UMC Clinical Quality and Professional Affairs Committee

December 2, 2024 2:00PM

UMC Trauma Building, Providence Suite 5th Floor

Las Vegas

AGENDA

University Medical Center of Southern Nevada
UMC GOVERNING BOARD
CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
December 2, 2024 2:00 p.m.
800 Hope Place, Las Vegas, Nevada
UMC Trauma Building, Providence Suite (5th Floor)

Notice is hereby given that a meeting of the UMC Governing Board Clinical Quality and Professional Affairs Committee has been called and will be held at the time and location indicated above, to consider the following matters:

This meeting has been properly noticed and posted online at University Medical Center of Southern Nevada's website http://www.umcsn.com and at Nevada Public Notice at https://notice.nv.gov/, and at University Medical Center 1800 W. Charleston Blvd. Las Vegas, NV (Principal Office)

- The main agenda is available on University Medical Center of Southern Nevada's website http://www.umcsn.com, For copies of agenda items and supporting back-up materials, please contact Stephanie Ceccarelli, Board Secretary, at (702) 765-7949. The Clinical Quality and Professional Affairs Committee may combine two or more agenda items for consideration.
- Items on the agenda may be taken out of order.
- The Clinical Quality and Professional Affairs Committee may remove an item from the agenda or delay discussion relating to an item at any time.
- Consent Agenda - All matters in this sub-category are considered by the Clinical Quality and Professional Affairs Committee to be routine and may be acted upon in one motion. Most agenda items are phrased for a positive action. However, the Clinical Quality and Professional Affairs Committee may take other actions such as hold, table, amend, etc.
- Consent Agenda items are routine and can be taken in one motion unless a Committee member requests that an item be taken separately. For all items left on the Consent Agenda, the action taken will be staff's recommendation as indicated on the item.
- Items taken separately from the Consent Agenda by Committee members at the meeting will be heard in order.

SECTION 1. OPENING CEREMONIES

CALL TO ORDER

1. Public Comment

2. Approval of minutes of the regular meeting of the UMC Clinical Quality and Professional Affairs Committee meeting on October 7, 2024 *(For possible action)*

3. Approval of Agenda. *(For possible action)*

SECTION 2. BUSINESS ITEMS

4. Receive an educational presentation regarding the Patient Safety Structural Measure (PSSM) from Patty Scott, Quality/Safety/Regulatory Officer; and direct staff accordingly.

5. Receive an update on the Quality, Safety, and Regulatory Program including any completed contract evaluations from Patty Scott, Quality/Safety/Regulatory Officer; and direct staff accordingly. *(For possible action).*

6. Receive an update on the FY26 Organizational Improvement/CEO Goals from Patty Scott, Quality/Safety/Regulatory Officer; and direct staff accordingly. *(For possible action).*

7. Review and recommend for approval by the Governing Board, the UMC Policies and Procedures Committee's activities of September 4, 2024; October 2, 2024; November 6, 2024 including the recommended creation, revision, and/or retirement of UMC policies and procedures; and take any action deemed appropriate. *(For possible action).*

SECTION 3. EMERGING ISSUES

8. Identify emerging issues to be addressed by staff or by the Clinical Quality and Professional Affairs Committee at future meetings; and direct staff accordingly.

COMMENTS BY THE GENERAL PUBLIC

All comments by speakers should be relevant to the Committee's action and jurisdiction.

UMC ADMINISTRATION KEEPS THE OFFICIAL RECORD OF ALL PROCEEDINGS OF UMC GOVERNING BOARD CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE. IN ORDER TO MAINTAIN A COMPLETE AND ACCURATE RECORD OF ALL PROCEEDINGS, ANY PHOTOGRAPH, MAP, CHART, OR ANY OTHER DOCUMENT USED IN ANY PRESENTATION TO THE BOARD SHOULD BE SUBMITTED TO UMC ADMINISTRATION. IF MATERIALS ARE TO BE DISTRIBUTED TO THE COMMITTEE, PLEASE PROVIDE SUFFICIENT COPIES FOR DISTRIBUTION TO UMC ADMINISTRATION.

THE COMMITTEE MEETING ROOM IS ACCESSIBLE TO INDIVIDUALS WITH DISABILITIES. WITH TWENTY-FOUR (24) HOUR ADVANCE REQUEST, A SIGN LANGUAGE INTERPRETER MAY BE MADE AVAILABLE (PHONE: 765-7949).

University Medical Center of Southern Nevada
UMC Governing Board Clinical Quality and Professional Affairs
October 7, 2024

UMC Providence Conference Room
Trauma Building, 5th Floor
800 Hope Place
Las Vegas, Clark County, Nevada
October 7, 2024 2:00 p.m.

The University Medical Center Governing Board Clinical Quality and Professional Affairs Committee met at the time and location listed above. The meeting was called to order at the hour of 2:03 p.m. by Chair Dr. Donald Mackay and the following members were present, which constituted a quorum of the members thereof:

CALL TO ORDER

Board Members:

Present:
Dr. Mackay – Chair
Laura Lopez-Hobbs
Renee Franklin
Jeff Ellis (WebEx)
Steve Weitman (Ex-Officio) (WebEx)
Bill Noonan (Ex-Officio) (WebEx)

Absent:
None

Also Present:
Tony Marinello, Chief Operating Officer
Jennifer Wakem, Chief Financial Officer
Patty Scott, Quality, Safety, & Regulatory Officer
Deb Fox, Chief Nursing Officer
Dr. Frederick Lippmann, Chief Medical Officer
Danita Cohen, Chief Experience Officer
Jeff Castillo, Director of Patient Experience
Susan Pitz, General Counsel
Stephanie Ceccarelli, Board Secretary

SECTION 1. OPENING CEREMONIES

ITEM NO. 1 PUBLIC COMMENT

Chair Dr. Mackay asked if there were any persons present in the audience wishing to be heard on any item on this agenda.

Speaker(s): None

ITEM NO. 2 Approval of minutes of the regular meeting of the UMC Governing Board Clinical Quality and Professional Affairs Committee meeting on August 5, 2024. *(For possible action)*

FINAL ACTION: A motion was made by Member Hobbs that the minutes be approved as presented. Motion carried by unanimous vote.

ITEM NO. 3 Approval of Agenda *(For possible action)*

FINAL ACTION: A motion was made by Member Hobbs that the agenda be approved as presented. Motion carried by unanimous vote.

SECTION 2. BUSINESS ITEMS

ITEM NO. 4 Receive an update on Pathways to Excellence and Magnet, including associated financial costs from Deb Fox, Chief Nursing Officer (CNO); and direct staff accordingly. *(For possible action).*

DOCUMENT(S) SUBMITTED**:**
- PowerPoint

DISCUSSION:

Deb Fox, Chief Nursing Officer, provided a nursing update to the Committee on Pathways to Excellence (P2E) and Magnet status and the associated financial costs.
A high-level overview of the history and context of both designations was provided. A research based article of the Business Case for Magnet Designation was provided from the Journal of Nursing Administration.

Both designations are nurse-centric. Pathways is the premier designation for health care organizations that demonstrate an ongoing commitment to, and provide empirical evidence of, a healthy nursing work environment. Magnet is an international designation that continually elevates patient care in an environment where nurses, collaborating with other inter-professionals deliver excellence through leadership, scientific discovery and dissemination and implementation of new knowledge. Both have designation with distinction to recognize stellar performance. There are 228 P2E hospitals in the US and only 2 in Nevada. There are over 596 Magnet designated hospitals and none in Nevada. Ms. Fox explained why there are so many more Magnet designated hospitals in the US than P2E designations.

Ms. Fox went on to explain the what, why and how UMC has obtained P2E designation. To confirm the designation, 60% or higher must complete the survey, at least 50% of respondents must strongly agree or agree to all 28 questions, 75% of respondents must strongly agree or agree with at least 21 out of 28 questions.

A historical timeline of Magnet was provided. The Magnet program was established in 1983 with 41 hospitals. In 1998, Magnet expanded to include long-term care facilities and was recognized internationally in 2000. By 2008, the 5-core components of Magnet were established, which include transformational leadership, structural empowerment, exemplary professional practice, new knowledge & innovation and empirical quality outcomes. The process of

obtaining Magnet status is lengthy due to the requirements of obtaining and submitting documents, which is limited to 4 dates during the year. Other challenges in quality data and HCAHPS scores were discussed. A detailed timeline to achieve designations for Pathways and Magnet were reviewed.

UMC has engaged the services of Healthlinx to assist writing and document submittal. Healthlinx will also help in preparation of the site visit, as well as data management and tracking. Ms. Fox continued the discussion regarding the inpatient and outpatient quality data story sources.

Ms. Fox reviewed the journey for Pathways and Magnet. The UMC journey to P2E Designation took 5-years and for the Magnet journey to Designation has taken 9-years. The majority of first time Magnet designees without Pathways takes 10-years to designate.

Detailed total costs associated with the designation journeys were reviewed, as well as additive fees from 2018-2024. A summary of expected new cost were also reviewed. There was continued discussion regarding the costs.

The Committee thanked Ms. Fox and appreciated the detailed presentation.

FINAL ACTION TAKEN:
None

ITEM NO. 5 Discuss Receive an update on HCAPHS/CCAPHS/ICARE4U Program from Jeff Castillo, Director of Patient Experience; and direct staff accordingly. ***(For possible action).***

DOCUMENT(S) SUBMITTED**:**
- PowerPoint

DISCUSSION:

Jeff Castillo presented the 3rd Quarter 2023 – 2nd Quarter 2024 HCAHPS and CCAPHS score results, as well as updates regarding the ICare4U program.

HCAHPS Data - Overall, there were positive trends year over year, with improvement shown in many of the categories. Strategies implemented to improve quietness at night have resulted in significant improvement over previous quarters.

UMC Pediatric CCAHPS scores for the same quarters were also reviewed. Overall, there was a drop in 1st quarter 2024 pediatric data results, but there has been a slight rebound in 2nd quarter data. There has been an increase in the number of surveys being returned. Rounding daily has increased which has helped to mitigate any patient complaints. Weekend coverage has also been implemented in pediatrics.

The top box trends for 2023 outperformed the previous 2-years categories for primary cares, quick cares and inpatient services. Hospital Compare data showed that UMC out performed Sunrise in 9 out of 10 elements and outperformed or tied Valley in 6 out of 10 elements.

Mr. Castillo next reviewed previously reported initiatives and ongoing action plans specific to patient experience, like unit of the week rounds, EMS outreach, ICARE 5.0 refresh, data experience comments from patients, Rollin with the Best celebrations, etc., as they are trending positively.

The committee asked if rounding in different units is helping to address hospital cleanliness. Mr. Castillo responded that there has been positive outcomes with the team rounding throughout the hospital.

Lastly, he reviewed numerous creative actions and initiatives that the team uses to improve patient experience, such as We Roll with the Best. He highlighted UMC's relationship with Mercy Air and other roll with the best celebrations.

The Committee commended the department on the new initiatives.

Chair Mackay asked about the specific challenges in HCAHPS scores. Ms. Fox stated that in ambulatory is at 44%; there are challenges in courtesy/respect and careful listening. A lengthy discussion ensued regarding opportunities for improvement in effective listening, communication, patient comprehension, quiet at night initiatives and discharge instructions.

FINAL ACTION TAKEN:
None

ITEM NO. 6 Review and recommend for approval by the Governing Board, the UMC Policies and Procedures Committee's activities of August 7, 2024 including the recommended creation, revision, and /or retirement of UMC policies and procedures; and take any action deemed appropriate. ***(For possible action)***

DOCUMENT(S) SUBMITTED**:**
- Policies and Procedures

DISCUSSION:

Policy and Procedures activities for August 7, 2024 were reviewed.

There were a total of 36 policies approved, none were retired and all were approved through the hospital Policy and Procedures Committee, Quality and Safety and Medical Executive Committee.

FINAL ACTION TAKEN:
A motion was made by Member Hobbs to approve that the UMC Policies and Procedures Committee's activities of August 7, 2024, and recommend for approval to the UMC Governing Board. Motion carried by unanimous vote.

ITEM NO. 7 Review and recommend approval by the Board of Hospital Trustees for University Medical Center of Southern Nevada, the proposed amendments to the UMC Medical and Dental Staff Bylaws and Rules & Regulations; as approved and recommended by the Medical Executive Committee on

September 24, 2024; and take any action deemed appropriate. *(For possible action)*

DOCUMENT(S) SUBMITTED**:**
- Medical Staff Bylaws

DISCUSSION:

Medical Staff Bylaws changes were reviewed for approval.

There was brief discussion regarding treating family members and the new Refer and Follow category, which was added to meet regulatory standards.

FINAL ACTION TAKEN:

A motion was made by Member Franklin to approve the proposed amendments Medical and Dental Staff Bylaws and Rules and Regulations, as approved and recommended by the Medical Executive Committee on September 24, 2024 be recommended for approval to the UMC Governing Board and the Hospital Board of County Commissioners. Motion carried by unanimous vote.

SECTION 3. EMERGING ISSUES

ITEM NO. 8 Identify emerging issues to be addressed by staff or by the Clinical Quality and Professional Affairs Committee at future meetings; and direct staff accordingly

DISCUSSION:

None

FINAL ACTION TAKEN:

None

COMMENTS BY THE GENERAL PUBLIC:

At this time, Chair Dr. Mackay asked if there were any persons present in the audience wishing to be heard on any items not listed on the posted agenda.
SPEAKERS(S): None

There being no further business to come before the Committee at this time, at the hour of 3:23 p.m., Chair Dr. Mackay adjourned the meeting.

MINTUES PREPARED BY: Stephanie Ceccarelli, Governing Board Secretary
APPROVED:

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
AGENDA ITEM

Issue:	**Patient Safety Structural Measure (PSSM) Update**	**Back-up:**
Petitioner:	Patricia Scott, Quality Patient Safety and Regulatory Officer	

Recommendation:

That the Governing Board Clinical Quality and Professional Affairs Committee receive an educational presentation regarding the Patient Safety Structural Measure (PSSM) from Patty Scott, Quality/Safety/Regulatory Officer; and direct staff accordingly. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

The Clinical Quality and Professional Affairs Committee will receive an educational update from Patty Scott regarding the Patient Safety Structural Measure.

