# UMC Clinical Quality and Professional Affairs Committee Meeting

Monday, February 2, 2026 2:00 p.m.

Delta Point Building - Emerald Conference Room - 1st Floor

Las Vegas, NV

# AGENDA

**University Medical Center of Southern Nevada**
UMC GOVERNING BOARD
CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
February 2, 2026 2:00 p.m.
901 Rancho Lane, Las Vegas, Nevada
Delta Point Building, Emerald Conference Room (1st 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 901 Rancho Lane, Las Vegas, NV.**

- 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 December 16, 2025. *(For possible action)*

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

## SECTION 2. BUSINESS ITEMS

4. Receive an update on the Quality, Safety, and Regulatory Program from Patty Scott, Quality/Safety/Regulatory Officer; and direct staff accordingly. (For possible action).

5. Review and recommend for approval by the Governing Board, the UMC Policies and Procedures Committee's activities of December 3, 2025 and January 7, 2026 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

6. 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***
***December 16, 2025***

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Sapphire Conference Room
Delta Point Building, 1st Floor
901 S. Rancho Lane
Las Vegas, Clark County, Nevada
December 16, 2025 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 2:05 p.m. by Chair Renee Franklin and the following members were present, which constituted a quorum of the members thereof:

## CALL TO ORDER

Board Members:

Present:
Renee Franklin, Chair
Laura Lopez-Hobbs
Dr. Don Mackay

Absent:
None

Also Present:
Tony Marinello, Chief Operating Officer
Patty Scott, Quality, Safety, & Regulatory Officer
Deb Fox, Chief Nursing Officer
Ronald Roemer, Dir. of Clinical Research & Compliance
Susan Pitz, General Counsel
Stephanie Ceccarelli, Board Secretary

## SECTION 1. OPENING CEREMONIES

### ITEM NO. 1 PUBLIC COMMENT

Chair Franklin 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 October 6, 2025. *(For possible action)*

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

**SECTION 2. BUSINESS ITEMS**

**ITEM NO. 4: Receive an update from Ronald Roemer, Director of Clinical Research & Compliance regarding the Clinical Trials and Institutional Review Board activities at UMC; and direct staff accordingly. (For possible action)**

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

DISCUSSION:

Mr. Roemer provided the 2025 annual review of the activities of the Institutional Review Board and Clinical Trials Office at UMC. In total there are 311 active studies currently being conducted. There are approximately 180 active IRB studies by department being conducted at UMC. The top studies are orthopedics and emergency medicine. He noted that interventional radiology and cardiology studies are a focus and this year, the IRB partnered with the NIH StrokeNet for research studies to advance stroke treatment. There are 131 active studies with UNLV; the top studies are in surgery and internal medicine. Over 157 types of submissions were reviewed and processed during the year.

Indirect costs are the expenses of doing business that are not readily identified with a specific grant, contract, or project. In February 2025, the federal indirect rate was cut to 15%. Previously, the rate was between 25% to 70%, therefore this cut has had a direct impact on research institutions. A discussion ensued regarding the fixed versus negotiated rates and funding of clinical research projects.

UMC's indirect rate is 30% for the federally funded research projects and industry sponsored research. Currently, there has been no direct impact to research at UMC. A discussion continued regarding research funding and progress.

FINAL ACTION TAKEN:

None

**ITEM NO. 5 Receive an update from Patty Scott, Quality/Safety Regulatory Officer on the FY26 Organizational Performance Goals; and direct staff accordingly. (For possible action)**

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

DISCUSSION:

Ms. Scott provided an update on the FY26 Organizational goals.

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

Progress is being made to develop and implement an electronic monitoring system for hand hygiene compliance. A vendor has been selected and will be onsite to implement the pilot program. Hand hygiene continues to show improvement since the last report. A discussion ensued regarding the feedback received from staff regarding the new hand hygiene program. The Committee will be monitoring this goal closely for compliance.

2. **Improve or sustain improvement over the last three (3) year trending period or remain under the national index of 1.0 for the following inpatient quality/safety measures:**

   Three of the five measures have shown improvement over previous reporting time frames. Teams are working on the two measures that did not show improvement.

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

   PSI90 and ED median arrival time measures met or maintained the established goals. A lengthy discussion followed about improving processes and the progress made in streamlining patient care in the quick care and primary care settings.

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

   Two of the three inpatient experience measures were met. Responsiveness of staff is being monitored for improvement.

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

   The four outpatient experience measures are being met. Communication with the provider is being monitored for improvement.

6. **Develop, implement, and execute plans/campaigns to support and improve the following performance goals/programs during FY26:** These measures remain in progress.

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 October 1, 2025 and November 5, 2025, 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 October 1, 2025 and November 5, 2025 were reviewed.

There were a total of 84 approved, 0 were retired. All were approved through the hospital Policy and Procedures Committee, Hospital Quality and Safety Committee and the Medical Executive Committee.

A discussion ensued regarding the review process by the Policy and Procedures committee.

FINAL ACTION TAKEN:

A motion was made by Member Mackay to approve that the UMC Policies and Procedures Committee's activities of October 1, 2025 and November 5, 2025 and recommend for approval to the UMC Governing Board. Motion carried by unanimous vote.

## SECTION 3. EMERGING ISSUES

**ITEM NO. 7 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 Franklin 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 2:47 p.m. Chair Franklin 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:** | **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, and Regulatory Program measures.

Cleared for Agenda
February 2, 2026

Agenda Item #

**4**

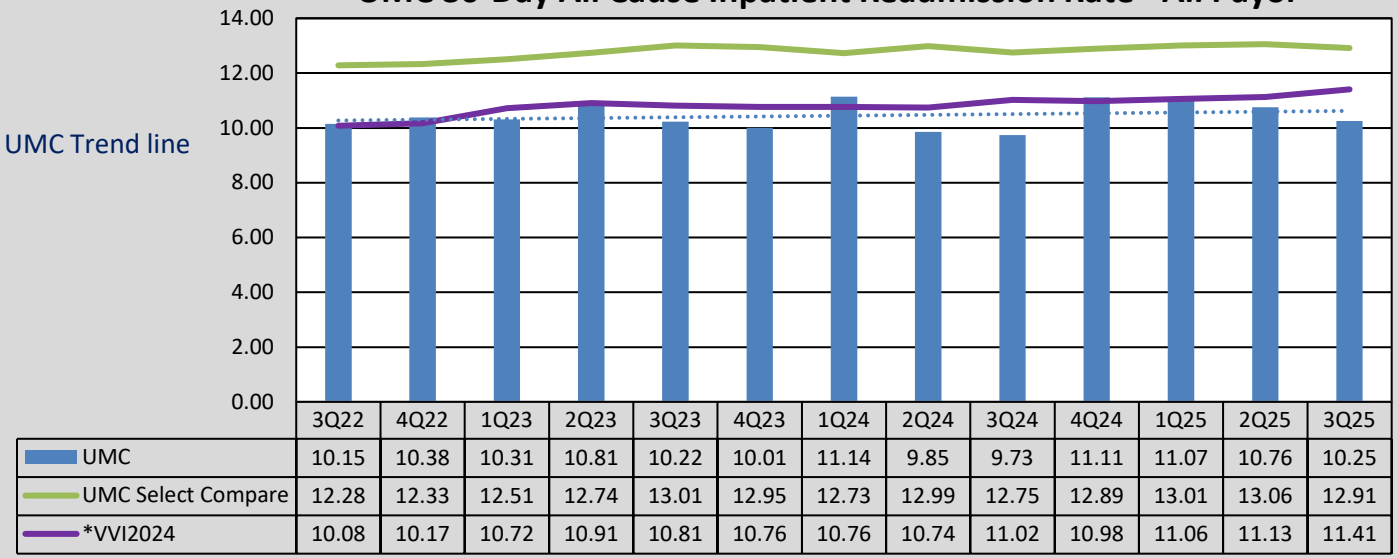
# Quality/Safety/Regulatory Update

UMC Governing Board Committee
Clinical Quality & Professional Affairs
February 2, 2026

