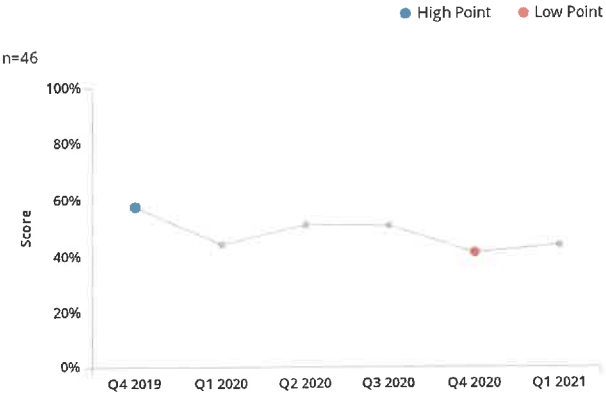
n	46
Top Box Score	43.70%
Score Goal	50.00%
Percentile Rank	1

Time Period	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021
n	16	13	52	42	49	46
Top Box Score	57.43%	44.03%	50.93%	50.67%	40.94%	43.70%
Percentile Rank	12	1	2	3	1	1

Top Box Score

43.70% ▲

PG Overall

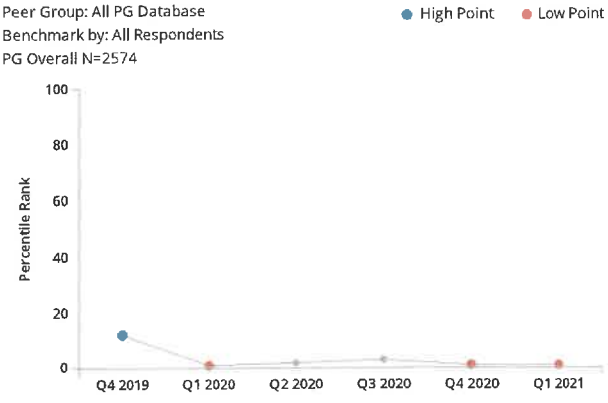


Top Box Percentile Rank

1st ▬

PG Overall

Peer Group: All PG Database
Benchmark by: All Respondents
PG Overall N=2574



Time Period	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021
n	16	13	52	42	49	46
Top Box Score	57.43%	44.03%	50.93%	50.67%	40.94%	43.70%
Percentile Rank	12	1	2	3	1	1

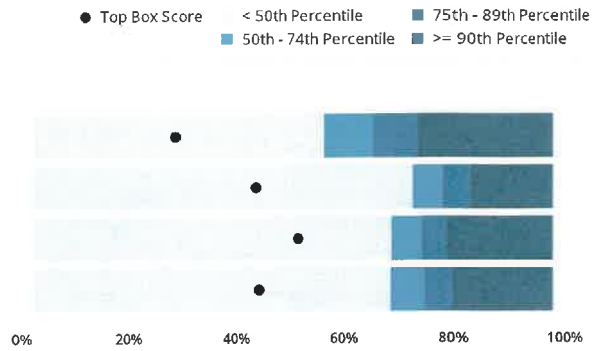
Section Performance

SORT BY: Default

SELECT: Standard

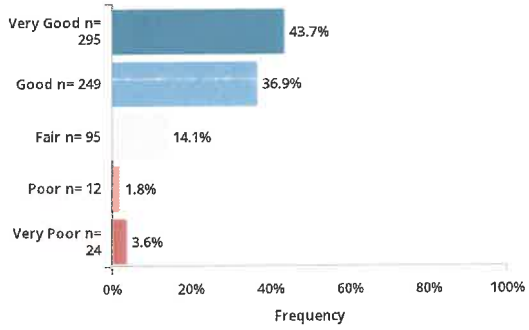
Peer Group: All PG Database
PG Overall N=2574

Survey Type	Section	n	Top Box Score	Percentile Rank
PG	Arrival	46	27.47%	1
PG	Nurses	46	43.19%	1
PG	Doctors	43	51.49%	3
PG	Overall Assessment	45	43.79%	1

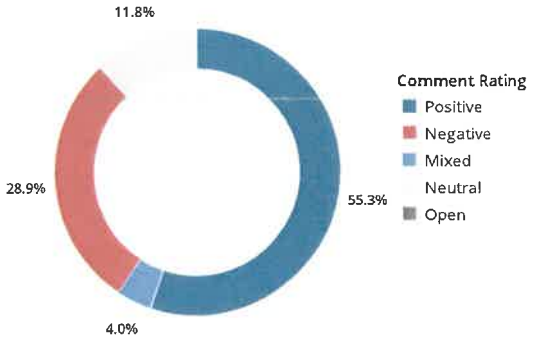


Distribution of Responses

PG Overall



Comment Distribution



N/A

PG Overall

Above Goal Below Goal

No Data Available

N/A

PG Overall

Above Goal Below Goal

No Data Available

Priority Index

PG Report Period: 6 months | CAHPS Report Period: 12 months
Benchmark by: All Respondents

Current Order	Survey Type	Question	Percentile Rank	Correlation
1	PG	Courtesy shown family/friends†	3	0.89
2	PG	Nurses took time to listen	4	0.88
3	PG	Staff kept family/friends informed†	5	0.85
4	PG	Helpfulness of first person†	3	0.82
5	PG	Staff cared about you as person	2	0.78
6	PG	Overall rating of care	7	0.89
7	PG	Waiting time before noticed arrival†	1	0.73
8	PG	Courtesy of nurses	3	0.78
9	PG	Waiting time to see doctors†	4	0.79
10	PG	How well pain was addressed†	7	0.83

† Custom Question ^ Focus Question

Dashboard Name: Survey Detail View | System Name: United Medical Center - System | System ID: 1410 | Facility Name: United Medical Center | Facility ID: 1410 | Service Line: Emergency Department | Metric: Top Box Score | Date Type: Received Date | Time Frame: Last Quarter | Peer Group: All PG Database | Current Benchmarking Period: 12/01/2020 - 02/28/2021 | Fiscal Start Month: 01 | Download Date & Time: Apr 9, 2021 2:54 pm EDT

▲ Positive ▼ Negative

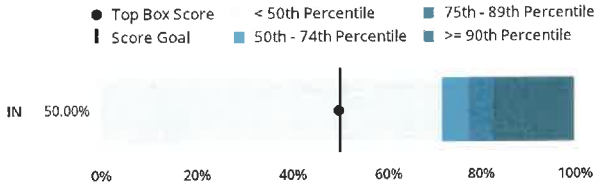
Survey Type	Sections/Domains	Items	Current n	Percentile Rank	Current Period (Q1-21)	Previous Period (Q4-20)	Change	
PG	Arrival	Waiting time before noticed arrival†	46	1	43.48%	40.82%	2.66%	▲
PG	Arrival	Helpfulness of first person†	46	1	41.30%	38.30%	3.01%	▲
PG	Arrival	Comfort of waiting area	45	1	24.44%	28.26%	-3.82%	▼
PG	Arrival	Waiting time to treatment area	46	1	30.43%	30.43%	0.00%	–
PG	Arrival	Waiting time to see doctors†	45	5	35.56%	37.78%	-2.22%	▼
PG	Nurses	Courtesy of nurses	46	1	41.30%	46.81%	-5.50%	▼
PG	Nurses	Nurses took time to listen	46	1	43.48%	40.43%	3.05%	▲
PG	Nurses	Nurses' attention to your needs	45	1	46.67%	43.48%	3.19%	▲
PG	Nurses	Nurses kept you informed†	43	1	44.19%	47.83%	-3.64%	▼
PG	Nurses	Nurses' concern for privacy	42	1	40.48%	51.06%	-10.59%	▼
PG	Nurses	Nurses' responses to quest/concerns	34	1	44.12%	N/A	--	–
PG	Doctors	Courtesy of doctors	42	2	52.38%	50.00%	2.38%	▲
PG	Doctors	Doctors took time to listen	41	8	58.54%	50.00%	8.54%	▲
PG	Doctors	Doctors informative re treatment	43	3	48.84%	43.48%	5.36%	▲
PG	Doctors	Doctors' concern for comfort	43	4	51.16%	43.48%	7.68%	▲
PG	Doctors	Doctors include you trtmt decision	33	1	45.45%	N/A	--	–
PG	Tests	Courtesy of person who took blood†	32	1	50.00%	51.61%	-1.61%	▼
PG	Tests	Concern for comfort blood drawn†	32	1	43.75%	46.67%	-2.92%	▼
PG	Tests	Waiting time for radiology test†	34	2	41.18%	48.48%	-7.31%	▼
PG	Tests	Courtesy of radiology staff†	34	1	44.12%	57.58%	-13.46%	▼
PG	Tests	Concern for comfort radiology test†	35	1	42.86%	61.11%	-18.25%	▼
PG	Family or Friends	Courtesy shown family/friends†	28	1	35.71%	29.41%	6.30%	▲
PG	Family or Friends	Staff kept family/friends informed†	29	1	31.03%	27.78%	3.26%	▲
PG	Family or Friends	Staff let family/friend be with you†	27	4	40.74%	31.25%	9.49%	▲
PG	Personal/Insurance Info	Courtesy during pers/insur info†	42	1	50.00%	41.86%	8.14%	▲
PG	Personal/Insurance Info	Privacy during pers/insur info†	42	2	50.00%	37.21%	12.79%	▲
PG	Personal/Insurance Info	Ease giving pers/insur info†	42	1	47.62%	39.53%	8.08%	▲
PG	Personal Issues	Informed about delays†	39	1	25.64%	26.09%	-0.45%	▼
PG	Personal Issues	How well pain was addressed†	41	3	36.59%	28.57%	8.01%	▲
PG	Personal Issues	Information about home care†	43	11	53.49%	39.02%	14.46%	▲
PG	Overall Assessment	Overall rating of care	45	1	42.22%	33.33%	8.89%	▲
PG	Overall Assessment	Staff cared about you as person	45	1	42.22%	31.82%	10.40%	▲
PG	Overall Assessment	Likelihood of recommending	44	3	47.73%	38.10%	9.63%	▲
PG	Overall Assessment	Staff worked together care for you	35	1	42.86%	N/A	--	–

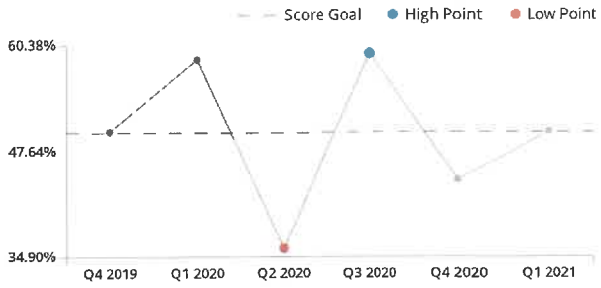
† Custom Question ^ Focus Question

Dashboard Name: Facility Scorecard | System Name: United Medical Center - System | System ID: 1410 | Facility Name: United Medical Center | Facility ID: 1410 | Service Line: Inpatient | Measure: CAHPS Rate 0-10 | Metric: Top Box Score | Date Type: Received Date | Time Frame: Last Quarter | Peer Group: All PG Database | Priority Index - Survey Type: Integrated | Priority Index View: External | CMS Reportable Responses: Not Applied | Skip Logic: Applied | Current Benchmarking Period: 12/01/2020 - 02/28/2021 | Fiscal Start Month: 01 | Download Date & Time: Apr 9, 2021 2:54 pm EDT

Service Line Performance

CAHPS Rate 0-10





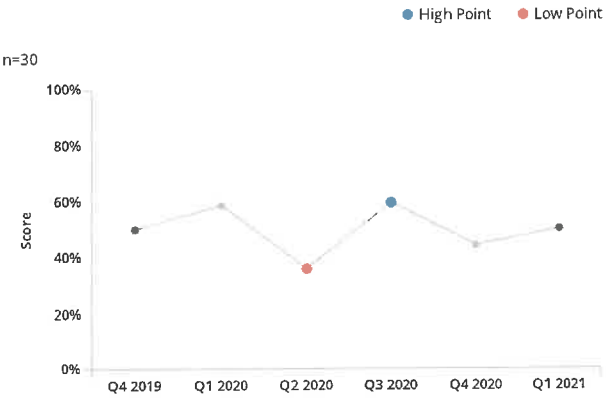
n	30
Top Box Score	50.00%
Score Goal	50.00%
Percentile Rank	1

Time Period	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021
n	20	41	39	32	43	30
Top Box Score	50.00%	58.54%	35.90%	59.38%	44.19%	50.00%
Percentile Rank	1	7	1	10	1	1

Top Box Score

50.00% ▲

CAHPS Rate 0-10

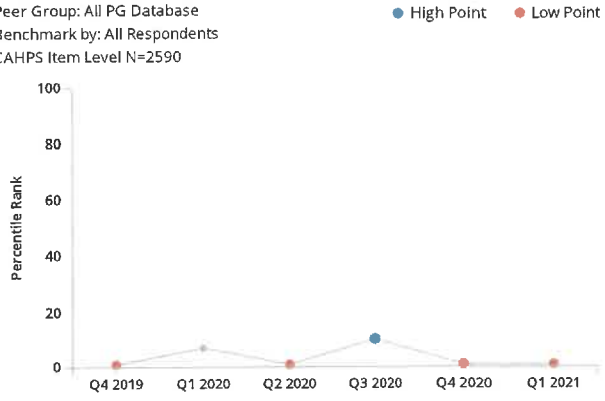


Top Box Percentile Rank

1st –

CAHPS Rate 0-10

Peer Group: All PG Database
Benchmark by: All Respondents
CAHPS Item Level N=2590



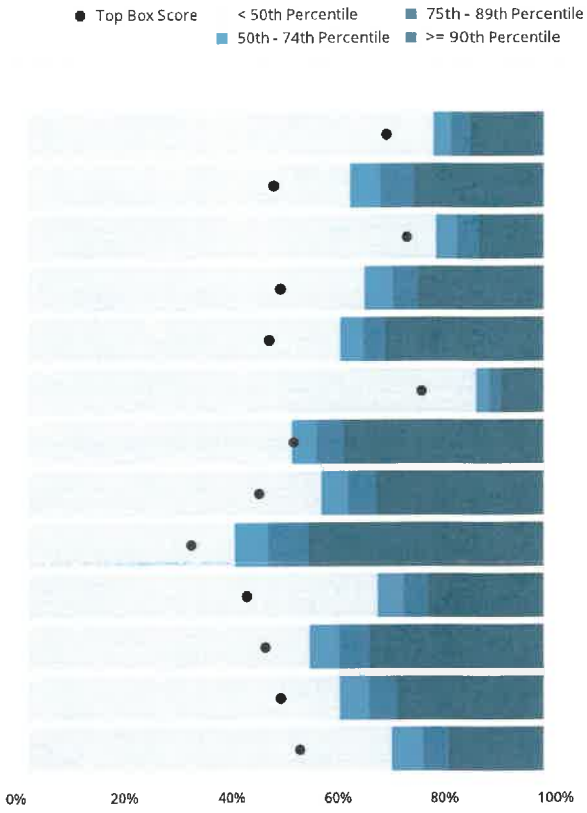
Time Period	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021
n	20	41	39	32	43	30
Top Box Score	50.00%	58.54%	35.90%	59.38%	44.19%	50.00%
Percentile Rank	1	7	1	10	1	1