Cleared for Agenda
December 2, 2024

Agenda Item #

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UMC
UNIVERSITY MEDICAL CENTER

The **Highest Level of Care** in Nevada

Patient Safety Structural Measure (PSSM)

Clinical Quality and Professional Affairs Committee
Monday, December 2, 2024

PSSM: Background

- A foundational commitment of healthcare is to ensure safety is embedded in the centuries-old Hippocratic Oath, “First, do no harm.”
- Over the past two decades, healthcare facilities have implemented various interventions and strategies to improve patient safety, with some documented successes. However, patient harm still occurs at significant rates.
- A systems-based approach to reducing patient harm is necessary within the complex healthcare ecosystem, to that end, CMS has implemented a new quality measure to assess how well organizations have implemented strategies and practices to strengthen systems for safety.

PSSM: Description

The PSSM:

- Is an **attestation-based measure** that assesses demonstration of a structure and culture that prioritizes patient safety.
- Includes **five domains**, each containing **multiple statements** that aim to capture the most salient structural and cultural elements of patient safety.
- Is designed to identify organizations that practice a systems-based approach to safety, as demonstrated by:
  - Leaders who prioritize and champion safety;
  - A diverse group of patients and families meaningfully engaged as partners in safety;
  - Practices indicative of a culture of safety; and
  - Continuous learning and improvement.

National Steering Committee for Patient Safety. Safer Together: A National Action Plan to Advance Patient Safety. Boston, Massachusetts: Institute for Healthcare Improvement; 2020. https://www.ihi.org/initiatives/national-steering-committee-patient-safety/national-action-plan-advance-patient-safety

Domain 1: Leadership Commitment to Eliminating Preventable Harm

- The Governing Board and senior leadership set the tone for commitment to patient safety.
- They are accountable for patient safety outcomes and to ensure that patient safety is the highest priority for the organization.
- While the Governing Board and organizational leadership may convene a board committee dedicated to patient safety, the most senior Governing Board must oversee all safety activities and hold organizational leaders accountable for outcomes.
- Patient safety should be central to all strategic, financial, and operational decisions.

Domain 1: Leadership Commitment to Eliminating Preventable Harm

- The Governing Board prioritizes safety as a core value:
  - Holds leadership accountable for patient safety; and
  - Identifies patient safety metrics to inform annual leadership performance reviews and compensation.
- Organizational leaders, including C-suite executives, place patient safety as a core institutional value:
  - One or more C-suite leaders oversee a system-wide assessment on safety (examples provided in the Attestation Guide);
  - Executes patient safety initiatives and operations, with specific improvement plans and metrics; and
  - Shares plans and metrics across all levels of the organization.

Domain 1: Leadership Commitment to Eliminating Preventable Harm

- The Governing Board, in collaboration with leadership ensures:
  - Availability of adequate resources to support patient safety (such as equipment, training, systems, personnel, and technology); and
  - At least 20% of the regular board agenda and discussion time for senior governing board meetings receives reports on patient and workforce safety events and initiatives (such as safety outcomes, improvement work, risk assessments, event cause analysis, infection outbreak, culture of safety, or other patient safety topics).
- Individuals on the Governing Board and C-suite executives are notified within 3 business days of any confirmed serious safety events resulting in significant morbidity, mortality, or other harm.

Domain 2: Strategic Planning & Organizational Policy

- Organizations must leverage strategic planning and organizational policies to demonstrate a commitment to safety as a core value through:
  - The use of written policies and protocols that demonstrate patient safety as a priority and identify goals, metrics and practices to advance progress;
  - Creating a system of accountability and transparency as it relates to patient safety;
  - Acknowledging that the ultimate goal is zero preventable harm, even while recognizing that this goal may not be currently attainable and requires a continual process of improvement and commitment; and
  - Understanding that patient safety and equity in care are inextricable, and therefore equity, with the goal of safety for all individuals, must be embedded in safety planning, goal-setting, policy, and processes.

Domain 2: Strategic Planning & Organizational Policy

- The organization's strategic plan shares its commitment to patient safety as a core value and outlines specific safety goals and associated metrics, including the goal of "zero preventable harm":
    - Safety goals include the use of metrics to identify and address disparities in safety outcomes based on patient characteristics determined by the organization to be most important for the specific populations served; and
    - Written policies and protocols are implemented to cultivate a **"Just Culture"** that balances no-blame and appropriate accountability, reflecting on the distinction between human error, at-risk behavior, and reckless behavior.*

Agency for Healthcare Research and Quality. The CUSP Method. https://www.ahrq.gov/hai/cusp/index.html

Domain 2: Strategic Planning & Organizational Policy

- The organization requires implementation of patient safety curriculum and competencies with regular assessments of these competencies for all roles, including action plans for advancing safety skills and behaviors:
    - Governing Board;
    - C-suite executives; and
    - Clinical and non-clinical staff.
- The organization has an action plan for workforce safety with improvement activities, metrics and trends that address issues such as slips/trips/falls prevention, safe patient handling, exposures, sharps injuries, violence prevention, fire/electrical safety, and psychological safety.

Domain 3: Culture of Safety & Learning Health System

- The organization must integrate a suite of evidence-based practices and protocols that are fundamental to cultivating the organization's culture prioritizing safety and establishing learning systems both within and across the organization.

- Practices focus on actively seeking and harnessing information to develop a proactive, organization-wide approach to optimizing safety and eliminating preventable harm.

- Organizations must establish an integrated infrastructure (that is, people and systems working collaboratively) and foster psychological safety among staff to effectively and reliably implement these practices.

Domain 3: Culture of Safety & Learning Health System

- The organization:
  - Conducts a culture of safety (COS) survey using a validated instrument annually, or every two years with pulse surveys on target units during non-survey years;
  - COS results are shared throughout the organization, and are used to inform unit-based interventions to reduce harm; and
  - Has a dedicated team that conducts event analysis of serious safety events using an evidence-based approach, such as the National Patient Safety Foundation's Root Cause Analysis and Action (RCA).*

Agency for Healthcare Research and Quality. (2019, September 7). Root Cause Analysis. https://psnet.ahrq.gov/primer/root-cause-analysis

- The organization:
  - Utilizes a patient safety metrics dashboard and external benchmarks (such as CMS Star Ratings or other national databases) to monitor performance and inform improvement activities on safety events (such as: medication errors, surgical/procedural harm, falls, pressure injuries, diagnostic errors, and healthcare-associated infections).
  - Implements a minimum of 4 of the following high reliability practices:
    - ✓ Tiered and escalating (e.g., unit, department, facility, system) safety huddles at least 5 days a week, with one day being a weekend, that include key clinical and non-clinical (e.g., lab, housekeeping, security) units and leaders, with a method in place for follow-up on issues identified.

Domain 3: Culture of Safety & Learning Health System

- Organizational leaders participate in monthly rounding for safety on all units, with C-suite executives rounding at least quarterly, with a method in place for follow-up on issues identified.

- A data infrastructure to measure safety, based on safety evidence (e.g., systematic reviews, national guidelines) and data from the electronic health record that enables identification and tracking of serious safety events and precursor events. This data is shared with:

  - C-suite executives at least monthly; and
  - The Governing Board at every regularly scheduled meeting.

- Technologies, including a computerized physician order entry (CPOE) system and a barcode medication administration system, that promote safety and standardization of care using evidence-based practices.

- The Organization:
  - Uses a defined improvement method (or hybrid of proven methods), such as Lean, Six Sigma, Plan-Do-Study-Act, and/or high reliability frameworks.
  - Trains all staff in team communication and collaboration;
  - Uses human factors engineering principles in the selection and design of devices, equipment, and processes; and
  - Participates in large-scale learning network(s) for patient safety improvement (such as national or state collaboratives), shares data on safety events and outcomes, and has implemented at least one best practice from the network or collaborative.

Domain 4: Accountability & Transparency

- Accountability for outcomes, as well as transparency around safety events and performance, represent the cornerstones of a culture of safety.

- For organization leaders, clinical and non-clinical staff, patients, and families to learn from safety events and prevent harm, there must exist a culture that promotes event reporting without fear or hesitation, and safety data collection and analysis with the free flow of information.

- The organization:

  - Has a confidential reporting system that allows staff to report patient safety events, near misses, unsafe conditions, and other concerns, and prompts a feedback loop to those who report;
  - Reports serious safety events and near misses to a Patient Safety Organization (PSO) listed by the Agency for Healthcare Research and Quality (AHRQ)*; and
  - Patient safety metrics are tracked and reported to all staff and made public in units (e.g., displayed on units so that staff, patients, families, and visitors can see).

Domain 4: Accountability & Transparency

- The organization has a defined, evidence-based communication and resolution program reliably implemented after harm events, such as AHRQ's Communication and Optimal Resolution (CANDOR) toolkit*, that contains the following elements:
  - Harm event identification;
  - Open and ongoing communication with patients and families about the harm event;
  - Event investigation, prevention, and learning;
  - Care-for-the-caregiver;
  - Financial and non-financial reconciliation; and
  - Patient-family engagement and on-going support
- Uses standard measures to track the performance of our communication and resolution program and reports these measures to the Governing Board at least quarterly.

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*Agency for Healthcare Research and Quality. (2022). Communication and Optimal Resolution (CANDOR). https://www.ahrq.gov/patient-safety/settings/hospital/candor/index.html

Domain 5: Patient & Family Engagement

- The effective and equitable engagement of patients, families, and caregivers is essential to safer, better care.

- Organizations must embed patients, families, and caregivers as co-producers of safety and health through meaningful involvement in safety activities, quality improvement, and oversight.

- Implements a Patient and Family Advisory Council that:

  - Ensures patient, family, caregiver, and community input to safety-related activities, including representation at board meetings, consultation on safety goal-setting and metrics, and participation in safety improvement initiatives; and
  - Includes patients and caregivers of patients who are diverse and representative of the patient population.

- Patients have comprehensive access to and are encouraged to view their own medical records via patient portals and other options.
  - The organization provides support to help patients interpret information that is culturally and linguistically appropriate, and to submit comments for potential correction to their records.

Domain 5: Patient & Family Engagement

- The organization:
  - Incorporates patient and caregiver input about patient safety events or issues (such as patient submission of safety events, safety signals from complaints or other patient safety experience data, patient reports of discrimination); and
  - Supports the presence of family and other designated persons (as defined by the patient) as essential members of a “safe care team” encouraging engagement in activities such as bedside rounding and shift reporting, discharge planning, and visitation 24 hours a day, as feasible.

DISCUSSION / QUESTIONS?

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UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
AGENDA ITEM

Issue:	**Quality, Safety and Infection Prevention Program Update**	**Back-up:**
Petitioner:	Patricia Scott, Quality, Patient Safety and Regulatory Officer	

Recommendation:

That the Governing Board Clinical Quality and Professional Affairs Committee receive an update on the Quality, Safety, and Regulatory Program including any completed contract evaluations from Patty Scott, Quality/Safety/Regulatory Officer; and direct staff accordingly. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

Patricia Scott, Patient Safety and Regulatory Officer, will provide an update on the Quality, Safety, and Regulatory Program measures and contract evaluations.

Cleared for Agenda
December 2, 2024

Agenda Item #
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Quality/Safety/Infection/Regulatory Update

UMC Governing Board Committee

Clinical Quality & Professional Affairs

December 2, 2024

Leapfrog Fall Safety Grade; CMS Star Rating

FALL 2024

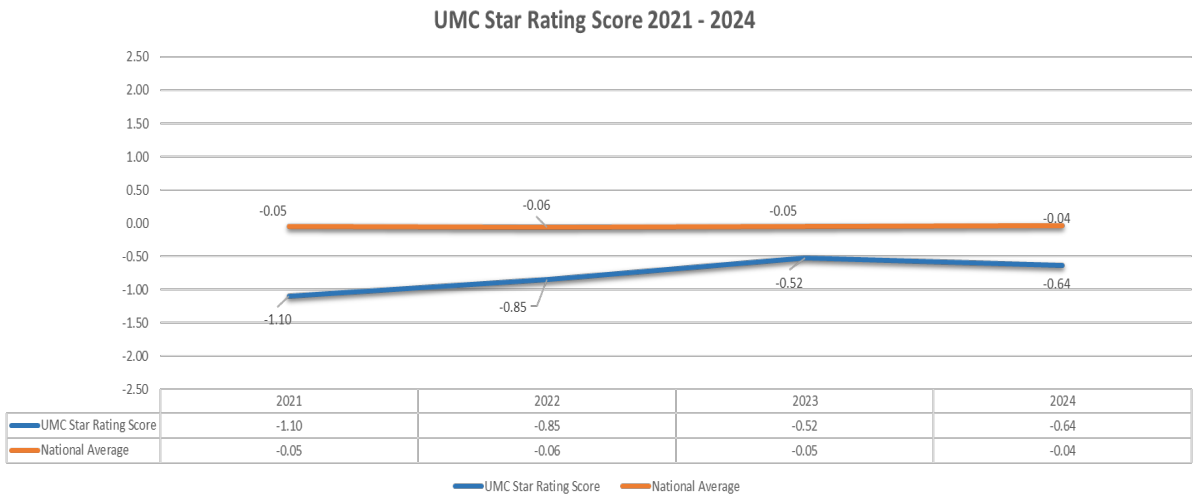
LEAPFROG HOSPITAL SAFETY GRADE

My Score	My Letter Grade
2.8105	C

More Information

Comparisons with Las Vegas hospitals in separate handout

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES



CMS = 2-Stars for Overall & HCAHPS; Birthing-Friendly Designation

A positive number is better
National Average Star Ratings: 3 out of 5 (-0.5259 - -0.0090)

Regulatory Update

Policies & Procedures

Why Change Accrediting Organizations?