# Quality Metrics

# Readmissions – All Cause

## UMC 30-Day All Cause Inpatient Readmission Rate - All Payor

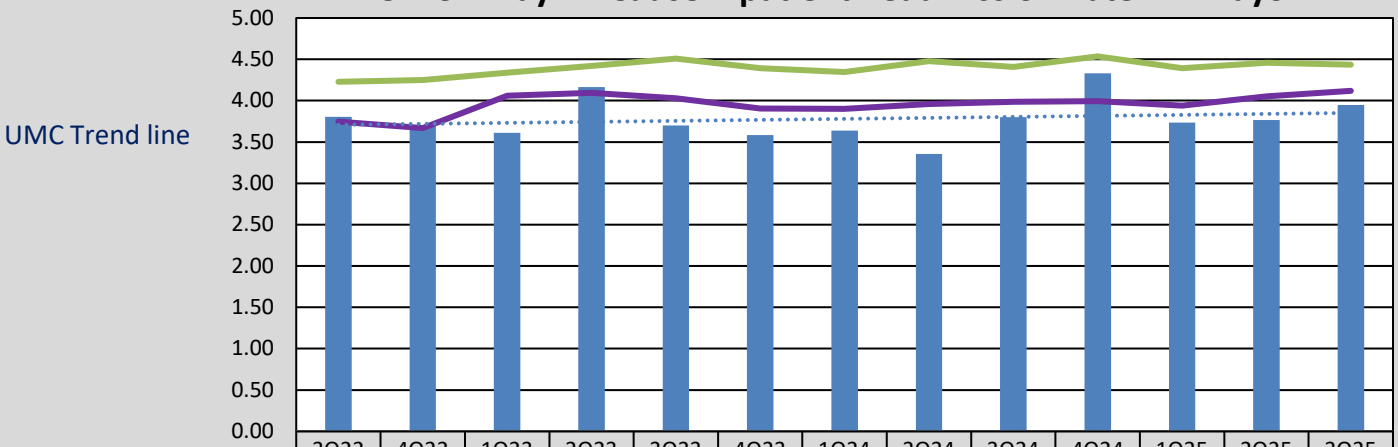



| | 3Q22 | 4Q22 | 1Q23 | 2Q23 | 3Q23 | 4Q23 | 1Q24 | 2Q24 | 3Q24 | 4Q24 | 1Q25 | 2Q25 | 3Q25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| UMC | 10.15 | 10.38 | 10.31 | 10.81 | 10.22 | 10.01 | 11.14 | 9.85 | 9.73 | 11.11 | 11.07 | 10.76 | 10.25 |
| UMC Select Compare | 12.28 | 12.33 | 12.51 | 12.74 | 13.01 | 12.95 | 12.73 | 12.99 | 12.75 | 12.89 | 13.01 | 13.06 | 12.91 |
| *VVI2024 | 10.08 | 10.17 | 10.72 | 10.91 | 10.81 | 10.76 | 10.76 | 10.74 | 11.02 | 10.98 | 11.06 | 11.13 | 11.41 |

**30 Day All Cause-Readmission (All Payer/Adult) Analysis 3Q25**

- Volume= 496/4838 vs 534/4965, previous quarter, for patients meeting CMS inclusion criteria.
- Increase observed.
- Overall trend stable.
- National CMS Compare (Medicare), UMC is “SAME”.

## UMC 7-Day All Cause Inpatient Readmission Rate - All Payor




| | 3Q22 | 4Q22 | 1Q23 | 2Q23 | 3Q23 | 4Q23 | 1Q24 | 2Q24 | 3Q24 | 4Q24 | 1Q25 | 2Q25 | 3Q25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| UMC | 3.81 | 3.70 | 3.61 | 4.16 | 3.70 | 3.59 | 3.64 | 3.36 | 3.80 | 4.33 | 3.74 | 3.77 | 3.95 |
| UMC Select Compare | 4.23 | 4.25 | 4.34 | 4.42 | 4.51 | 4.39 | 4.35 | 4.48 | 4.41 | 4.54 | 4.39 | 4.46 | 4.44 |
| *VVI2024 | 3.75 | 3.67 | 4.06 | 4.09 | 4.03 | 3.90 | 3.90 | 3.96 | 3.99 | 4.00 | 3.94 | 4.05 | 4.12 |

**7 Day All Cause-Readmission (All Payer/Adult) Analysis 3Q25**

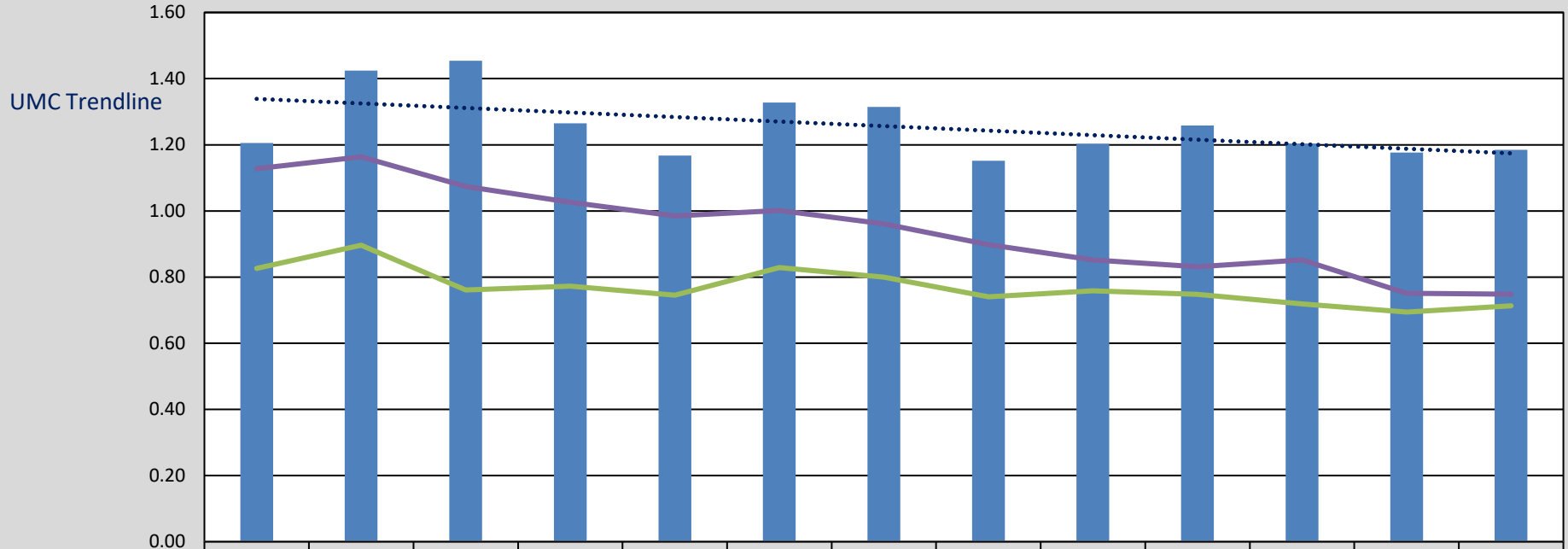
- Volume= 191/4838 vs 187/4965, previous quarter, for patients meeting CMS inclusion criteria.
- Overall trend stable.