Section Performance

SORT BY: Default | SELECT: Standard

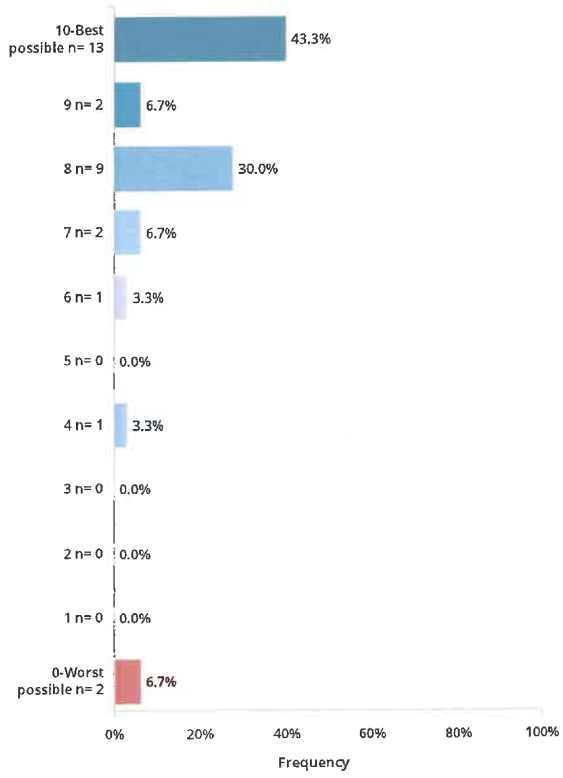
Peer Group: All PG Database
CAHPS Section/Domain Level N=2599 | PG Overall N=1491

Survey Type	Section	n	Top Box Score	Percentile Rank
CAHPS	Comm w/ Nurses	31	69.89%	7
CAHPS	Response of Hosp Staff	25	47.92%	4
CAHPS	Comm w/ Doctors	31	73.91%	15
CAHPS	Hospital Environment	31	49.19%	1
CAHPS	Comm About Medicines	20	46.94%	2
CAHPS	Discharge Information	28	76.79%	3
CAHPS	Care Transitions	31	51.72%	51
PG	Room	26	44.90%	6
PG	Meals	27	31.48%	16
PG	Nurses	25	42.47%	1
PG	Doctors	26	46.05%	16
PG	Personal Issues	29	49.07%	7
PG	Overall Assessment	30	52.81%	3

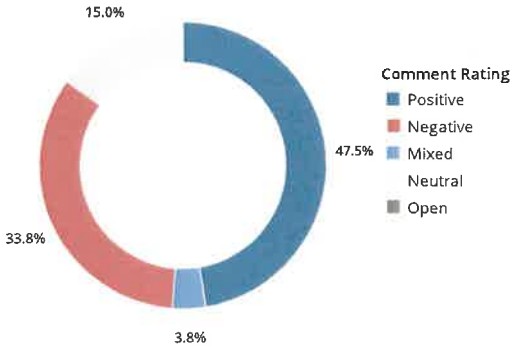


Distribution of Responses

CAHPS Rate 0-10



Comment Distribution



Unit Performance

CAHPS Rate 0-10

Above Goal Below Goal

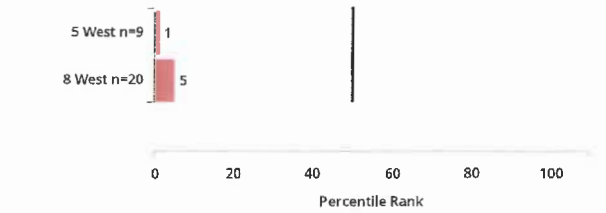
SET GOAL

50

SEARCH

SORT BY

Default (A-Z)



Specialty Performance

CAHPS Rate 0-10

Above Goal Below Goal

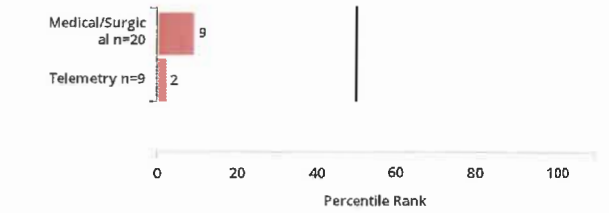
SET GOAL

50

SEARCH

SORT BY

Default (A-Z)



Unit	n	Top Box Score	Percentile Rank
5 West	9	44.44%	1
8 West	20	55.00%	5

Specialty	n	Top Box Score	Percentile Rank
Medical/Surgical	20	55.00%	9
Telemetry	9	44.44%	2

Priority Index

PG Report Period: 6 months | CAHPS Report Period: 12 months
Benchmark by: All Respondents

Current Order	Survey Type	Question	Percentile Rank	Correlation
1	PG	Likelihood of recommending	1	0.62
2	PG	Attention to needs	1	0.59
3	PG	Promptness response to call†	1	0.58
3	PG	Overall rating of care	1	0.58
5	CAHPS	Recommend the hospital	1	0.57
6	PG	Nurses kept you informed	1	0.56
7	CAHPS	Staff describe medicine side effect	2	0.57
8	PG	Response to concerns/complaints	1	0.55
8	PG	Staff include decisions re:trtmnt	1	0.55
8	PG	Staff worked together care for you	1	0.55
8	CAHPS	Nurses listen carefully to you	1	0.55

† Custom Question ^ Focus Question

Dashboard Name: Survey Detail View | System Name: United Medical Center - System | System ID: 1410 | Facility Name: United Medical Center | Facility ID: 1410 | Service Line: Inpatient | Metric: Top Box Score | Date Type: Received Date | Time Frame: Last Quarter | Peer Group: All PG Database | CMS Reportable Responses: Not Applied | Skip Logic: Applied | Current Benchmarking Period: 12/01/2020 - 02/28/2021 | Fiscal Start Month: 01 | Download Date & Time: Apr 9, 2021 2:55 pm EDT

▲ Positive ▼ Negative

Survey Type	Sections/Domains	Items	Current n	Percentile Rank	Current Period (Q1-21)	Previous Period (Q4-20)	Change	
CAHPS	Global Items	Rate hospital 0-10	30	1	50.00%	44.19%	5.81%	▲
CAHPS	Global Items	Recommend the hospital	30	1	43.33%	35.71%	7.62%	▲
CAHPS	Comm w/ Nurses	Nurses treat with courtesy/respect	31	4	74.19%	67.44%	6.75%	▲
CAHPS	Comm w/ Nurses	Nurses listen carefully to you	31	9	67.74%	56.82%	10.92%	▲
CAHPS	Comm w/ Nurses	Nurses expl in way you understand	31	12	67.74%	63.64%	4.11%	▲
CAHPS	Response of Hosp Staff	Call button help soon as wanted it	24	5	45.83%	32.50%	13.33%	▲
CAHPS	Response of Hosp Staff	Help toileting soon as you wanted	8	4	50.00%	43.75%	6.25%	▲
CAHPS	Comm w/ Doctors	Doctors treat with courtesy/respect	31	2	74.19%	79.55%	-5.35%	▼
CAHPS	Comm w/ Doctors	Doctors listen carefully to you	31	25	74.19%	70.45%	3.74%	▲
CAHPS	Comm w/ Doctors	Doctors expl in way you understand	30	42	73.33%	72.09%	1.24%	▲
CAHPS	Hospital Environment	Cleanliness of hospital environment	31	1	48.39%	58.14%	-9.75%	▼
CAHPS	Hospital Environment	Quietness of hospital environment	30	14	50.00%	53.49%	-3.49%	▼
CAHPS	Comm About Medicines	Tell you what new medicine was for	20	1	55.00%	52.63%	2.37%	▲
CAHPS	Comm About Medicines	Staff describe medicine side effect	18	12	38.89%	36.84%	2.05%	▲
CAHPS	Discharge Information	Staff talk about help when you left	28	6	75.00%	61.76%	13.24%	▲
CAHPS	Discharge Information	Info re symptoms/prob to look for	28	3	78.57%	78.79%	-0.22%	▼
CAHPS	Care Transitions	Hosp staff took pref into account	29	11	34.48%	28.21%	6.28%	▲
CAHPS	Care Transitions	Good understanding managing health	30	77	56.67%	40.48%	16.19%	▲
CAHPS	Care Transitions	Understood purpose of taking meds	25	75	64.00%	39.39%	24.61%	▲
PG	Admission	Speed of admission†	23	1	34.78%	37.14%	-2.36%	▼
PG	Admission	Courtesy of person admitting†	21	1	38.10%	45.45%	-7.36%	▼
PG	Room	Pleasantness of room decor†	25	11	32.00%	36.11%	-4.11%	▼
PG	Room	Room cleanliness†	25	3	40.00%	43.24%	-3.24%	▼
PG	Room	Courtesy of person cleaning room	24	2	50.00%	54.29%	-4.29%	▼
PG	Room	Room temperature	25	19	40.00%	30.56%	9.44%	▲
PG	Room	Noise level in and around room†	26	13	34.62%	34.29%	0.33%	▲
PG	Meals	Temperature of the food	27	27	37.04%	21.62%	15.42%	▲
PG	Meals	Quality of the food	27	9	25.93%	27.50%	-1.57%	▼
PG	Meals	Courtesy of person served food†	24	1	41.67%	55.56%	-13.89%	▼
PG	Nurses	Friendliness/courtesy of nurses†	26	1	53.85%	55.26%	-1.42%	▼
PG	Nurses	Promptness response to call†	22	2	40.91%	41.03%	-0.12%	▼
PG	Nurses	Nurses' attitude toward requests	25	1	40.00%	48.72%	-8.72%	▼
PG	Nurses	Attention to needs	24	1	45.83%	43.59%	2.24%	▲

PG	Nurses	Nurses kept you informed	24	1	41.67%	39.47%	2.19%	▲
PG	Nurses	Skill of nurses†	24	1	54.17%	52.50%	1.67%	▲
PG	Tests and Treatments	Wait time for test or treatments†	27	12	40.74%	35.90%	4.84%	▲
PG	Tests and Treatments	Explanations:happen during T&T†	26	23	53.85%	33.33%	20.51%	▲
PG	Tests and Treatments	Courtesy of person who took blood†	26	1	50.00%	38.46%	11.54%	▲
PG	Tests and Treatments	Courtesy of person started IV†	23	1	47.83%	38.46%	9.36%	▲
PG	Visitors and Family	Accomm/comfort for visitors†	13	4	30.77%	33.33%	-2.56%	▼
PG	Visitors and Family	Staff attitude toward visitors†	11	1	36.36%	33.33%	3.03%	▲
PG	Doctors	Time doctors spent with you	26	13	38.46%	35.90%	2.56%	▲
PG	Doctors	Doctors' concern questions/worries	25	13	48.00%	41.03%	6.97%	▲
PG	Doctors	Doctors kept you informed	25	26	52.00%	46.15%	5.85%	▲
PG	Doctors	Friendliness/courtesy of doctors†	26	5	53.85%	48.72%	5.13%	▲
PG	Doctors	Skill of doctors†	24	12	62.50%	56.41%	6.09%	▲
PG	Discharge	Extent felt ready discharge†	29	17	55.17%	48.84%	6.34%	▲
PG	Discharge	Speed of discharge process†	28	37	50.00%	39.53%	10.47%	▲
PG	Discharge	Instructions for care at home†	28	5	50.00%	41.46%	8.54%	▲
PG	Personal Issues	Staff concern for privacy	28	2	46.43%	34.88%	11.54%	▲
PG	Personal Issues	How well pain was addressed†	29	2	44.83%	45.00%	-0.17%	▼
PG	Personal Issues	Staff addressed emotional needs	27	18	51.85%	34.15%	17.71%	▲
PG	Personal Issues	Response to concerns/complaints	24	13	50.00%	31.71%	18.29%	▲
PG	Personal Issues	Staff include decisions re:trtmnt	29	10	48.28%	27.50%	20.78%	▲
PG	Overall Assessment	Staff worked together care for you	30	5	56.67%	41.86%	14.81%	▲
PG	Overall Assessment	Likelihood of recommending	29	4	51.72%	35.00%	16.72%	▲
PG	Overall Assessment	Overall rating of care	30	1	50.00%	45.00%	5.00%	▲

† Custom Question ^ Focus Question

Utility Management Performance Indicators

QUALITY / SAFETY / SCORECARD - FACILITIES

#	MEASURE	GOAL	PERFORMANCE											
			Years											
			YTD 2020	YTD 2021	Oct' 20	Nov' 20	Dec' 20	Jan' 21	Feb' 21	Mar' 21	Apr'21	May' 21	Jun' 21	Jul' 21	Aug' 21	Sept' 21
#	PROCESS															
1	PM Completion Rate on Utility Components or Systems	100%			100%	100%	100%	100%	100%	100%						
2	Quarterly Differential Pressure Testing of Special Environment Areas	100%			100%	100%	100%	100%	100%	100%						
3	Domestic Water Sampling / Treatment	100%			100%	100%	100%	100%	100%	100%						
4	Steam Utility Failures	10 % reduction or 5			3	2	2	0	1	0						
5	Air Handler Reliability / HVAC & Failure	<5%			70%	70%	70%	70%	70%	70						
6	Power Fluctations / Outages				0	1	0	0	0	1						
7	Water Intrusion / Flooding Incidents				14	5	9	8	7	17						
8	Contract Labor / HVAC/Chiller Rental				$98,075.00	$64,075.00	$64,075.00	$64,075.00	$23,890							
9	Contract Labor / Water Intrusion				$88,373.57	$15,868.32	$0.00	$0.00	$0.00							
10	OT Hrs				250	109	149	179.5	167.5	280						

*December & January Water Intrudions were managed by Facilties & EVS Personnel

FY 2021 Not-For-Profit Hospital Corporation - The Joint Commision SAFER Matrix
Limited Findings