- DNV (Det Norske Veritas – "The Norwegian Truth")
- **Annual survey process** with dedicated DNV team lead surveyor
- DNV is an integrated accreditation program utilizing the:
  - National Integrated Accreditation for Healthcare Organizations (NIAHO) standards
  - ISO:9001 Quality Management System Certification standards
    - The international standard that specifies requirements for a quality management system (QMS)
- DNV standards:
  - Mirror the CMS Conditions of Participation (COP)
  - Only change when the COP's are updated
- Fosters continual regulatory readiness (avoids the three-year "ramp up")
- DNV process aligns with UMC's Quality, Safety, & Regulatory initiatives…….to **PREVENT ZERO HARM!**

Journey to ISO 9001 Certification

ISO = International Organization of Standardization

Measures Contributing to LF Score	Standard Weight	UMC	Sunrise	Southern Hills	MT View	Valley	Spring Valley	Summerlin	Centennial Hills	Henderson	St. Rose San Martin	St. Rose Siena	North Vista	Source & Timeframe
Computerized Physician Order Entry (CPOE)	6.171%	100	100	100	100	100	100	100	100	100	100	100	100	2024 LF Survey
Bar Code Medication Administration (BCMA)	6.017%	100	100	100	100	100	100	100	100	100	100	100	100	2024 LF Survey
ICU Physician Staffing (IPS)	6.887%	100	100	100	100	100	100	100	100	100	100	100	100	2024 LF Survey
Safe Practice 1: Culture of Leadership Structures and Systems	3.043%	120	101.54	120	110.77	120	120	120	120	120	120	120	120	2024 LF Survey
Safe Practice 2: Culture Measurement, Feedback, & Intervention	3.187%	120	120	120	120	120	120	120	120	120	120	120	120	2024 LF Survey
Total Nursing Care Hours per Patient Day	4.726%	40	15	15	15	70	40	70	40	40	70	70	100	2024 LF Survey 01/01/2023 - 12/31/2023
Hand Hygiene	4.898%	100	100	100	100	100	100	100	100	100	100	100	100	2024 LF Survey
H-COMP-1: Nurse Communication	2.988%	86	83	89	87	87	88	88	87	87	91	89	84	CMS 10/01/2022 - 09/30/2023
H-COMP-2: Doctor Communication	2.986%	86	82	87	85	86	85	86	84	85	89	87	88	CMS 10/01/2022 - 09/30/2023
H-COMP-3: Staff Responsiveness	3.038%	79	74	83	81	79	80	79	76	75	83	83	74	CMS 10/01/2022 - 09/30/2023
H-COMP-5: Communication about Medicines	3.041%	67	65	71	70	71	70	70	68	69	74	74	70	CMS 10/01/2022 - 09/30/2023
H-COMP-6: Discharge Information	3.019%	82	78	82	80	80	82	82	79	82	84	86	78	CMS 10/01/2022 - 09/30/2023
Foreign Object Retained	4.234%	0.000	0.084	0.000	0.081	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	CMS 07/01/2021 - 06/30/2023
Air Embolism	2.419%	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	CMS 07/01/2021 - 06/30/2023
Falls and Trauma	4.926%	0.000	0.000	0.169	0.322	0.368	0.503	0.283	0.642	0.152	0.555	0.509	0.333	CMS 07/01/2021 - 06/30/2023
CLABSI	4.519%	1.075	0.690	0.576	0.961	0.101	0.647	0.714	0.630	0.671	0.301	0.820	0.000	2024 LF Survey 01/01/2023 - 12/31/2023
CAUTI	4.614%	1.310	0.262	1.123	0.230	0.165	0.138	0.387	0.133	0.101	0.000	0.570	0.000	2024 LF Survey 01/01/2023 - 12/31/2023
SSI: Colon	3.444%	2.103	0.678	0.877	0.925	0.822	0.203	1.485	0.631	0.000	1.769	1.436	N/A	2024 LF Survey 01/01/2023 - 12/31/2023
MRSA	4.455%	0.919	1.008	1.904	0.229	0.751	0.855	0.000	0.771	0.778	1.088	0.331	0.000	2024 LF Survey 01/01/2023 - 12/31/2023
C. Diff	4.459%	0.650	0.007	0.049	0.167	0.049	0.144	0.335	0.179	0.058	0.285	0.474	0.296	2024 LF Survey 01/01/2023 - 12/31/2023
PSI 4: Death rate among surgical inpatients with serious treatable conditions	1.972%	191.91	122.63	129.74	132.61	148.57	140.16	149.36	163.70	169.56	183.84	137.19	N/A	CMS 07/01/2020 - 06/30/2022
CMS Medicare PSI 90: Patient safety and adverse events composite	14.958%	0.97	0.93	0.80	0.91	0.91	1.00	1.35	1.25	0.79	1.68	1.19	0.88	CMS 07/01/2020 - 06/30/2022
LEAPFROG SCORE		**2.8105**	**2.8222**	**3.1699**	**3.0251**	**3.2594**	**3.1171**	**2.8567**	**2.7732**	**3.2757**	**2.6527**	**3.0132**	**3.3274**	
LEAPFROG Fall 2024 Grade		**C**	**C**	**B**	**B**	**A**	**B**	**C**	**C**	**A**	**C**	**B**	**A**	
Spring 2024 Grade		**C**	**C**	**B**	**B**	**B**	**B**	**C**	**C**	**A**	**C**	**B**	**B**	

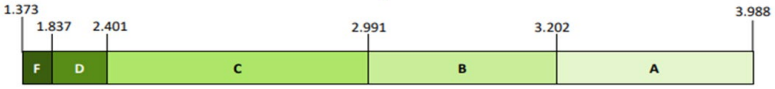
N/A	Not Applicable

	Not Publicly Reported

Fall 2024 Cut-Off Points

Grade	Safety Grade Criteria *(at or above cut point)*	Percentage of Hospitals
A	≥ 3.202	32%
B	≥ 2.991	24%
C	≥ 2.401	36%
D	≥ 1.837	7%
F	< 1.373	<1%

Higher is Better

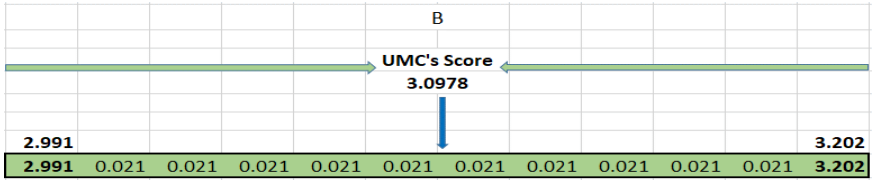


Fall 2024 Compare Hospital Counts	
A	3
B	4
C	5
D	0
F	0

UMC Leapfrog Individual Measure - Compare

Measure Domain	Measure	Hospital's Score Fall 2022	Hospital's Score Spring 2023	Trend
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	100	100	
	Bar Code Medication Administration (BCMA)	100	100	
	ICU Physician Staffing (IPS)	100	100	
	Safe Practice 1: Culture of Leadership Structures and Systems	120	120	
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	120	120	
	Safe Practice 9: Nursing Workforce	100	100	
	Hand Hygiene	100	100	
	H-COMP-1: Nurse Communication	87	86	
	H-COMP-2: Doctor Communication	87	86	
	H-COMP-3: Staff Responsiveness	80	79	
	H-COMP-5: Communication about Medicines	69	70	
	H-COMP-6: Discharge Information	82	82	
Outcome Measures	Foreign Object Retained	0	0	
	Air Embolism	0	0	
	Falls and Trauma	0	0.221	
	CLABSI	1.181	1.097	
	CAUTI	0.787	0.959	
	SSI: Colon	1.239	1.819	
	MRSA	2.594	1.702	
	C. Diff.	1.002	0.585	
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	160.8	159.17	
	CMS Medicare PSI 90: Patient safety and adverse events composite	1.18	0.81	
Process Measure Domain Score:				
Outcome Measure Domain Score:				
Process/Outcome Domains - Combined Score:				
Normalized Numerical Score:		2.812	3.0978	
Hospital Safety Grade (Letter Grade):	Grade	C	B	

Better
Worse
No Change



UMC Leapfrog Individual Measure - Compare

	LEAPFROG				UMC														
	Measures Contributing to LF Score	Best Score Possible	Standard Weight	Mean	UMC Trend	Fall 2024	Spring 2024	Fall 2023	Spring 2023	Fall 2022	Spring 2022	Fall 2021	Spring 2021	Fall 2020	Spring 2020	Fall 2019	Spring 2019	Fall 2018	Spring 2018	Fall 2017
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	100	6.171%	79.04		100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	Bar Code Medication Administration (BCMA)	100	6.017%	80.51		100	100	100	100	100	100	100	100	45	100	100	100	100		
	ICU Physician Staffing (IPS)	100	6.887%	64.45		100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	Safe Practice 1 : Culture of Leadership Structures and Systems	120	3.043%	117.40		120	120	120	120	120	120	120	120	120	120	120	120	120	120	120
	Safe Practice 2: Culture Measurement , Feedback & Intervention	120	3.187%	116.60		120	120	120	120	120	120	120	120	120	120	120	92.31	92.31	120	120
	Total Nursing Care Hours Per Patient Day	100	4.726%	76.10		40	N/A	N/A												
	Hand Hygiene	100	4.898%	72.43		100	100	100	100	100	100	100	N/A	N/A	60	60	60	60	60	60
	H-COMP-1 - Nurse Communication	100	2.988%	90.04		86	86	86	86	87	87	88	88	87	86	84	84	84	84	83
	H-COMP-2 - Doctor Communication	100	2.986%	89.90		86	86	85	86	87	87	87	87	86	84	84	84	85	84	84
	H-COMP-3 - Staff Responsiveness	100	3.038%	81.48		79	78	78	79	80	81	80	80	80	80	78	76	76	76	74
	H-COMP-5 - Communication about Medicines	100	3.041%	74.33		67	70	70	70	69	70	72	72	70	69	69	68	68	68	68
	H-COMP-6 - Discharge Information	100	3.019%	85.14		82	82	82	82	82	82	81	81	80	79	78	80	81	80	79
Outcome Measures	Foreign Object Retained	0.00	4.234%	0.014		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
	Air Embolism	0.00	2.419%	0.002		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
	Falls and Trauma	0.00	4.926%	0.385		0.000	0.169	0.169	0.221	0.000	0.000	0.281	0.281	0.281	0.437	0.437	0.180	0.180	0.580	0.580
	CLABSI	0.00	4.519%	0.687		1.075	1.195	1.060	1.097	1.181	1.175	1.047	0.765	0.879	1.008	1.128	0.887	0.786	1.006	0.555
	CAUTI	0.00	4.614%	0.577		1.310	1.167	1.134	0.959	0.787	1.330	1.479	1.123	1.164	1.122	1.578	0.932	0.584	0.707	0.725
	SSI: Colon	0.00	3.444%	0.852		2.103	2.403	2.081	1.819	1.239	1.309	2.545	2.204	2.701	2.033	1.774	1.036	1.503	2.286	2.946
	MRSA	0.00	4.455%	0.746		0.919	1.332	1.460	1.702	2.594	2.124	1.934	1.684	1.655	1.416	0.879	1.004	0.919	1.451	1.659
	C. Diff	0.00	4.459%	0.418		0.650	0.482	0.310	0.585	1.002	1.183	1.083	1.116	1.086	1.045	1.098	1.013	0.936	1.061	1.186
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	0.00	1.972%	168.34		191.91	191.91	159.17	159.17	160.80	160.80	160.80	202.90	202.94	205.14	205.14	176.75	176.75	158.99	168.360
	CMS Medicare PSI 90: Patient safety and adverse events composite	0.00	14.958%	1.01		0.97	0.97	0.81	0.81	1.18	1.18									
	LEAPFROG SCORE					2.8105	2.8708	3.0796	3.0978	2.8115	2.7593	2.5619	2.5016	2.2297	2.3737	2.3528	2.4860	2.5612	2.4493	2.3328
	LEAPFROG Grade					C	C	B	B	C	C	C	D	D	D	D	D	C	D	D

Fall 2024 Cut-Off Points

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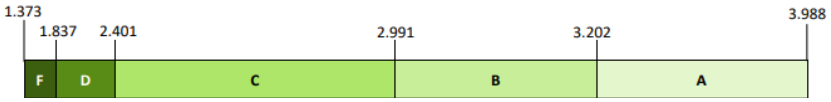
C	≥ 2.401	36%
D	≥ 1.837	7%
F	< 1.373	<1%

Better than previous reporting period
Same as previous reporting period
Worse than previous period
N/A in previous reporting period

