UMC Clinical Quality and Professional Affairs Committee Meeting

Monday, June 3, 2024 2:00 p.m.

UMC Trauma Building - Providence Suite - 5th Floor

AGENDA

University Medical Center of Southern Nevada
UMC GOVERNING BOARD
CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
June 3, 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 April 1, 2024 *(For possible action)*

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

SECTION 2. BUSINESS ITEMS

4. Receive an update on Clinical Research and Institutional Review Board activities from Ron Roemer, Director of Clinical Research and Compliance; and direct staff accordingly. *(For possible action)*

5. Receive an update on the Annual Infection Prevention Program Evaluation and Plan from Kathy Johnson, Director of Infection Prevention; and direct staff accordingly. *(For possible action)*

6. Receive an update on the Quality, Safety, and Regulatory Program 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 April 3 & May 1, 2024 including the recommended creation, revision, and/or retirement of UMC policies and procedures; and take any action deemed appropriate. *(For possible action)*

8. Receive an update on the FY24 Organizational Improvement/CEO Goals from Patty Scott, Quality/Safety/Regulatory Officer; and direct staff accordingly. *(For possible action)*

SECTION 3. EMERGING ISSUES

9. 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).

UMC Providence Conference Room
Trauma Building, 5th Floor
800 Hope Place
Las Vegas, Clark County, Nevada
April 1, 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 2:07 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
Jeff Ellis (WebEx)
Renee Franklin (WebEx)
Steve Weitman (Ex-Officio) (WebEx)

Absent:
None

Also Present:
Tony Marinello, Chief Operating Officer
Patty Scott, Quality, Safety, & Regulatory Officer (WebEx)
Dr. Frederick Lippmann, Chief Medical Officer
Jamie King, Director of Pharmacy
Danita Cohen, Chief Experience Officer
Jeff Castillo, Director of Patient Experience
Jovi Remitio, Director of Patient Experience and Medical Staff Services
Tye Masters, Attorney
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 February 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)*

Item 5 was tabled to be heard at a future meeting.

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

SECTION 2. BUSINESS ITEMS

ITEM NO. 4 Receive an update on Medication Management/Safety including the Antibiotic and Opioid Stewardship Programs from Jamie King, Director of Pharmacy; and direct staff accordingly. *(For possible action)*

DOCUMENT(S) SUBMITTED**:**
- Power Point Presentation

DISCUSSION:

Jamie King, Director of Pharmacy, provided an overview of the activities related to medication management and safety.

Over the past year, the Opioid Stewardship program has been reinitiated. This is a pharmacy-led, multi-disciplinary committee that includes physicians, nurses, IT and Epic staff members, as well as education and quality staff. The team meets every other month and evaluates Joint Commission requirements and recommendations for opioid stewardship and safety. Accomplishments include removal of multiple codeine products from formulary, implemented automatic print of informed consents for opioid medications and education provided by tranquility nurses regarding non-pharmacologic treatment options.

Antimicrobial Stewardship has expanded. Over 5,000 patients have been monitored regularly. Compliance with antimicrobial recommendations has increased to 73%, which has resulted in a significant cost savings. The goal for compliance with antimicrobial recommendations is 75%.

Chairman Mackay asked if there is physician resistance. Ms. King responded that we have a good pharmacy/physician collaboration here at UMC and there has been minimal resistance from physicians.

Pharmacy remodel of the sterile compounding suite was completed in September of 2023. The enhanced suite has a new USP 800 compliant hazardous sterile compounding room, a new USP 797 compliant non-hazardous sterile compounding room, as well as increased air changes per hour, which decreases risk of microbial growth, and an interlocking pass-through system.

Examples of medication safety improvements and best practices include paralytic safety evaluations, creation of epinephrine kits to minimize error-prone processes associated with emergencies, and implemented strategies to decrease alert

fatigue in Epic and analyzed smart-pump soft-limit overrides and evaluated current limits.

Ms. King next reviewed the activities of the Pharmacy Multidisciplinary Workgroups and diversion monitoring.

Lastly, planning is underway to re-open an outpatient pharmacy. This will allow for optimal care for UMC patients, allowing patients to have medications prior to discharge from the hospital.

FINAL ACTION TAKEN:

None

ITEM NO. 5 **Receive an update on Magnet including associated financial costs from Deb Fox, Chief Nursing Officer (CNO); and direct staff accordingly.** ***(For possible action).***

DOCUMENT(S) SUBMITTED**:**
- None

DISCUSSION:

This item was tabled and will be presented at a future meeting.

FINAL ACTION TAKEN:
None

ITEM NO. 6 **Receive an update on the Quality, Safety, Infection Prevention, and Regulatory Program from Patty Scott, Quality/Safety/Regulatory Officer; and direct staff accordingly.** ***(For possible action)***

DOCUMENT(S) SUBMITTED**:**
- Power Point

DISCUSSION:

In patient safety, there were 10 events reported to the state registry in the 4th quarter of 2023. All cases were reported within the required state timeframes and RCA with actions were taken on all cases. Monitoring for sustainment of actions through the hospital safety committee. There was a brief review of the types of injuries reported.

There were a total of 53 grievances in the 3rd and 4th quarters of 2023; 7 were substantiated. By location, there are about 38% in quick and primary care locations, 36% in hospitals, and 26% in emergency locations. The majority of grievances were care team related concerns, followed by attitude/behavior, service delivery and patient concerns. The overall totals of rates per 1000 was .022, which is down from the prior year.

FINAL ACTION TAKEN:
None

ITEM NO. 7 Receive an update on the FY24 Organizational Improvement/CEO Goals from Patty Scott, Quality/Safety/Regulatory Officer; and direct staff accordingly. *(For possible action)*

DOCUMENT(S) SUBMITTED**:**
-Power Point

DISCUSSION:

Ms. Scott reviewed the Quality Performance Objectives for the first through third quarters of FY24.

1. **Improve or sustain improvement from prior year (CY21 / CY22) to meet/exceed state and/or national averages; HAI below national SIR of 1.0.**

   PSI-90 and CAUTI infections measures were lower that prior year and did not meet the national benchmark. The other measures were better than prior year, but are not meeting the national ratio.

2. **Demonstrate implementation and ensure improvement plans are in place (as necessary) for the following Health Care Equity – Social Determinants of Health (SDOH) measures (IP / OP):**

   Screening measures have been implemented and established for all three measures related to the social determinants of health.

3. **Improve or sustain improvement from prior year (CY22 / CY23) for the following patient experience measures (IP / OP):**

   All measures showed improvement over prior year. Physician and nurse communication and staff responsiveness measures still struggle to meet state and national averages.

4. **Demonstrate improvement (utilizing the Star Ratings) from prior calendar year (CY22/CY23) in the overall perception of case/services at UMC Ambulatory Care through the following online review sites**

   This goal is on track. The Google and Yelp scores have remained positive and consistent or improved in both categories.

5. **Improve or sustain improvement as delineated for the following employee engagement measures (IP / OP):**

   All measures have been met with the exception of one, related to developing alternative education on customer service as an adjunct to ICARE principles for clinic setting.

FINAL ACTION TAKEN:

None

ITEM NO. 8 Review and recommend for approval by the Governing Board, the completed Contract Performance Evaluations; and take any action deemed appropriate. ***(For possible action)***

DOCUMENT(S) SUBMITTED**:**
- Contract Performance Evaluations

DISCUSSION:

All contract performance evaluations were completed and all met performance standards.

There was discussion regarding the evaluation criteria and the process of reviewing the contracts to ensure they are compliant.

FINAL ACTION TAKEN:

A motion was made by Member Hobbs to approve that the completed contract evaluations, and recommend for approval to the UMC Governing Board. Motion carried by unanimous vote.

ITEM NO. 9 Review and recommend for approval by the Governing Board, the UMC Policies and Procedures Committee's activities of February 7 and March 6, 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 February 7 and March 6, 2024 were reviewed.

There were a total of 76 approved, 6 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 February 7 and March 6, 2024, and recommend for approval to the UMC Governing Board. Motion carried by unanimous vote.

SECTION 3. EMERGING ISSUES

ITEM NO. 10 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 2:54 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: **Clinical Research Updates**	**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 Clinical Research and Institutional Review Board activities from Ron Roemer, Director of Clinical Research and Compliance; and direct staff accordingly.** ***(For possible action)***	