Report Page No.	Risk Scale	Limited	Standard Text & EP Text	Finding(s)	Assigning Accountability	Status	% JAN	% FEB	% MAR
P. 13	High	IC.02.02.01 EP 2	**Standard Text:** The hospital reduces the risk of infections associated with medical equipment, devices, and supplies. **EP Text**: The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies.	During tracer activities in the ED, it was discovered that reusable, sharp instruments are not being transported to the dirty utility room in a closed container, and are hand carried without a closed container. The ED Director and Quality Department scribe were present for the finding. The finding was corrected on site by placing 3 clean closed biohazard containers in the clean supply room for staff to use to transport the instruments from the procedure room to the dirty utility room.	The Infection Preventionist and ED Nurse Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	The activities to monitor compliance will include random audits via Infection Control/Environment of Care Rounds on the availability and placement of the biohazard puncture resistant containers in the clean supply room. In addition other activities to ensure compliance will include random interviews of staff to ensure understanding of handling soiled surgical instruments. Review Staff compliance with Education material provided.	100%	100%	100%
P. 12	Moderate	EC.02.06.01 EP 20	**Standard Text**: The hospital establishes and maintains a safe, functional environment. **EP Text:** Areas used by patients are clean and free of offensive odors.	During tracer activities on the BHU, in room 422 there were electrodes found stuck on the bathroom door. Room 422 was not occupied and was ready for a patient admission. The Unit Manager and Quality Department scribe was present for the observation.	The Behavioral Health Manager and ED RN Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	Behavioral Health leadership will perform 10 random room inspections audits monthly.	100%	100%	100%
P. 19	Moderate	MM.03.01.01 EP 7	**Standard Text:** The hospital safely stores medications. **EP Text:** All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings.	During tour of the Orthopedic clinic, a multi dose vial of lidocaine was used. It was label for opening date. No 28 discard date was present as required by hospital policy: " Medication Administration Policy" dated 2/1/2020. This was witnessed by Ambulatory Director and scribe accompanying the surveyor.	The Director of Ambulatory Rehab Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	To ensure proper medication management, labeling of vial monitoring will be put in place for multi-dose vials in specialty/orthopedic clinic in regards to beyond use dates. New and existing medical assistants and providers will have mandatory annual multi-dose vial education in Relias.	100%	100%	100%
P. 20	Moderate	NPSG.15.01.01 EP 1	**Standard Text:** Reduce the risk for suicide. **EP Text:** For psychiatric hospitals and psychiatric units in general hospitals: The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the hospital takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). For non-psychiatric units in general hospitals: The organization implements procedures to mitigate the risk of suicide for patients at high risk for suicide, such as one-to-one monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient's medical care, assessing objects brought into a room by visitors, and using safe transportation procedures when moving patients to other parts of the hospital.	During tracer activities on the BHU, in room 422 there was no plastic safety cover on the thermostat, which was identified as a safety risk on the unit risk assessment. Room 422 was not occupied and ready for a patient admission. The Unit Manager and Quality Department scribe were present for the observation. The finding was corrected on site.	The VP of Facilities and Support Services and Behavioral Health Unit is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	A semiannual Ligature Risk assessment will be documented to ensure compliance of safety measures.	100%	100%	100%

FY 2021 Not-For-Profit Hospital Corporation - The Joint Commision SAFER Matrix
Limited Findings

Report Page No.	Risk Scale	Limited	Standard Text & EP Text	Finding(s)	Assigning Accountability	Status	% JAN	% FEB	% MAR
P. 8	Low	EC.02.02.01 EP 12	**Standard Text:** The hospital manages risks related to hazardous materials and waste. **EP Text:** The hospital labels hazardous materials and waste. Labels identify the contents and hazard warnings. * (See also IC.02.01.01, EP 6)	During tracer activities in the ED it was discovered that dirty instruments were transported to the dirty utility room without a biohazard label. The ED Director and Quality Department scribe were present for the finding.	The Infection Preventionist and ED Nursing Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	UMC purchased additional biohazard puncture resistant containers. Random audits via Infection Control/Environment of Care Rounds to ensure biohazard puncture resistant containers are properly labeled.	100%	100%	100%
P. 9	Low	EC.02.04.03 EP 3	**Standard Text:** The hospital inspects, tests, and maintains medical equipment. **EP Text:** The hospital inspects, tests, and maintains non-high-risk equipment identified on the medical equipment inventory. These activities are documented.	Hydrocollator water changes and cleaning not performed per manufacturer's recommendations. Confirmed by Ambulatory director and QA staff with surveyor.	The VP of Facilities and Support Services and Director of Rehabilitation Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	To monitor compliance a monthly review of the hydrocullator cleaning log book will be conducted.	100%	100%	100%
P. 9	Low	EC.02.05.05 EP 5	**Standard Text:** The hospital inspects, tests, and maintains utility systems. **EP Text:** The hospital inspects, tests, and maintains the following: Infection control utility system components on the inventory. The completion date and the results of the activities are documented.	Ice machines in the 8th floor Telemetry Unit had an accumulation of white lime scale around the outside and inside of dispensing chute. This was verified by Unit manager and staff accompanying the surveyor.	The VP of Facilities and Support Services and Infection Control is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	The procedures identified to monitor compliance with performance will include review of documentation and surveillance of the Preventive Maintenance (PM) of the ice machines during environment of care rounding.	100%	100%	100%
P. 10	Low	EC.02.05.07 EP 1	**Standard Text:** The hospital inspects, tests, and maintains emergency power systems. **EP Text:** At least monthly, the hospital performs a functional test of emergency lighting systems and exit signs required for egress and task lighting for a minimum duration of 30 seconds, along with a visual inspection of other exit signs. The test results and completion dates are documented.	At the time of survey, the documentation of the monthly testing of battery lights and inspection of exit lights did not include an inventory to ensure that each and every one was completed.	The VP of Facilities and Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	The inspection logs will be reviewed on a monthly basis for compliance with battery powered lights and exit light inspections. For instances of non-compliance a corrective action plan will be sent to the VP of Facilities & Support Services.	100%	100%	100%
P. 10	Low	EC.02.05.07 EP 2	**Standard Text:** The hospital inspects, tests, and maintains emergency power systems. **EP Text:** Every 12 months, the hospital performs a functional test of battery-powered lights on the inventory required for egress and exit signs for a duration of 1 1/2 hours. For new construction, renovation, or modernization, battery-powered lighting in locations where deep sedation and general anesthesia are administered is tested annually for 30 minutes. The test results and completion dates are documented.	At the time of survey, the documentation of the annual functional testing of battery lights did not include an inventory to ensure that each and every light had been tested.	The VP of Facilities and Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	Review the log for functional testing compliance monthly.	100%	100%	100%
P. 11	Low	EC.02.06.01 EP 1	**Standard Text:** The hospital establishes and maintains a safe, functional environment. **EP Text:** Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.	At the time of survey, there was a stained ceiling tile in the corridor by Radiology room #1030. During environmental tour of Pharmacy, peeled paint on furnace ducts above exposed ceiling was noted over area where medications were being stored. This was confirmed by pharmacy director and VP of Facilities & Support Services. Furnace ducts were repainted and defect corrected and confirmed by surveyor prior to leaving HCO.	The VP of Facilities and Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	All thermostats will be removed from Behavioral Health Unit patient rooms. Address all stained ceiling tiles within 24 hours of discovery. Address peeling paint in clean areas within 24 hours of discovery.	100%	100%	100%

FY 2021 Not-For-Profit Hospital Corporation - The Joint Commision SAFER Matrix
Limited Findings

Report Page No.	Risk Scale	Limited	Standard Text & EP Text	Finding(s)	Assigning Accountability	Status	% JAN	% FEB	% MAR
P. 12	Low	LS.02.01.10 EP 11	**Standard Text:** Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat. **EP Text:** Fire-rated doors within walls and floors have functioning hardware, including positive latching devices and self-closing or automatic-closing devices (either kept closed or activated by release device complying with NFPA 101-2012:7.2.1.8.2). Gaps between meeting edges of door pairs are no more than 1/8 of an inch wide, and undercuts are no larger than 3/4 of an inch. Fire-rated doors within walls do not have unapproved protective plates greater than 16 inches from the bottom of the door. Blocking or wedging open fire-rated doors is prohibited.	At the time of survey, the door in the 1-hour rated fire wall by OR#9 was in need of adjustment, rendering it to not be fully self-closing and positive-latching. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Increase surveillance (EP-8), Other-Deficiency will be promptly corrected. (EP-15)	The VP of Facilities and Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	The Facilities staff will perform a documented monthly functional test on all fire doors ensuring the self-closer device operates appropriately thus causing the door to latch.	100%	100%	100%
P. 13	Low	LS.02.01.10 EP 14	**Standard Text:** Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat. **EP Text:** The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes penetrating the walls or floors are protected with an approved fire-rated material.	At the time of survey, the space around cables within a four-inch conduit sleeve penetrating the floor of the IT closet by room #755 was not properly sealed with an intumescent fire-stop system. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Other-Deficiency will be promptly corrected.(EP-15). At the time of survey, the space around cables within two conduit sleeves penetrating the floor of the 3East IT closet were not properly sealed with an intumescent fire stop system. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Other-Deficiency will be promptly corrected.(EP-15).	The VP of Facilities and Support Services and Chief Information Officer is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	To monitor compliance monthly visual inspections and annually will be monitored for compliance with this element of performance. The vendor will use an approved fire stop material.	100%	100%	100%
P. 13	Low	LS.02.01.20 EP 1	**Standard Text**: The hospital maintains the integrity of the means of egress. **EP Text:** Doors in a means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side, unless a compliant locking configuration is used, such as a delayed-egress locking system as defined in NFPA 101-2012: 7.2.1.6.1 or access-controlled egress door assemblies as defined in NFPA 101-2012: 7.2.1.6.2. Elevator lobby exit access door locking is allowed if compliant with 7.2.1.6.3.	At the time of survey, the emergency exit stair door in the kitchen was in need of repair. Neither this surveyor nor members of the hospital team were able to open it, even after multiple tries. The hospital maintenance team immediately repaired it. This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission.	The VP of Facilities and Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	The Facilities staff will perform monthly observation of all emergency exit stair doors. The inspection results will be reported to the Hospital's Joint Commission Compliance Committee, as well as the Environment of Care Committee on a monthly basis.	100%	100%	100%

FY 2021 Not-For-Profit Hospital Corporation - The Joint Commision SAFER Matrix
Limited Findings

Report Page No.	Risk Scale	Limited	Standard Text & EP Text	Finding(s)	Assigning Accountability	Status	% JAN	% FEB	% MAR
P. 13	Low	LS.02.01.20 EP 14	**Standard Text:** The hospital maintains the integrity of the means of egress. **EP Text:** Exits, exit accesses, and exit discharges (means of egress) are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice.	At the time of survey, there were multiple carts and equipment, not in use, located in the egress corridors in ICU. At this point, the area had not been identified as a suite as defined by Life Safety Code. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Increase surveillance(EP-8), Conduct education promoting awareness of deficiencies (EP-13). At the time of survey, there were seven pieces of equipment, not in use, stored in the egress corridor in the Radiology Department. This corridor was not within the area defined as a suite under Life Safety Code. It was adjacent to it. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Increase surveillance (EP-8).	The VP of Facilities and Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	Annually a vendor will be employed annually to evaluate the Life Safety drawings and make changes as necessary.	100%	100%	100%
P. 15	Low	LS.02.01.20 EP 41	**Standard Text:** The hospital maintains the integrity of the means of egress. **EP Text:** Signs reading "NO EXIT" are posted on any door, passage, or stairway that is neither an exit nor an access to an exit but may be mistaken for an exit.	The "dead end" corridor by room #8835 and the "dead end" corridor by room #8803 could both be mistaken for paths to exit but are not. At the time of survey, they lacked the required "NO EXIT" signs. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Other-Deficiency will be promptly corrected.(EP-15). The door to the patio in the Healing Garden could be mistaken for a path to exit but is not. At the time of survey, it lacked a "NO EXIT" sign. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Other-Deficiency will be promptly corrected.(EP-15).	The VP of Facilities and Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	The United Medical Center will continue to have their environment of care rounds and will inspect and evaluate the facility for specific doors and pathways that could be mistaken as a path to an exit.	100%	100%	100%
P. 16	Low	LS.02.01.30 EP 3	**Standard Text:** The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke. **EP Text:** All existing hazardous areas have doors that are self-closing or automatic-closing. These areas are protected by either a fire barrier with one-hour fire-resistive rating or an approved electrically supervised automatic sprinkler system. Hazardous areas include, but are not limited to, boiler and fuel-fired heater rooms, central/bulk laundries larger than 100 square feet, paint shops, repair shops, soiled linen rooms, trash collection rooms with containers exceeding 64 gallons, laboratories employing flammable or combustible materials deemed less than a severe hazard, and storage rooms greater than 50 square feet used for storage of equipment and combustible supplies.	Supply room #3342 is greater than one hundred square feet. At the time of survey, the door was in need of adjustment, rendering it to not be fully self-closing and positive-latching. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Other-Deficiency will be promptly corrected.(EP-15). At the time of survey, the door to trash room SS91, a storage room greater than one hundred square feet, was in need of maintenance, rendering it to not be fully self-closing and positive-latching. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Other-Deficiency will be promptly corrected.(EP-15).	The VP of Facilities Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	The Facilities staff will perform monthly a documented functional test for all doors located at the entrance all fully self-closing and positive-latching. The inspection results will be reported to the Hospital's Joint Commission Compliance Committee, as well as the Environment of Care Committee on a monthly basis.	100%	100%	100%

FY 2021 Not-For-Profit Hospital Corporation - The Joint Commision SAFER Matrix
Limited Findings

Report Page No.	Risk Scale	Limited	Standard Text & EP Text	Finding(s)	Assigning Accountability	Status	% JAN	% FEB	% MAR
P. 18	Low	LS.02.01.35 EP 6	**Standard Text:** The hospital provides and maintains systems for extinguishing fires. **EP Text:** There are 18 inches or more of open space maintained below the sprinkler to the top of storage.	At the time of survey, there was storage less than eighteen inches below the sprinklers in EOP Storage Room G072. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Increase surveillance (EP-8), Conduct education promoting awareness of deficiencies (EP-13).	The VP of Facilities and Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	All Emergency supply rooms located on the ground floor will be added to the Environment of Care rounding schedule.	100%	100%	100%

FY 2021 Not-For-Profit Hospital Corporation - The Joint Commision SAFER Matrix
Pattern Findings

Report Page No.	Risk Scale	Pattern Scope	Standard Text & EP Text	Findings	Assigning Accountability	Status	% JAN	% FEB
	High		None					
	Moderate		None					
P. 23	Low	EC.02.03.03 EP 3	**Standard Text:** The hospital conducts fire drills. **EP Text:** When quarterly fire drills are required, they are unannounced and held at unexpected times and under varying conditions. Fire drills include transmission of fire alarm signal and simulation of emergency fire conditions.	In review of fire drill documentation for calendar year 2020, there were multiple drills on each shift that were at exactly the same time or varied by less than one hour.	The VP of Facilities and Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	The VP of Facilities & Support services and the Director of Safety & Security will continue to provide written fire drill results (matrix) to the Environment of Care on a monthly basis.	100%	100%
P. 27	Low	LS.02.01.34 EP 9	**Standard Text:** The hospital provides and maintains fire alarm systems. **EP Text:** The ceiling membrane is installed and maintained in a manner that permits activation of the smoke detection system.	At the time of survey, there was a total of approximately forty square inches of open space around conduits penetrating the suspended ceiling of the OR Equipment Room that was not sealed, negatively impacting the function of the smoke detector and sprinklers in the room. Tthere were three ceiling tiles out in the 6th floor nursing station, negatively impacting the function of the smoke detectors and sprinklers in the area. There was an approximately 3/4-inch gap between a smoke detector in PACU and the ceiling, exposing the approximately four-inch in diameter hole in the ceiling above. There were two ceiling tiles out near room #3333, negatively impacting the function of the smoke detectors and sprinklers in the area. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Other-Deficiency will be promptly corrected. (EP-15)	The VP of Facilities and Support Services and Facilities Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	All missing ceiling tiles were replaced on the 6th floor. All missing ceiling tiles were replaced on the 3rd floor. The gap around the conduit penetration in the drop ceiling located in the OR Equipment storage room was sealed. The smoke detector was mounted flush with the ceiling located in PACU.	100%	100%