Higher is Better



UMC CMS Comparison to Las Vegas Acute Care Hospitals														
Hospital Compare Measures	**UMC**	**Sunrise**	**Southern Hills**	**MT View**	**Spring Valley**	**Valley**	**Centennial Hills**	**Summerlin**	**Henderson**	**St. Rose DeLima**	**St. Rose San Martin**	**St. Rose Siena**	**North Vista**	**Reporting Period**
Overall Hospital Star Rating	★★	★	★★★★	★★★★	★★	★★	★	★★	★★★	NA	★★★	★★★	★	
HCAHPS Star Rating	★★	★	★★★	★★	★★	★★	★★	★★	★★	NA	★★★	★★★	★★	
HCAHPS														
Patients who reported that their nurses "Always" communicated well H-COMP-1	70%	64%	73%	71%	70%	71%	68%	74%	66%	NA	78%	74%	69%	01/01/2023 - 12/31/2023
	Nevada Average = 77%							National Average = 80%						
Patients who reported that their doctors "Always" communicated well H-COMP-2	70%	63%	72%	67%	67%	68%	65%	72%	64%	NA	77%	71%	75%	01/01/2023 - 12/31/2023
	Nevada Average = 75%							National Average = 80%						
Patients who reported that they "Always" received help as soon as they wanted H-COMP-3	57%	50%	61%	58%	53%	55%	51%	53%	49%	NA	63%	61%	51%	01/01/2023 - 12/31/2023
	Nevada Average = 63%							National Average = 66%						
Patients who reported that staff "Always" explained about medicines before giving it to them H-COMP-5	51%	48%	55%	54%	53%	57%	48%	56%	53%	NA	58%	58%	49%	01/01/2023 - 12/31/2023
	Nevada Average = 56%							National Average = 62%						
Patients who reported that their room and bathroom were "Always" clean H-CLEAN-HSP	64%	63%	75%	68%	66%	59%	64%	75%	71%	NA	72%	69%	70%	01/01/2023 - 12/31/2023
	Nevada Average = 73%							National Average = 73%						
Patients who reported that the area around their room was "Always" quiet at night H-QUIET-HSP	45%	50%	53%	50%	50%	49%	55%	58%	55%	NA	57%	54%	49%	01/01/2023 - 12/31/2023
	Nevada Average = 55%							National Average = 62%						
Patients who reported that YES, they were given information about what to do during their recovery at home CARE TRANSITION	81%	77%	82%	79%	82%	80%	80%	83%	83%	NA	85%	85%	78%	01/01/2023 - 12/31/2023
	Nevada Average = 84%							National Average = 86%						
Patients who "Strongly Agree" they understood their care when they left the hospital DISCHARGE INFORMATION	43%	38%	53%	42%	43%	42%	40%	43%	42%	NA	50%	50%	38%	01/01/2023 - 12/31/2023
	Nevada Average = 48%							National Average = 52%						
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest) H-HSP-RATING / H-RECMND	60%	53%	71%	62%	61%	57%	60%	66%	59%	NA	76%	66%	59%	07/01/2022-06/30/2023
	Nevada Average = 65%							National Average = 72%						
Patients who reported YES, they would definitely recommend the hospital H-HSP-RATING / H-RECMND	57%	50%	74%	62%	61%	54%	61%	68%	56%	NA	77%	68%	58%	01/01/2023 - 12/31/2023
	Nevada Average = 65%							National Average = 70%						

Hospital Compare Measures	UMC	Sunrise	Southern Hills	Mountain View	Spring Valley	Valley	Centennial Hills	Summerlin	Henderson	St. Rose De Lima	St. Rose San Martin	St. Rose Siena	North Vista	Reporting Period
UMC CMS Comparison to Las Vegas Acute Care Hospitals														
Overall Hospital Star Rating	★★	★	★★★★	★★★★	★★	★★	★	★★	★★★	NA	★★★	★★★	★	
HCAHPS Star Rating	★★	★	★★★	★★	★★	★★	★★	★★	★★	NA	★★★	★★★	★★	
Sepsis Care														
Percentage of patients who received appropriate care for severe sepsis and septic shock (SEP-1) *higher percentages are better* SEP-1	79%	65%	68%	60%	44%	53%	55%	48%	59%	NA	66%	56%	71%	1/1/2023-12/31/2023
	Nevada Average = 63%							National Average = 62%						
Colonoscopy Follow-up														
Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy ASC-9	NA	NA	93%	67%	88%	67%	89%	93%	98%	NA	NA	45%	NA	1/1/2023-12/31/2023
	Nevada Average = 89%							National Average = 92%						
Emergency Department Care														
Emergency Department Volume	Very High	Very High	Very High	Very High	Very High	High	Very High	High	Very High	Medium	Medium	Very High	High	Reporting Period
Percentage of patients who left the emergency department before being seen *lower percentages are better*	1%	0%	0%	1%	0%	1%	1%	1%	0%	1%	1%	1%	1%	1/1/2022-12/31/2022
	Nevada Average = 1%							National Average = 3%						
Average (median) time patients spent in the emergency department before leaving from the visit *lower number of minutes is better*	216 min	171 mins	108 mins	154 mins	178 mins	218 mins	168 mins	199 mins	186 mins	108 mins	164 mins	198 mins	149 mins	1/1/2022-12/31/2022
	Nevada Average *(other very high volume hospitals)* = 164 mins							National Average *(other very high volume hospitals)* = 197 mins						
Volume Legend (Patients Annually)	Low: 0 - 19,999 Medium: 20,000 - 39,999 High: 40,000 - 59,999 Very High: 60,000+													
Preventative Care														
Healthcare workers given influenza vaccination IMM-3 *higher percentages are better*	77%	38%	41%	34%	81%	81%	74%	48%	77%	66%	69%	73%	58%	10/1/2023-3/31/2024
	Nevada Average = 66%							National Average = 80%						
Safe Use of Opioids														
Proportion of inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on, two or more opioids or an opioid and benzodiazepine concurrently at discharge *lower percentages are better*	13%	14%	16%	19%	15%	17%	13%	13%	13%	18%	17%	13%	8%	1/1/2023-12/31/2023
	Nevada Average = 14%							National Average = 15%						
Pregnancy and Delivery Care														
Percent of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery wasn't medically necessary (PC-01) *lower percentages are better* PC-01	0%	1%	2%	6%	0%	NA	0%	0%	0%	NA	4%	0%	NA	1/1/2023-12/31/2023
	Nevada Average = 1%							National Average = 3%						
Surgical Complications														
Serious complications PSI-90 Composite	0.97 (No different than the national value)	0.88 (No different than the national value)	0.85 (No different than the national value)	0.89 (No different than the national value)	1.18 (No different than the national value)	0.86 (No different than the national value)	1.19 (No different than the national value)	1.16 (No different than the national value)	0.88 (No different than the national value)	NA	1.51 (Worse than the national value)	1.09 (No different that the national value)	0.90 (No different than the national value)	7/1/2021-6/30/2023
	National Average = 1.00													
Deaths among patients with serious treatable complications after surgery (PSI-4) PSI-4-SURG-COMP	180.38 (No different than the national rate)	127.66 (Better than the national rate)	130.68 (No different than the national rate)	161.61 (No different than the national rate)	163.64 (No different than the national rate)	146.34 (No different than the national rate)	190.95 (No different than the national rate)	138.60 (No different than the national rate)	172.52 (No different that the national rate)	NA	187.88 (No different than the national rate)	162.51 (No different than the national rate)	NA	7/1/2021-6/30/2023
	National Average = 176.55													
Rate of complications for hip/knee replacement patients COMP-HIP-KNEE	3.4% (No different than the national rate) (N=34)	4.1% (No different than the national rate)	3.0% (No different than the national rate)	3.0% (No different than the national rate)	3.0% (No different than the national rate)	4.0% (No different than the national rate)	3.4% (No different than the national rate)	NA	3.3% (No different than the national rate)	NA	NA	3.5% (No different than the national rate)	NA	7/1/2020-3/31/2023
	National Average = 3.5%													
Infections														
Central line-associated bloodstream infections (CLABSI) in ICUs and select wards HAI-2 *Lower numbers are better*	1.075 (No different than the national benchmark)	0.690 (No different than the national benchmark)	0.576 (No different than the national benchmark)	0.991 (No different than the national benchmark)	0.647 (No different than the national benchmark)	0.101 (Better than the national benchmark)	0.630 (No different than the national benchmark)	0.769 (No different than the national benchmark)	0.671 (No different than national benchmark)	NA	0.362 (No different than the national benchmark)	0.782 (No different than the national benchmark)	0.000 (No different than the national benchmark)	1/1/2023-12/31/2023
	National Benchmark = 1.000													
Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards HAI-2	1.310 (No different than the national benchmark)	0.262 (Better than the national benchmark)	1.123 (No different than the national benchmark)	0.245 (Better than the national benchmark)	0.138 (Better than the national benchmark)	0.165 (Better than the national benchmark)	0.133 (Better than the national benchmark)	0.387 (Better than the national benchmark)	0.101 (Better than the national benchmark)	NA	0.000 (No different than the national benchmark)	0.635 (No different than the national benchmark)	0.000 (No different than the national benchmark)	1/1/2023-12/31/2023
	National Benchmark = 1.00													
Surgical site infections (SSI) from colon surgery HAI-3 *Lower numbers are better*	2.103 (Worse than the national benchmark)	0.678 (No different than the national benchmark)	0.877 (No different than national benchmark)	0.925 (No different than the national benchmark)	0.203 (Better than the national benchmark)	0.822 (No different than the national benchmark)	0.631 (No different than the national benchmark)	1.485 (No different than the national benchmark)	0.000 (Better than the national benchmark)	NA	1.995 (No different than the national benchmark)	1.522 (No different than the national benchmark)	NA	1/1/2023-12/31/2023
	National Benchmark = 1.000													
Surgical site infections (SSI) from abdominal hysterectomy HAI-4 *Lower numbers are better*	NA	1.361 (No different than national benchmark)	NA	0.941 (No different than the national benchmark)	NA	NA	0.000 (No different than the national benchmark)	1.908 (No different than the national benchmark)	NA	NA	NA	NA	NA	1/1/2023-12/31/2023
	National Benchmark = 1.000													
Methicillin-resistant Staphylococcus Aureus (MRSA) blood infections HAI-5 *Lower numbers are better*	0.919 (No different than the national benchmark)	1.134 (No different than national benchmark)	1.779 (No difference than national benchmark)	0.238 (Better than the national benchmark)	0.852 (No different than the national benchmark)	0.751 (No different than the national benchmark)	0.771 (No different than the national benchmark)	0.000 (Better than the national benchmark)	0.779 (No different than the national benchmark)	NA	1.127 (No different than the national benchmark)	0.496 (No different than the national benchmark)	0.000 (No than the national benchmark)	1/1/2023-12/31/2023
	National Benchmark = 1.000													
Clostridium difficile (C.diff.) intestinal infections (HAI-6) HAI-6 *Lower numbers are better*	0.654 (Better than national benchmark)	0.009 (Better than the national benchmark)	0.049 (Better than the national benchmark)	0.170 (Better than the national benchmark)	0.143 (Better than the national benchmark)	0.049 (Better than the national benchmark)	0.179 (Better than the national benchmark)	0.337 (Better than the national benchmark)	0.058 (Better than the national benchmark)	NA	0.285 (Better than the national benchmark)	0.474 (Better than the national benchmark)	0.298 (Better than the national benchmark)	1/1/2023-12/31/2023
	National Benchmark = 1.000													
Mortalities														
Death rate for COPD patients MORT-30-COPD	8.1% (No different than the national rate)	9.7% (No different that the national rate)	9.3% (No different that the national rate)	9.4% (No different than the national rate)	8.0% (No different than the national rate)	8.8% (No different than the national rate)	12.5% (No different than the national rate)	8.4% (No different than the national rate)	8.6% (No different than the national rate)	NA	9.4% (No different than the national rate)	11.0% (No different that the national rate)	8.9% (No different than the national rate)	7/1/2020-6/30/2023
	National Average = 9.4%													
Death rate for heart attack patients MORT-30-AMI	12.7% (No different than the national rate)	13.1% (No different than the national rate)	12.0% (No different that the national rate)	9.8% (No different than the national rate)	13.9% (No different than the national rate)	12.2% (No different than the national rate)	13.0% (No different than the national rate)	13.0% (No different than the national rate)	13.6% (No different than the national rate)	NA	13.3% (No different than the national rate)	13.2% (No different than the national rate)	13.0% (No different than the national rate)	7/1/2020-6/30/2023
	National Average = 12.6%													
Death rate for heart failure patients MORT-30-HF	9.5% (No different than the national rate)	8.8% (Better than the national rate)	8.0% (Better than the national rate)	7.6% (Better than the national rate)	13.5% (No different than the national rate)	10.7% (No different than the national rate)	13.9% (No different than the national rate)	10.6% (No different than the national rate)	11.8% (No different than the national rate)	NA	10.7% (No different than the national rate)	12.1% (No different than the national rate)	7.7% (Better than the national rate)	7/1/2020-6/30/2023
	National Average = 11.9%													
Death rate for pneumonia patients MORT-30-PN	16.5% (No different than the national rate)	18.5% (No different than the national rate)	14.4% (Better than the national rate)	15.4% (Better than the national rate)	20.0% (No different than the national rate)	17.4% (No different tan the national rate)	17.9% (No different than the national rate)	15.7% (No different than the national rate)	17.4% (No different than the national rate)	NA	20.8% (No different than the national rate)	16.5% (No different than the national rate)	16.1% (No different than the national rate)	7/1/2020-6/30/2023
	National Average = 17.9%													
Death rate for stroke patients MORT-30-STK	13.0% (No different than the national rate)	14.7% (No different than the national rate)	13.3% No different than the national rate)	13.9% (No different than the national rate)	21.1% (Worse than the national rate)	16.6% (No different than the national rate)	15.8% (No different than the national rate)	13.0% (No different than the national rate)	12.7% (No different than the national rate)	NA	11.7% (No different than the national rate)	13.0% (No different than the national rate)	NA	7/1/2020-6/30/2023
	National Average = 13.9%													
Death rate for CABG surgery patients MORT-30-CABG	3.0% (No different than the national rate)	2.9% (No different than the national rate)	NA	2.4% (No different than the national rate)	2.0% (No different than the national rate)	4.0% (No different than the national rate)	NA	4.5% (No different than the national rate)	NA	NA	4.8% (No different than the national rate)	4.5% (No different than the national rate)	NA	7/1/2020-6/30/2023
	National Average = 2.8%													
Readmissions														
Rate of readmission for chronic obstructive pulmonary disease (COPD) patient READM-30-COPD	20.7% (No different than the national rate) (N=82)	20.8% (No different than the national rate)	18.2% (No different than the national rate)	20.4% (No different than the national rate)	19.0% (No different than national rate)	18.0% (No different than national rate)	18.4% (No different than the national rate)	18.5% (No different than the national rate)	19.9% (No different than the national rate)	NA	18.7% (No different than the national rate)	18.4% (No different than the national rate)	19.0% (No different than the national rate)	7/1/2022-6/30/2023
	National Average = 18.5%													
Rate of readmission for heart attack patients (READ-30-AMI) EDAC-30-AMI	14.6% (No different than the national rate) (N=48)	14.3% (No different than the national rate)	13.3% (No different than the national rate)	13.8% (No different than the national rate)	13.9% (No different than the national rate)	14.4% (No different than the national rate)	13.4% (No different than the national rate)	15.2% (No different than the national rate)	14.4% (No different than the national rate)	NA	13.9% (No different than the national rate)	13.4% (No different than the national rate)	NA	7/1/2020-6/30/2023
	National Average = 13.7%													
Rate of readmission for heart failure patients EDAC-30-HF	21.9% (No different than the national rate) (N=185)	22.3% (No different than the national rate)	18.8% (No different than the national rate)	19.7% (No different than the national rate)	22.7% (No different than the national rate)	20.2% (No different than the national rate)	20.9% (No different than the national rate)	20.6% (No different than the national rate)	21.3% (No different than the national rate)	NA	20.0% (No different than the national rate)	21.2% (No different than the national rate)	21.8% (No different than the national rate)	7/1/2020-6/30/2023
	National Average = 19.8%													
Rate of readmission for pneumonia patients EDAC-30-PN	15.7% (No different than the national rate) (N=155)	16.4% (No different than the national rate)	17.6% (No different than the national rate)	15.9% (No different than the national rate)	18.2% (No different than the national rate)	15.7% (No different than the national rate)	18.6% (No different than the national rate)	19.1% (Worse than the national rate)	16.4% (No different that the national rate)	NA	16.8% (No different than the national rate)	18.6% (No different than the national rate)	16.5% (No different than the national rate)	7/1/2020-6/30/2023
	National Average = 16.4%													
Rate of readmission for coronary artery bypass graft (CABG) surgery patients READM-30-CABG	10.6% (No different than the national rate) (N=57)	12.2% (No different than the national rate)	NA	11.5% (No different than the national rate)	10.6% (No different than the national rate)	10.7% (No different than the national rate)	NA	10.9% (No different than the national rate)	NA	NA	11.7% (No different than the national rate)	9.8% (No different than the national rate)	NA	7/1/2020-6/30/2023
	National Average = 10.7%													
Rate of readmission after hip/knee replacement READM-30-HIP-KNEE	4.3% (No different than the national rate) (N=39)	4.6% (No different than the national rate)	4.6% (No different than the national rate)	4.2% (No different than national rate)	4.7% (No different than national rate)	4.6% (No different than the national rate)	5.2% (No different than the national rate)	NA	4.0% (No different than the national rate)	NA	NA	4.6% (No different than the national rate)	NA	7/1/2020-6/30/2023
	National Average = 4.5%													
Rate of readmission after discharge from hospital (Hospital-Wide) READM-30-HOSP-WIDE	15.2% (No different than the national rate) (N=1662)	14.9% (No different than the national rate)	15.4% (No different than the national rate)	14.5% (No different than national rate)	15.7% (No different than the national rate)	15.8% (No different than the national rate)	16.1% (Worse than the national rate)	16.0% (Worse than the national rate)	16.0% (Worse than the national rate)	NA	14.5% (No different than the national rate)	15.0% (No different than the national rate)	15.1% (No different than the national rate)	7/1/2020-6/30/2023
	National Average = 14.6%													
Health Equity														
Hospital Commitment to Health Equity *Using social determinants of health data, including race, ethnicity, language, gender identity, sex, sexual orientation, and disability status helps ensure everyone has access to equitable care and coverage* *Equity is a strategic priority: 1 point* *Data Collection: 1 point* *Data Collection: 1 point* *Quality Improvement: 1 point* *Leadership Engagement: 1 point* *Facility Total Score*	5 out of 5 points	5 out of 5 points	5 out of 5 points	5 out of 5 points	5 out of 5 points	5 out of 5 points	5 out of 5 points	5 out of 5 points	5 out of 5 points	5 out of 5 points	5 out of 5 points	5 out of 5 points	5 out of 5 points	1/1/2023-12/31/2023