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
June 3, 2024

Agenda Item #

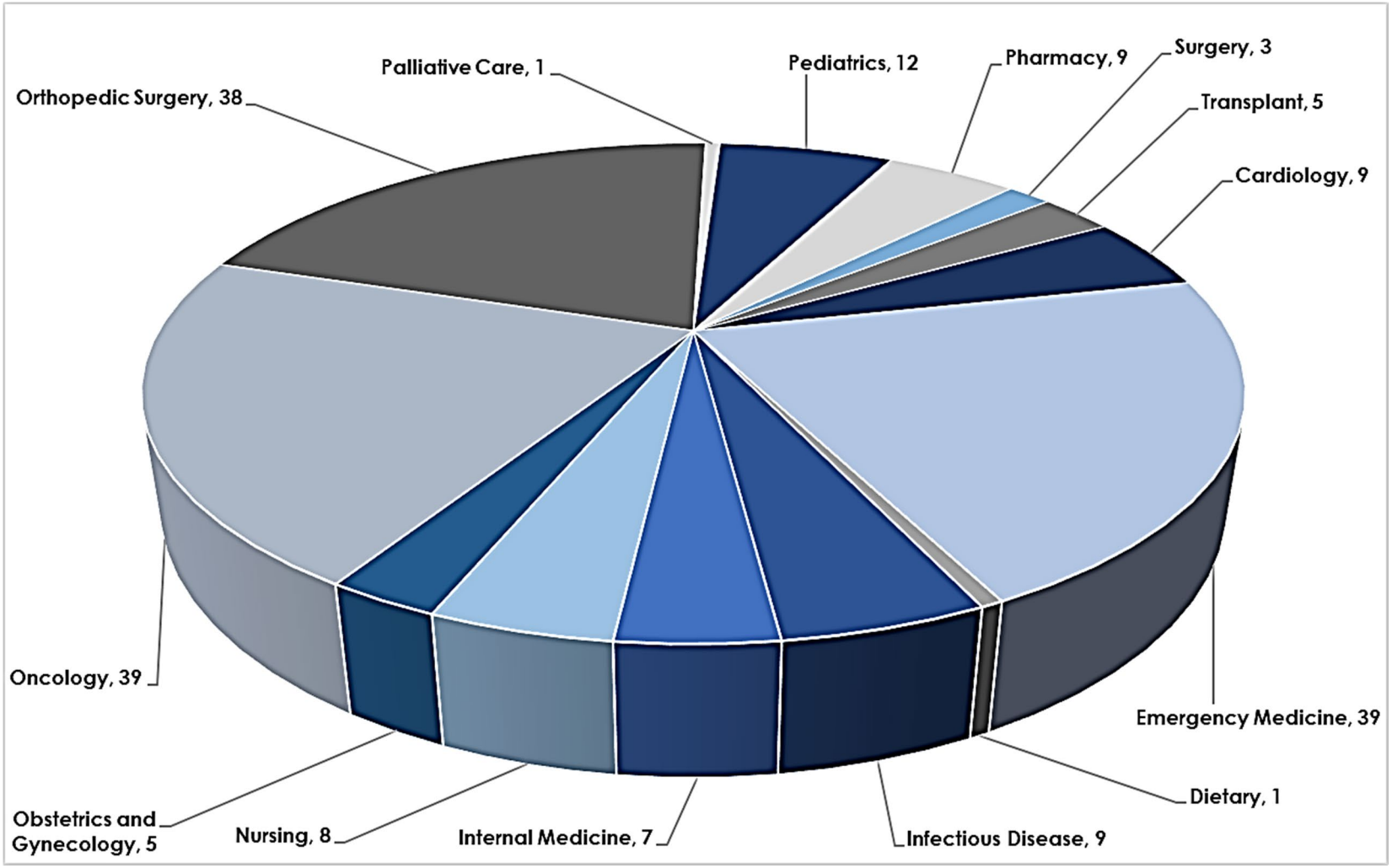
4

Clinical Trials Office

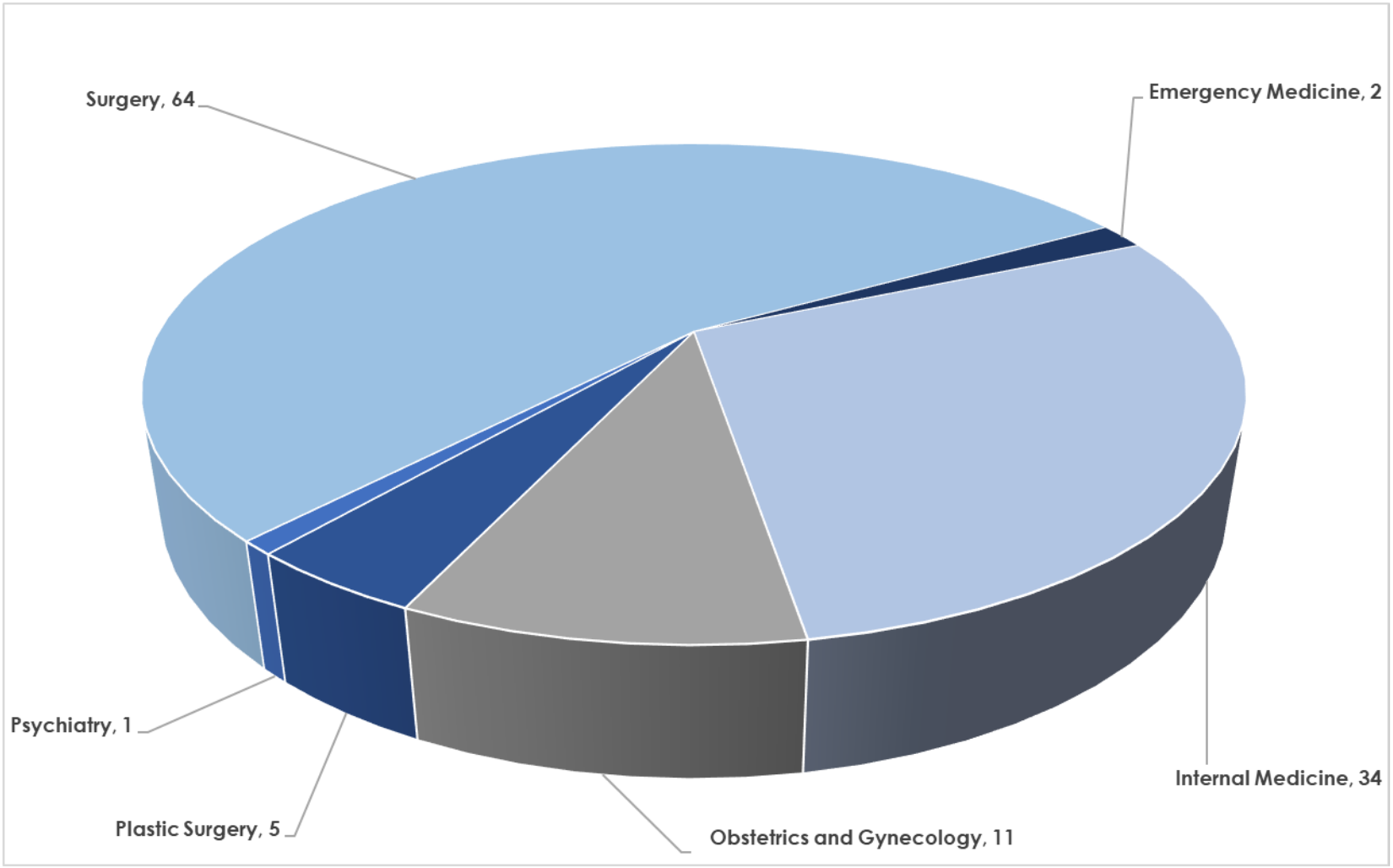
Clinical Research Annual Report
June 2024

CTO and IRB 2023 Data

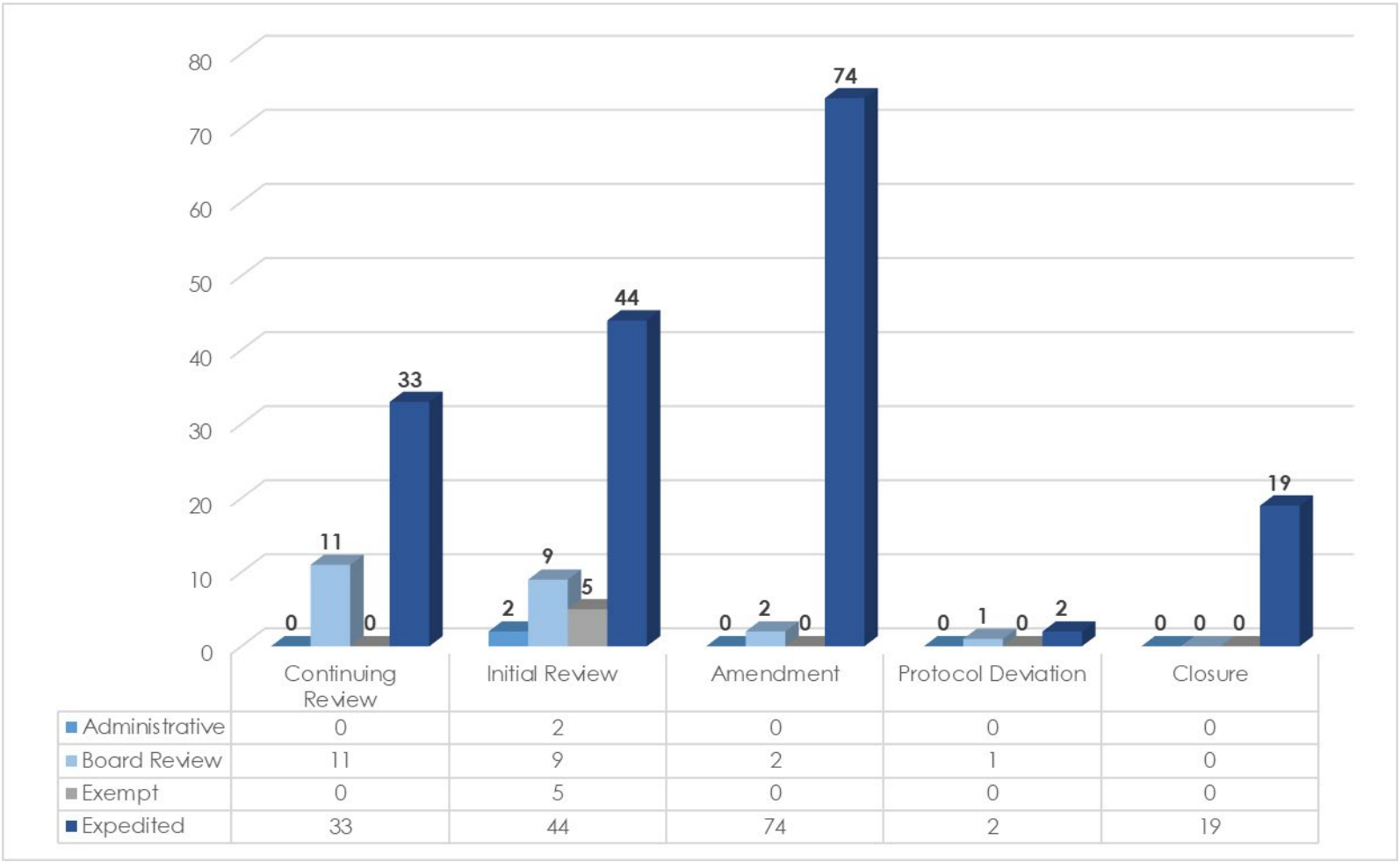
Active IRB Studies by Department UMC



Active IRB Studies by Department UNLV

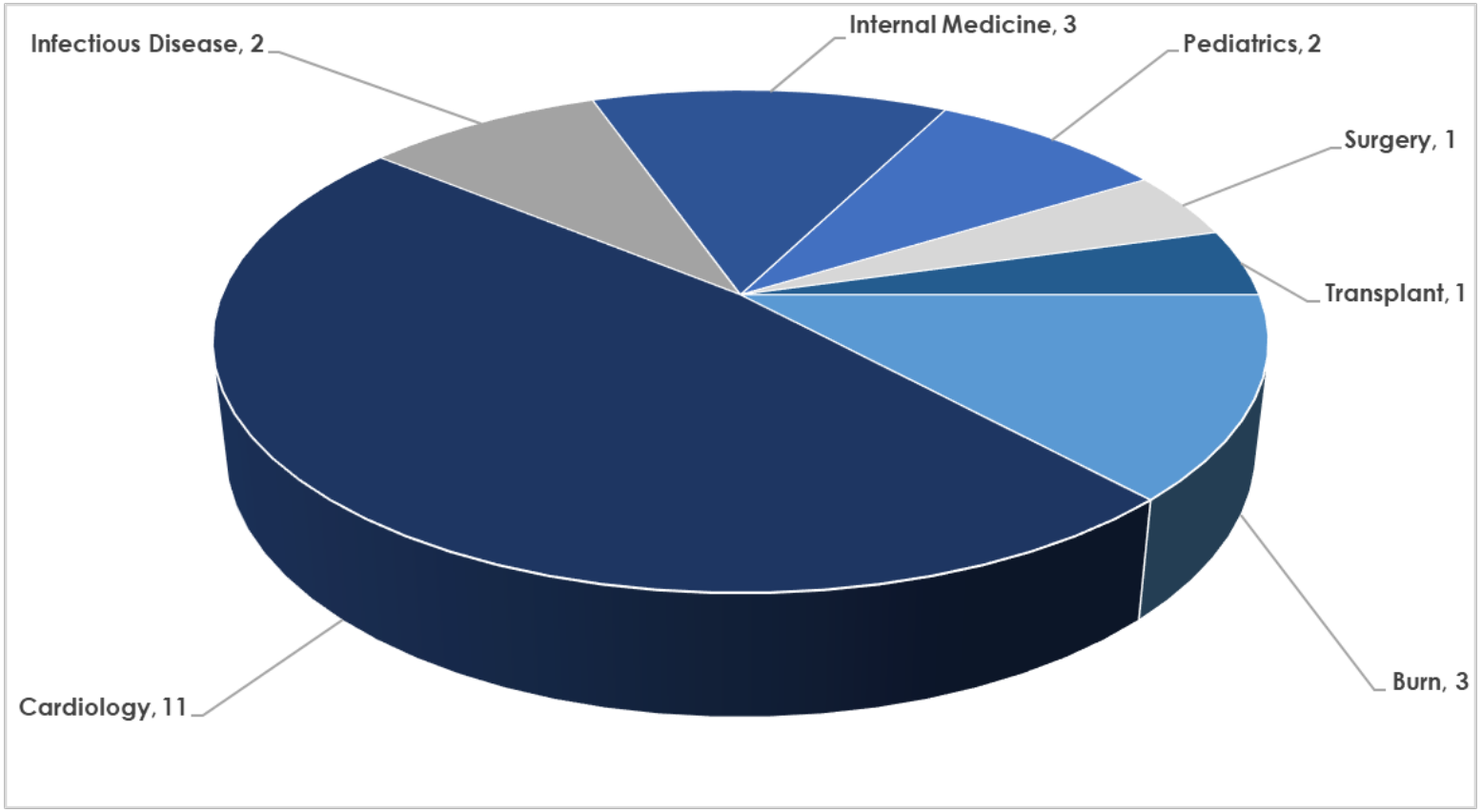


IRB Submission 2023

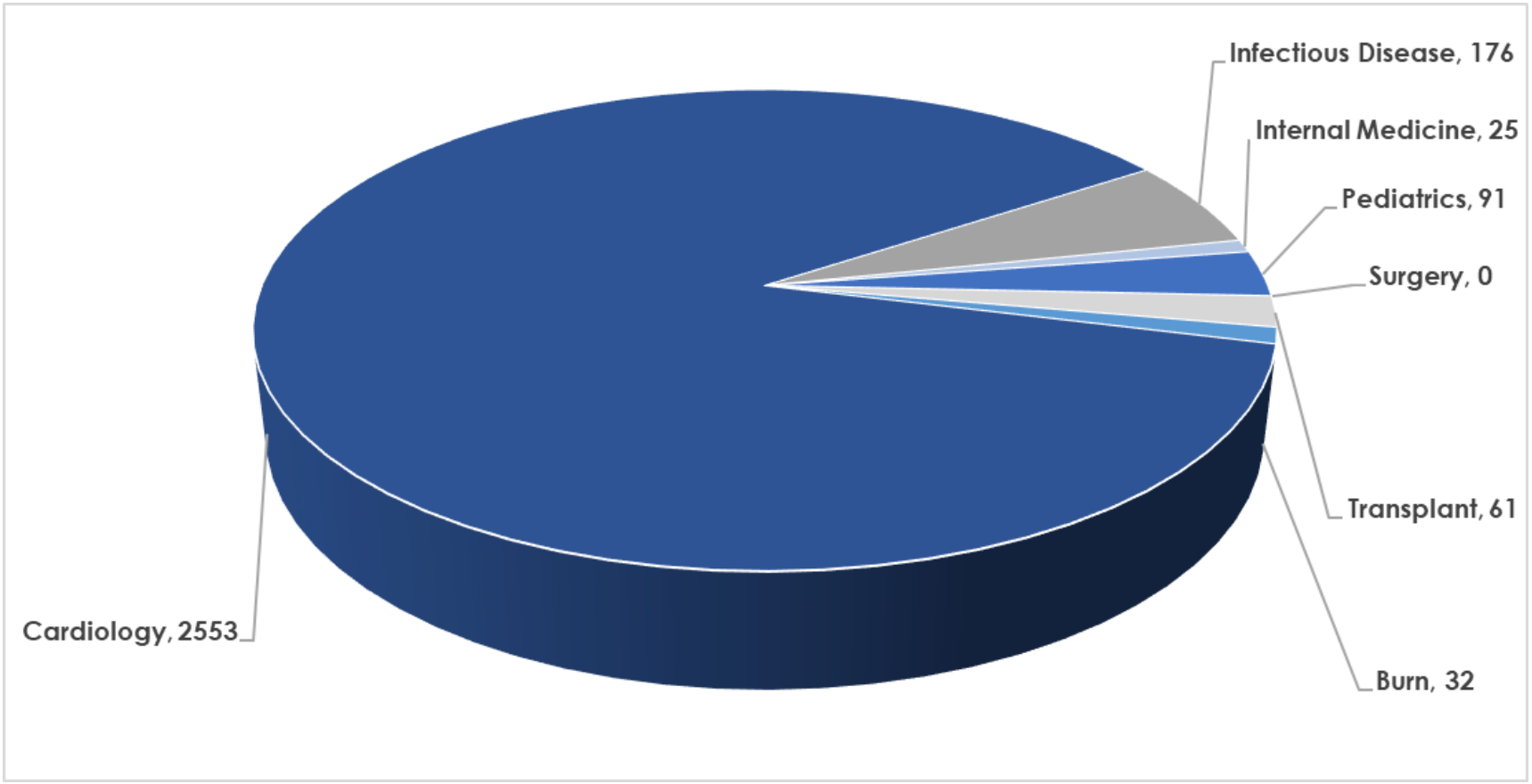


	Continuing Review	Initial Review	Amendment	Protocol Deviation	Closure
Administrative	0	2	0	0	0
Board Review	11	9	2	1	0
Exempt	0	5	0	0	0
Expedited	33	44	74	2	19