Report Page No.	Risk Scale	Pattern Scope	Standard Text & EP Text	Findings	Assigning Accountability	Status	% JAN	% FEB
P. 27	Low	LS.02.01.35 EP 14	**Standard Text:** The hospital provides and maintains systems for extinguishing fires. **EP Text:** The hospital meets all other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012: 18/19.3.5.	At the time of survey, there was an approximately 1/4-inch gap between a sprinkler escutcheon and the suspended ceiling. This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Other-Deficiency will be promptly corrected. (EP-15)	The VP of Facilities and Support Services and Facilities Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	The escutcheon plate was affixed to the ceiling illuminating the gap. The missing ceiling tile was replaced. Upon receipt of a missing ceiling tile, a work order will be generated to replace the missing tile within 4-hours. All completed work orders are evaluated on a monthly basis. The work order completion % for the missing ceiling tiles will be reviewed monthly, and a monthly report will be provided to the Environment of Care Committee, Quality and the Performance Improvement Committee.	100%	100%
P. 27	Low	MS.06.01.07 EP 9	**Standard Text:** The organized medical staff reviews and analyzes all relevant information regarding each requesting practitioner's current licensure status, training, experience, current competence, and ability to perform the requested privilege. **EP Text:** Privileges are granted for a period not to exceed two years.	In 2 of 2 medical staff/credentialing files reviewed, gaps of 2 to 3 days from one two year credentialed period to the next cycle. Thus allowing the physician to be credentialed for more than the expected two year period. This was verified by the CMO and accreditation staff present.	The Chief Medical Officer is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	Provisional reviews and re-appointment applications will be reviewed by the Medical Affairs Manager. Focused effort to ensure that no provisional reviews extend beyond the designated 12-month period and no appointments or re-appointments to the Medical Staff extend beyond the designated 24-month period. Any extension or gap of days prior to credentialing must be supported by clear documentation explaining why the extension or gap has occurred. It should be noted that according to the Medical Staff Bylaws, when a re-appointment application has not been fully processed before the member's appointment expires, the Medical Staff member's privileges shall be automatically suspended until the review is complete.	100%	100%

Report Page No.	Risk Scale	Widespread	Standard Text & EP Text	Findings	Assigning Accountability	Status	% JAN	% FEB
P. 11	High	EC.02.05.09 EP 12	**Standard Text:** The hospital inspects, tests, and maintains medical gas and vacuum systems. **EP Text:** The hospital implements a policy on all cylinders within the hospital that includes the following:- Labeling, handling, and transporting (for example, in carts, attached to equipment, on racks) in accordance with NFPA 99-2012: 11.5.3.1 and 11.6.2 - Physically segregating full and empty cylinders from each other in order to assist staff in selecting the proper cylinder - Adaptors or conversion fittings are prohibited- Oxygen cylinders, containers, and associated equipment are protected from contamination, damage, and contact with oil and grease- Cylinders are kept away from heat and flammable materials and do not exceed a temperature of 130°F - Nitrous oxide and carbon dioxide cylinders do not reach temperatures lower than manufacturer recommendations or -20°F- Valve protection caps (if supplied) are secured in place when cylinder is not in use- Labeling empty cylinders - Prohibiting transfilling in any compartment with patient care.	At the time of survey, there were 25 H-size medical gas chambers that were not secured in any manner, free standing on the floor, in the medical gas rooms at the receiving area.	The VP of Facilities and Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	Document the weekly checks will be submitted to the facilities Administrative Assistant who maintain written copies for review by the Facilities Director. In addition, a monthly check will be included in EOC hazard surveillance rounds	100%	100%
P. 19	Moderate	MS.08.01.03 EP 1	**Standard Text:** Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal. **EP Text:** The process for the ongoing professional practice evaluation includes the following: There is a clearly defined process in place that facilitates the evaluation of each practitioner's professional practice.	In 3 of 3 medical staff/credentialing files reviewed, revealed the process was not ongoing as OPPE was completed only at the time of reappointment - every 2 years. This was verified by CMO and medical staff coordinator.	The Chief Medical Officer is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	Medical Staff providers audit for compliance with OPPE/FPPE process. Provisional Staff will be reviewed every 6 months within the 12-month period, and reappointments will be reviewed every 8 months within the 24-month period.	100%	100%
P. 9	Low	EC.02.03.05 EP 25	**Standard Text:** The hospital maintains fire safety equipment and fire safety building features. **EP Text:** The hospital has annual inspection and testing of fire door assemblies by individuals who can demonstrate knowledge and understanding of the operating components of the door being tested. Testing begins with a pre-test visual inspection; testing includes both sides of the opening.	Documentation dated 2/19/2020 indicated that 105 of 180 rated door assemblies in the building had failed the required annual inspection. At the time of survey, 11/10/2020, repairs had not begun on these doors.	The VP of Facilities Support Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	The Facilities department will request a PO immediately after receiving the annual fire inspection results to begin repairs on non-complaint doors.	100%	100%
P. 20	Low	TS.03.02.01 EP 2	**Standard Text:** The hospital traces all tissues bi-directionally. **EP Text:** The hospital identifies, in writing, the materials and related instructions used to prepare or process tissues.	In 3 of 3 patient records reviewed, In 3 of 3 patient records reviewed, the HCO did not record the lot number of the sterile normal saline used to reconstitute tissue. Confirmed by tissue manager and QA staff with surveyor.	The Operating Room Manager is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.	Monthly reporting of audit results, with the goal of obtaining 100% compliance.	100%	100%

COMPLETED FIRE DRILL MATRIX

Hospital Name: United Medical Center (UMC) Score at EC

Quarterly Hospital Fire D

Day = M, Tu, W, Th, F, Sa, Su Time: 24 hour formatted			Q1			Q2			
			Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.
1st Shift	Normal	**Location/Building**	1st Core	1st Fl HR	8th Fl				
		Day	F	F	F				
		Date	1/8/21	1/26/21	3/12/21				
		Time	1330	0903	1005				
	ILSM	**Location/Building**		CNMC					
		Day		Su					
		Date		2/28/21					
		Time		1500					
2nd Shift	Normal	**Location/Building**	3rd Fl	4th Fl	5th Fl				
		Day	Tu	M	Sa				
		Date	1/12/21	2/15/21	3/27/21				
		Time	2001	1800	2230				
	ILSM	**Location/Building**	CNMC						
		Day	Su						
		Date	1/31/21						
		Time	2130						
3rd Shift	Normal	**Location/Building**	5th Fl	2nd Fl	6th Fl				
		Day	Th	Su	W				
		Date	1/22/21	2/7/21	3/24/21				
		Time	0300	0500	0106				
	ILSM	**Location/Building**			CNMC				
		Day			F				
		Date			3/19/21				
		Time			0130				

Previous and Current High Risk Fire Drills (recommended not requ

Location:	**Previous**	**Current**	**Location:**	**Previous**	**Current**	**Location:**	**Previous**	**Current**	**Location:**
Kitchen			**Surgery**			**Cath/EP Lab**			**MRI**
Day	W	Th	Day			Day			Day
Date			Date			Date			Date
Time			Time			Time			Time

Quarterly Ambulatory Fire Drills

		Q1	Q2	Q3	Q4		Q1
1st Shift	**Location/Building**	AST				**Location/Building**	
	Day	Tu				Day	
	Date					Date	
	Time					Time	

Annual Business Occupancy Fire Drills (2 Years of drills)

	Previous	**Current**		**Previous**	**Current**		**Previous**	**Current**	
Building	**Medical Office Buliding**		**Building**			**Building**			**Building**
Day	W	Th	Day			Day			Day
Date			Date			Date			Date
Time			Time			Time			Time

Definitions of Shifts: Provide timeframes for shift hours below (e.g. 1st shift: 0700-1600, 2nd shift: 1600-2400, 3rd shift: 2400-0700)

COMPLETED FIRE DRILL MATRIX

1st	
2nd	
3rd	

NA Not applicable for no shift, building,
NC Not completed or missed

COMPLETED FIRE DRILL MATRIX

C.02.03.03 EP3

rills

Q3		Q4		
Aug.	Sep.	Oct.	Nov.	Dec.

uired)

Previous	Current	Location:	Previous	Current
		Plant		
		Day		
		Date		
		Time		

Q2	Q3	Q4

Previous	Current		Previous	Current
		Building		
		Day		
		Date		
		Time		

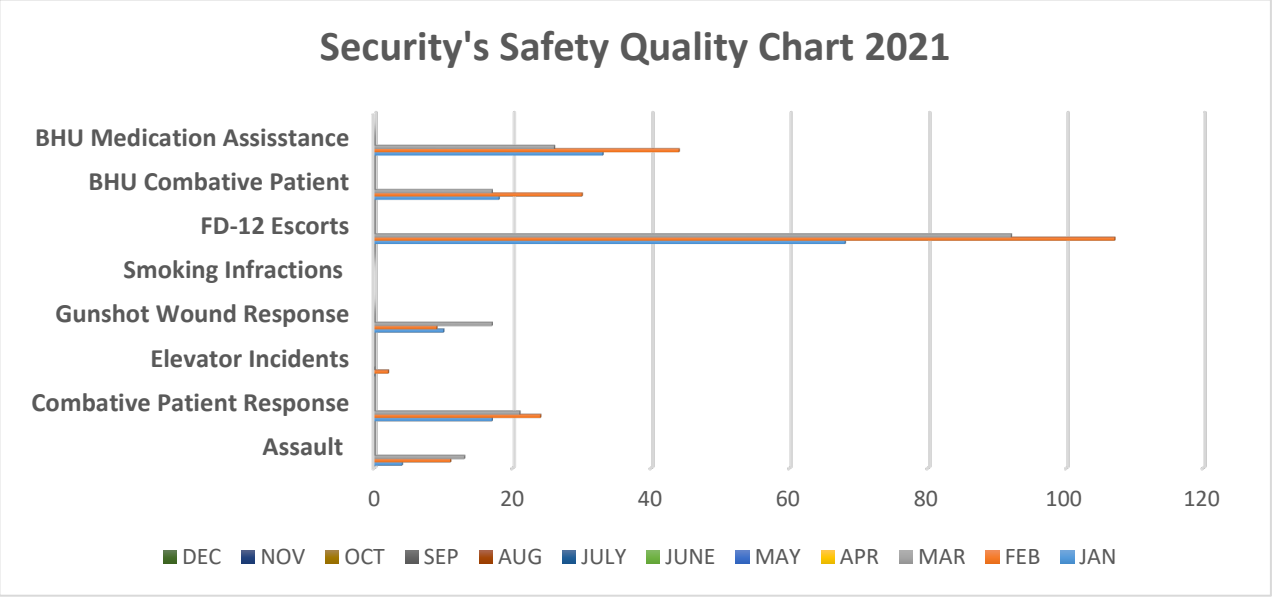
COMPLETED FIRE DRILL MATRIX

location or ILSM.

SECURITY 2021 QUALITY SAFETY SCORECARD

	MEASURE	GOAL		PERFORMANCE					
				JAN	FEB	MAR	APR	MAY	JUNE
1	Assault			4	11	13			
2	Combative Patient Response			17	24	21			
3	Elevator Incidents			0	2	0			
4	Gunshot Wound Response			10	9	17			
5	Smoking Infractions								
6	FD-12 Escorts			68	107	92			
7	BHU Combative Patient			18	30	17			
8	BHU Medication Assisstance			33	44	26			
9	Physician Ordered Restraints	100%		Yes	Yes	Yes			
10	Usecured Door Checks	100%		Yes	Yes	Yes			
11	Fire Drills (1 Shift Per QTR)	100%		Yes	Yes	Yes			
12	Fire Extinguishers Check	100%		Yes	Yes	Yes			
	C=Compliant - Grey= N/A								

				JULY	AUG	SEP	OCT	NOV	DEC
1	Assault								
2	Combative Patient Response								
3	Elevator Incidents								
4	Gunshot Wound Response								
5	Smoking Infractions								
6	FD-12 Escorts								
7	BHU Combative Patient								
8	BHU Medication Assisstance								
9	Physician Ordered Restraints	100%							
10	Usecured Door Checks	100%							
11	Fire Drills (1 Shift Per QTR)	100%							
12	Fire Extinguishers Check	100%							
	C = Compliant - Grey = N/A								



Finance Committee

Open Report

- April 26: Reg Mtg

Not-For-Profit Hospital Corporation Board of Directors
Finance Committee: DM Wayne Turnage, Chair
Reg Mtg Agenda: Monday, April 26, 2021 @330p

Agenda – 4/24/2021, 4p

I. CALL TO ORDER / RECORDING / ROLL CALL

II. MINUTES

Attachment/Agenda Item		Included in Shared Drive	Committee Action Req'd
B1	Minutes – Mar 23	X	Vote

III. FINANCE, FINANCIALS & BUDGET

Attachments/Agenda Item		Included in Shared Drive	Committee Action Req'd
C1	**Mazars $2.2M Budget Reduction & Cost Savings:** *PPT* update on progress, including key areas requested by the DM in March	Not provided	Discuss
C2	**CFO Monthly Financials** – March 2021	X	Vote
C3	**Cash position & Subsidy**: (1) CFO discussion re cash position/ timing; (2) DM & AJ subsidy next steps	N/A	Discuss
C4	**Mazars to provide *written* detailed lists/documentation**	Not provided	Discuss
C5	**Friday, May 7 – COH FY22 Budget Oversight Hearing for UMC:** preparation; OCA/EOM expectation; COH expectation	N/A	Discuss

IV. CONTRACTS & POs

Attachments/Agenda Item		Included in Shared Drive	Committee Action Req'd
D1	Proposed Contracts/POs for review and approval, if any	X	Vote
D2	CY 2021 Council Transmittals Monthly Report	X	FYI

V. SETTLEMENTS

Attachments/Agenda Item		Included in Shared Drive	Committee Action Req'd
E1	Proposed settlements for review and approval, if any	X	Vote

VI. NEW BUSINESS/OLD BUSINESS

- Fri, May 7 – FY22 Council COH Budget Hearing ***(new date)***
- Council's summer recess – planning ahead for approval of key contracts

VII. ANNOUNCEMENTS *(Dates subject to change)*

Thurs, Apr 22	Mayor transmits proposed FY22 Budget & BSA
Fri, Apr 23	Council – Hearing on Mayor's proposed FY22 Budget & BSA
	Finance Committee – Regular Monthly Meeting
Wed, Apr 28	Board – Monthly meeting
Tues, May 4	Council – Regular Leg Mtg *(Apr 28 – UMC deadline)*
Fri, May 7	**Council – COH FY22 Budget & BSA Oversight Hrgs: NFPHC, DMHHS, DHCF**
Fri, May 21	Finance Committee – Regular Monthly Meeting
Tues, May 25	**Council – COH FY22 Budget & BSA Mark up Meeting**
Tues, June 1	Council – Regular Leg Mtg *(May 26 – UMC deadline)*
Mon, June 21	Finance Committee – Regular Monthly Meeting
Tues, June 29	Council – Regular Leg Mtg *(June 23 – UMC deadline)*
Tues, July 13	Council – Additional Leg Mtg *(July 7 – UMC deadline; Council Chair controls the agenda)*
July 15 – Sept 15	**Council – Summer Recess (No transmittals or Council mtgs)**
Fri, July 23	Finance Committee – Regular Monthly Meeting
Fri, Aug 20	Finance Committee – Regular Monthly Meeting
Mon, Sept 20	Finance Committee – Regular Monthly Meeting
Tues, Sept 21	Council – Additional Leg Mtg *(Sept 15 – UMC deadline; Council Chair controls the agenda)*
Tues, Oct 5	Council – Regular Leg Mtg *(Sept 29 – UMC deadline)*

VIII. ADJOURNMENT

Notice of Intent to close. The NFPHC hereby gives notice that if necessary, it may close and move to executive session to discuss contracts, settlements, legal matters with an attorney, collective bargaining negotiations, personnel matters, and public health emergency matters. D.C. Official Code §§2-575(b)(2)(4A)(5)(8)(10).