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
AGENDA ITEM

Issue: **FY25 Organizational Improvement/CEO Goals Update**	**Back-up:**
Petitioner: Patricia Scott, Quality, Patient Safety and Regulatory Officer	

Recommendation:

That the Governing Board Clinical Quality and Professional Affairs Committee receive an update on the FY25 Organizational Improvement/CEO Goals from Patty Scott, Quality/Safety/Regulatory Officer; and take any action deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

The Clinical Quality committee will receive an update on the UMC Organizational goals for FY25.

Cleared for Agenda
December 2, 2024

Agenda Item #

6

UNIVERSITY MEDICAL CENTER

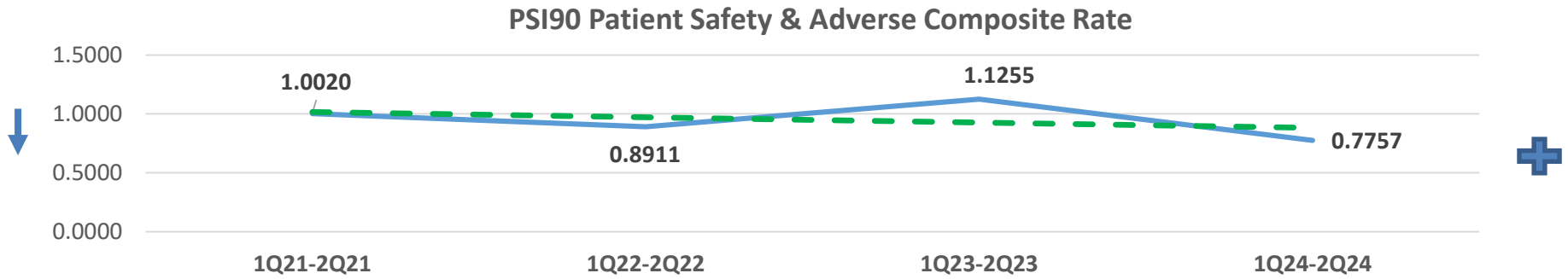
Quality Performance Objectives – FY25

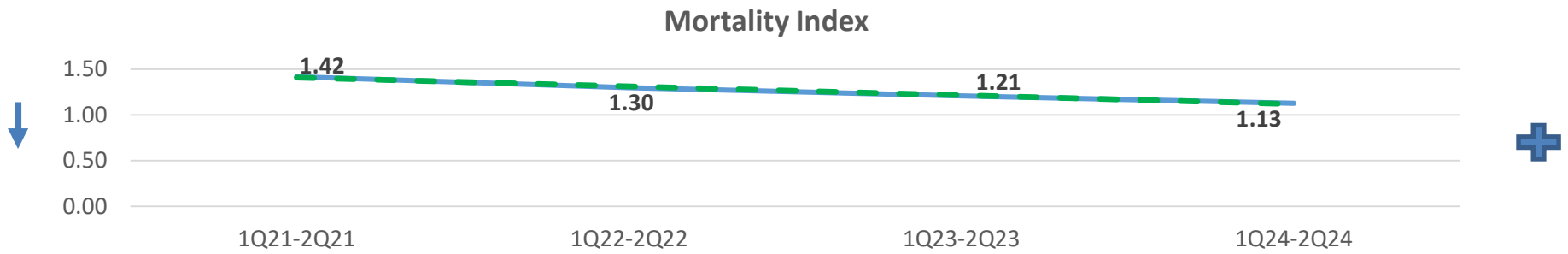
Approved by the Governing Board

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement over the last three (3) year trending period for the following inpatient quality/safety measures:





Lower is better. Higher is better Goal Met Goal Not Met Trend Line: Improvement Sustained Needs Improvement

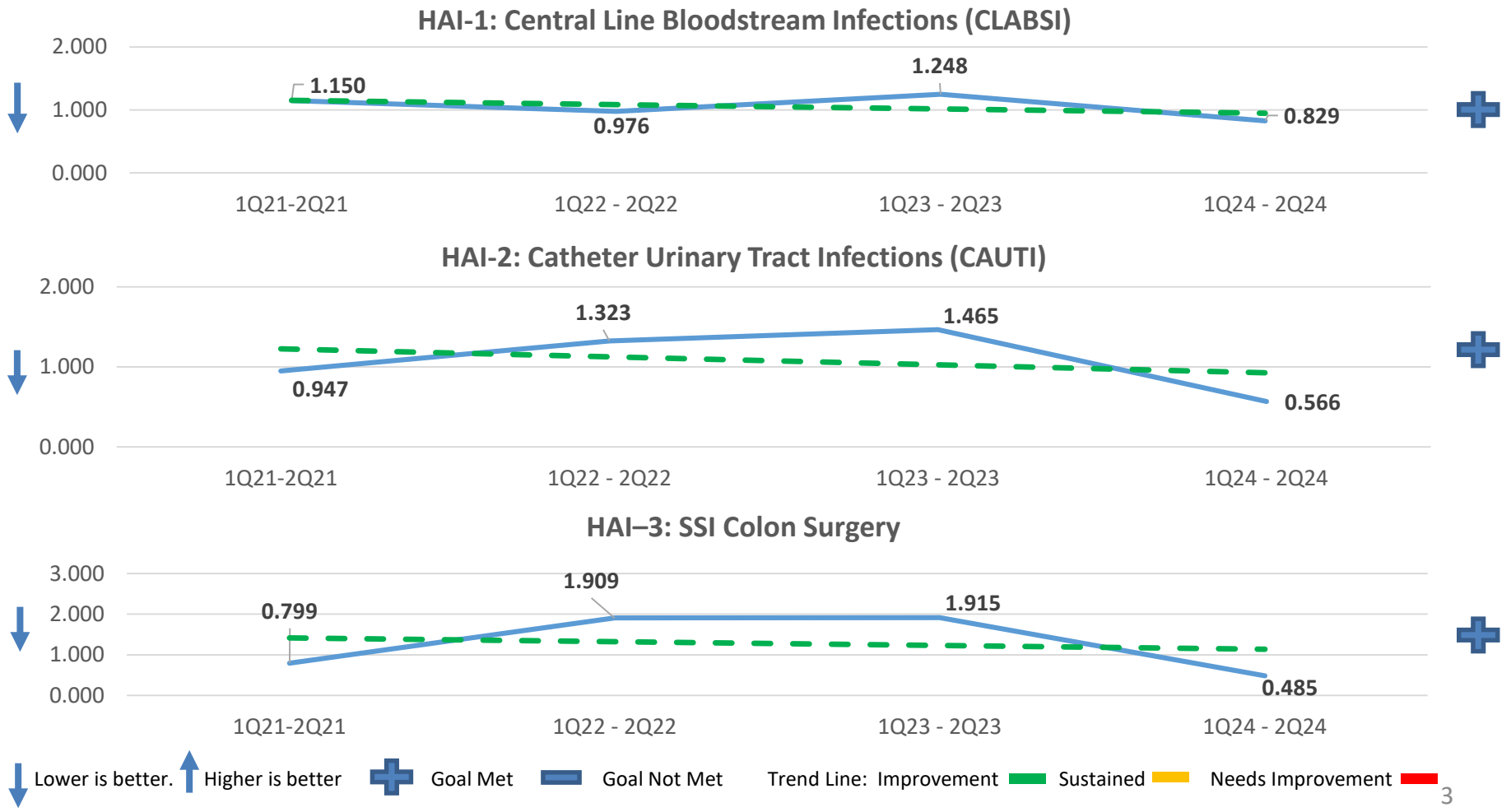
Data Source: Vizient Clinical Database

PSI 90 is a composite of the following 10, PSI indicators: pressure ulcers, iatrogenic pneumothorax, fall with hip fracture, peri-operative hemorrhage/hematoma, peri-operative metabolic complications, post-op respiratory failure, peri-op pulmonary embolism/deep vein thrombosis, post-op sepsis, post-op wound dehiscence, & accidental puncture/laceration.
Mortality O/E - The ratio of Observed to Expected mortality. An O/E ratio **above** 1.0 indicates observed mortality higher than the Vizient expected value. All data sets are compared with Vizient's AMC 2024 Risk Adjusted Methodology.

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement over the last three (3) year trending period for the following inpatient quality/safety measures:

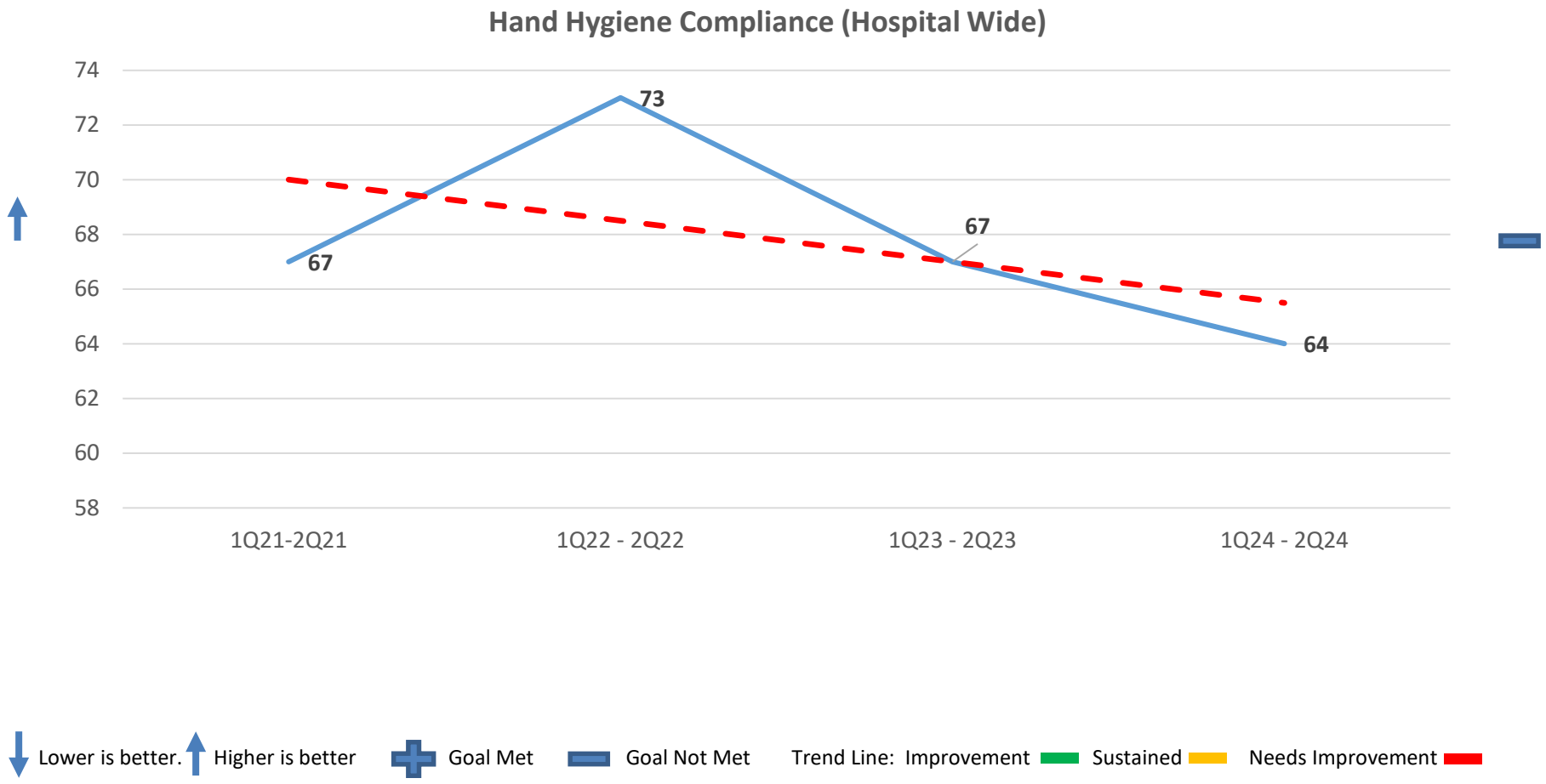


Data Source: UMC Infection Control Department - NHSN

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement over the last three (3) year trending period for the following inpatient quality/safety measures:

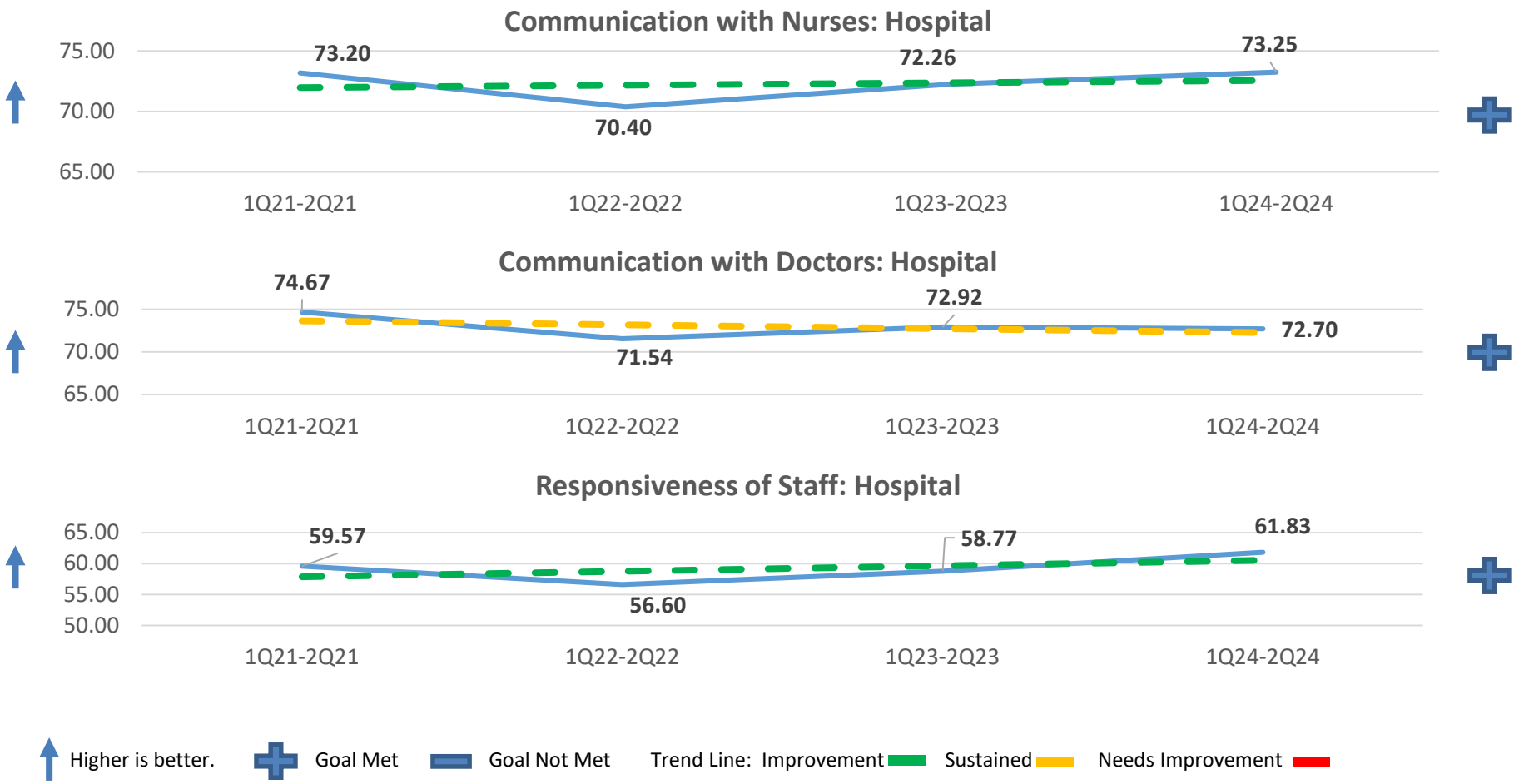


Data Source: UMC Infection Control Department - Observational Auditing

Quality Performance Objective

FY23 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement over the last three (3) year trending period for the following patient experience measures (IP):

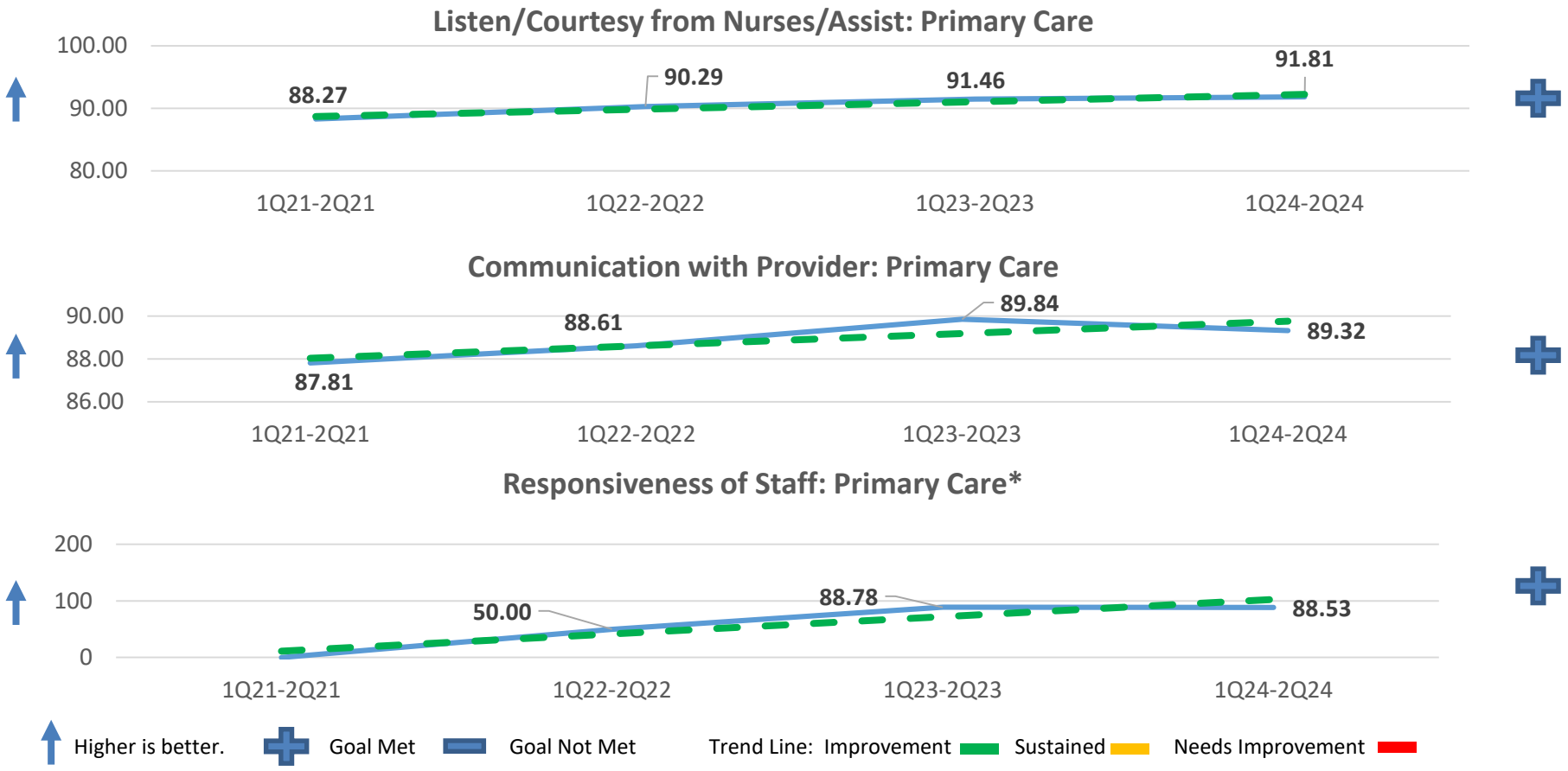


Data Source: HCAHPS Measures by Service Date - Press Ganey; Employee Recognition – Various UMC Recognition Programs.
Press Ganey Top Box by Service Date

Quality Performance Objective

FY23 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement over the last three (3) year trending period for the following patient experience measures (OP):

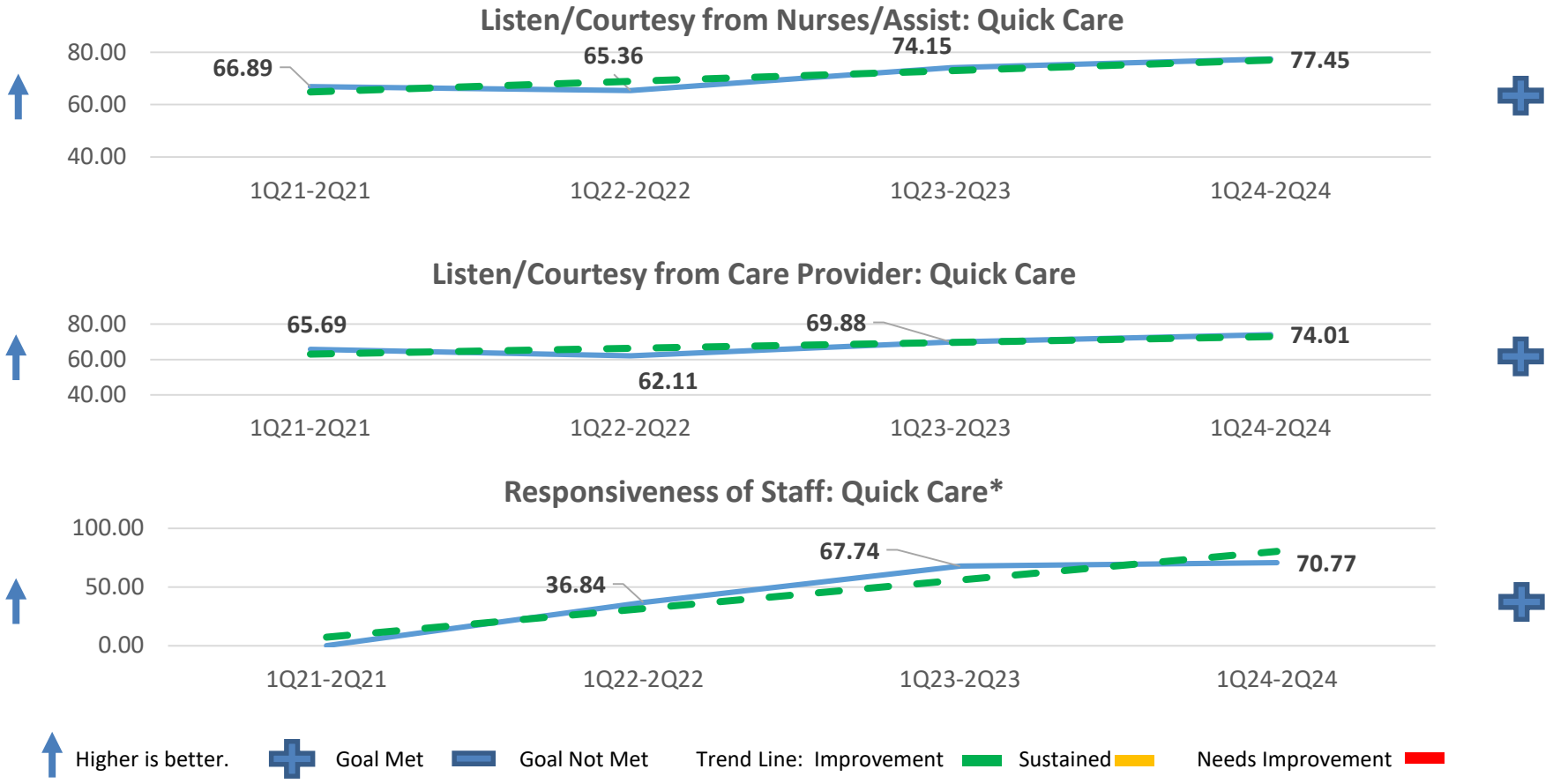


Data Source: HCAHPS Measures by Service Date - Press Ganey; Employee Recognition – Various UMC Recognition Programs.
Press Ganey Top Box by Service Date
*Response not available for 1Q-2Q 2021 Press Ganey Survey.