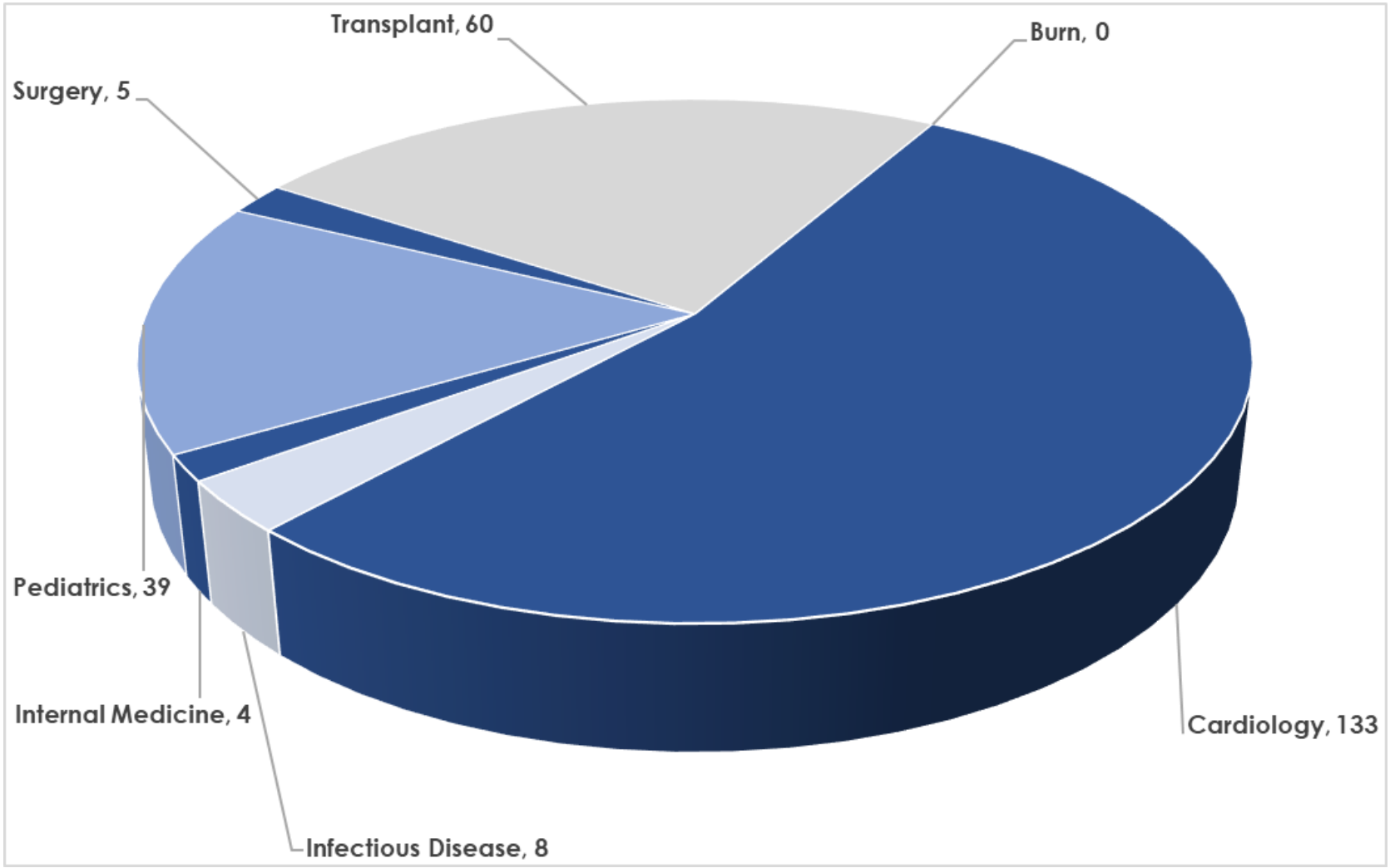
Active CTO Studies by Department



Screening by Department



Enrollment by Department



Current Clinical Trials Status

DISCUSSION / QUESTIONS?

Ronald Roemer
Director Clinical Research and Compliance
Clinical Trials Office and Institutional Review Board
(702) 207-8345

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

Issue:	**Annual Infection Prevention Program Updates**	**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 Annual Infection Prevention Program Evaluation and Plan from Kathy Johnson, Director of Infection Prevention; and direct staff accordingly. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
June 3, 2024

Agenda Item #
5

2023 Infection Prevention Plan Evaluation
2024 Annual Infection Prevention Plan

UMC Governing Board Committee
Clinical Quality & Professional Affairs
June 3, 2024

Purpose of the Plan

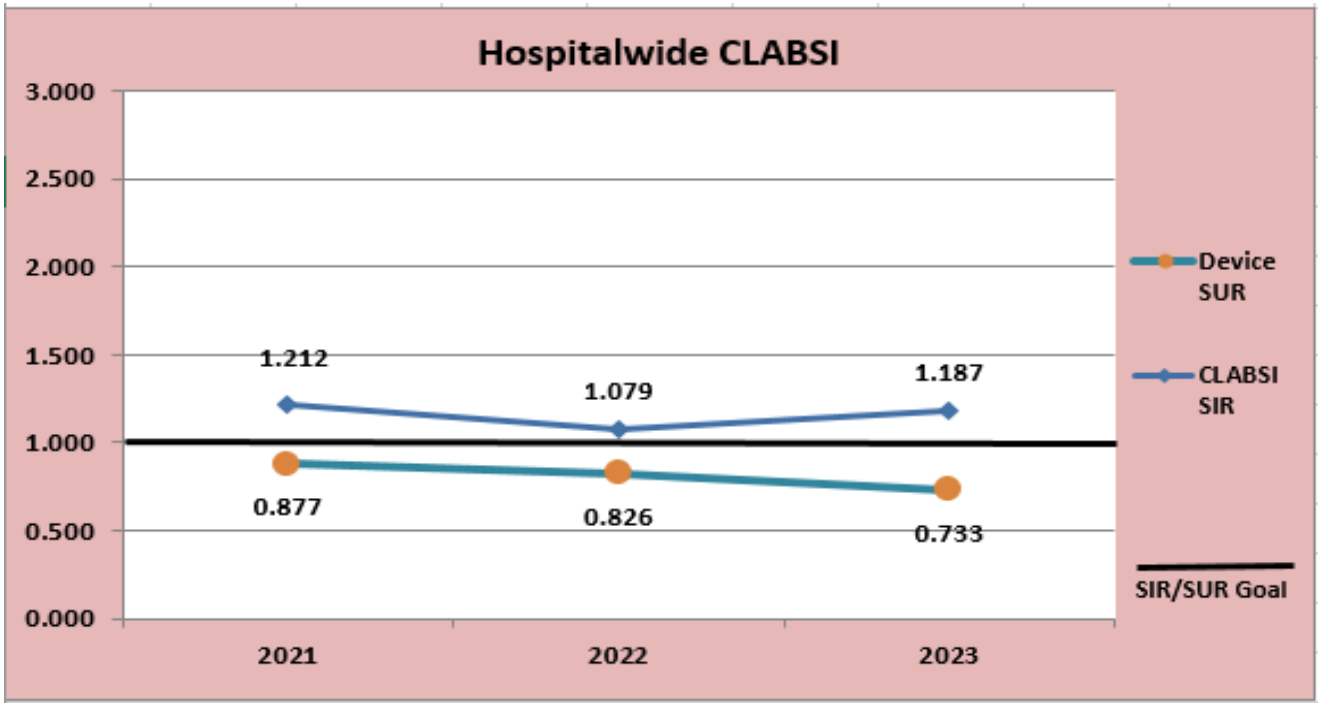
- Provides the framework necessary to reduce the possibility of acquiring or transmitting infection that is specific to the organization's services and population:
  - Outlines yearly goals and actions
  - Defines team composition and roles
  - Collaborates with department leaders to identify opportunities for improvement and implement actions
  - Defines evaluation methods and analyzes infection data for patterns / trends
  - Assesses risk to identify and mitigate infection risk
  - Designs a continuous learning, improvement and system environment

- Designates authority to IP Director and ID Medical Director for oversight of program
- Governs Infection Prevention/Control Committee

2023 Accomplishments

- Improvement in CLABSI events by ↓12 events (SIR 1.187), decrease in CAUTI events by ↓8 events (SIR 1.264) & VAE events ↓36 events SIR (1.547)
- Improvement in all device utilization SIR < 1.000
- Improvement in all device utilization SIR < 1.000 Improvement in SIRS: MRSA SIR (0.919)/ C diff SIR (0.655)
- Increased surveillance and unit prevalence by IP: 178 black light & 64 device audits
- Improvement in hospital vaccination rate 78%
- Annual Fit Testing & PAPR evaluation instituted again for all HCWs
- Infection Control Performance Improvement projects included:
  - Candida auris Education
  - MRSA Nasal and CHG Decolonization in IMCs
  - Continued with causal analysis; action plans and ad hoc committees for device related infections
  - Increase surgical service surveillance

Central Line-Associated Blood Stream Infections (CLABSI)

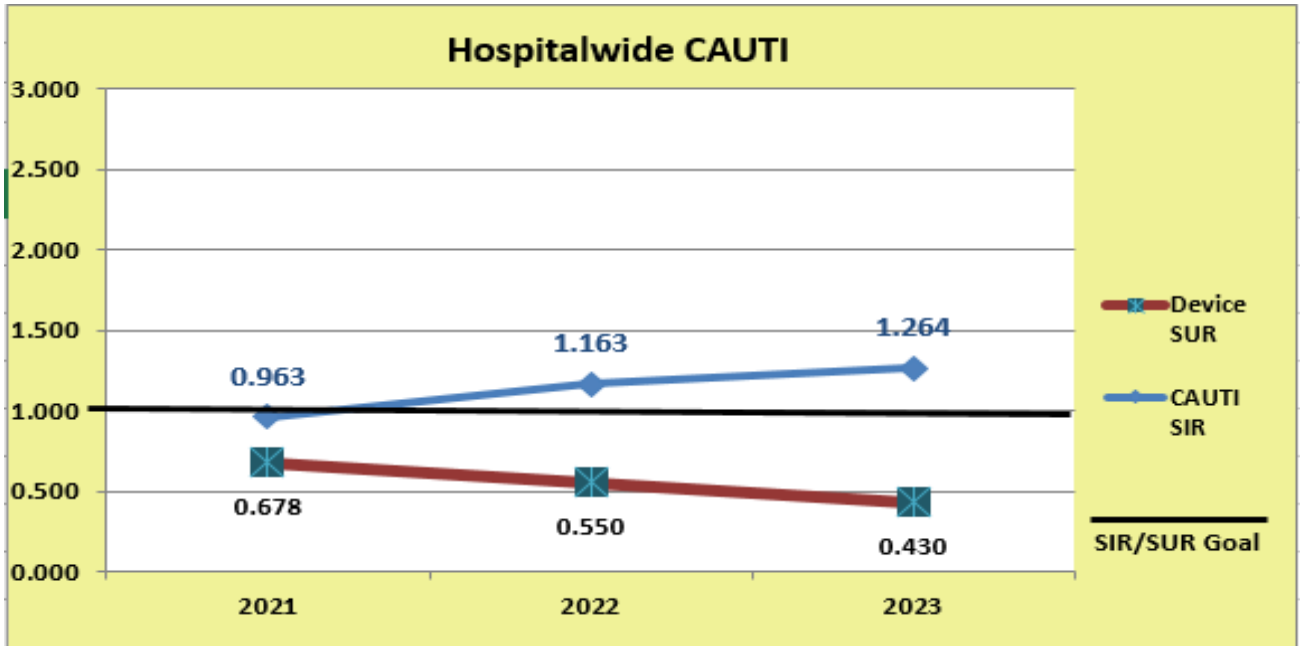


CLABSI Year	Patient Days	Central Line Days	Device Utilization	Device SUR	Total CLABSIs	CLABSI Rate	Expected CLABSIs	CLABSI SIR
2021	159951	36829	23%	0.877	55	1.49	45.372	1.212
2022	172435	35986	21%	0.826	47	1.31	43.556	1.079
2023	158372	27472	17%	0.733	39	1.42	32.844	1.187