Not-For-Profit Hospital Corporation
Draft Finance Committee Meeting Minutes
March 23, 2021 @ 1:30 pm

Present: **Directors: Wayne Turnage, Angell Jacobs, Dr. Dawson**
UMC Staff: Lilian Chukwuma, Perry Sheeley, Mike Austin, Toya Carmichael, Colene Daniel, Roosevelt Dzime-Assison, Marcela Maamari, Ken Blackwell, Tamika Hardy, David Perry
Mazars: Cheyenne Holland
DCHF: Kai Blissett

Agenda Item	Discussion	Action Item
I. Call to order/Roll Call	Called to order by Kai at 1:34pm. Roll call by Toya Carmichael	
II. Meeting Minutes	Kai noted Toya is working with vendor for February minutes. Motion to approve by DM Turnage, 2nd by Dir. Jacobs, unanimous vote.	
III. Finance, Financials & Budget	• DM Turnage noted Chair May's email where she stated that tomorrow she will announce the formation of a closure committee and appoint a Chair of the Committee to begin to scale hospital services back and prepare for the implementation of the new hospital. There will be a number of responsibilities that come out of that committee which we will have to report back to DOH. Parallel to that, the operator is asked to use its discretion to implement some staff reductions to put in place some reductions that do not require board approval. The Finance Committee will not vote on these decisions but want some clarity to be able to answer any questions from the Board tomorrow.	

	• Cheyenne Holland reported that - Operator is working on two tracks. One dealing with the closure process and the other is regarding the normal operations of the hospital. • Last month we showed how we get down to the studs. We have identified 62 FTEs that will be eliminated and have already been given notice that their position is being eliminated OR we have removed some vacant positions. $5.2 million costs for several payouts and issued a 3/17 warn notice for those effected staff and union notices knowing that if we were to put these in the place in the next few weeks we have that look back period. There are 4 positions that were immediately terminated when UMC turned the vaccine clinic over to Walgreens. 5 FTEs were vacant due to recent terminations and we are not backfilling these positions. We have a plan and are currently working with legal and contracting to outsource our in-patient dialysis which will reduce that cost dramatically. Also looking to reduce the food services contract and reduce operating hours based on a decrease of people on campus. As part of our initial restructuring we are eliminating outpatient wound care and we are also looking at certain clinics that are not as busy as other clinics and consolidating physician time to be more efficient with those services without eliminating the core services we need to provide. • DM Turnage asked on the parallel track how many FTEs will be eliminated in addition to the 62 positions already mentioned. Cheyenne stated she does not have those numbers yet and it will depend on how quickly we want to move forward with a reduction in services. DM Turnage said the closure committee will determine that but was just wondering how many FTEs have been identified as part of the closure. • Dir. Jacobs asked Cheyenne if the 62 positions are known so that they can be provided to Finance. Cheyenne noted yes, the specific list was sent to Finance late Friday afternoon. Dir. Jacobs asked if the physician contract renegotiation is part of the step down or the reduction plan?	

	Cheyenne stated the physician contracts are part of the reduction plan since we are looking at how to consolidate and redirect services. The $5 million is the annual costs and $2.2 for the remaining of the fiscal year. • Dr. Dawson asked Cheyenne about her mention of Walgreens? Cheyenne explained that Walgreens is now running the vaccine clinic on the 6th floor and we are still running registration but we are not paying Walgreens for the service. Dr. Dawson asked if we are able to start digitizing the vaccination card through Walgreens instead of having to keep the card? Colene stated Marcela and Dr. Strudwick will ask Walgreens if this is possible. • Dir. Jacobs asked why Walgreens was brought on board to run the vaccination clinic. Colene explained that DOH asked us to offer 2,500 vaccinations per week instead of 500 but we did not have the capacity to do so. Thus DOH and Walgreens entered into a partnership for Walgreens to come and take over the clinic. • Lillian noted the numbers provided were off. Explained that it is not an immediate 55 FTEs that can be done immediately, there are only 5 that can be done now. Cheyenne clarified that of the FTEs identified, were provided a warn notice so that if approved we can move forward on May 17th.	
III. Financials	• Lillian Chukwuma - Directed attention to the Gap tracking sheet. We have eliminated many of the gap measures because whatever the operator comes up with will replace this. Majority of what has been done does not amount to more than $500k. So what we have left is the GW contract. GW is running 200k short every month but we are still hopeful. From the beginning number we are short $24.6 million year to date by end of the year assuming GW realizes that $5million. If we look into the next quarter and GW brings in more we will readjust where we are. • Page 4 is a narrative of the numbers on page 16. Our ER is the piece that needs to be looked at because our ER volumes are really low. The plan that Cheyenne put together there was no reduction in expenses although activities are down by half.	

	• Our DISH was going to be much lower but we received a little bit more than the last time. • When we look at expenses which is a problem for us, our salaries are higher as OT continues to be on the rise but the CEO was explaining that we had to incur a lot of OT for security to keep the hospital safe. We are tracking to be at $3million in OT. Our benefits are higher than what we budgeted because we laid a lot of people off and all of them have hit the unemployment line. Contract staffing is high because the agencies are all charging a COVID rate whether the job is COVID related or not but we are hoping with the med surge restructure this will change. Other expenses continue to be high because our insurance continues to cost more than expected. • Page 16 is the number format of the summary Lillian just reviewed. If you look at admissions for February it was not so bad. We are keeping ED as is while we lower inpatient, etc. Lillian noted that we are in a bad position because as we start giving warn notices and no one knows who is going to get one, people start to jump so we will not have anyone here to provide services by the end of 2022. • DM Turnage noted that the mayor's budget comes out on 4/22 and asked if we will need money for payroll before April 22nd. If so, the city will have to come up with another mechanism to help UMC meet payroll. • Dir. Jacobs said that if the mayor put the money in the BSA, OCFO lets it move forward with the force of law. But Dir. Jacobs will check if it needs to be stand alone and not in the BSA. DM Turnage asked Dir. Jacobs to check and let the committee know. • Kai said that if the Mazars contract is going in April, maybe everything can be packaged together then. • DM Turnage said we will need an amount to make the request. Lillian said based on what the plan is, the best it will be is $5million. DM Turnage reminded Lillian that she does not know what the closure committee will recommend. DM Turnage will report out to the full board that the Finance Committee looked at financials through February that show a gap of $22million and Dir. Jacobs will get back to DM Turnage about how to approach the CA to ensure UMC has enough to make payroll in April.	

	Motion to approve January and February financials by DM Turnage, 2nd by Jacobs, unanimous vote. • Lillian reminded the committee that we have not been able to approve any contracts so where does this come in? Dir. Jacobs noted that the hospital's position still has not changed we still do not have any money. Once Dir. Jacobs checks the mechanism for the request, and we make a request that is approved then the hospital can start approving contracts again. • DM Turnage and Dir. Jacobs will work with CM Gray to develop the language for the legislation.	
V. Contracts	• Mike Austin presented one new contract. Mazars contract, new contract, not a CBE or local vendor. Total cost is $3,617,788.00. Lillian noted that she has not received it so she cannot certify it. Motion to approve pending fiscal certification by DM Turnage, 2nd by Dir. Jacobs, unanimous vote. • Kai noted no settlements ready for today but there are two matters that are being sent to Governance Committee for review. • Section 6 includes final 2021 meeting schedule so Toya can publish if need be. • The other item is an introduction to the new process of how the committee will review and approve contracts, asked everyone to take a look at the changes and send Kai feedback so this can begin in April. • Highlighted upcoming Council meeting dates.	

VI. Oversight		
IX. New Business/Old Business	N/A	
X. Announcements	N/A	
Adjournment	**Meeting adjourned by Kai at 2:43pm.**	

Not For Profit Hospital Corporation
United Medical Center

Board of Directors Meeting

Preliminary Financial Report Summary

For the month ending March 31, 2021

DRAFT

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Gap Measures Tracking

	FY 2021 Original Gap Measures Gain/(Loss)	Realized/ Recognized/ Adjusted	Balance to be Realized	Percentage Completed (Realized/ FY21 Adjusted Gap Measures)
Net Income/(Loss) from Operations:			**($30,419,220)**	
Add: Initiatives to be Realized				
Various Issues Affecting Admission	$4,300,000	$0	$0	0.0%
GWUMFA Professional Fees Collection	$7,200,000	$2,545,994	$4,654,006	35.4%
Supply Chain/Contracts	$600,000	$0	$0	0.0%
Salary and Agency Reduction	$1,000,000	$0	$0	0.0%
Managed Care	$500,000	$0	$0	0.0%
Subtotal	**$13,600,000**	**$2,545,994**	**$4,654,006**	18.7%
Projected Net Income (Loss) from Operations			**($25,765,214)**	
Original Projected Income			$1,176,483	
Shortfall from Budget			($26,941,697) *	

***Need a plan to close the 26.9M gap from Mazar. Mazar has a plan to realize 2.2M in 2021 and continues to work for additional gap closing measures.**

Report Summary

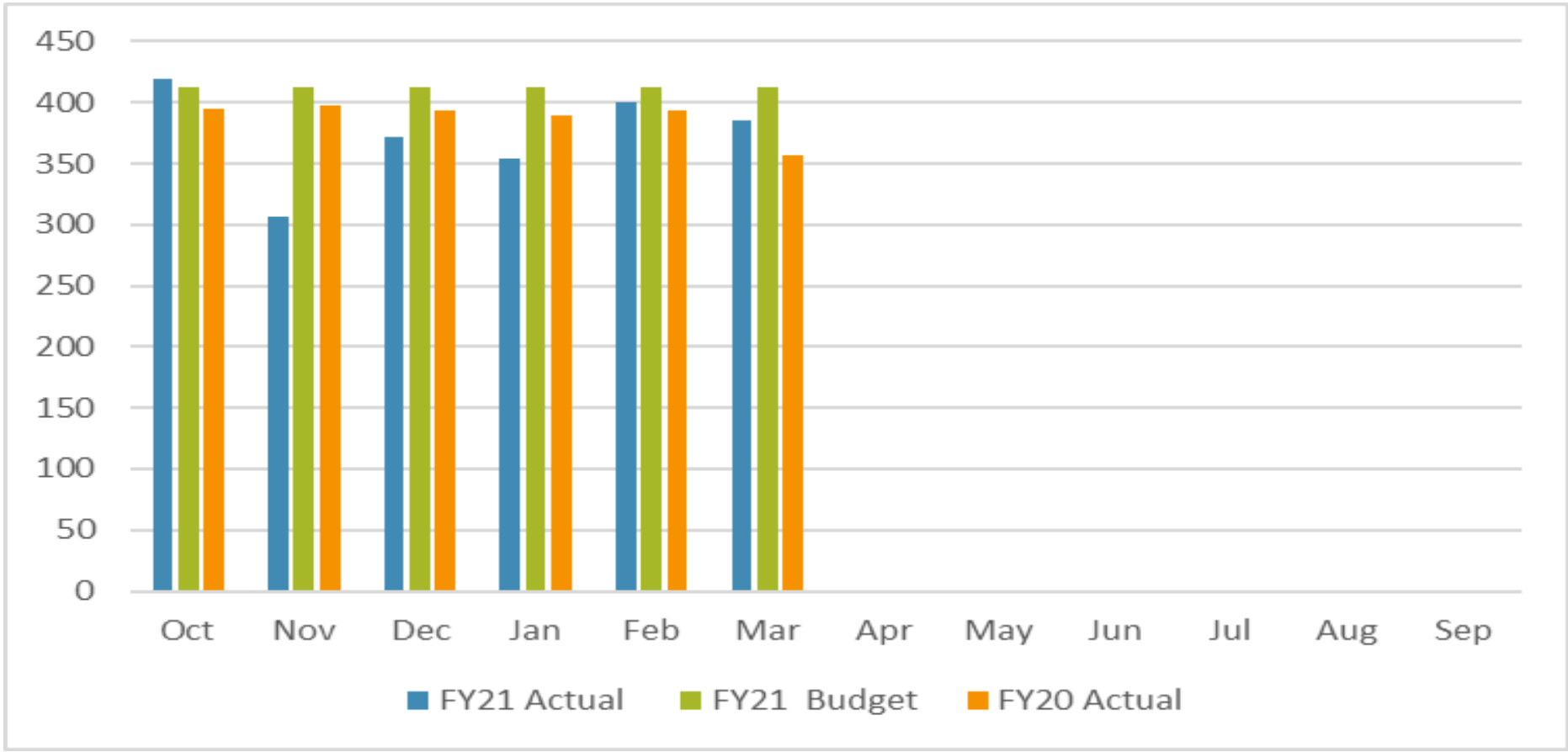
- **Revenue**
  - **Total operating revenue is lower than budget by 19% (2.1M) month to date (MTD) and 15% (10.2M) year to date (YTD), due to the following factors:**
    - **Net patient revenues are below budget by 31% (2.5M) MTD and 26% (12.4M) YTD, due to the following:**
      - **Admissions are below budget by 7% for the month and 10% YTD.**
      - **ER visits are below budget by 23% MTD and 27% YTD.**
      - **Inpatient Surgeries are below budget by 22% MTD but over budget by 14% YTD.**
      - **Radiology visits are below budget by 36% MTD and 27%YTD.**
    - **DSH revenue is on budget MTD but below budget by 14% (813K) YTD.**
    - **GWMFA collections are lower than budget by 12% (74K) MTD and 29% (1M) YTD.**
- **Expenses**
  - **Total operating expenses are higher than budget by 14% (1.6M) MTD and 9% (5.9M) YTD.**
  - **Contributing factors are as follows:**
    - **Salaries are over budget by 4% MTD (148K) and 7% (1.7M) YTD, primarily due to overtime.**
      - **Overtime is approximately 1.8M over budget YTD.**
    - **Employee benefits are over budget by 4% (46K) MTD and over budget 16% (1.1M) YTD.**
    - **Contract Labor is over budget by 162% (270K) MTD and 120% (1.2M) YTD, due to higher agency rates.**
    - **Pharmaceuticals are over budget 48% (115K) MTD and 13% (183K) YTD, due to COVID drugs.**
    - **Other Expenses are higher than budget by 59% (536K) MTD and 36% (2.0M) YTD as a result of increases in insurance and repair costs.**