Quality Performance Objective

FY23 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement over the last three (3) year trending period for the following patient experience measures (OP):

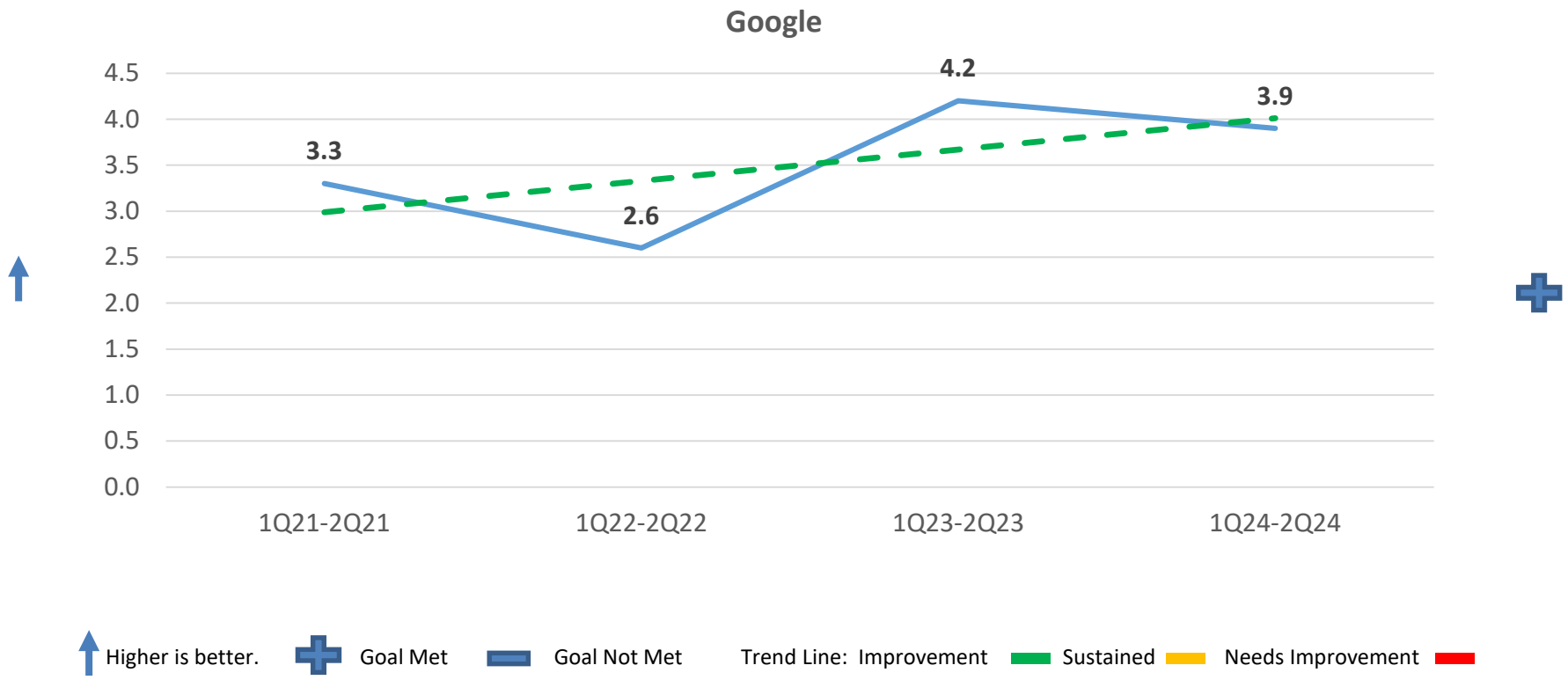


Data Source: HCAHPS Measures by Service Date - Press Ganey; Employee Recognition – Various UMC Recognition Programs.
Press Ganey Top Box by Service Date.
*Response not available for 1Q-2Q 2021 Press Ganey Survey.

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement (utilizing the Star Ratings) over the last three (3) year trending period in the overall patient perception of care (OP):

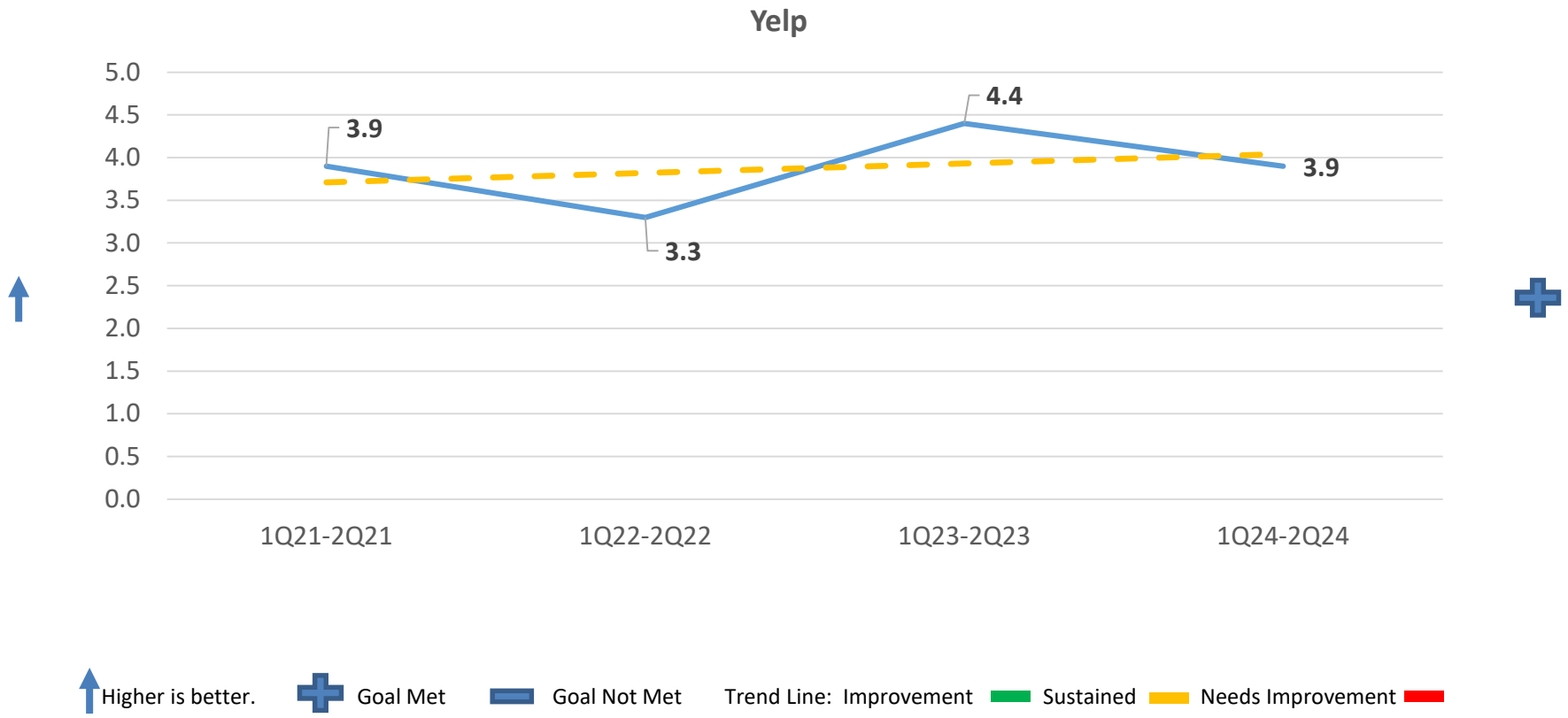


Date Source: UMC Experience Department, Yelp and Google websites. Average Star Score and Total Reviews during time period.
Score Range: 1-5 (5 Being the Highest)

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement (utilizing the Star Ratings) over the last three (3) year trending period in the overall patient perception of care (OP):



Date Source: UMC Experience Department, Yelp and Google websites. Average Star Score and Total Reviews during time period.
Score Range: 1-5 (5 Being the Highest)

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

Employed physician & employee engagement / alignment measures (FY25):

Measure	Goal Met
Attain 100% onboarding attendance compliance with all UMC employed physicians. Onboarding is defined by the following two components: attends hospital/provider orientation; provided with performance metric expectations.	In Progress
Attain 90% physician engagement / alignment survey participation, utilizing information gained to develop plans for improvement as other providers join the organization / service line.	In Progress
Reach 80% of UMC employees with additional ICARE training specifically focused on service recovery.	In Progress

Data provided by Patient Experience

DISCUSSION / QUESTIONS?

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UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
AGENDA ITEM

Issue: **UMC Policies and Procedures**	**Back-up:**
Petitioner: Patricia Scott, Quality, Patient Safety and Regulatory Officer	

Recommendation:

That the Governing Board Clinical Quality and Professional Affairs Committee review and recommend for approval by Governing Board, the UMC Policies and Procedures Committee's activities of September 4, 2024; October 2, 2024; November 6, 2024 including the recommended creation, revision, and /or retirement of UMC policies and procedures; and take any action deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
December 2, 2024

Agenda Item #
7

Regulatory Update

Policies & Procedures

Regulatory Update, Policy/Procedures

- Regulatory / Accreditation Surveys

- Policy / Procedure Approval
  - Timeframe: October 2 & November 6, 2024
  - Total approved: 81
  - Total retired: 3
  - Approved through Hospital P/P, Quality, MEC

October 2, 2024 Hospital Policy / Procedure Committee
As part of our regular policy review, the attached policies have been reviewed and updated by necessary hospital leaders/experts in order to reflect current regulatory rules and industry standards. A summary of the changes to each policy is included below.
Total of 39 Approved, 3 Retired

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Pediatric Stroke Protocol	New	Approved as Submitted	Reviewed and formatted to Policy Template. Vetted by Pediatric Department.
Pediatric Sedation Unit	Revised	Approved as Submitted	Made provisions for the use on Intranasal Dexmedetomidine and changed Aldrete Scoring to Modified Aldrete Scoring to match what is in EPIC and what is being practiced. Vetted by Pediatric Department.
CT Reconstruction of Images	New	Approved as Submitted	New protocol created for CT reconstruction of images by work group that included: Chief of Staff, Chief Medical Officer, Medical Director of Imaging, Medical Director of Emergency Department, Director of Imaging Services, Executive Director of Support Services, and Quality/Safety/Regulatory Officer.
Pediatric Code Blue, Emergency Response	Revised	Approved as Submitted	Minor wording changes, defined code team; clarified physician lead; added language relative to signing the death certificate. Vetted by Pediatric Department.
Patients Presenting with Complaint of Dysuria, Patients 3 Years of Age and Older	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Clinical Director of Critical Care Services, Dr. Trautwein and Pediatric Department.
Safe Handling of Cytotoxic Antineoplastic Medications for Non-Pharmacy Personnel	Revised	Approved as Submitted	Updated policy format. Revisions under the following sections: **Title:** Removed Pharmacists and Pharmacy Staff from the policy. **Scope:** Removed Pharmacists and Pharmacy Staff from the policy and added oncology and non-oncology setting. **Purpose:** Updated information related to potential exposure to cytotoxic drugs. **Policy**: Changed excreta to bodily fluids **Procedures**: Added sections A. Training, B. Personal Protective Equipment (PPE), C. PPE Usage, D. Equipment, E. Chemotherapy Precautions, F. Patient Bodily Fluids, and G. Employee Precautions. **References**: updated. Vetted by Safety Manager, Pharmacy and ACNO.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
No Co-Signature Required Approved List	Revised	Approved with Revisions	Reviewed. Added Consult to Baby Steps, updated pneumococcal vaccine. Vetted by ACNO.
Nursing Incentive Programs	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by ACNO.
Nursing Pronouncing of Death	Revised	Approved as Submitted	Updated to new template. Scheduled review, no changes. Updated NRS language to align with the current statues. Vetted by ACNO and legal with MEC approval.
Pest Control	Revised	Approved as Submitted	Added to new template. Scheduled review, no changes. Vetted by EVS and Infection Prevention/Control.
Confidential Paper Disposal and Shredding Bins	Revised	Approved as Submitted	Minor formatting and grammar change. Revised the definition of PHI for closer alignment with regulatory definition. Vetted by Privacy Officer and EVS Director.
Imprest Cash Fund	Revised	Approved as Submitted	Transferred to new template. Updated policy to align with current practice. Vetted by Steven Hughey/Finance.
Cash Control	Revised	Approved as Submitted	Transferred to new template. Updated policy to align with current practice. Vetted by Steven Hughey/Finance.
Handwashing in Sterile Processing	Revised	Approved with Revisions	Reviewed policy and edited template format. Updated reference. Vetted by Sterile Processing Manager.
Pediatric Intensive Care Unit (PICU) Admission Criteria	Revised	Approved as Submitted	Updated to current template format but no changes made. Vetted by PICU Clinical Manager and Pediatric Department.
Ultrasound Guided Peripheral IV (USGPIV) and Extended Dwell USGPIV (Inpatient)	New	Approved as Submitted	New policy. Vetted with Nursing, Quality and Infection Control.
Cardiac Cath - Power Injector	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Director of Cardiovascular Services and ACNO.
Right Heart Catheterization Procedure	Revised	Approved as Submitted	Added to new template. Scheduled review, no changes. Vetted by Director of Cardiovascular Services and ACNO.
Radio-Frequency Catheter Ablation	Revised	Approved as Submitted	Added to new template. Scheduled review, no changes. Vetted by Director of Cardiovascular Services and ACNO.
Patient Recovery-Cardiac Invasive and Non-Invasive Procedures (Outpatient)	Revised	Approved with Revisions	Added to new template. Updated scope and title to specify outpatient. Vetted by Director of Cardiovascular Services and ACNO.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Adult Palliative Care Program	Revised	Approved as Submitted	Language change from physician to provider, included other interdisciplinary members such as case manager, and recommendations for nursing care for CAT III/comfort care patients. Vetted by Emily Brown and ACNO.
Withholding or Withdrawal of Medical Treatments	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Emily Brown and ACNO.
Pediatric Wheezing	Revised	Approved with Revisions	Updated language around orders per protocol. Vetted by Pediatric Nurse Supervisor, Clinical Director Critical Care Services and ACNO.
Pediatric Vomiting	Revised	Approved with Revisions	Updated language around orders per protocol. Vetted by Pediatric Nurse Supervisor, Clinical Director Critical Care Services and ACNO.
Pediatric Testicular Pain	Revised	Approved with Revisions	Updated language around orders per protocol. Vetted by Pediatric Nurse Supervisor, Clinical Director Critical Care Services and ACNO.
Pediatric Stridor	Revised	Approved with Revisions	Updated language around orders per protocol. Vetted by Pediatric Nurse Supervisor, Clinical Director Critical Care Services and ACNO.
Application of Topical Anesthetic to Lacerations in the Pediatric Emergency Department	Revised	Approved with Revisions	Updated language around orders per protocol. Vetted by Pediatric Nurse Supervisor, Clinical Director Critical Care Services and ACNO.
Clinical Alarm Management	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Critical Care Director - SICU, MICU, Neuro ICU, Burn Care and ACNO.
Emergency Airway Management Guideline	Revised	Approved with Revisions	Reviewed by stakeholders. Added PICU to Scope. Vetted by stakeholders, Trauma Program Manager, Clinical Director Critical Care Services – Trauma and ACNO.
Conversion of Enteral Medications to the Appropriate Dosage Form and Route	Revised	Approved as Submitted	Added Procedure #4 which discusses that pharmacy may adjust dosage form based on patient specific parameters and/or pharmacy needs. Vetted by Director of Pharmacy.
Medication Management: Ordering and Verification	Revised	Approved as Submitted	Reviewed. Removed redundant medication classes and added muscle relaxers. Removed statement that pharmacy could renew controlled substances overnight (approved by Margaret Covelli (ACNO), Dianne Knapp (ACNO), and Dr. Lippman (CMO)). Vetted by Director of Pharmacy.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Pharmaceutical Waste	New	Approved as Submitted	New policy. Vetted by Supply Chain, EVS, Safety, Education and Director of Pharmacy.
High Alert Medications	Revised	Approved as Submitted	Moved all standardized safeguards into the procedure section. Additional safeguards specific to each medication category are listed in the tables. Added PCEA section. Removed sodium acetate and sodium phosphate from concentrated electrolytes (not on ISMP list); added magnesium sulfate (on ISMP list). Removed lepirudin and nesiritide from heparin and antithrombotics; moved argatroban into this section from critical care infusions. Added propofol and epoprostenol to critical care infusions. Added oxytocin and magnesium to continuous infusions (other) (ISMP recommendations). Vetted by Patient Safety, Pharmacy and ACNO.
Naloxone Nasal Spray Dispensing in Conjunction with the Southern Nevada Health District	New	Approved as Submitted	New policy. Vetted by Director of Pharmacy.
Patient Safety Event Reporting (Safety Intelligence)	Revised	Approved as Submitted	Updated the definition of near miss event to match AHRQ recent definition. Updated the ADR and ADE definition to match current policy. Changed LIP to licensed practitioner and updated references. Vetted by Director of Patient Safety.
Midline Catheter	New	Approved as Submitted	New Policy. Vetted with Nursing, Quality and infection control.
Temporary Implanted Local Pain Management System	New	Approved as Submitted	New policy. Change in device use. Move to template. Edits based on recommendations from Pharmacy Director and Medical Director of Anesthesia.
Operating and Procedural Management Efficiency: Key Performance Indicators (KPI), Measures, and Guidelines	New	Approved as Submitted	New policy. Vetted by Director of Peri-Operative Service and CNO. Revised title based upon MEC recommendation. Revised formatting with grammatical edits.
Focused Professional Practice Evaluation (FPPE) Policy for Newly Privileged Practitioners	Revised	Approved as Submitted	Updated initial FPPE requirements and term. Updated CMS approved accredited facility language. Vetted by Medical Staff.