CLABSI Reduction Strategies:

- ERAD Device Reduction Task Force
- Timely RCA on device infections with action plans
- Product analysis (swab caps)

Catheter-Associated Urinary Tract Infection (CAUTI)

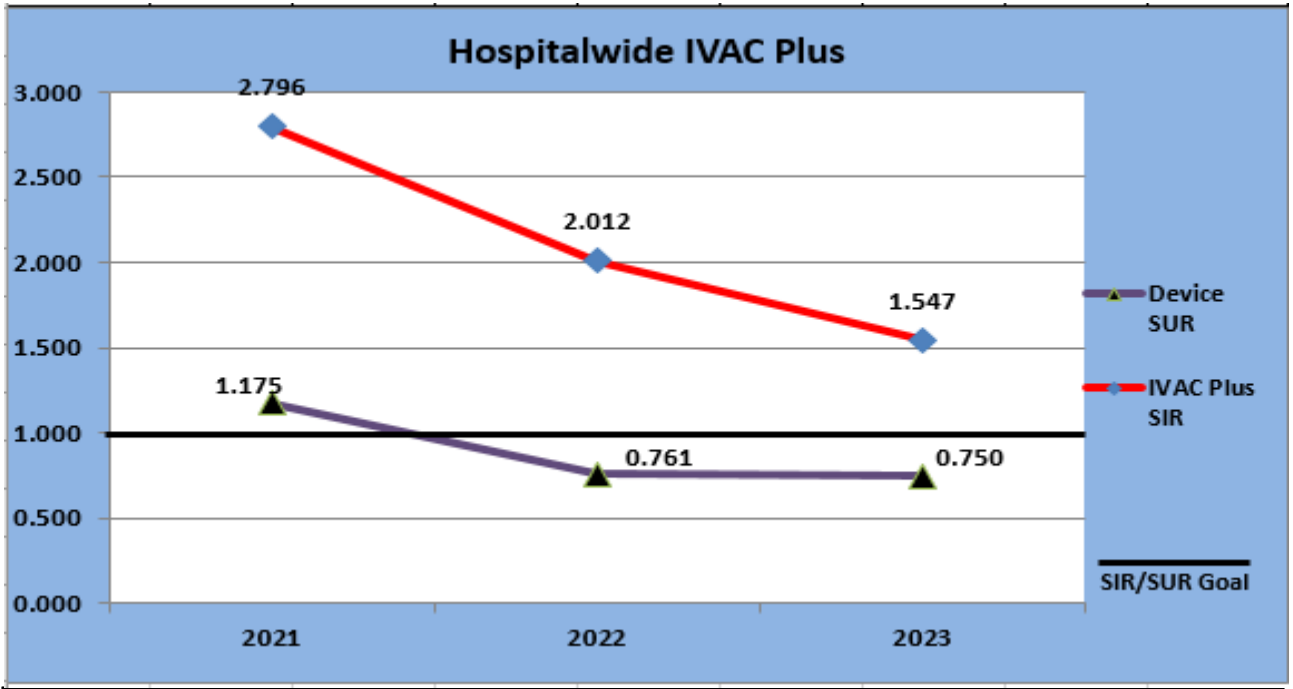


CAUTI Year	Patient Days	Foley Catheter Days	Device Utilization	Device SUR	Total CAUTIs	CAUTI Rate	Expected CAUTIs	CAUTI SIR
2021	154037	23996	16%	0.678	38	1.58	39.452	0.963
2022	165075	20835	13%	0.550	39	1.87	33.546	1.163
2023	152030	15355	10%	0.430	31	2.02	24.519	1.264

CAUTI Reduction Strategies:

- ERAD Device Reduction Task Force
- Timely RCA on device infections with action plans
- Reinforce Nurse Driven Foley Removal Protocol
- Hospital-wide initiative for least restrictive/invasive device

Hospitalwide Ventilator-Associated Complications (IVAC)

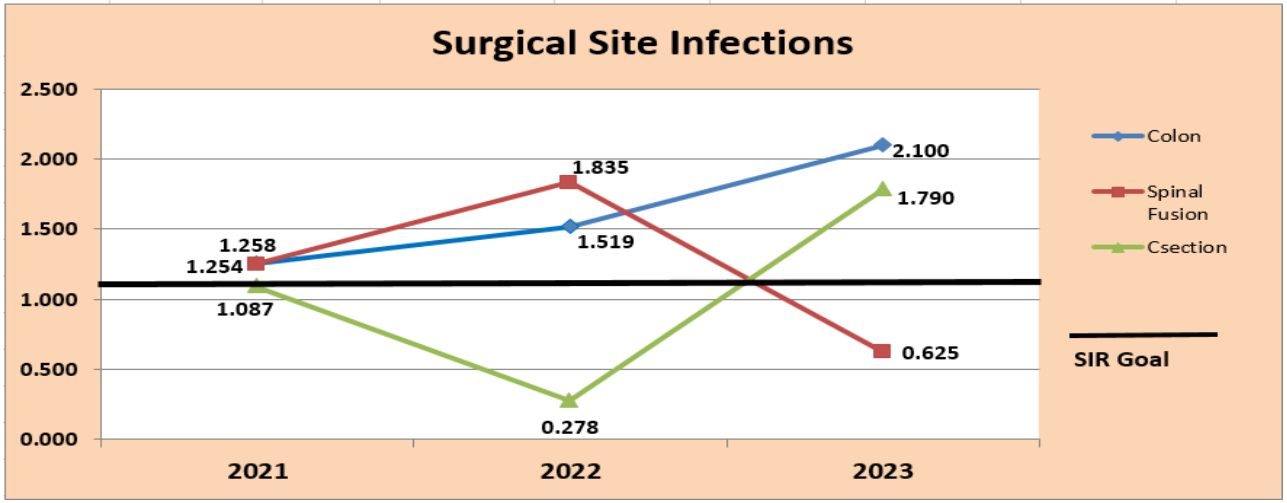


IVAC Plus Year	Patient Days	Ventilator Days	Device Utilization	Device SUR	Total IVAC Plus	IVAC Plus Rate	Expected IVAC Plus	IVAC Plus SIR
2021	144297	16745	12%	1.175	149	8.90	53.298	2.796
2022	154365	12056	8%	0.761	91	7.51	45.222	2.012
2023	143308	11051	8%	0.750	55	4.98	35.557	1.547

IVAC Reduction Strategies:

- Reconvene PI task Force
- Reeducation and Implementation of ABCDEF Bundle
- Timely review of IVAC Infections by Respiratory with RCAs

Surgical Site Infections (SSI)

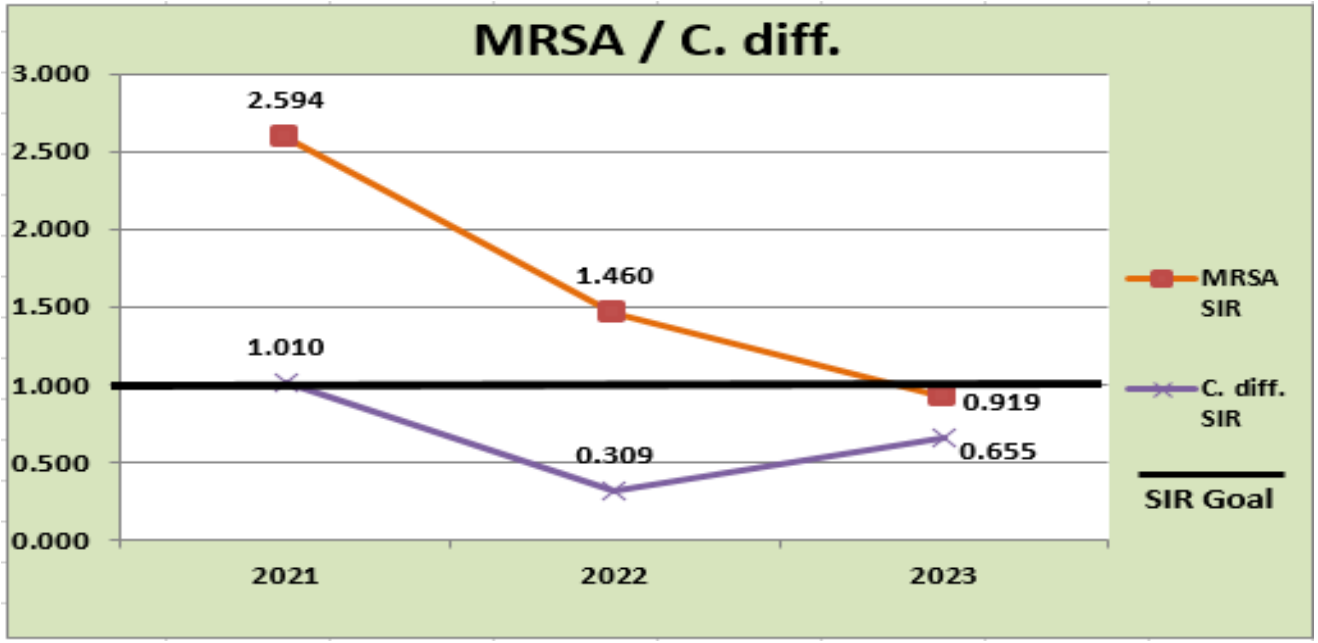


Surgery Type		2021	2022	2023
Colon	Procedures	229	229	193
	Predicted	15.104	16.459	12.86
	Infections	19	25	27
	SIR	1.258	1.519	2.100
C-section	Procedures	335	364	406
	Predicted	3.679	3.593	3.91
	Infections	4	1	7
	SIR	1.087	0.278	1.790
Spinal Fusion	Procedures	220	194	167
	Predicted	3.986	3.271	3.199
	Infections	5	6	2
	SIR	1.254	1.835	0.625

SSI Reduction Strategies:

- Timely review of SSIs and distribution to key stakeholders
- Gap analysis on each SSIs
- SSI task force developed

MRSA & C. diff

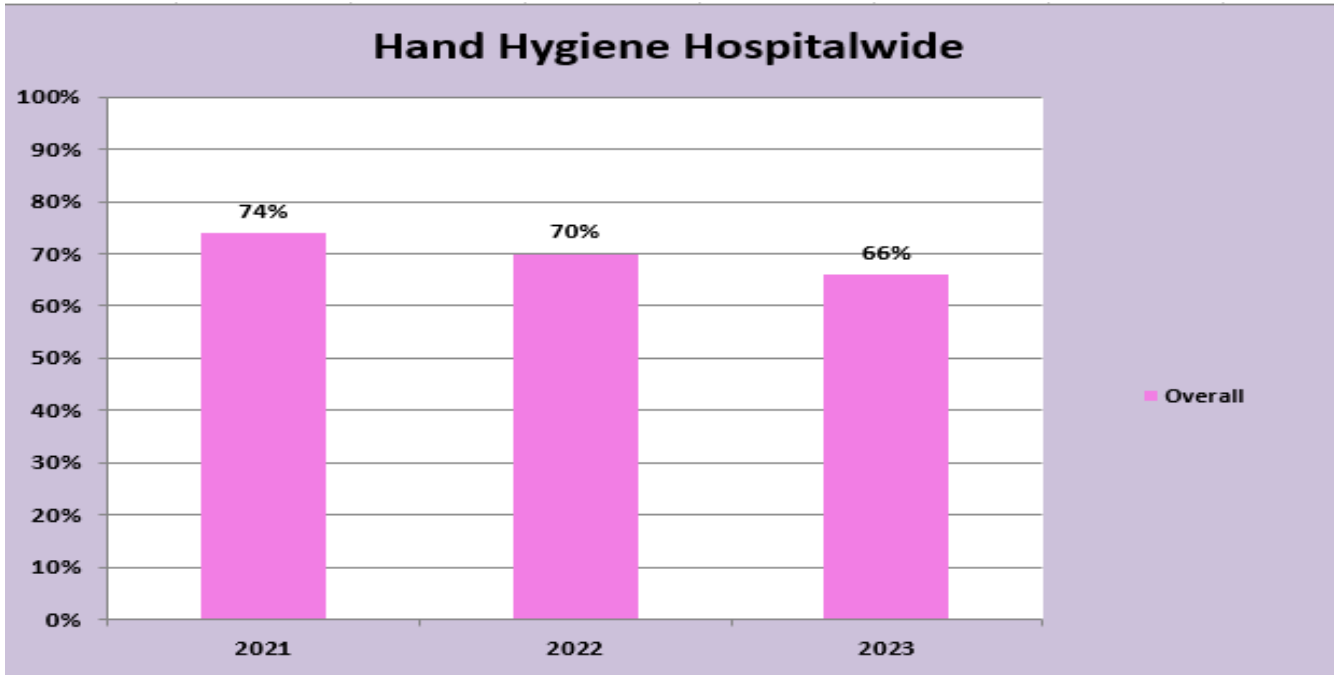


	2021	2022	2023
MRSA Events	28	18	11
MRSA SIR	2.594	1.460	0.919
C. diff Events	107	37	58
C. diff SIR	1.010	0.309	0.655