- **Cash on Hand – 28 days**

Key Indicators

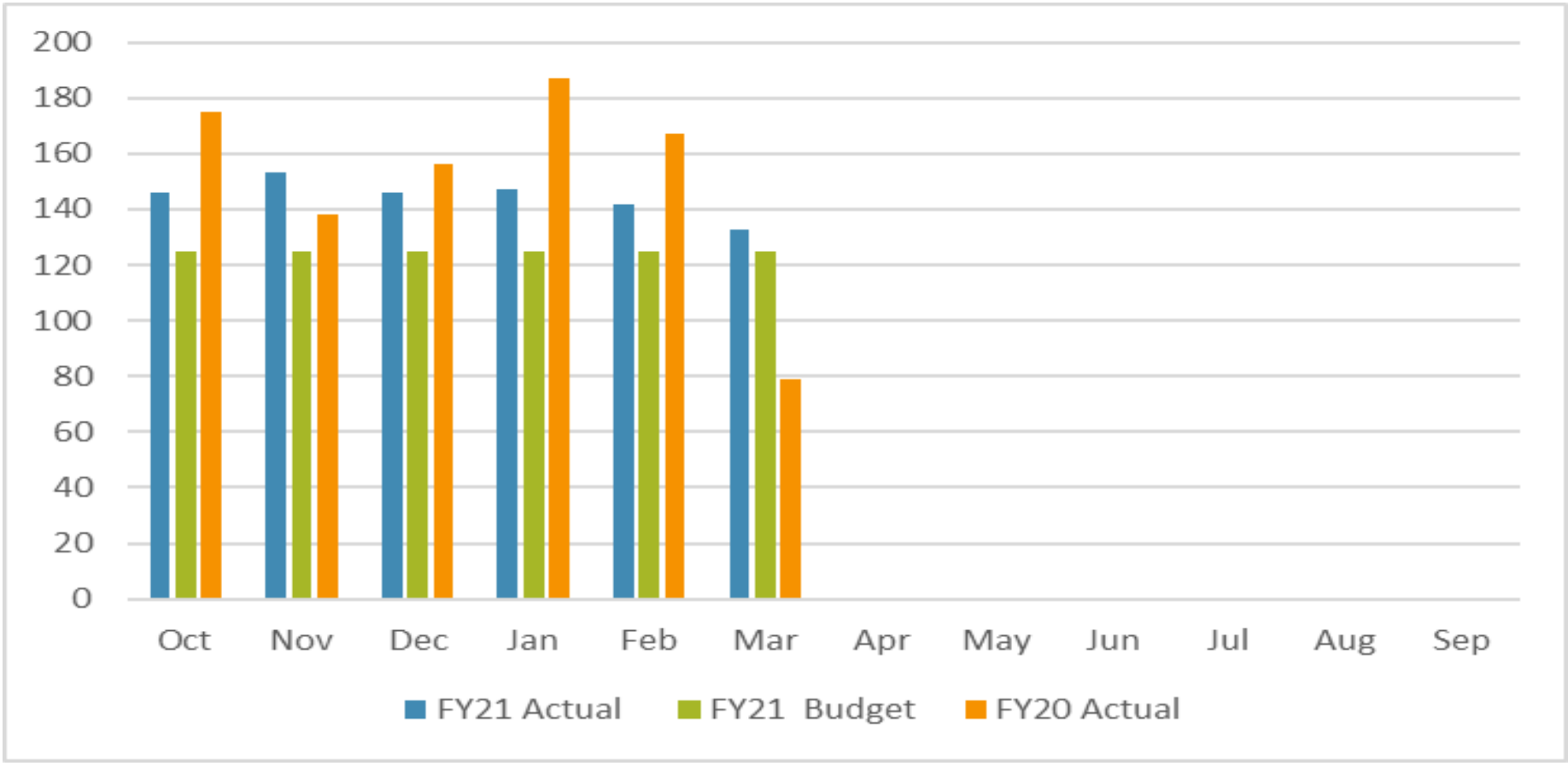
Fiscal Year 2021 thru 03/31/2021 Key Performance Indicators	Calculation	MTD Actual	MTD Budget	MTD FY20	Actual Trend	Desired Trend
VOLUME INDICATORS:						
Admissions (Consolidated)	Actual Admissions	385	413	350	▼	▲
Inpatient/Outpatient Surgeries	Actual Surgeries	133	125	79	▲	▲
Emergency Room Visits	Actual Visits	3,184	4,125	3,737	▼	▲
PRODUCTIVITY & EFFICIENCY INDICATORS:						
Number of FTEs	Total Hours Paid/Total Hours YTD	704	654	793	▲	▼
Case Mix Index	Total DRG Weights/Discharges	1.27	1.23	1.29	▲	▲
Salaries/Wages and Benefits as a % of Total Expenses	Total Salaries, Wages, and Benefits /Total Operating Expenses (exludes contract services)	48%	54%	60%	▼	▼
PROFITABILITY & LIQUIDITY INDICATORS:						
Net Account Receivable (AR) Days (Hospital)	Net Patient Receivables/Average Daily Net Patient Revenues	71.0	85.0	82.0	▼	▼
Cash Collection as a % of Net Revenue	Total Cash Collected/ Net Revenue	92%	92%	102%	=	▲
Days Cash on hand	Total Cash /(Operating Expenses less Depreciation/Days)	28	45	52	▼	▲
Operating Margin % (Gain/Loss YTD)	Net Operating Income/Total Operating Revenue	-27.8%	1.0%	-9.1%	▼	▲

Total Admissions (Consolidated)



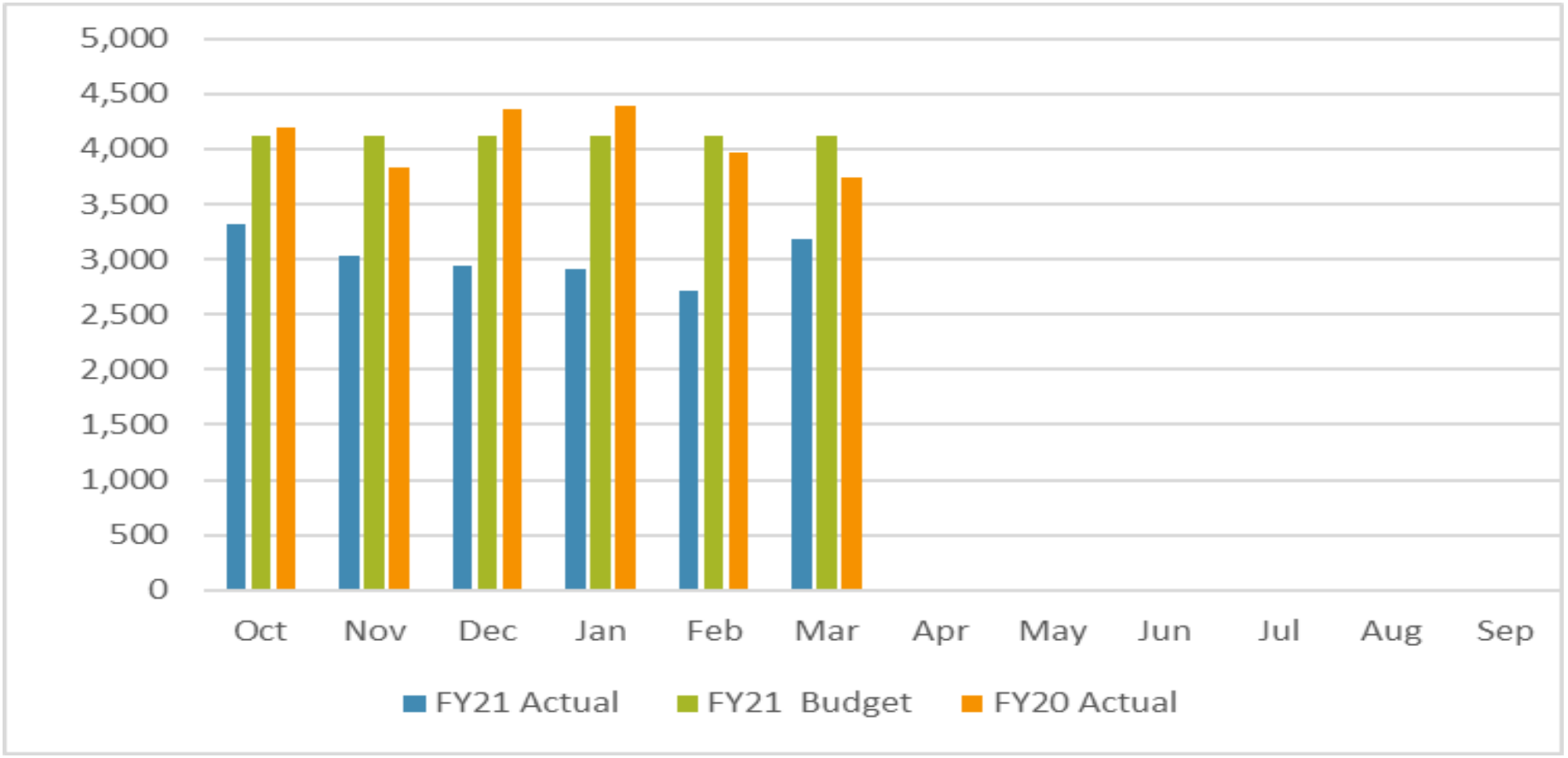
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY21 Actual	419	306	372	354	400	385						
FY21 Budget	413	413	413	413	413	413						
FY20 Actual	395	398	393	389	393	350						

Inpatient/Outpatient Surgeries



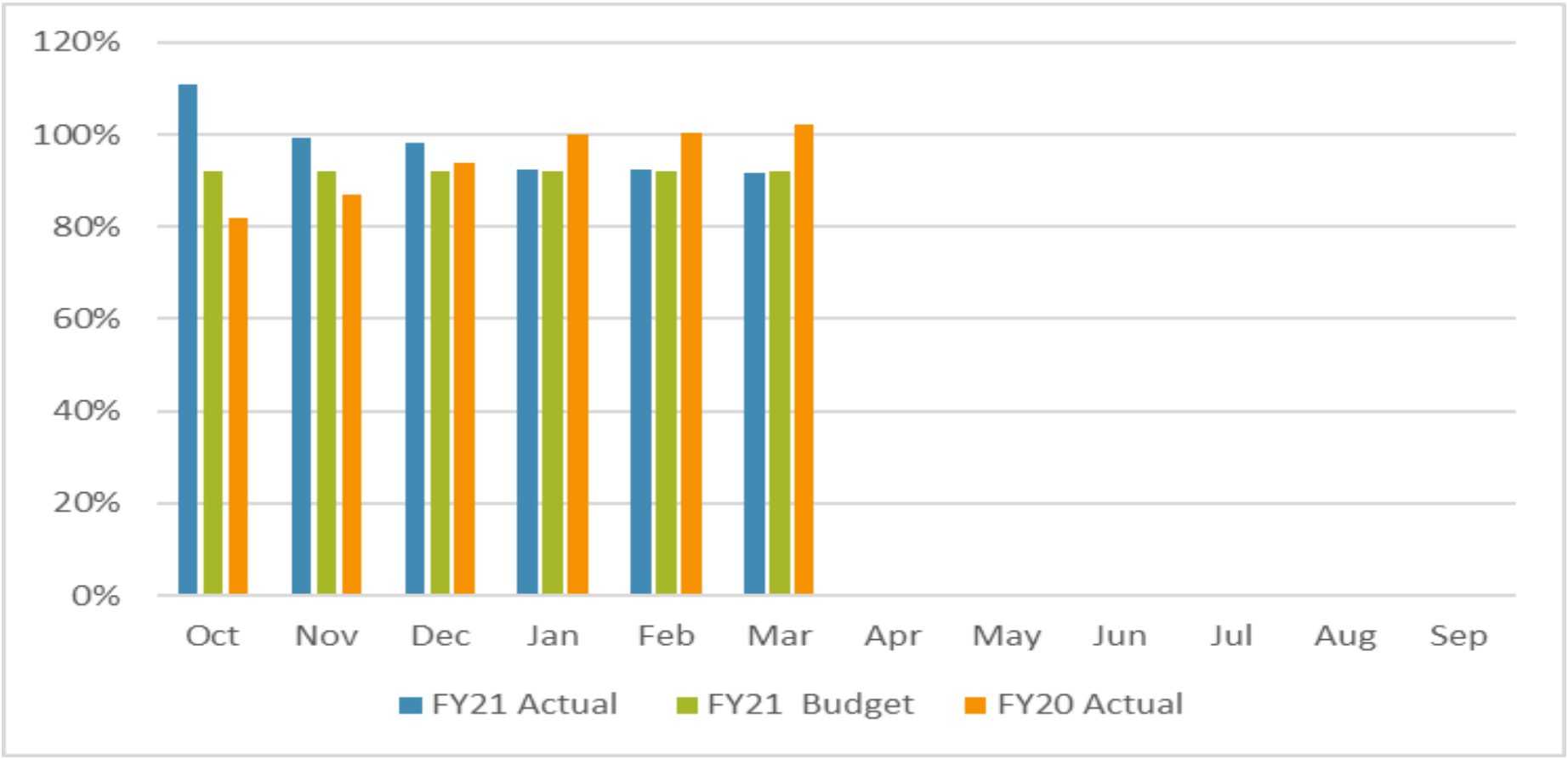
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY21 Actual	146	153	146	147	142	133						
FY21 Budget	125	125	125	125	125	125						
FY20 Actual	175	138	156	187	167	79						