November 6, 2024 Hospital Policy / Procedure Committee
As part of our regular policy review, the attached policies have been reviewed and updated by necessary hospital leaders/experts in order to reflect current regulatory rules and industry standards. A summary of the changes to each policy is included below.
Total of 42 Approved, 0 Retired

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Court Order & Subpoena Disclosures	Revised	Approved as Submitted	Reviewed with HIM and Legal. Minor formatting change. Grammar/Language changes. Vetted by Privacy Officer.
HIPAA Non-Retaliation	Revised	Approved as Submitted	Manual modification from Compliance to Privacy. Policy Owner modification from Compliance to Privacy Officer. Scope modification from Hospitalwide to Organization-wide. Policy language rearranged for better flow. No other content change. Minor formatting changes. Vetted by Privacy Officer.
Animal Bite Protocol	Revised	Approved as Submitted	Updated to include Mesquite Animal Control, City of Henderson Animal Control updated phone number, clarified with Clark County Animal Control they prefer fax to call. Vetted by Harkiranjot Mangat, Lisa Renfro, and QC Medical Director Dr. Kothari.
Respiratory - Invasive & Non-Invasive Guidelines	Revised	Approved as Submitted	Updated to include language about daily weaning. Vetted by Director of Respiratory Services.
Respiratory – Staffing Guidelines	Revised	Approved as Submitted	Updated to clarify that minimum staffing of RTs throughout the hospital will be 12 RTs. Vetted by Director of Respiratory Services.
Patient Inducement	New	Approved as Submitted	New policy. Full review with committee with opportunity for revisions. Vetted by Compliance Officer and Corporate Compliance Committee (including COO, CFO and GB liaison).
UMC Hosted Educational Events	Revised	Approved as Submitted	Review of policy with minor changes to align with current ACCME standards. Updated to current template format. Vetted by Compliance Officer.
OIG LEIE Exclusion Screening	Revised	Approved as Submitted	Review of policy with no changes to content, only updated to current template format. Vetted by Compliance Officer.
Influx of Infectious Patients	Revised	Approved as Submitted	Updated to new Joint Commission standard included terms of high-consequence infectious diseases and hierarchy of control. Vetted by Director of Infection Control/Prevention,

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
			Emergency Preparedness Program Coordinator, Medical Director Inpatient & Outpatient Infectious Disease Services and Quality Patient Safety & Regulatory Officer.
Active Surveillance Testing	Revised	Approved as Submitted	Updated the MRSA screening protocol to include selected med-surg patients. Vetted by Director of Infection Prevention & Control and Medical Director Inpatient & Outpatient Infectious Disease Services.
Expiration of the Neonate	Revised	Approved as Submitted	New template. Otherwise remains the same. Vetted by Pediatric Department.
Needle Aspiration and Chest Tube Insertion, Management, and Removal (NICU)	Revised	Approved with Revisions	Minor grammatical changes. Updated to new template. Vetted by Pediatric Department.
Social Service, Public Health Nurse Referrals- NICU and Perinatal	Revised	Approved as Submitted	Updated references, changed wording from "public health nurse" to SNHD. Vetted by Pediatric Department.
HIM Documentation Query	Revised	Approved as Submitted	Reviewed and add escalation processes for Professional Coding. Vetted by HIM Assistant Director.
Patient's Personal Medications – Storage and Use	Revised	Approved as Submitted	Added administration of other patient-supplied medications at clinics. Vetted by Ambulatory Director and Director of Pharmacy.
Medication Formulary System	Revised	Approved as Submitted	Added language stating that addition to formulary requests for contrast agents will be handled through the Radiology Department and not go through P&T Committee. Vetted by Pharmacy.
Pediatric Gastrostomy Tube Care	Revised	Approved as Submitted	Removed outdated recommendations such as checking residuals. Edited for clarity. Vetted by Pediatric Department.
Assessment and Care of the "Difficult" Airway Patient in the Pediatric Intensive Care Unit (PICU)	Revised	Approved as Submitted	Placed on new template. Edits made and items removed for contradiction to other policies and to streamline policy. Reviewed by PICU intensivists. Vetted by Pediatric Department.
Expiratory Muscle Strength Training	Revised	Approved as Submitted	Reviewed and update, no significant changes. Vetted by Rehab Services Director and ACNO.
Speaking Valve Management	Revised	Approved as Submitted	Updated for added related procedures. Vetted by Rehab Services Director and ACNO.
Supervision of Rehabilitation Technicians	Revised	Approved as Submitted	Scheduled review, no changes Vetted by Rehab Services Director and ACNO.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Rehabilitation Services In-Service Education	Revised	Approved as Submitted	Minor content changes; new format. Vetted by Rehab Services Director and ACNO.
Ultrasound Guided Peripheral IV Placement (USGPIV)	Revised	Approved as Submitted	No changes. Vetted by Clinical Director of Critical Care Services and ACNO.
Requisition for Personnel	Revised	Approved as Submitted	Revised A-B Added staffing standards language and contact information, and reclassification to a per-diem status. Correcting from a Policy to a Procedure. Vetted by Chief Human Resources Officer.
"At Will" Employment	Revised	Approved as Submitted	Added Physician Compensation Plan. Added #5. No other content changes. Vetted by Chief Human Resources Officer.
Availability to Work	Revised	Approved as Submitted	Clarified non-union represented classifications follow SEIU policy unless UMC determines otherwise. Added UMC may establish different attendance and policy standards. Vetted by Chief Human Resources Officer.
Definitions – Human Resources	Revised	Approved as Submitted	Added modification and interpretation language. Added Anniversary Date. Clarified illegal drugs not legally obtainable under either state or federal law. Clarified OT language. Added "applicable" under recall definitions. Vetted by Chief Human Resources Officer.
Educational Development Program	Revised	Approved as Submitted	B.1.a - Format change; D.7 – Content change (Added corrective action for failure to complete mandatory training.) Changing back to Procedure – accidently identified as Policy. Vetted by Chief Human Resources Officer.
Employee/Labor Relation Program	Revised	Approved as Submitted	Removed Qualifying Period language. Modified layoff language to align with operational need. Revised recall language. Clarified probationary language. Vetted by Chief Human Resources Officer.
Employee Records Program	Revised	Approved as Submitted	Modified language for discipline removal for union vs. nonunion classifications. Vetted by Chief Human Resources Officer.
Employment Eligibility Verification	Revised	Approved as Submitted	Correcting to Procedure from Policy. Added C(1-4) to identify discipline path if recert documentation isn't provided. Vetted by Chief Human Resources Officer.
Meal and Rest Periods	Revised	Approved as Submitted	Changed #6 & #7 the 48 hour time period for submitting exception form to 24 hours. Vetted by Chief Human Resources Officer.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Performance Evaluation Program	Revised	Approved as Submitted	Revised B-C language for non-union represented classifications to allow for modifications as desired by UMC. Removed references to changing annual review dates, etc. Added /revised language in H1, H3, H4, H5, to reflect new requirements. Correcting from Policy to Procedure. Vetted by Chief Human Resources Officer.
Performance Review Program	Revised	Approved as Submitted	#2 Modified language to allow for moving to a focal review date. Removed references to qualifying review. Vetted by Chief Human Resources Officer.
Position Classification and Compensation Plans	Revised	Approved as Submitted	Modified Section F language for promotions and demotions. Modified language regarding economic benefits for all nonunion represented classifications. Section G. Content changes – Revised corrective action to match new Hospital Requirement Matrix. Revised Section E2 to allow for UMC offer different economic and non-economic benefits for nonrepresented classifications. Vetted by Chief Human Resources Officer.
Recording Time Through Electronic Time Clocks	Revised	Approved as Submitted	Added paragraph #3 regarding time exception forms and time frame to submit. Vetted by Chief Human Resources Officer.
Recruitment and Selection Program	Revised	Approved as Submitted	Added language in #2 regarding staffing standards, and removed language regarding qualifying reviews. Section K. Content change – Added (4) correction action for noncompliance with license requirement. Vetted by Chief Human Resources Officer.
Standards of Basic Nursing Care Medical-Surgical-Telemetry	Revised	Approved with Revisions	Added in HFNC guidelines, Safety Sitter definition, Standards 7 and 8. Vetted by Clinical Director of Medical Surgical Services and ACNO.
Standards of Basic Nursing Care - ICU	Revised	Approved with Revisions	Revised to provide clarity concerning: Oral care/teeth brushing, equipment use and change, and reassessment standards. Vetted by Critical Care Managers and Directors and ACNO.
Medication Management Process – Parenteral Chemotherapy/Biotherapy	Revised	Approved as Submitted	Updated policy format, simplified name, and added additional definitions and references. Policy updates include: current practice of a non-oncology center; addition of fellow prescribing for non-oncology indications; the updated chemotherapy/biotherapy verification checklist. Vetted by Pharmacy.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Oral Cytotoxic and Antineoplastic Medications	Revised	Approved as Submitted	Simplified name of policy, updated format, and added additional definitions. Content changes include: pharmacist ability to modify a dose/frequency and addition of fellow being able to order for non-oncology indications. Vetted by Pharmacy.
Code White Pathway for ED and Inpatients	Revised	Approved as Submitted	Updated to meet current practice guidelines and to modify monitoring parameters to be in compliance with the stroke surveyor's request for performance improvement. Vetted by Core Team, Stroke Interdisciplinary Members, Dr. Tamer Ammar, Dr. David Obert, ACNO, Radiology, ED, Managers and or Charge nurses of the following units: SICU/NSCU, 3 South, 3 West, PACU, 1400, 1500, CCU/CVCU, CIMC, 2 South, 2 West, 4 North, 4 South, 5 South, 5 North, and TCU.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
AGENDA ITEM

Issue: **Emerging Issues**	**Back-up:**
Petitioner: Patricia Scott, Quality, Patient Safety and Regulatory Officer	
Recommendation: **That the Governing Board Clinical Quality and Professional Affairs Committee identify emerging issues to be addressed by staff or by the Clinical Quality and Professional Affairs Committee at future meetings; and direct staff accordingly. (*For possible action)***	

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
December 2, 2024

Agenda Item #

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