MRSA & C. diff:

- New C. diff testing protocol infection vs. colonization
- Collaboration continues with EVS Leadership on environmental cleaning protocols and backlight audits
- Drive hand hygiene and PPE compliance

Hand Hygiene Compliance

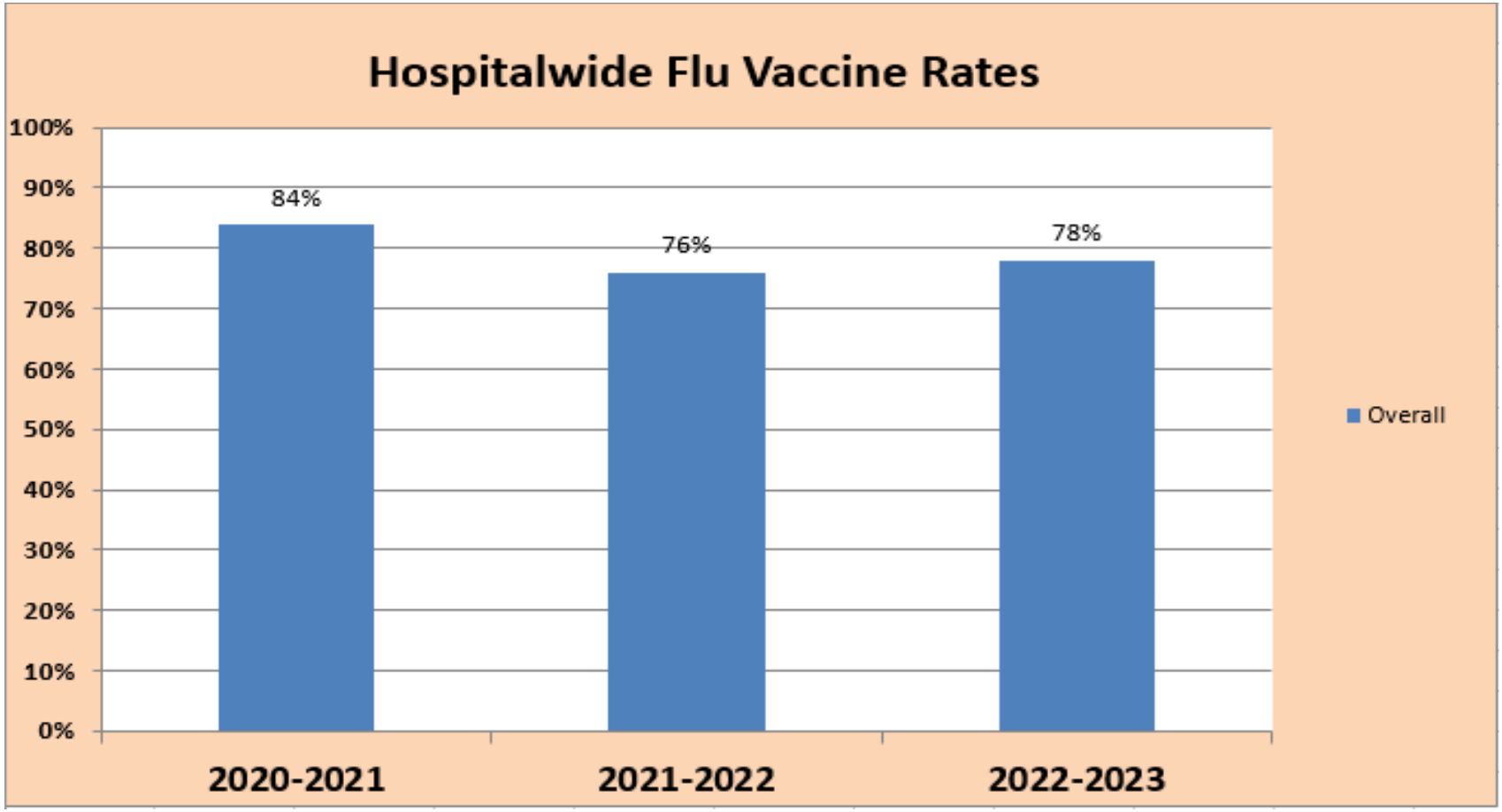


HH Year	Overall Compliance
2021	74%
2022	70%
2023	66%

Hand Hygiene Strategies:

- Increase audits with secret shoppers all units
- Transparency with audits to units and leadership
- Monthly data available for leadership via intranet

Influenza Vaccination Program



Compliance Analysis:

- Mandatory Masking without vaccination
- Flu clinics and nurse volunteers
- Note voluntarily mask use throughout the year

Includes: Employees, LIP, Residents, Students, & Volunteers

2024 Risks, Priorities & Interventions

Community	• Public Health Pandemic & Highly Infections Diseases • Bioterrorism • Candida auris • Long-term Care	• Collaborate with SNHD, CDC & Healthcare Facilities for EBP related to emerging disease with HCW education • Policy update with repetitive verbiage **Identify, Isolate, Inform** • Emergency Preparedness Drills/Ebola Retraining • Surveillance and Screening
Patient	• Device Related Infections • (CLABSI, CAUTI, VENTILATOR) • SSIs • MDRO pathogen	• Timely Surveillance; Just-In-Time Education, Causal Analysis with Unit-based Action Plans • CLABSI/CAUTI Multidisciplinary PI Charters • Antibiotic Stewardship; Personal Protective Equipment (PPE) • EPIC Care Alerts with Timely Isolation & Surveillance • SSI Bundle and Pre-Op bathing, Nasal Decolonization, SSI task force

2024 Risks, Priorities & Interventions

Environmental	• Environmental Cleaning • Infrastructure Failure	• Black Light Surveillance and Just-In-Time Coaching • Construction Rounding with Timely Feedback • Product Evaluation • Multidisciplinary Construction Meeting • Policy Update and Risk Assessments
Healthcare Worker	• Hand Hygiene Compliance • PPE Compliance • Proper Isolation Precautions and Prevention Practices	• Surveillance and Data Transparency • Coaching, Training, Education • Electronic HH monitoring evaluation • Policy update with repetitive verbiage **Identify, Isolate, Inform** • EPIC Care Alerts with timely isolation & surveillance

DISCUSSION / QUESTIONS?

Kathy Johnson BSN, RN, CIC
Director of Infection Prevention & Control and Employee Health
(702) 383-1809

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, 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.

Cleared for Agenda
June 3, 2024

Agenda Item #
6

Quality/Safety/Regulatory Update

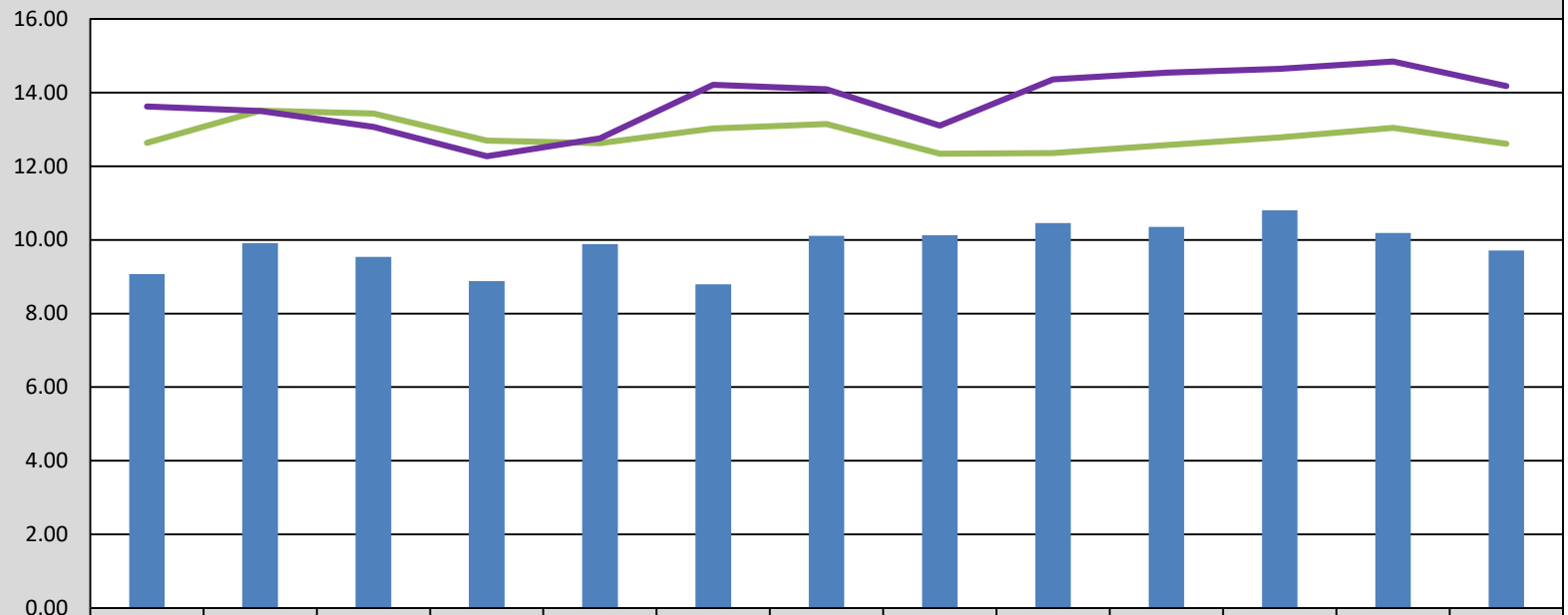
UMC Governing Board Committee

Clinical Quality & Professional Affairs

June 3, 2024

Quality Measures

Readmissions – 30-Day All Cause

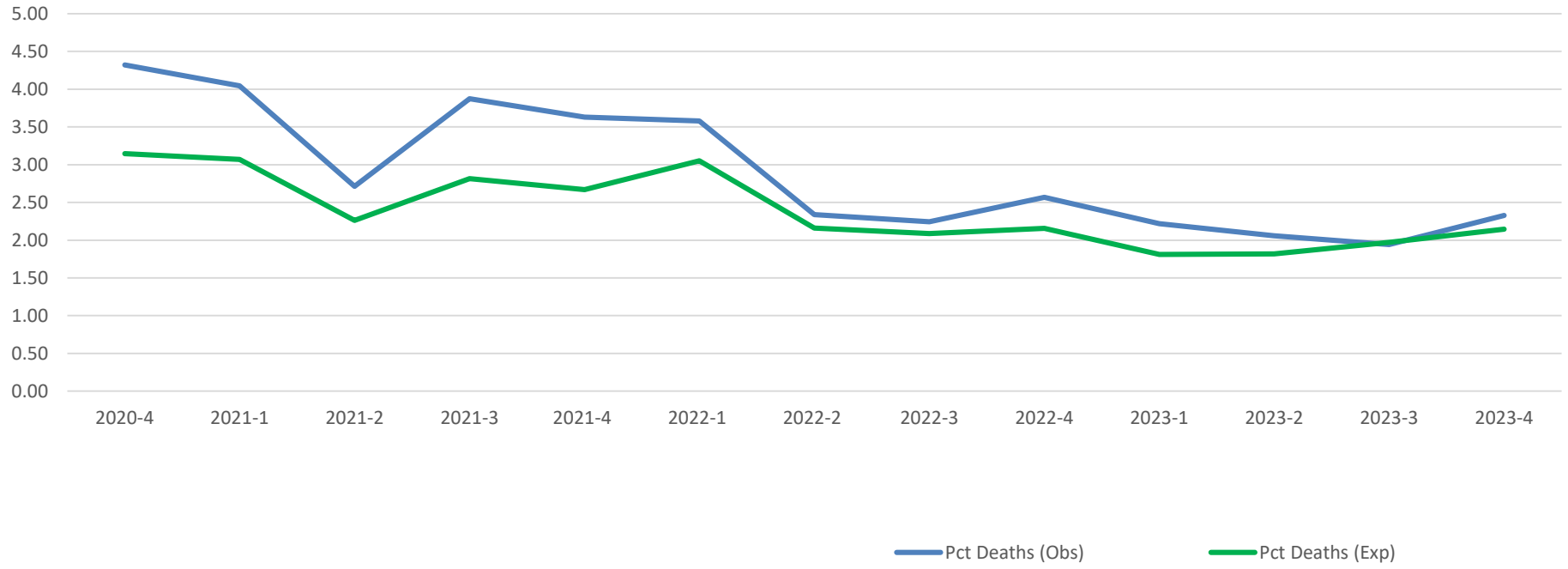


	4Q20	1Q21	2Q21	3Q21	4Q21	1Q22	2Q22	3Q22	4Q22	1Q23	2Q23	3Q23	4Q23
UMC %	9.07	9.92	9.54	8.88	9.88	8.79	10.11	10.13	10.45	10.35	10.80	10.19	9.71
UMC Select Compare	12.63	13.51	13.44	12.70	12.63	13.02	13.15	12.35	12.36	12.58	12.79	13.05	12.61
VVI Select Compare	13.62	13.50	13.07	12.28	12.76	14.22	14.09	13.10	14.36	14.54	14.65	14.84	14.18

- Volume= 431/4438 vs 477/4681, previous quarter, for patients meeting CMS inclusion criteria.
- Overall trend declining in 4th Q 2023.
- National CMS Compare (Medicare), UMC is “SAME”.