Total Emergency Room Visits



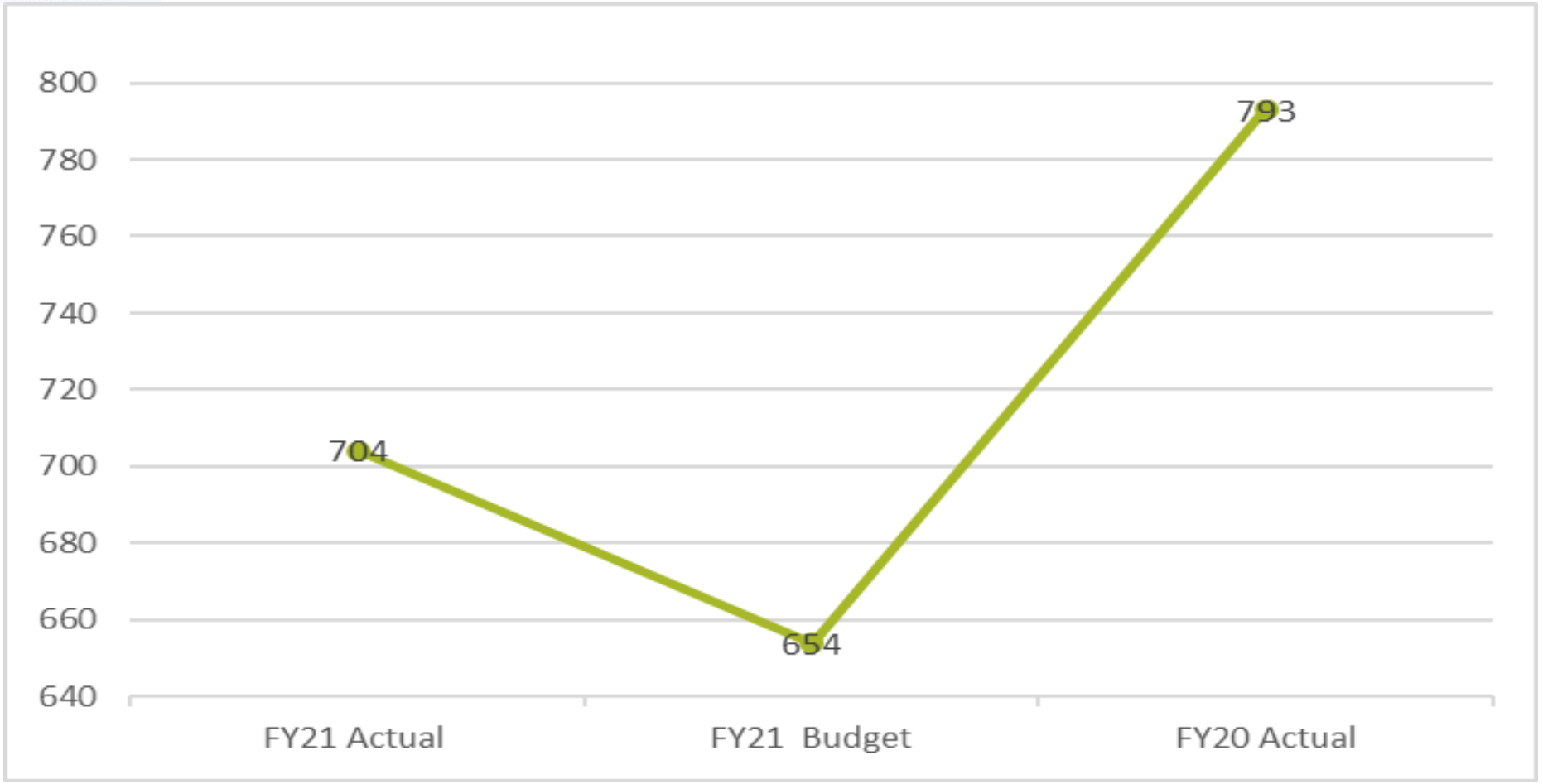
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY21 Actual	3,313	3,037	2,947	2,909	2,716	3,184						
FY21 Budget	4,125	4,125	4,125	4,125	4,125	4,125						
FY20 Actual	4,194	3,836	4,365	4,386	3,965	3,737						

Cash Collection as a % of Net Revenues



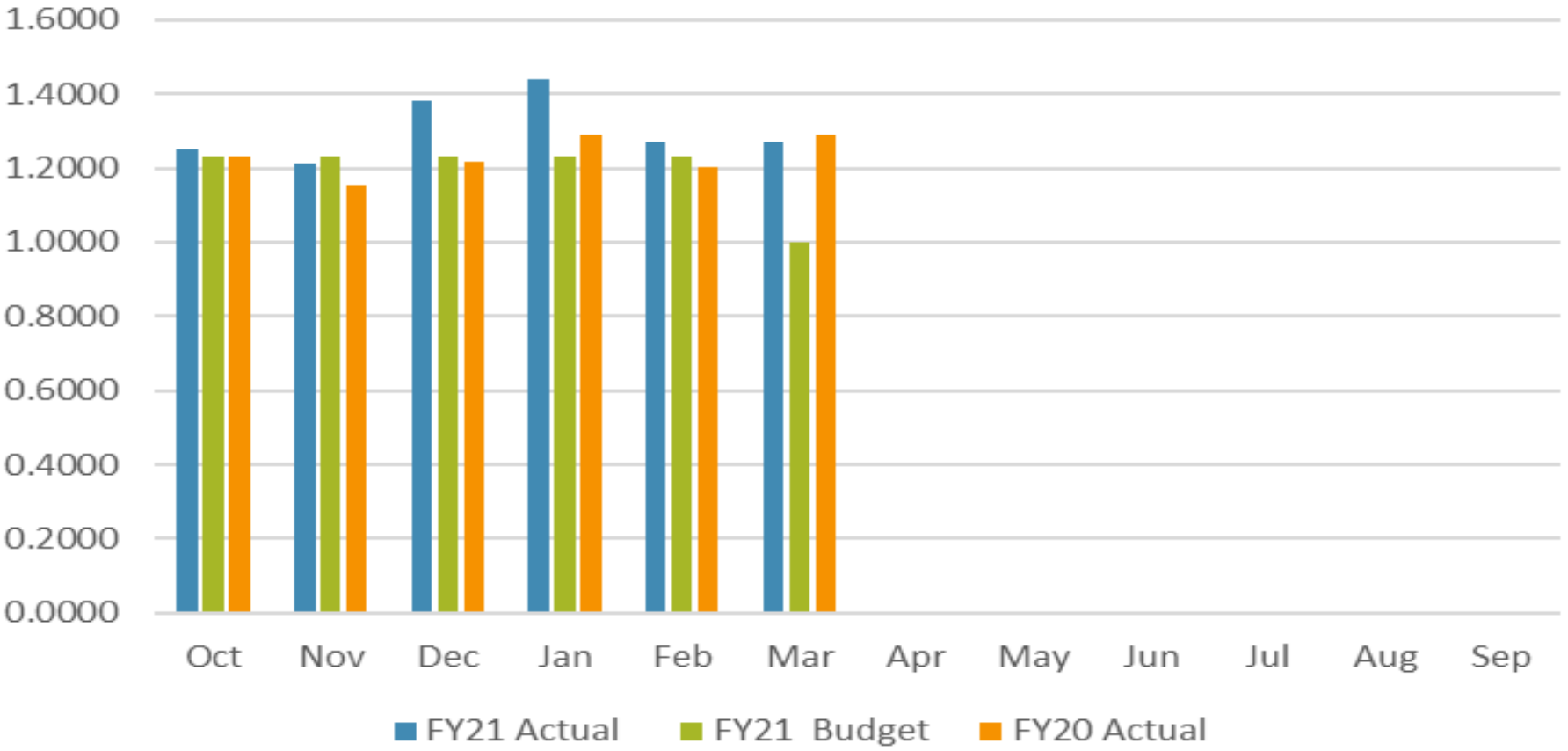
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY21 Actual	111%	99%	98%	92%	92%	92%						
FY21 Budget	92%	92%	92%	92%	92%	92%						
FY20 Actual	82%	87%	94%	100%	100%	102%						

Number of FTEs



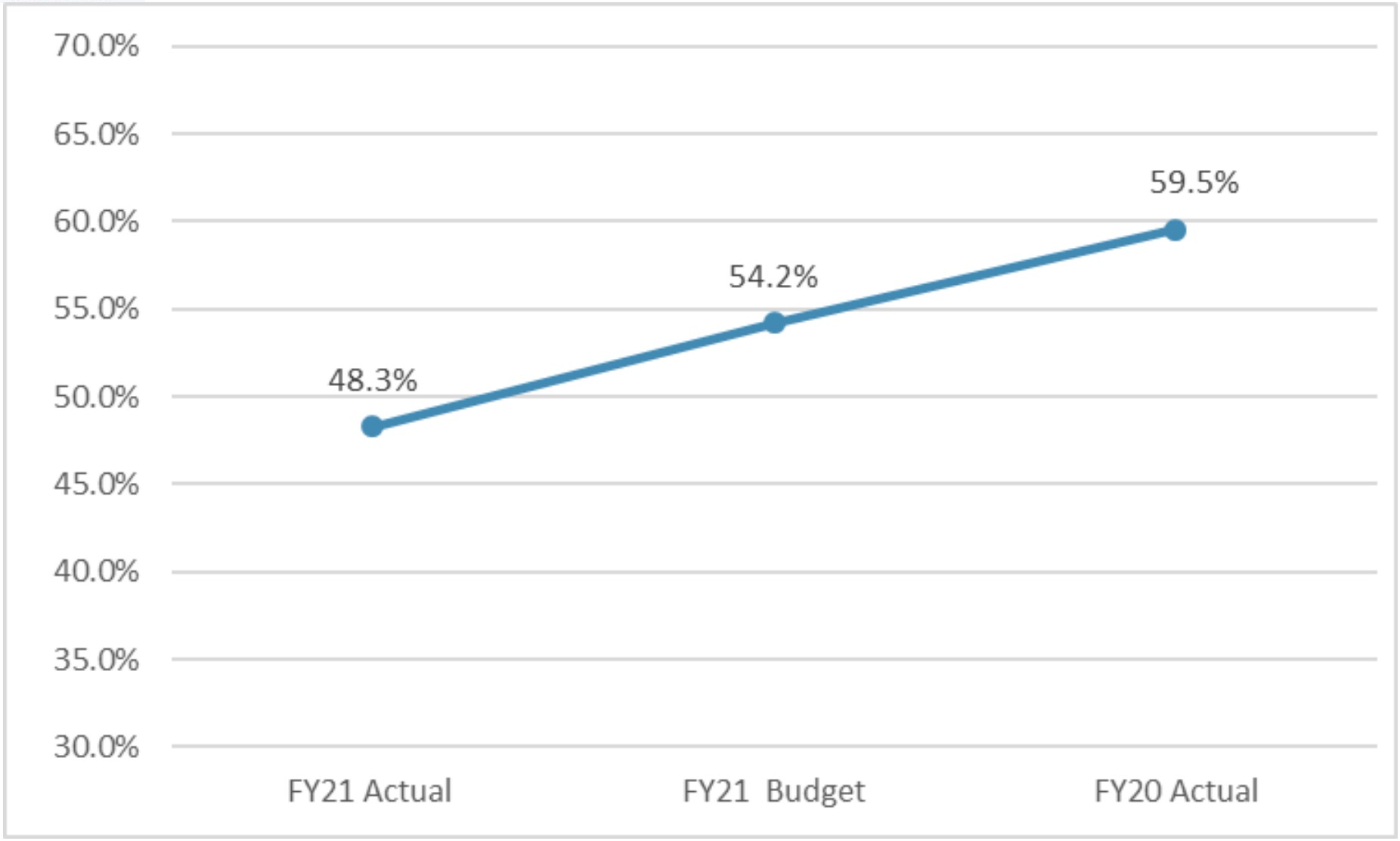
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY21 Actual	764	771	766	725	724	704						
FY21 Budget	654	654	654	654	654	654						
FY20 Actual	748	770	779	788	804	793						

Case Mix Index

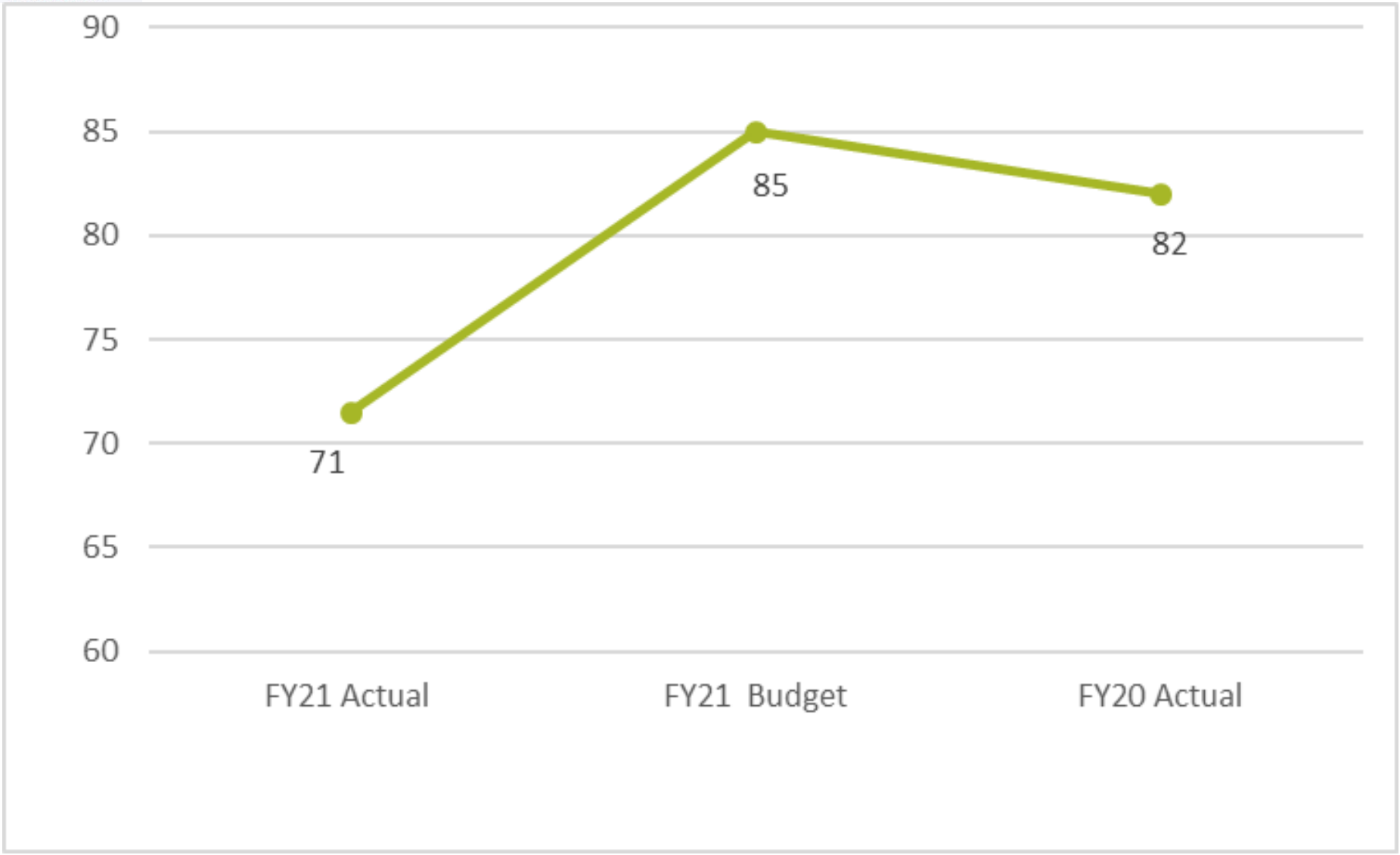


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY21 Actual	1.2500	1.2100	1.3800	1.4400	1.2700	1.2700						
FY21 Budget	1.2300	1.2300	1.2300	1.2300	1.2300	1.2300						
FY20 Actual	1.2300	1.1530	1.2190	1.2900	1.2010	1.2910						