**Data Source: Vizient**

**UMC Select Compare:**
Cedars-Sinai Health System, LAC+USC Healthcare Network, UC Davis Medical Center, UC San Diego Health, UCSF Medical Center, Oregon/OHSU, University of Utah Hospitals

**Vulnerable Index Compare (VVI) 2024:** a quantitative assessment of community social determinants of health (SDOH) factors that may influence a person’s overall health. Vizient selected peer groups.

# Mortality Index – Inpatient; All Payors

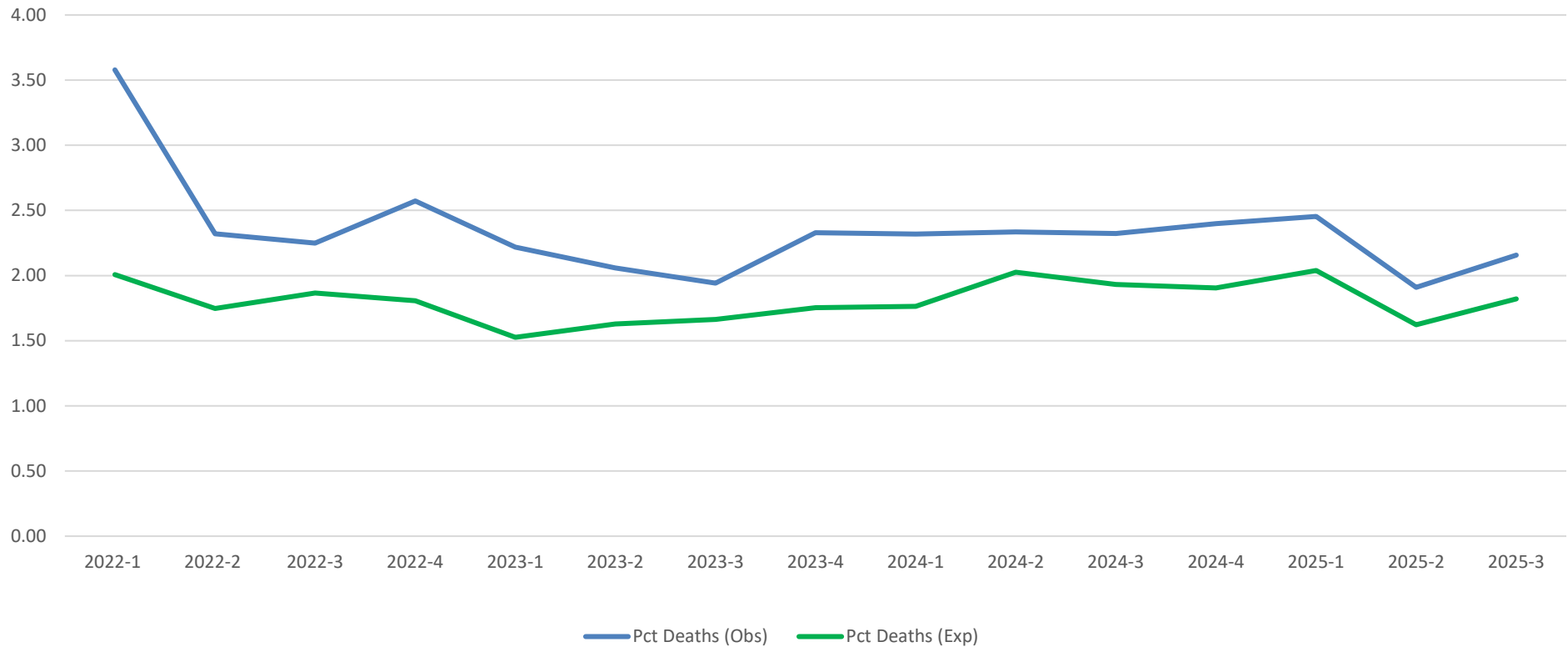



| | 3Q22 | 4Q22 | 1Q23 | 2Q23 | 3Q23 | 4Q23 | 1Q24 | 2Q24 | 3Q24 | 4Q24 | 1Q25 | 2Q25 | 3Q25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| UMC Index | 1.21 | 1.42 | 1.45 | 1.26 | 1.17 | 1.33 | 1.31 | 1.15 | 1.20 | 1.26 | 1.20 | 1.18 | 1.18 |
| UMC Select Compare | 0.83 | 0.90 | 0.76 | 0.77 | 0.75 | 0.83 | 0.80 | 0.74 | 0.76 | 0.75 | 0.72 | 0.69 | 0.71 |
| *VVI2024 | 1.13 | 1.16 | 1.07 | 1.03 | 0.98 | 1.00 | 0.96 | 0.90 | 0.85 | 0.83 | 0.85 | 0.75 | 0.75 |

- 3Q25 Mortality Index is 1.18. Same as previous quarter.
- Hospital wide deaths increased to 133, from 122 in previous quarter.
- Inpatient discharges decreased to 6164, from 6389 in previous quarter. Overall trend is down.
- Vizient Risk Adjusted %, deaths observed rate 2.16% over an expected rate of 1.82%; Index = 1.18.
- 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.

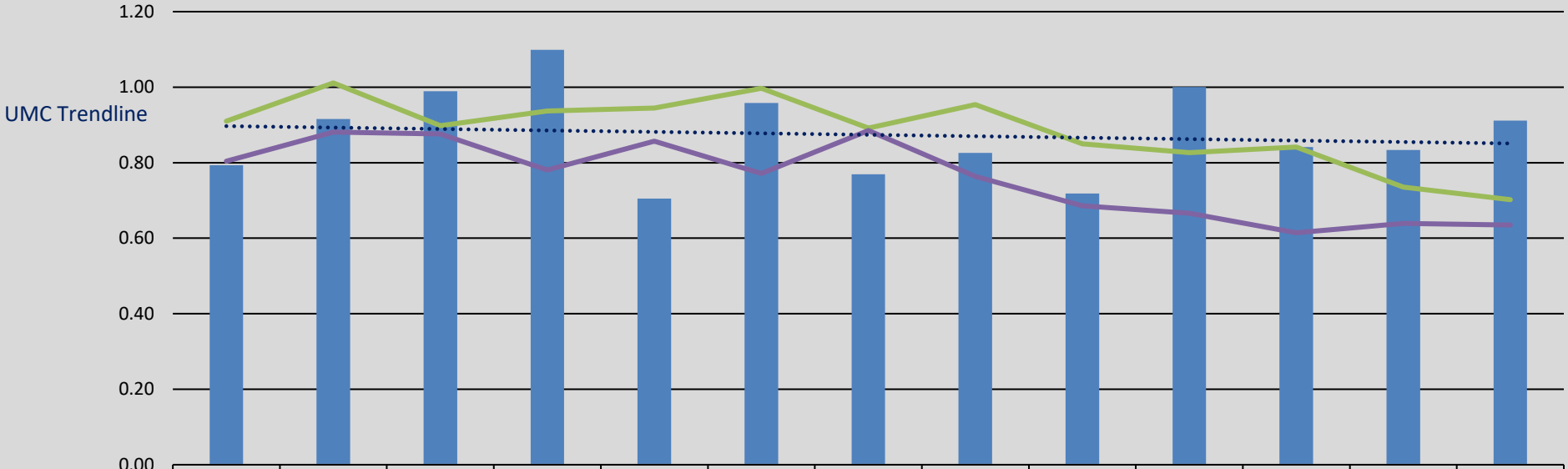
**Data Source: Vizient**
**UMC Select Compare:**
Cedars-Sinai Health System, LAC+USC Healthcare, UC Davis, UC San Diego, UCSF, Oregon/OHSU, University of Utah Hospitals.
**Vulnerable Index Compare (VVI):**
Emory Saint Joseph Atlanta, Emory University Hospital Atlanta, Harris Health System Houston, Maricopa 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 vs Expected