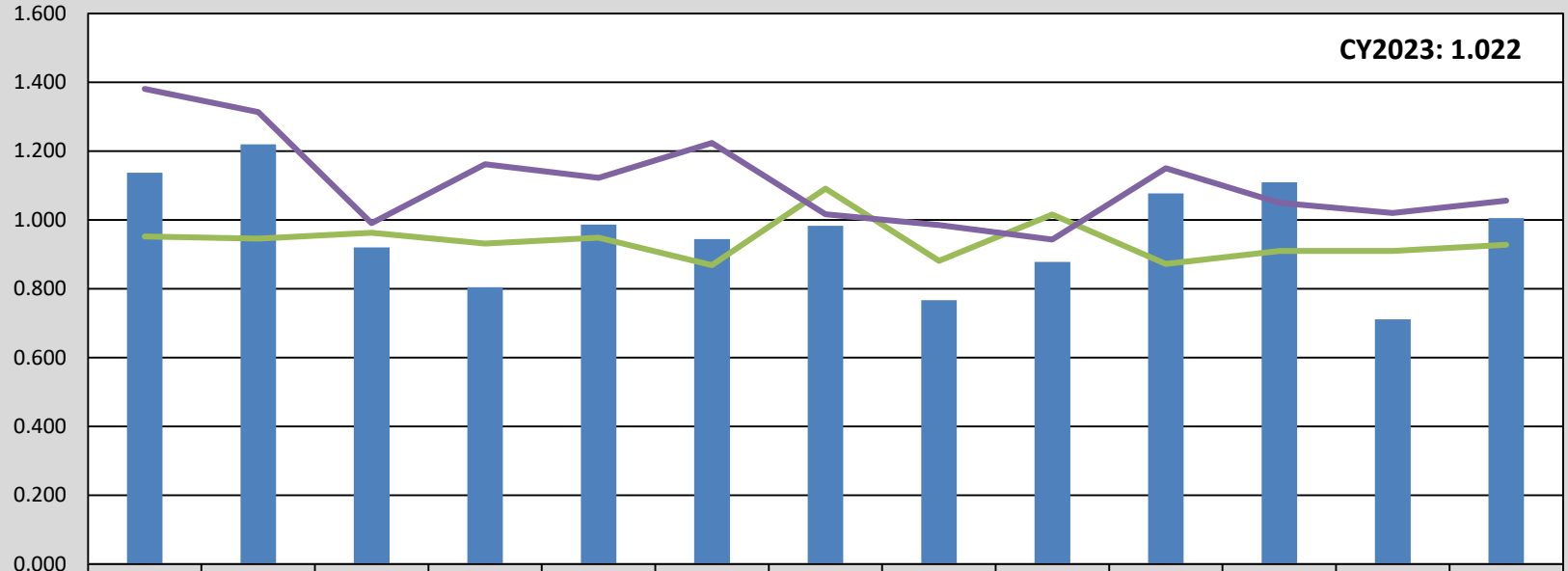
Data Source: Vizient
UMC Select Compare: Cedars-Sinai Health System, LAC+USC Healthcare, UC Davis, UC San Diego, UCSF, Oregon/OHSU, University of Utah Hospitals.
Vulnerable Index Compare (VVI): Emory Saint Joseph Atlanta, Emory University Hospital Atlanta, Harris Health System Houston, Maricopa Health System Phoenix, North Vista, Ochsner Kenner LA, Ochsner New Orleans, Parkland Dallas, Rush University Chicago, St. Joseph Med Center Houston, University Hospital Newark, University of Illinois Chicago.

Mortality Risk Adjusted – Observed / Expected



- Observed / Expected rate converging to close gap with slight uptick 4Q23.
  - ✓ All mortalities are reviewed by CQPS with goal to increase expected mortality by working to improve clinical documentation and coding of ROM / SOI; appropriate admission status.
- Using Vizient 2023 Risk Adjusted Methodology.

PSI – 90 Composite



	4Q20	1Q21	2Q21	3Q21	4Q21	1Q22	2Q22	3Q22	4Q22	1Q23	2Q23	3Q23	4Q23
UMC	1.137	1.220	0.920	0.805	0.987	0.945	0.983	0.767	0.878	1.077	1.110	0.711	1.006
UMC Select Compare	0.952	0.946	0.963	0.932	0.949	0.869	1.091	0.881	1.016	0.872	0.910	0.910	0.928
VVI Select Compare	1.381	1.314	0.991	1.162	1.123	1.224	1.017	0.985	0.943	1.150	1.050	1.020	1.056

PSI-90 (Adult) Composite: PSI-90 is an average of O/E risk adjusted ratio for 10 PSI's:

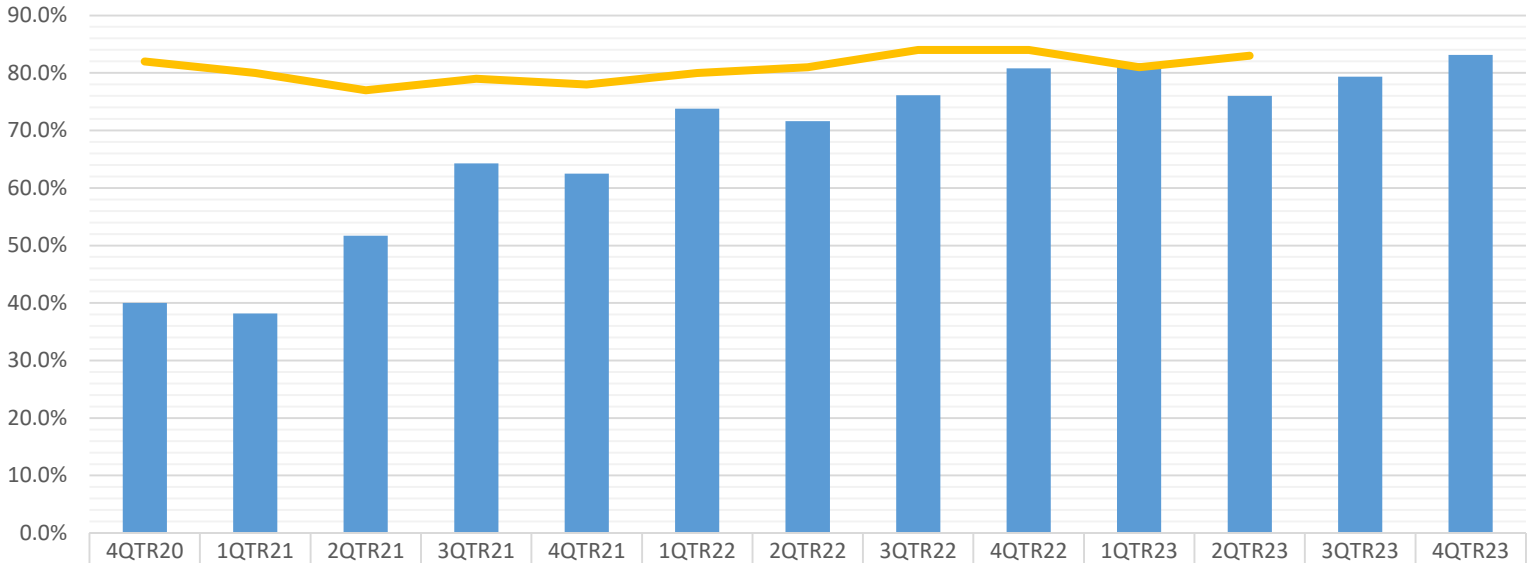
1. PSI-3 Pressure Ulcers (5)
2. PSI-6 Iatrogenic Pneumothorax (5)
3. PSI-8 Fall with Hip Fracture (0)
4. PSI-9 Peri-op Hemorrhage or Hematoma (5)
5. PSI-10 Post-op Acute Kidney Injury Requiring Dialysis/Peri-op Physio-Metabolic Derangement (2)
6. PSI-11 Post-op Respiratory Failure (6)
7. PSI-12 Peri-Op PE/DVT (29)
8. PSI-13 Post-Op Sepsis (6)
9. PSI-14 Post-Op Wound Dehiscence (4)
10. PSI-15 Unrecognized Abdominopelvic Accidental Puncture/Laceration (3)

Data Source: Vizient
UMC Select Compare: Cedars-Sinai Health System, LAC+USC Healthcare, UC Davis, UC San Diego, UCSF, Oregon/OHSU, University of Utah Hospitals
Vulnerable Index Compare (VVI): Emory Saint Joseph Atlanta, Emory University Hospital Atlanta, Harris Health Houston, Maricopa Health System Phoenix, North Vista, Ochsner Kenner LA, Ochsner New Orleans, Parkland Dallas, Rush University Chicago, St. Joseph Med Center Houston, University Hospital Newark, University of Illinois Chicago.

Severe Sepsis / Septic Shock Bundle Compliance

SEP-1 Severe Sepsis/Septic Shock Early Management Bundle

- higher percentage is better

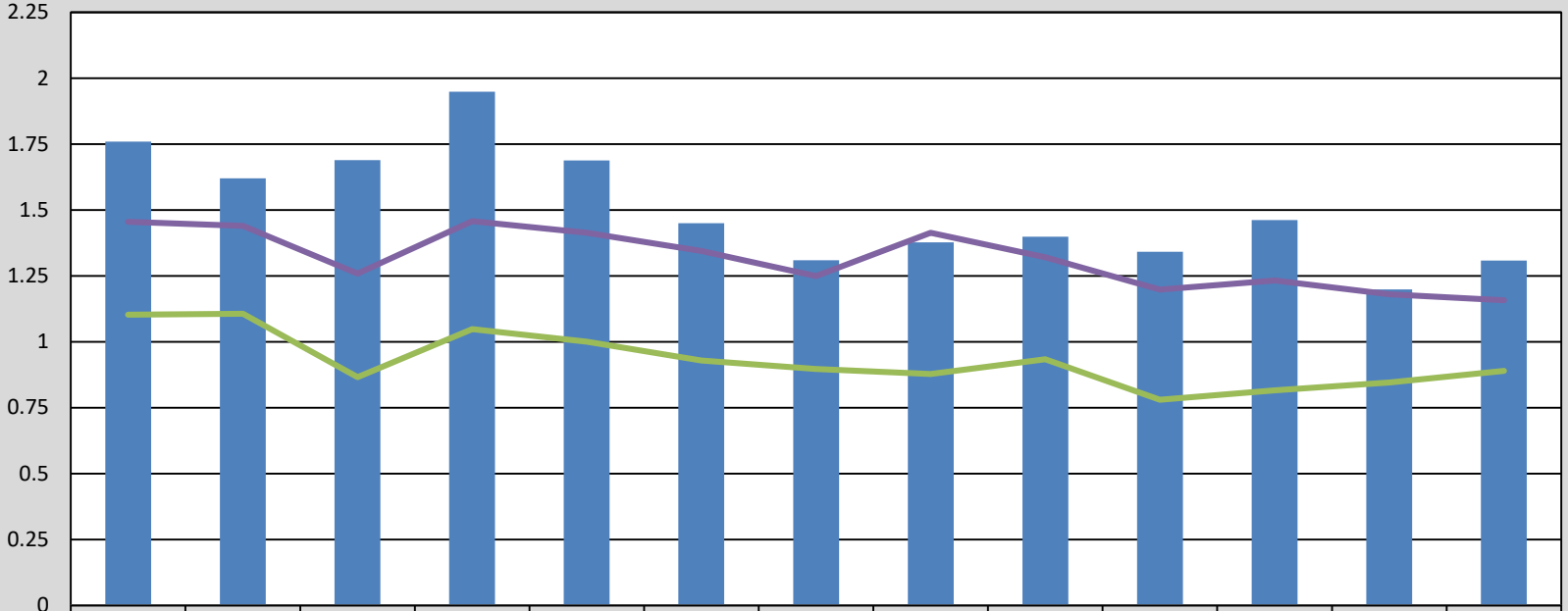


	4QTR20	1QTR21	2QTR21	3QTR21	4QTR21	1QTR22	2QTR22	3QTR22	4QTR22	1QTR23	2QTR23	3QTR23	4QTR23
UMC	40.0%	38.2%	51.7%	64.3%	62.5%	73.8%	71.6%	76.1%	80.8%	81.7%	76.0%	79.4%	83.1%
Vizient Members 90th Pct	82.0%	80.0%	77.0%	79.0%	78.0%	80.0%	81.0%	84.0%	84.0%	81.0%	83.0%		