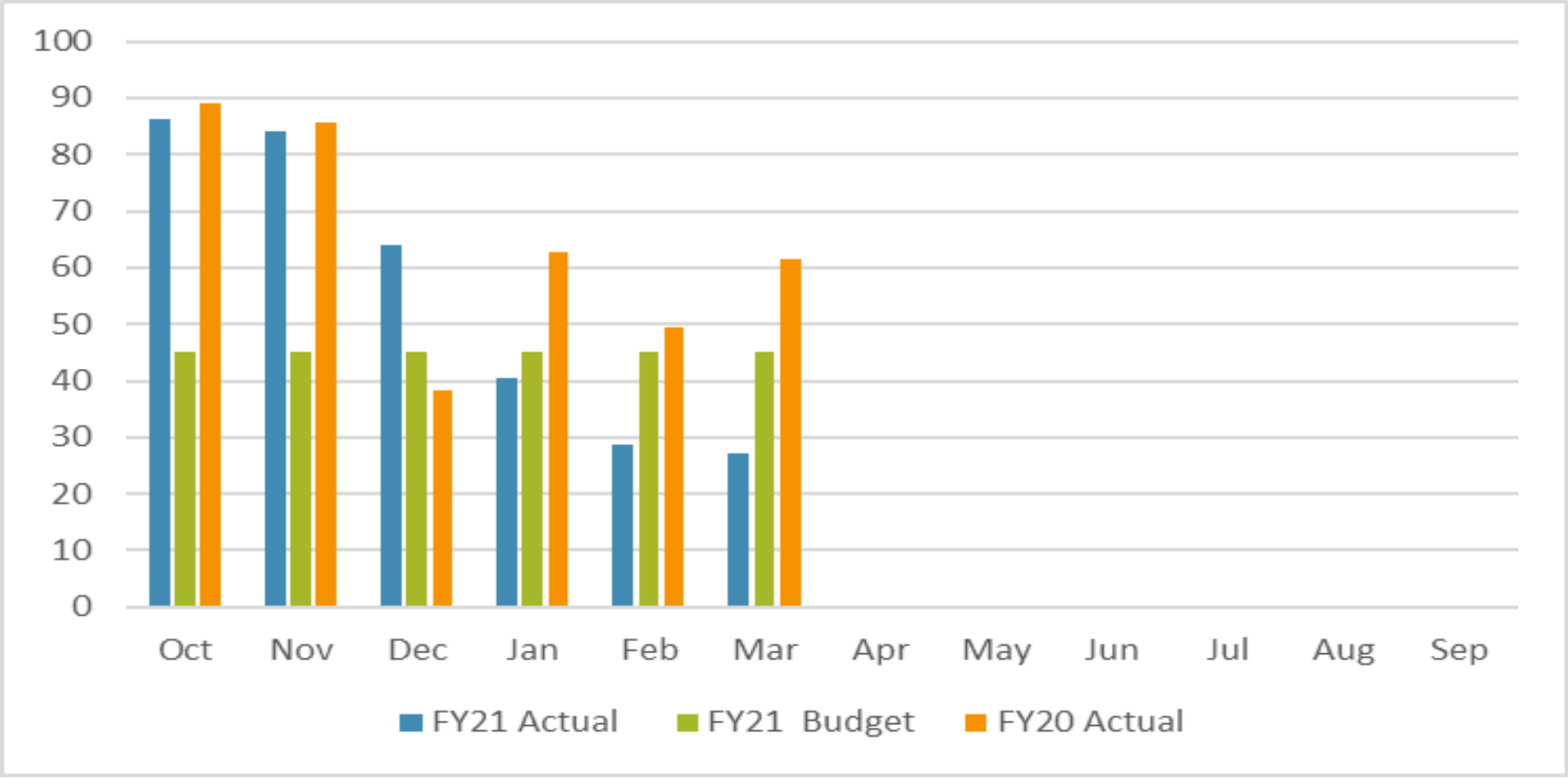
Salaries/Wages & Benefits as a % of Operating Expenses (less 2 major contracts)



Net Accounts Receivable (AR) Days With Unbilled

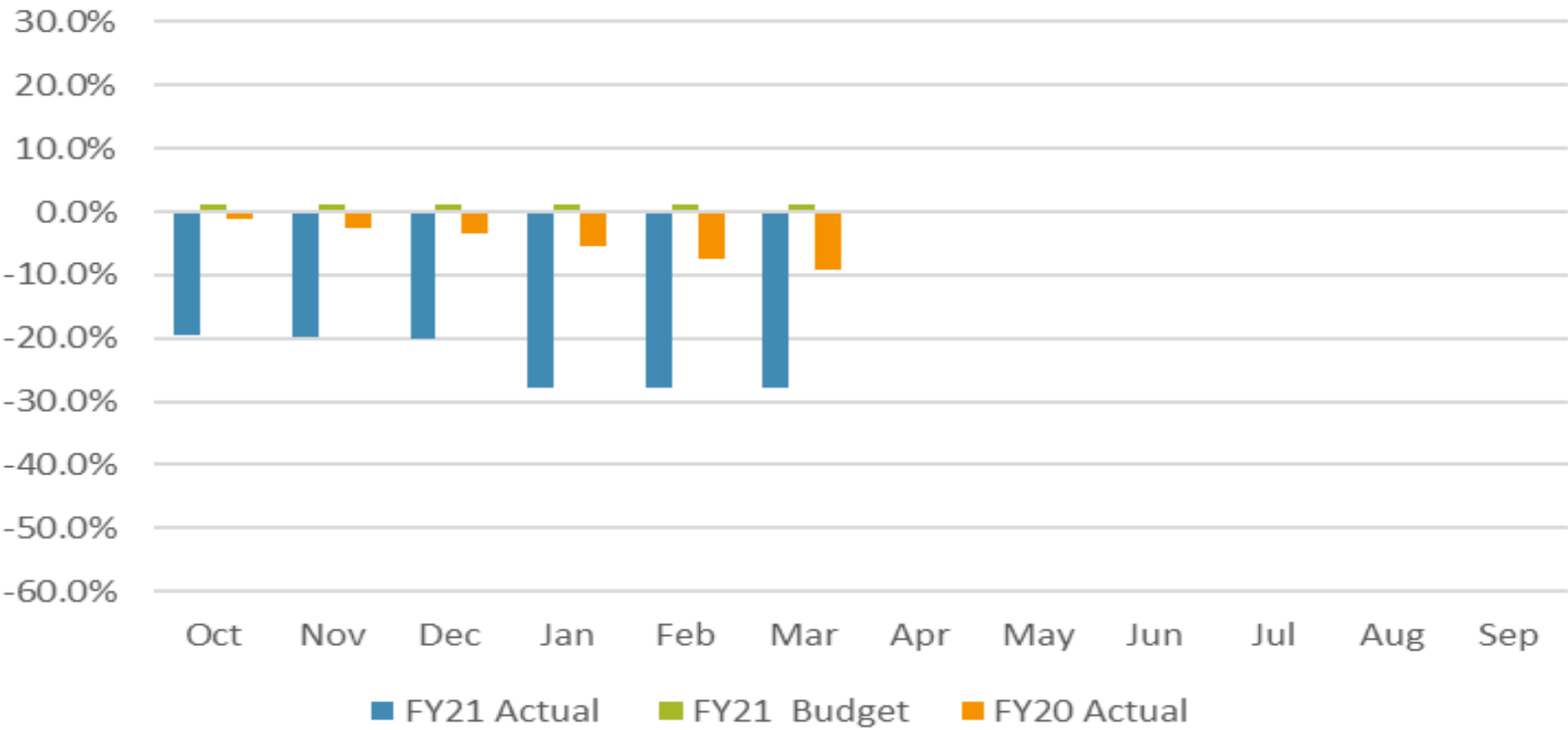


Days Cash On Hand



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY21 Actual	86	84	64	40	29	28						
FY21 Budget	45	45	45	45	45	45						
FY20 Actual	89	86	38	63	50	52						

Operating Margin % (Gain or Loss)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY21 Actual	-19.4%	-19.7%	-20.0%	-27.8%	-27.8%	-27.8%						
FY21 Budget	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%						
FY20 Actual	-1.3%	-2.6%	-3.5%	-5.5%	-7.4%	-9.1%						

Income Statement

FY21 Operating Period Ending March 31, 2021

	Month of March			Variance				2021 Year to Date			Variance			
	Actual	Budget	Prior	Actual/Budget		Actual/Prior		Actual	Budget	Prior	Actual/Budget		Actual/Prior	
Statistics														
Admission	385	413	350	(28)	-7%	35	10%	2,236	2,475	2,293	(239)	-10%	(57)	-2%
Patient Days	2,475	2,308	4,972	167	7%	(2,497)	-50%	13,514	13,847	29,325	(333)	-2%	(15,811)	-54%
Emergency Room Visits	3,184	4,125	3,737	(941)	-23%	(553)	-15%	18,106	24,750	24,483	(6,644)	-27%	(6,377)	-26%
Clinic Visits	2,693	1,093	761	1,600	146%	1,932	254%	12,369	6,556	6,291	5,813	89%	6,078	97%
IP Surgeries	45	58	39	(13)	-22%	6	15%	362	348	335	14	4%	27	8%
OP Surgeries	88	67	40	21	31%	48	120%	505	402	567	103	26%	(62)	-11%
Radiology Visits	488	765	588	(277)	-36%	(100)	-17%	3,331	4,592	5,226	(1,261)	-27%	(1,895)	-36%
Revenues														
Net Patient Service	5,409	7,875	6,167	(2,466)	-31%	(758)	-12%	34,830	47,251	41,371	(12,421)	-26%	(6,541)	-16%
DSH	964	964	964	(0)	0%	-	0%	4,971	5,784	5,784	(813)	-14%	(812)	-14%
CNMC Revenue	74	177	195	(102)	-58%	(121)	-62%	890	1,060	1,308	(171)	-16%	(419)	-32%
Other Revenue	2,456	2,007	2,587	449	22%	(131)	-5%	15,211	12,044	16,350	3,167	26%	(1,139)	-7%
Total Operating Revenue	**8,903**	**11,023**	**9,913**	**(2,120)**	**-19%**	**-1,010**	**-10%**	**55,902**	**66,139**	**64,813**	**(10,237)**	**-15%**	**(8,911)**	**-14%**
Expenses														
Salaries and Wages	4,317	4,170	4,956	148	4%	(638)	-13%	26,730	25,018	27,885	1,713	7%	(1,154)	-4%
Employee Benefits	1,130	1,084	1,314	46	4%	(184)	-14%	7,554	6,505	7,769	1,050	16%	(215)	-3%
Contract Labor	436	167	257	270	162%	180	70%	2,198	1,000	1,560	1,198	120%	639	41%
Supplies	1,173	1,208	1,061	(35)	-3%	112	11%	5,948	7,251	6,074	(1,302)	-18%	(126)	-2%
Pharmaceuticals	356	241	229	115	48%	126	55%	1,629	1,446	1,292	183	13%	337	26%
Professional Fees	1,665	1,734	1,031	(69)	-4%	634	61%	10,519	10,401	9,589	118	1%	930	10%
Purchased Services	1,335	1,412	1,705	(76)	-5%	(370)	-22%	8,778	8,471	10,472	307	4%	(1,694)	-16%
Other	2,095	910	1,201	1,185	130%	894	74%	8,078	5,460	6,077	2,618	48%	2,002	33%
Total Operating Expenses	**12,508**	**10,925**	**11,754**	**1,583**	**14%**	**754**	**6%**	**71,435**	**65,551**	**70,717**	**5,884**	**9%**	**718**	**1%**
Operating Gain/ (Loss)	**(3,605)**	**98**	**(1,841)**	**(3,703)**	**-3777%**	**(1,763)**	**96%**	**(15,534)**	**588**	**(5,905)**	**(16,122)**	**-2741%**	**(9,629)**	**163%**

Balance Sheet

As of the month ending March 31, 2021

Mar-21	Feb-21	MTD Change		Sep-20	YTD Change
			Current Assets:		
$ 23,938	$ 26,999	$ (3,060)	Cash and equivalents	$ 53,402	$ (29,464)
13,683	15,806	(2,123)	Net accounts receivable	14,651	(968)
6,525	6,526	(1)	Inventories	6,024	501
3,473	4,583	(1,110)	Prepaid and other assets	1,054	2,419
47,620	53,915	(6,295)	Total current assets	$ 75,131	$ (27,511)
			Long- Term Assets:		
-	-	-	Estimated third-party payor settlements	-	-
65,405	65,950	(545)	Capital Assets	69,722	(4,317)
65,405	65,950	(545)	Total long term assets	69,722	(4,317)
$ 113,026	$ 119,865	$ (6,839)	Total assets	$ 144,853	$ (31,827)
			Current Liabilities:		
$ -	$ -	$ -	Current portion, capital lease obligation	$ -	$ -
14,940	15,123	(182)	Trade payables	18,773	(3,833)
11,966	11,519	447	Accrued salaries and benefits	11,838	128
3,243	2,593	649	Other liabilities	2,594	649
30,148	29,235	914	Total current liabilities	33,205	(3,057)
			Long-Term Liabilities:		
7,505	9,730	(2,226)	Unearned grant revenue	13,890	(6,385)
7,330	7,304	26	Estimated third-party payor settlements	7,219	111
1,848	1,848	-	Contingent & other liabilities	1,629	219
16,682	18,882	(2,200)	Total long term liabilities	22,738	(6,056)
			Net Position:		
66,195	71,749	(5,554)	Unrestricted	88,910	(22,715)
66,195	71,749	(5,554)	Total net position	88,910	(22,715)
$ 113,026	$ 119,865	$ (6,840)	Total liabilities and net position	$ 144,853	$ (31,827)

Statement of Cash Flow
As of the month ending March 31, 2021

Dollars in Thousands

Month of March			Year-to-Date	
Actual	Prior Year		Actual	Prior Year
		Cash flows from operating activities:		
$ 8,521	$ 7,991	Receipts from and on behalf of patients	$ 40,880	$ 46,811
(6,069)	(5,240)	Payments to suppliers and contractors	(43,037)	(30,631)
(4,726)	(5,639)	Payments to employees and fringe benefits	(34,157)	(34,851)
(94)	5,966	Other receipts and payments, net	(5,180)	10,649
(2,368)	3,078	Net cash provided by (used in) operating activities	(41,494)	(8,022)
		Cash flows from investing activities:		
-	-	Proceeds from sales of investments	-	-
-	-	Purchases of investments	-	-
-	-	Receipts of interest	-	1
-	-	Net cash provided by (used in) investing activities	-	1
		Cash flows from noncapital financing activities:		
-	-	Repayment of notes payable	-	-
-	-	Receipts (payments) from/(to) District of Columbia	15,000	22,140
-	-	Net cash provided by noncapital financing activities	15,000	22,140
		Cash flows from capital and related financing activities:		
-	-	Net cash provided by capital financing activities	-	-
(11)	82	Receipts (payments) from/(to) District of Columbia	(130)	3,330
(682)	(948)	Change in capital assets	(2,840)	(2,690)
(692)	(866)	Net cash (used in) capital and related financing activitie	(2,970)	640
(3,060)	2,212	Net increase (decrease) in cash and cash equivalents	(29,464)	14,759
26,999	**44,480**	**Cash and equivalents, beginning of period**	**53,402**	**31,933**
$ 23,938	**$ 46,692**	**Cash and equivalents, end of period**	**$ 23,938**	**$ 46,692**
		Supplemental disclosures of cash flow information		
		Cash paid during the year for interest expense		
		Equipment acquired through capital lease		
		Net book value of asset retirement costs		