- Risk adjusted mortality rate was observed at 2.16 over an expected of 1.82 (O/E).
- Observed / Expected rate – need to continue to close gap through CDI initiatives.
  - ✓ 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 2024 Risk Adjusted Methodology.

# Patient Safety Indicators (PSI – 90)



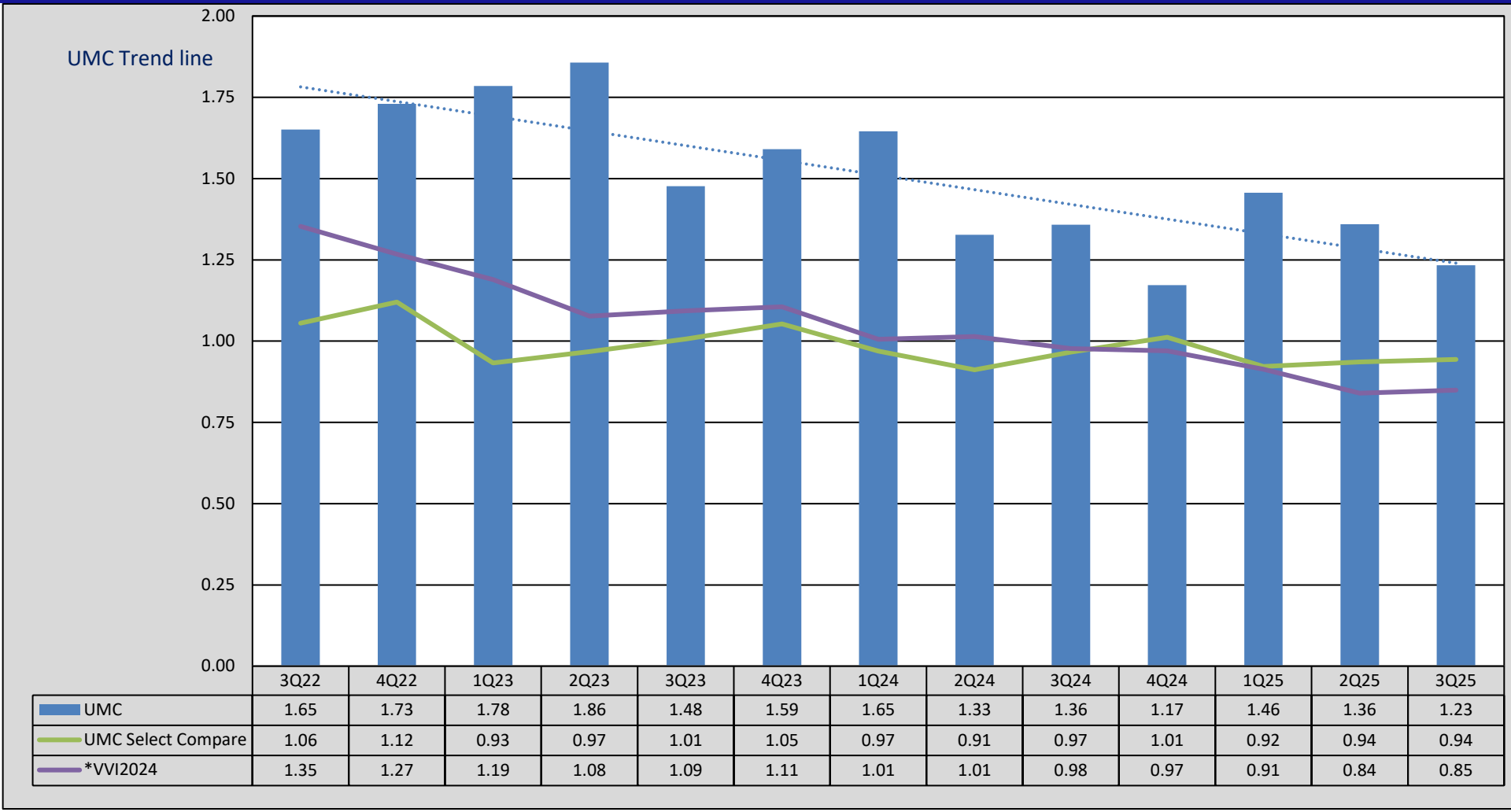

| | 3Q22 | 4Q22 | 1Q23 | 2Q23 | 3Q23 | 4Q23 | 1Q24 | 2Q24 | 3Q24 | 4Q24 | 1Q25 | 2Q25 | 3Q25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| UMC | 0.79 | 0.92 | 0.99 | 1.10 | 0.70 | 0.96 | 0.77 | 0.83 | 0.72 | 1.00 | 0.84 | 0.83 | 0.91 |
| UMC Select Compare | 0.91 | 1.01 | 0.90 | 0.94 | 0.94 | 1.00 | 0.89 | 0.95 | 0.85 | 0.83 | 0.84 | 0.74 | 0.70 |
| VVI Select Compare | 0.80 | 0.88 | 0.88 | 0.78 | 0.86 | 0.77 | 0.89 | 0.76 | 0.69 | 0.67 | 0.61 | 0.64 | 0.64 |