Actions:

- Code Sepsis Guideline and Lactic Acid Protocol updated February, 2023
- Feedback to clinical staff when Sepsis Screening Panel is not utilized
- RN New Hire Orientation (408 through December, 2023)
- Critical Care New Grad presentation April and September, 2023
- ED Resident presentation August, 2023
- Sound IP Physician presentation November, 2023

Sepsis Mortality Index



	4Q20	1Q21	2Q21	3Q21	4Q21	1Q22	2Q22	3Q22	4Q22	1Q23	2Q23	3Q23	4Q23
UMC	1.76	1.62	1.69	1.95	1.69	1.45	1.31	1.38	1.40	1.34	1.46	1.20	1.31
UMC Select Compare	1.10	1.11	0.87	1.05	1.00	0.93	0.90	0.88	0.93	0.78	0.82	0.85	0.89
VVI Select Compare	1.46	1.44	1.26	1.46	1.41	1.34	1.25	1.41	1.32	1.20	1.23	1.18	1.16

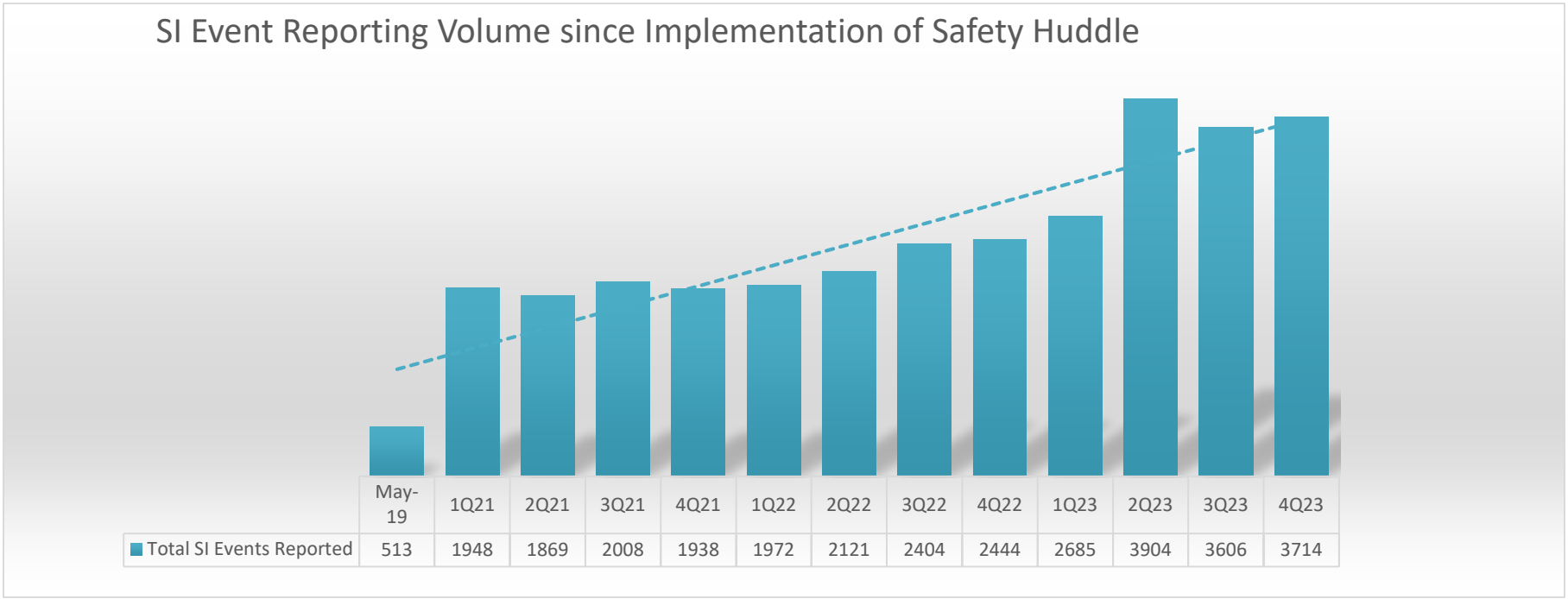
- Sepsis mortality increased, 52 from 55, an increase in mortality index, 1.31 from 1.20.
- Inpatient discharges in 4Q23 decreased by 179 patients from prior quarter (6236 3Q23 vs 6057 4Q23) with sepsis cases increasing from 445 to 466
- UMC % of risk-adjusted sepsis mortalities: expected 9.02% / observed 11.80%. Mortality Index = Obs /Exp deaths

Patient Safety

Promoting a Culture of Quality/Safety - 2023

Promoting a culture of quality, safety, accountability, and reliability:

- 36% increase in safety intelligence (SI) reporting
- 44% increase in the reporting of near misses
- Culture of Safety survey score improvement from 3.64 (2021) to 3.67 (2023)



State Reported Safety Events – 2023

- 33 events reported
- All cases reported within required State timeframes
- RCA with actions taken on all cases
- Monitoring for sustainment through Hospital Quality/Safety Committee

Event	2022	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total	Comments
Fall with Injury	4	1	2	1	2	6	Adult ED-1; 1500-2; 4N-1; 2W-1; 1400-1
Pressure Injury - 3/4/Unstage	37	10	2	5	6	23	CCU/CVCU-5; MICU-2; TICU-2; 4S-1; 1400-2; 5S-3; BCU-2; 3W-3; OR-1; NSCU/SICU-2
Retained Foreign Object	1					0	
Wrong Side Surgery/Procedure	0				1	1	OR
Medication Error	0					0	
Assault	1		1			1	2S
Homicide	1					0	
Device Failure	1					0	
Burn	1	1			1	2	OR; Perinatal
TOTAL	**46**	12	5	6	10	**33**	

Leapfrog Patient Safety Grade – Spring 2024

Safety Grade Release Date	Score	Letter Grade
Spring 2024	2.8708	C
Fall 2023	3.0796	B
Spring 2023	3.0978	B
Fall 2022	2.8115	C
Spring 2022	2.7593	C
Fall 2021	2.5619	C
Spring 2021	2.5016	D

THE LEAPFROG GROUP
Giant Leaps for Patient Safety

LEAPFROG
HOSPITAL
SAFETY GRADE

Regulatory

Policies & Procedures

Regulatory; Policy/Procedures

- Regulatory / Accreditation Surveys

- Policy / Procedure Approval
  - Timeframe: April 3, 2024 & May 1, 2024
  - Total approved: 71
  - Total retired: 6
  - Approved through Hospital P/P, Quality, MEC

DISCUSSION / QUESTIONS?

Patricia Scott, MSNA, BSN, RN, RHIA, CPHQ, CCDS, CPHRM, CLSSBB
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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 April 3 & May 1, 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
June 3, 2024

Agenda Item #
7

April 3, 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 34 Approved, 4 Retired

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Procedural Sedation: Moderate and Deep	Revised	Approved with Revisions	Separated order for procedure from sedation medications. Added wording per updated practice guidelines regarding IV access, recognition of apnea and airway obstruction, recommendation for supplemental oxygen on all patients unless contraindicated, re-ordered patient monitoring for improved flow and focus, changed capnography to "recommended," updated post-procedure monitoring language, added "Post Procedural Assessment" to match EPIC documentation requirements, remove "Discharge Criteria from Sedation" scale, replaced with Modified Aldrete scale to match EPIC documentation, added ASA classification and reassessment immediately before procedure to Focused H&P documentation requirements, updated references to most current, removed outdated references. Vetted by Perioperative Services Director, ACNO and Medical Director of Anesthesia.
Reporting Adverse Medical Device Incidents	New	Approved as Submitted	New policy/procedure based upon Code of Federal Regulations. Includes notification, removal and securement, investigation, and reporting of adverse medical devices. Vetted by CQPS.
Chain of Command: Communication of Care Concerns	Revised	Approved as Submitted	Updated to current template; revised outdated policy/procedure to current clinical and operational standards/practice. Vetted by CQPS.
Informed Consent	Revised	Approved as Submitted	Replaced Physician with Licensed Practitioner where applicable. Updated references. Added definitions. Made grammatical edits and revisions to flow of P/P in coordination with Nevada law. Vetted by Quality, Patient Safety, & Regulatory Officer and Legal.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Advance Directive for Health Care	Revised	Approved with Revisions	Placed on updated template. Reordered flow and processes contained within the document. Updated references. Made formatting and grammatical changes. Reviewed against current patient handbook/information to ensure consistency. Vetted by Quality, Patient Safety, & Regulatory Officer & Legal.
Neonatal Intensive Care Unit Nursing Standards of Care/Practice Guidelines	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by NICU Clinical Manager, NICU Charge nurses and Dr. Banfro.
Pediatric Anticoagulation Reversal	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Trauma Manager and ACNO.
Intake & Output, Recording of, for Pediatric Patients	Revised	Approved as Submitted	New Template, updated information and reference. Vetted by Pediatric Department.
Operating Room Block Management	Revised	Approved as Submitted	Policy Name change. Separation of content for a focused policy/guideline. Addition and update references. Vetted by Dr. Carmen Flores, Dr. Anderson Hu and Director of Perioperative Services.
Operating Room Case Scheduling	New	Approved as Submitted	New policy. Vetted by Director of Peri-Operative Service and CNO.
Transmissible Spongiform Encephalopathies (TSE) Specifically Creutzfeldt-Jakob Disease (CJD)	Revised	Approved as Submitted	Updated to new template. Scheduled review, no changes. Vetted by Perioperative Services Manager and ACNO.
Universal Protocol for Surgical and Non-Surgical Invasive Procedures	Revised	Approved with Revisions	Scheduled review, no changes. Vetted by Perioperative Services Director and ACNO.
Internal/External Disaster Plan for Surgery	Revised	Approved with Revisions	Updated to new template. Scheduled review, no changes. Vetted by Perioperative Services Manager and ACNO.
Perioperative Fire/Disaster Evacuation Plan	Revised	Approved as Submitted	Updated to new template. Scheduled review, no changes. Vetted by Perioperative Services Manager.
Linen Resource	Revised	Approved as Submitted	Updated to new template. Scheduled review, no changes. Vetted by Director of EVS, Director of Infection Control, and Executive Director of Support Services.
Routine Storage and Disposal of Trash	Revised	Approved as Submitted	Update product information from Sani Pak machine to Sterilizer. Vetted by Director of EVS,

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
			Director of Infection Prevention, and Executive Director of Support Services.
Cleaning Instructions-Neonatal Warmer	New	Approved as Submitted	New procedure. Vetted by EVS and Infection Prevention.
Controlled Substances: Witness/Chain-of-Custody Validation Requirements	Revised	Approved as Submitted	Added situations that require a witness, added requirement for immediate waste with some exceptions, clarified that authorized witnesses will have privileges in the ADC. Vetted by Director of Pharmacy and ACNO.
Miscellaneous Medication Monitoring	Revised	Approved as Submitted	Placed in new template. Added darbepoetin to the policy with updated hold parameters. Vetted by Pharmacy.
Stress Ulcer Prophylaxis Stewardship	New	Approved as Submitted	New protocol. Vetted by Pharmacy.
Medication Management: Ordering and Verification	Revised	Approved as Submitted	Changed aminoglycoside auto-stop from 7 days to 2 days. Vetted by Pharmacy.
Patient's Personal Medications – Storage and Use	Revised	Approved as Submitted	Added administration of patient supplied cabotegravir/rilpivirine (cabenuva) at Wellness clinic. Vetted by Pharmacy.
Guidelines for Burn and Anesthesia	Revised	Approved as Submitted	Changed verbiage in Scope and Purpose to include anesthesia providers and burn patients. Vetted by Burn Program and ACNO.
Ryan White Clinical Quality Management (CQM) Policy and Procedures	New	Approved as Submitted	New policy. Vetted by Wellness.
Utilization of Epic Secure Chat Messaging Tool	New	Approved with Revisions	New policy/procedure. Vetted by Nursing, IT, Compliance/Privacy and CQPS.
Utilization Management Plan	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Care Management and CFO.
Obstetrical (OB) Hemorrhage/Code Crimson	Revised	Approved with Revisions	Updated to reflect current Evidence-based practice. Created algorithm C and updated other appendices. Vetted by Chairman of OBGYN Department, Director – Maternal/Child Division, Blood Bank Supervisor, Public Safety/PBX and Trauma.
Guideline for CORTRAK Enteral Feeding System Use in the Pediatric Population	Revised	Approved as Submitted	Placed in Policy Template Format—no changes to policy. Vetted by

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Guideline for Enteral Feeding Access System (Cortrak) in the Adult Critical Care Units	Revised	Approved as Submitted	Placed on policy template, removed procedural equipment and general procedure explanation. Vetted by Critical Care Committee.
Transcutaneous Blood Gas Monitoring (TCM)	New	Approved as Submitted	New policy. Developed from specific Sentec information and Lippincott information that did not conflict or contradict Sentec user information. Staff will be educated using read and sign method.
Adult Nursing Lactic Acid Protocol Order for Early Sepsis Identification	Revised	Approved as Submitted	New Format, corrected grammar/punctuation. Approved order to "Per protocol, co-signature not required." Vetted by Critical Care Committee and ACNO.
Urinary Bladder: Indwelling Catheter - Insertion, Care & Maintenance of; Intermittent Catheterization; Bladder Scanner Use	Revised	Approved as Submitted	Updated to 2022 SHEA/IDSA standards. Updated voiding times to 4- 6 hours instead of every 6. Vetted by Director of Infection Prevention and ACNO.
Tobacco/Smoke Free Facility	Revised	Approved as Submitted	Scheduled review, no changes. Updated to new template.
Restraints	Revised	Approved as Submitted	Updated to add "corporal punishment" as an exclusion for use of restraints in order to meet TJC standards. Vetted by CQPS.

May 1, 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 37 Approved, 2 Retired

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Use of Verbal and/or Telephone Orders	Revised	Approved as Submitted	Added existing P/P to new P/P template differentiating policy from procedure. Made language and sentence structure edits. Added references. Changed manual and owner of P/P.
Patient Rights and Responsibilities	Revised	Approved as Submitted	Updated scope and references, minor grammatical changes. Vetted by Quality/Safety/Regulatory Officer.
Informed Consent	Revised	Approved with Revisions	Replaced Physician with Licensed Practitioner where applicable. Updated references. Added definitions. Made grammatical edits and revisions to flow of P/P in coordination with Nevada law. Vetted by Quality, Safety, & Regulatory Officer and Legal.
Fresenius - Hemodialysis Policies for Contracted Services - Memo	Revised	Approved as Submitted	Updated 2024 Fresenius contract memo.
Potassium Infusion for the Pediatric Patient	Revised	Approved with Revisions	Scheduled review. Added max hourly doses for potassium. Replaced MD with Licensed Practitioner. Vetted by Pharmacy and Pediatric Department.
Central Line Vascular Access Device - Adult		Approved as Submitted	Updated to 2024 standards; added disinfection cap; minor grammar changes; added measurement requirement. Continuous tubing changed to 7 days. Updated Implanted Port section: Table 1 Flushing and Medication Administration: at least 10ml flush; De-accessing an Implanted Port for spelling correction under number 7; leaking From Site/Port: updated policy under number 4.

			Updated reference number 2.
Employee Health Services	Revised	Approved as Submitted	Revisions and Changes made to the following: Certification of Good Health; Latent TB Confidential Reporting; Tdap requirements. Clarified 2 step requirements. Updated accommodation section. Vetted by Director of Infection Prevention.
Active Surveillance Testing	Revised	Approved as Submitted	Added Candida auris screening protocol. Policy name change to Active Surveillance Testing. Vetted by Director of Infection Prevention.
Merchandise Returns/ Repairs Through Supply Chain/Purchasing	Revised	Approved as Submitted	Placed on new template. Minimal updates for current process and formatting. Vetted by Supply Chain Services.
Coding – Continuing Education (CE) Accumulation	New	Approved as Submitted	New guideline. Vetted by HIM Director.
Security Management Plan	Revised	Approved as Submitted	Minor changes. Reviewed and approved by EOC Committee.
Utility Systems Management Plan	Revised	Approved as Submitted	Minor changes. Reviewed and approved by EOC Committee.
Hazardous Materials and Waste Management Plan	Revised	Approved with Revisions	Minor changes. Reviewed and approved by EOC Committee.
Safety Management Plan	Revised	Approved as Submitted	Minor changes. Reviewed and approved by EOC Committee.
2023 Safety Management Plan Evaluation	Revised	Approved as Submitted	Minor changes. Reviewed and approved by EOC Committee.
Emergency Preparedness Management Plan	Revised	Approved as Submitted	Revisions made to document are based on Joint Commission standards change. Reviewed and approved by EOC Committee.
Environment of Care	Revised	Approved as Submitted	Minor changes to verbiage. Reviewed and approved by EOC Committee.
Inspection, Testing, and Maintenance of Portable Fire Extinguishers	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Safety Manager and EOC Committee.
Medical Equipment Management Plan	Revised	Approved as Submitted	Updated 2024 Medical Equipment Management Plan with removal of Risk Manager and addition of Center for Quality

			and Patient Safety. Vetted by Safety Program Manager, EOC Committee.
Guidelines for In-line One-Way Speaking Valve Application for Tracheostomy on the Ventilator	New	Approved as Submitted	New guideline. Vetted by Respiratory therapy, Pulmonology, ENT and Trauma.
Methemoglobinemia Guideline	Revised	Approved with Revisions	Updated nitrate/nitrite examples and corrected duplicate nitrate error. Vetted by Burn Program Manager and Dr. Saquib.
Burn Activation Guideline	Revised	Approved as Submitted	Added "The Trauma Emergency Medicine attending or designee will notify the on-call burn attending of the transfer" to the Inter-Facility Transfer section. Vetted by Burn Program Manager and Dr. Saquib.
Management of Drug Shortages	Revised	Approved as Submitted	Updated to new template, added purpose statement, changed to policy. Vetted by Pharmacy.
Adult Pharmacist Anticoagulation Protocol	Revised	Approved as Submitted	Scheduled review. No changes. Vetted by Pharmacy Director.
Medication Reconciliation	Revised	Approved as Submitted	Removed Med Action Plan from transplant section due to being phased out; moved to new template; minor grammatical changes for clarity. Vetted by Director of Pharmacy.
Return/Destruction of Outdated Pharmaceuticals	Revised	Approved as Submitted	Scheduled review; moved to new template; added definitions; removed extraneous language. Vetted by Director of Pharmacy.
Medication Formulary Systems	Revised	Approved as Submitted	Scheduled review; moved to new template; Minor modifications to verbiage and formatting to enhance clarity. Vetted by Director of Pharmacy.
Pharmaceutical Research Studies	Revised	Approved as Submitted	Removal of pharmacy requirement for checking for consent, clarification of destruction process. Vetted by Director of Pharmacy.
Intrathecal Preparation	Revised	Approved as Submitted	Added reference to following USP 800 Standards. Vetted by Pharmacy Department.
Outpatient Admittance	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Director of Imaging Services.
HIPAA Privacy Compliance Documentation (Retention)	Revised	Approved as Submitted	Minor formatting changes. No changes to content. Vetted by Privacy Officer.

Adult Whole Blood Massive Transfusion Guideline	New	Approved with Revisions	New guideline. Vetted by Dr. Knoblock, Dr. McNickle, Dr. Dugan, Dr. Kuhls, Liliana Leelo, Joyce Dobard, Steve Ingerson, Elizabeth Erb-Ryan, and Lisa Rogge.
Administration of Blood and Blood Products	Revised	Approved as Submitted	Added adult female trauma patients greater than or equal to 50 years of age can receive LTOWB. Vetted by Transfusion Safety Committee and Trauma Program Manager.
Blood Transfusion Guidelines, Adult	Revised	Approved as Submitted	Added adult female trauma patients greater than or equal to 50 years of age can receive LTOWB. Vetted by Transfusion Safety Committee and Trauma Program Manager.
Interfacility Transfer of Trauma Patients	Revised	Approved as Submitted	Updated to include "Chief of the appropriate UMC Medical Staff" for evaluation per MEC recommendation.
RD (Registered Dietitian) Auth – Adult Patient	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Clinical Nutrition Manager and Executive Director, Support Services.
Respiratory – Airway Cuff Pressure (Inflation, Monitoring & Deflation)	Revised	Approved as Submitted	Updated to new template. No substantive changes. Included language for minimum leak technique and minimum occlusion volume. Updated reference material to research document published within past five years. Vetted by Director of Respiratory Services.

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

Issue: **FY24 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 FY24 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 FY24.

Cleared for Agenda
June 3, 2024

Agenda Item #
8

Quality Performance Objectives – FY24

Approved by Governing Board

Quality Performance Objective

FY24 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement in the following **quality/safety measures** from prior year (CY22/ CY23) to meet/exceed state and/or national averages; HAI below national SIR of 1.0

Measure	1Q22 – 4Q22	1Q23 – 4Q23	Benchmark	Prior Year and Benchmark Met
PSI-90: Patient Safety & Adverse Events Composite** ↓	0.883	1.022	1	− −
HAI-1: Central Line Bloodstream Infections (CLABSI) ↓	1.060	1.075	1	− −
HAI-2: Catheter Urinary Tract Infections (CAUTI) ↓	1.134	1.31	1	− −
HAI–3: SSI Colon Surgery ↓	2.081	2.103	1	− −
Pressure injuries (stage 3/4/unstageable) reported to State Registry (reported as defined by NV State / AHRQ)* ↓	37	23	N/A	+ +

↓ Lower is better. + Goal Met − Goal Not Met ⊘ No Published Benchmark

Data Source: PSI-90 and Overall Mortality – Vizient Clinical Database; HAIs – CMS NHSN; Pressure Injuries – State Registry. **PSI-90 using AHRQ Version 2023. National benchmarks from most recent April 2024 CMS Hospital Compare Preview Report.
CMS National and State Benchmark will exclude 1Q2020 and 2Q2020 data due to COVID Pandemic for VBP purposes. Pressure injuries: * = Rate / 100

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.

Quality Performance Objective

FY24 Clinical Quality & Professional Affairs Committee

Demonstrate implementation and ensure improvement plans are in place (as necessary) for the following **Health Care Equity – Social Determinants of Health (SDOH)** measures (IP / OP)

Measure	1Q22 – 4Q22	1Q23 – 4Q23	Epic/Medisolv/Plan Implementation Met	Improvement Plans In Place
SDOH 1 – Inpatients screened for SDOH	N/A	N/A	Yes	• Epic and Medisolv SDOH Modules Implemented. • Mapping of reported data is complete.
SDOH 2 – Inpatients identified as having ≥ 1 social risk factors	N/A	N/A	Yes	
Identify & develop plan for improvement in 1 measure within the SDOH domain as defined by TJC NPSG-16 (PCP) • Patient's screened for transportation needs / Total Visits • Decrease in "No Show" rate in PCP Clinics	12% 11212/90259	12% 14266/115657	Yes	• Obtained and reviewing contract with Lyft. • Increased patient awareness / education on transportation opportunities.

Quality Performance Objective

FY24 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement from prior year (CY22 / CY23) for the following **patient experience** measures (IP / OP)

Measure	1Q22 – 4Q22	1Q23 – 4Q23	*CMS State	*CMS National	Prior Year/Benchmark Met
*Communication with Nurses: Hospital IP	69.8	71.9	75	79	+ − −
Listen/Courtesy from Nurses/Assist: PC	90.8	91.6			+ ⊘ ⊘
Listen/Courtesy from Nurses/Assist: QC	67.9	74.3			+ ⊘ ⊘
*Communication with Doctors: Hospital IP	71.9	73.7	74	80	+ − −
Communication with Provider: PC	89.2	90.1			+ ⊘ ⊘
Listen/Courtesy from Care Provider: QC	64.3	70.5			+ ⊘ ⊘
Responsiveness of Staff (IP)	56.5	58.6	65	66	+ − −
Responsiveness of Staff (PC)	91.7	93.2			+ ⊘ ⊘
Responsiveness of Staff (QC)	65.2	69.8			+ ⊘ ⊘

↑ Higher is better. + Goal Met − Goal Not Met ⊘ No Published Benchmark

Data Source: HCAHPS Measures by Service Date - Press Ganey; Employee Recognition – Various UMC Recognition Programs.
*State and National benchmarks from most recent April 2024 CMS Hospital Compare Preview Report. CMS National and State Benchmark will exclude 1Q2020 and 2Q2020 data due to COVID Pandemic for VBP purposes.

Quality Performance Objective

FY24 Clinical Quality & Professional Affairs Committee

Demonstrate improvement (utilizing the Star Ratings) from prior calendar year (CY22/CY23) in the overall **perception of case/services at UMC Ambulatory Care** on the following online review sites

Measure	1Q22 – 4Q22	1Q23 – 4Q23	UMC Goal Met
Google ↑	4.1 431	4.1 299	✚
Yelp ↑	3.7 156	4.2 162	✚

↑ Higher is better. ✚ Goal Met ▬ Goal Not Met ⊘ No Published Benchmark

Date Source: UMC Experience Department, Yelp and Google websites. Average Star Score and Total Reviews during time period.

Quality Performance Objective

FY24 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement as delineated for the following **employee engagement** measures (IP / OP)

Measure	Goal Met
Develop alternative education on customer service as an adjunct to ICARE principles for clinic setting. Educate each clinic by end of FY24.	In Progress
Extract and present Patient Experience survey data with comments for all disciplines/departments. Data and reports will be placed on the manager dashboard for all leaders to have easy access, as well as accessible on the UMC intranet. Data will be completed and updated for FY23/24.	Yes
Develop a plan to optimize utilization of the middle information desk for use as a social area celebrating EOM, awards, raffles, & prizes by end of FY24.	Yes
Develop and implement 1 new initiative to celebrate employees optimizing patient experience and quality/safety by end of FY24.	Yes
Develop and initiate plan to educate ICARE principles and HCAHPS for PRN employees and residents by end of FY24.	Yes

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: **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
June 3, 2024

Agenda Item #
9