**3Q25 PSI-90 (Adult) Composite: PSI-90 is an average of O/E risk adjusted ratio for 10 PSI's:**

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

**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.

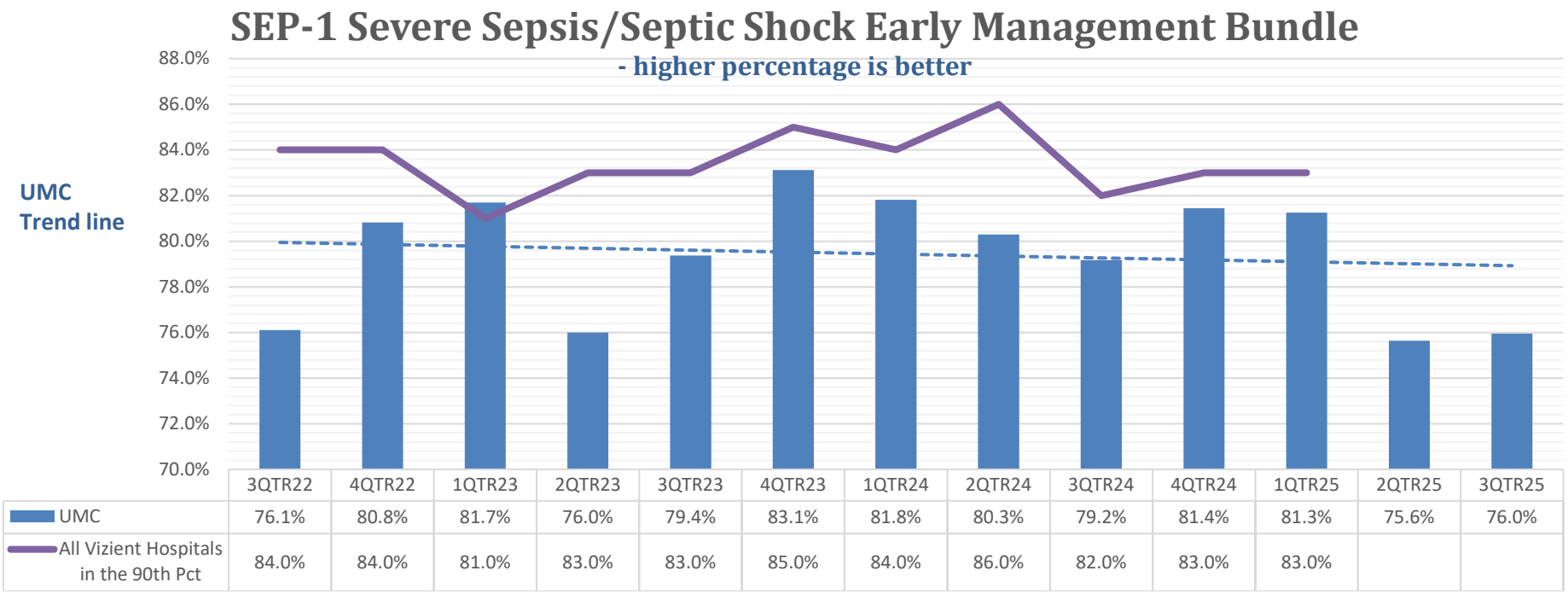
# Sepsis Mortality Index




| | 3Q22 | 4Q22 | 1Q23 | 2Q23 | 3Q23 | 4Q23 | 1Q24 | 2Q24 | 3Q24 | 4Q24 | 1Q25 | 2Q25 | 3Q25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| UMC | 1.65 | 1.73 | 1.78 | 1.86 | 1.48 | 1.59 | 1.65 | 1.33 | 1.36 | 1.17 | 1.46 | 1.36 | 1.23 |
| UMC Select Compare | 1.06 | 1.12 | 0.93 | 0.97 | 1.01 | 1.05 | 0.97 | 0.91 | 0.97 | 1.01 | 0.92 | 0.94 | 0.94 |
| *VVI2024 | 1.35 | 1.27 | 1.19 | 1.08 | 1.09 | 1.11 | 1.01 | 1.01 | 0.98 | 0.97 | 0.91 | 0.84 | 0.85 |

- Sepsis deaths increased from 48 to 50, with a mortality index of 1.23, from 1.36.
- 3Q25 inpatient discharges decreased from 2Q25 of 6389 vs 3Q23 of 6164; Sepsis cases decreased from 557 to 501.

# Severe Sepsis / Septic Shock Bundle




| | 3QTR22 | 4QTR22 | 1QTR23 | 2QTR23 | 3QTR23 | 4QTR23 | 1QTR24 | 2QTR24 | 3QTR24 | 4QTR24 | 1QTR25 | 2QTR25 | 3QTR25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| UMC | 76.1% | 80.8% | 81.7% | 76.0% | 79.4% | 83.1% | 81.8% | 80.3% | 79.2% | 81.4% | 81.3% | 75.6% | 76.0% |
| All Vizient Hospitals in the 90th Pct | 84.0% | 84.0% | 81.0% | 83.0% | 83.0% | 85.0% | 84.0% | 86.0% | 82.0% | 83.0% | 83.0% | | |

**Core Measure Fallout Breakdown:**

<u>19 total fallouts:</u>

- Lactic acid outside of timeframe: 10/19; AED=8, 2W=1, SICU=1
- Blood culture outside timeframe: 6/19; AED=3, CCU=1, CVCU=1, TICU=1,
- Antibiotic outside timeframe: 2/19; AED=2
- Fluids <30 ml/kg: 1/19; AED=1

**Actions**:

- Discussion with ED Leadership to review Code Sepsis requirements and determine a corrective action plan.
- Education regarding requirements for the Sepsis bundle will be assigned to ED staff with a relatively short turnaround time to ensure immediate correction.
- Education regarding Sepsis bundle requirements for providers to ensure all appropriate tests are ordered.
- The sepsis predictive model changed to new trigger system, NEWS2. This initiative is being led by 2 ICU physicians.

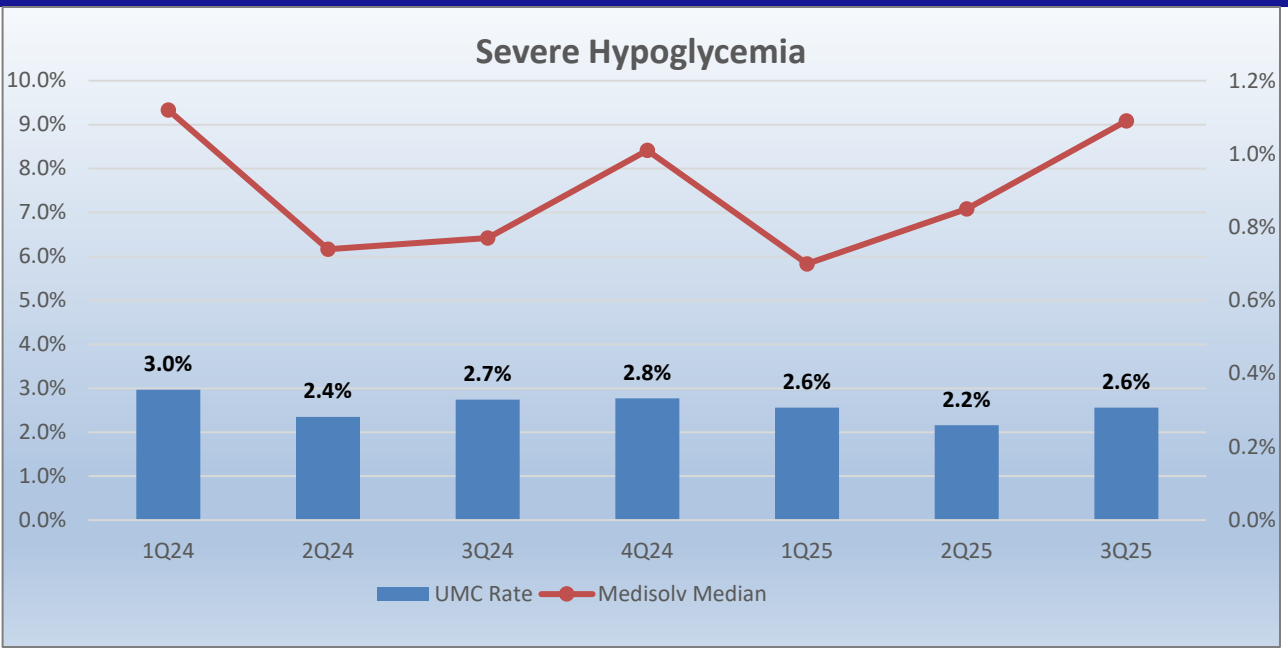
**Core Measure Data Source: Medisolv**

**Vizient UMC Select Compare Group:**

Cedars-Sinai Health System, LAC+USC Healthcare Network, UC Davis Medical Center, UC San Diego Health, UCSF Medical Center, Oregon/OHSU, University of Utah Hospitals

**Vulnerable Index Compare (VVI) 2024:** a quantitative assessment of community social determinants of health (SDOH) factors that may influence a person's overall health. Vizient selected peer groups.

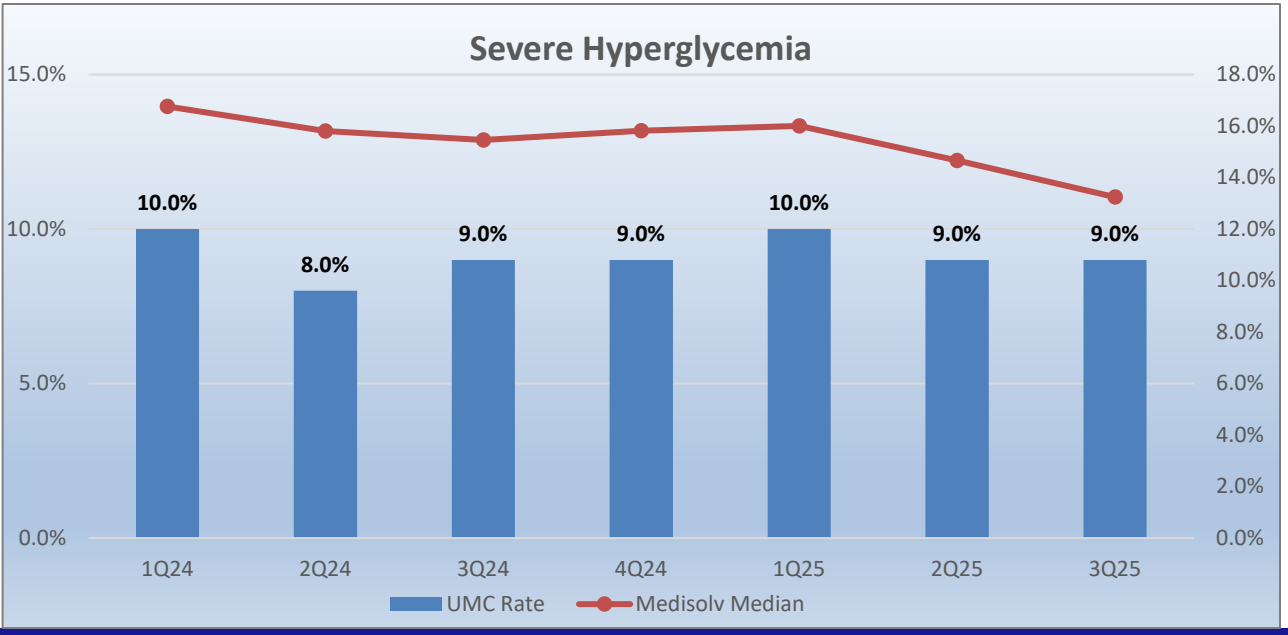
# Severe Hypoglycemia & Hyperglycemia




This measure assesses the number of inpatient hospitalizations for patients age 18 and older who were administered at least one hypoglycemic medication during the encounter, who suffer the harm of a severe hypoglycemic event during the encounter.

A lower number is better

CMS National Rate: 1%

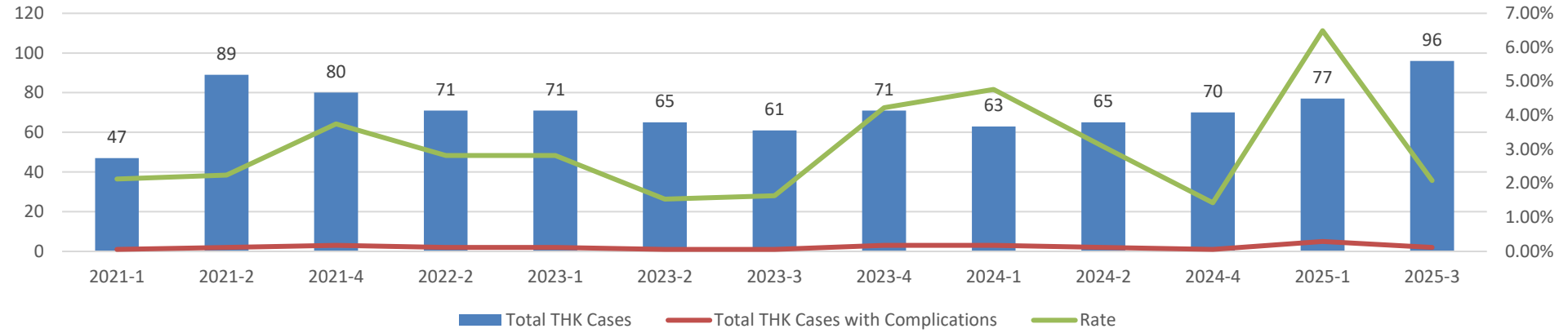



This measure assesses the number of inpatient hospital days for patients age 18 and older with a hyperglycemic event (harm) per the total qualifying inpatient hospital days for that encounter.

A lower number is better

CMS National Rate: 8%

# Total Hip & Knee Complication Rates – IP & OP




| **Discharge Quarter | Total THK Cases | Total THK Cases with Complications | Rate | THK-1 AMI Count | THK-2 Pneumonia count | THK-3 Sepsis/ Septicemia Shock Count | THK-4 Surgical Site Bleeding Count | THK-5 Pulmonary Embolism Count | THK-6 Death count | *THK-7 Mechanical Complication Count | THK-8 Periprosthetic Joint Infection/ Wound Infection Count |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2021-1 | 47 | 1 | 2.13% | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| 2021-2 | 89 | 2 | 2.25% | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 |
| 2021-4 | 80 | 3 | 3.75% | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 2 |
| 2022-2 | 71 | 2 | 2.82% | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 |
| 2023-1 | 71 | 2 | 2.82% | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| 2023-2 | 65 | 1 | 1.54% | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| 2023-3 | 61 | 1 | 1.64% | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| 2023-4 | 71 | 3 | 4.23% | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 |
| 2024-1 | 63 | 3 | 4.76% | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 3 |
| 2024-2 | 65 | 2 | 3.08% | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| 2024-4 | 70 | 1 | 1.43% | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| 2025-1 | 77 | 5 | 6.49% | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 2 |
| 2025-3 | 96 | 2 | 2.08% | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 |
| Totals | 830 | 26 | 3.13% | 0 | 3 | 3 | 0 | 1 | 0 | 8 | 15 |

- *Mechanical complications following a TKR or THR can include: implant loosening, wear and tear on the implant components, malalignment of the implant, component fracture, dislocation, osteolysis (bone loss around the implant), instability due to improper ligament balance, and issues related to incorrect implant sizing or positioning, all of which can lead to pain, decreased range of motion, and potential need for revision surgery.
- Source: Vizient THK Complication Report
- **Zero Rate Quarters, not listed: 2021-3, 2022-1, 2022-3, 2022-4, 2024-3, 2025-2. All Quarter case totals included in Total THK cases and Total Rate. CMS National Rate = 3.6%

# Patient Safety

# Grievances

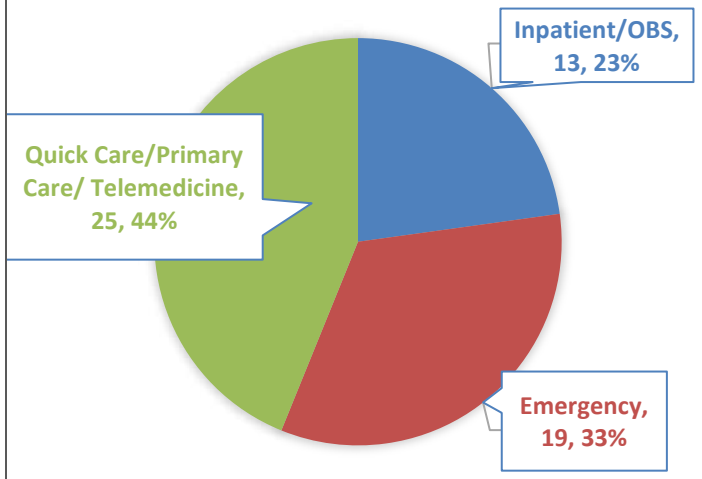
# 2025 Sentinel Events – Reported to State

| Event | 2024 | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter | Total | Comments |
|---|---|---|---|---|---|---|---|
| Fall with Injury | 0 | 1 | 2 | 0 | 1 | 4 | 4N- fx wrist; admitting-rib fx; 5N-femur fx; 2W-SDH-death |
| Pressure Injury - 3/4/Unstage | 24 | 9 | 5 | 5 | 7 | 26 | 3S-1;MICU-3; TICU-4; 2W-1; CIMC-1; 1500-1; CCU/CVCU-3; NSCU/SICU-6; 4S-4; 5S-1; 3W-1 |
| Retained Foreign Object | 3 | 0 | 2 | 0 | 0 | 2 | OR- shaver blade and guidewire |
| Wrong Side Surgery/Procedure | 1 | 0 | 1 | 1 | 1 | 3 | 2 OR- block; 1 OR- chest tube |
| Wrong Site Surgery/Procedure | 1 | 0 | 0 | 0 | 0 | 0 | |
| Assault | 0 | 0 | 0 | 0 | 0 | 0 | |
| Homicide | 0 | 0 | 0 | 0 | 0 | 0 | |
| Device Failure | 0 | 0 | 0 | 0 | 0 | 0 | |
| Burn | 0 | 0 | 0 | 1 | 0 | 1 | OR-abd cautery |
| Self Harm | 0 | 0 | 1 | 0 | 0 | 1 | ED-swallowed needle |
| TOTAL | **29** | 10 | 11 | 7 | 9 | **37** | |

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

# Grievances – 3Q25 & 4Q25

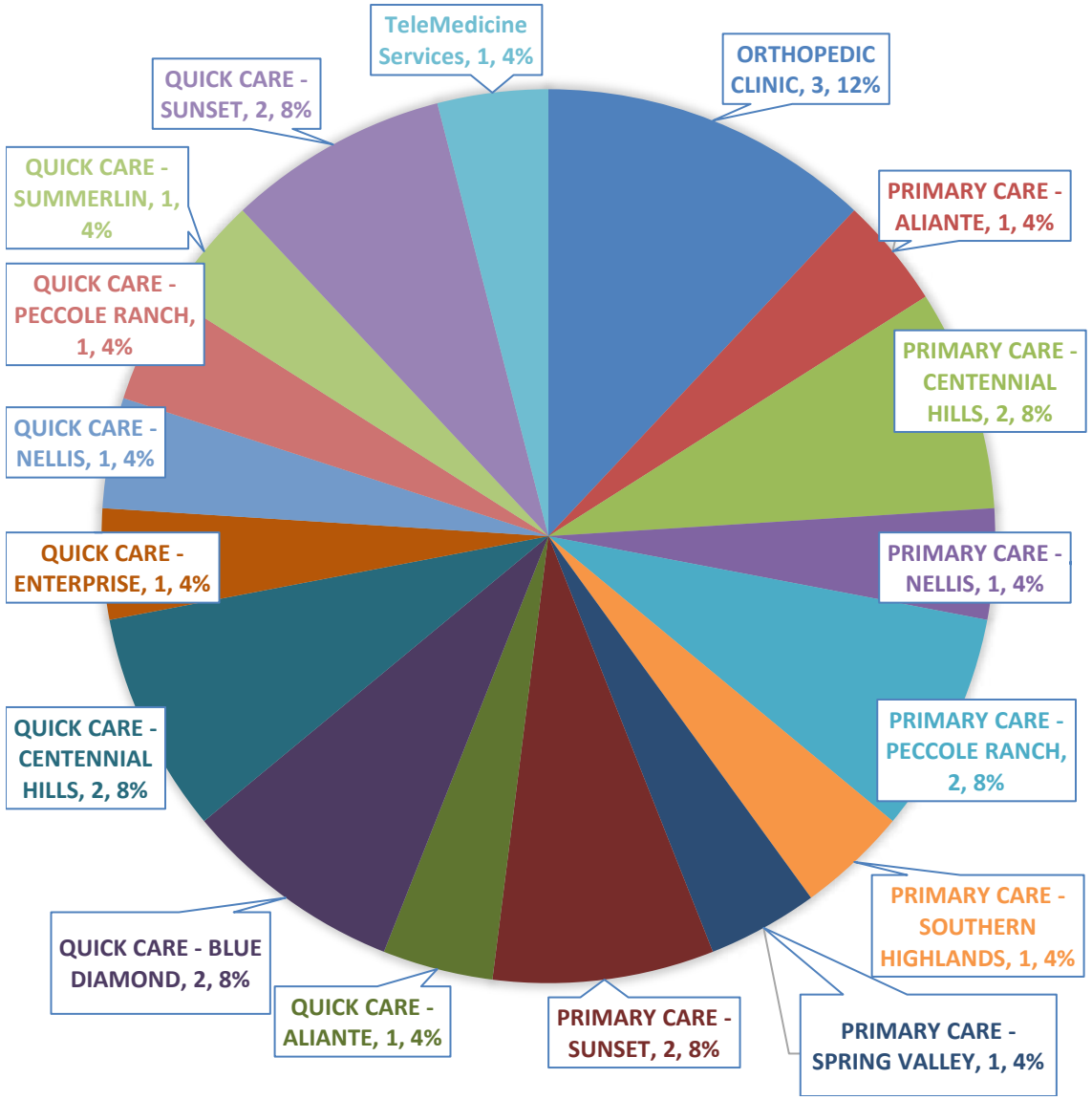
## GRIEVANCE BY LOCATION



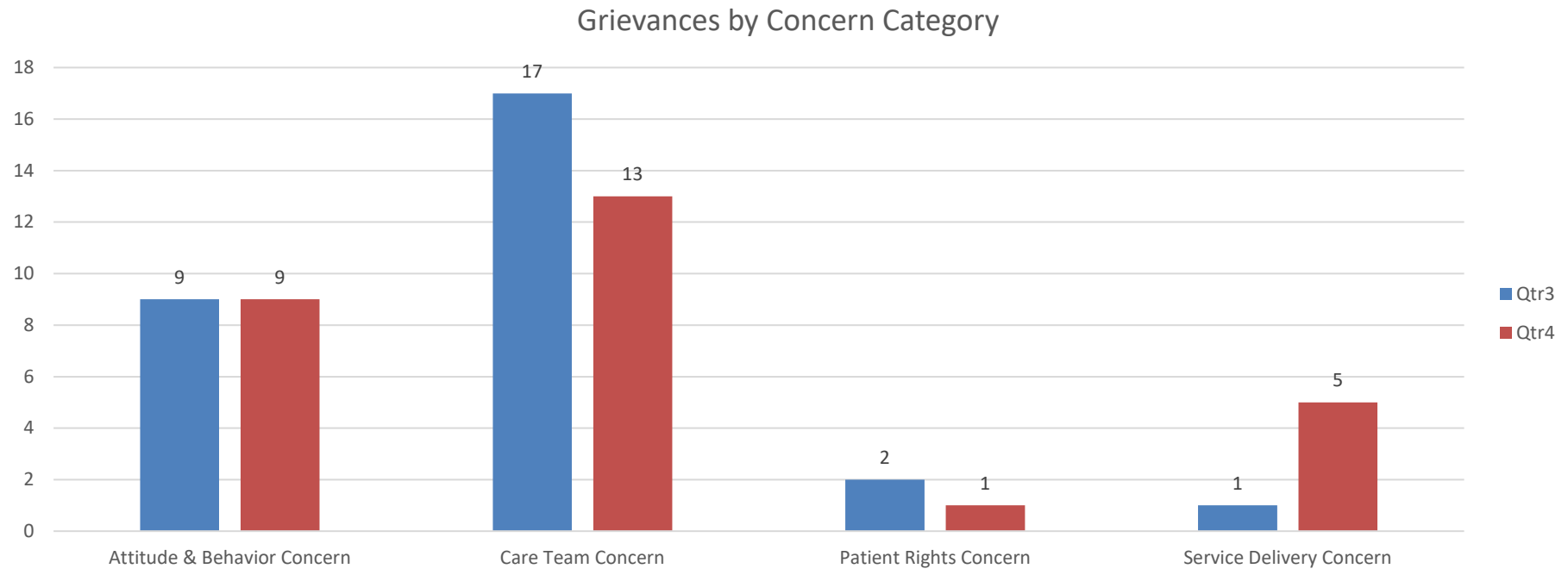

**Emergency Services – 19**
**Inpatient/OBS - 13**

- Children's Hospital – 2
- Critical Care – 1
- Imaging – 1
- Main Campus – 5
  - Case Management – 2
  - Physical Therapy – 1
  - Patient Access Services – 1
  - OP Burn Care Therapy – 1
- Med/Surg/IMC – 4

## GRIEVANCE QC/PC/TELEMEDICINE - 25



# Grievances – 3Q25 & 4Q25




57 total grievances were received over 4 reported concern categories. 11 grievances could be substantiated.

- ✓ **Care Team** accounted for 53% of reported concerns; included in this category: Communication/Explanation, Coordination of Care Team, Diagnosis Related, Pain Management, Patient Care.
- ✓ **Attitude & Behavior** accounted for 32% of reported concerns; included in this category: Lack of Concern/Uncaring, Rude or Unprofessional Behavior, Not Helpful.
- ✓ **Service Delivery** accounted for 11% of reported concerns; included in this category: Appointment/Procedure Cancellation, Wait Time
- ✓ **Patient Rights** accounted for 6% of reported concerns; included in this category: EMTALA

# Grievance Rate Per 1000 Discharges / Encounters

| Patient Type | Year | Total Discharges/Encounters | Total Grievances Received | Rate Per 1000 |
|---|---|---|---|---|
| Inpatient/OBS | 2023 | 30182 | 41 | 1.36 |
| | 2024 | 30279 | 59 | 1.95 |
| | 1Q25 | 7735 | 9 | 1.16 |
| | 2Q25 | 7786 | 13 | 1.67 |
| | **3Q25** | **7646** | **8** | **1.05** |
| | **4Q25** | **7813** | **5** | **0.64** |
| Emergency Department | 2023 | 87786 | 26 | 0.30 |
| | 2024 | 108936 | 37 | 0.34 |
| | 1Q25 | 28072 | 2 | 0.07 |
| | 2Q25 | 28538 | 5 | 0.18 |
| | **3Q25** | **28759** | **8** | **0.28** |
| | **4Q25** | **28493** | **11** | **0.39** |
| Quick Care/Primary Care/Telemedicine | 2023 | 348692 | 40 | 0.11 |
| | 2024 | 356604 | 43 | 0.12 |
| | 1Q25 | 93607 | 11 | 0.12 |
| | 2Q25 | 83322 | 8 | 0.10 |
| | **3Q25** | **93607** | **13** | **0.14** |
| | **4Q25** | **83322** | **12** | **0.14** |
| Overall Totals | 2023 | 466660 | 107 | 0.23 |
| | 2024 | 495819 | 139 | 0.28 |
| | 1Q25 | 129414 | 22 | 0.17 |
| | 2Q25 | 119646 | 26 | 0.22 |
| | **3Q25** | **117060** | **29** | **0.25** |
| | **4Q25** | **120590** | **28** | **0.23** |

**Data Source:** IP/OBS Data – Vizient, ED – EPIC, QC/PCP/Telemedicine - EPIC

# Accreditation / Regulatory Policies & Procedures

# Accreditation/Regulatory Activity; Policy/Procedures

- Accreditation/Regulatory Activity

- Policy / Procedures for Approval:
  - Timeframe:  December 3, 2025 & January 7, 2026
  - Total approved: 97
  - Total retired: 3
  - Approved through Hospital P/P, Quality, MEC

# 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 December 3, 2025 and January 7, 2026, 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
February 2, 2026

Agenda Item #

**5**

**December 3, 2025 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, 0 Retired**

| POLICY NAME | NEW/ REVISED | HPP COMMITTEE DECISION | SUMMARY |
|---|---|---|---|
| Policy, Procedures, Protocols and Guideline Management | Revised | Approved as Submitted | Added #4 under Policy; vetted by Quality/Regulatory Officer. |
| Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) | Revised | Approved as Submitted | Revised to strengthen accountability for practitioner improvement plans by adding a 30-day submission requirement for Department Chiefs, with contingency development by the PIC Chair and Chief of Staff if the deadline is missed. An escalation process was added for Chiefs who fail to submit improvement plans twice within a rolling two-year period. References to "designee" were replaced with "Department Chief or Vice Chief" to ensure consistent Medical Staff leadership involvement. Vetted by Quality/Safety/Regulatory Officer; PI Program Manager; PIC Committee. |
| Medical & Dental Staff Peer Review | Revised | Approved as Submitted | Updated to align with the revised OPPE/FPPE improvement plan requirements and escalation process. PIC Chair term was changed to a three-year appointment to match other PIC member terms, and PIC attendance requirements were clarified to reinforce committee participation expectations, aligned with Medical and Dental Staff Bylaws. Updated references, vetted by Quality/Safety/Regulatory Officer; PI Program Manager; PIC Committee. |
| GME Closures and Reductions | New | Approved as Submitted | New Policy, Vetted by Academic Affiliation Analyst and Academic and External Affairs Administrator. |
| Resident Clinical and Education Work Hours | New | Approved as Submitted | New Policy, Vetted by Academic Affiliation Analyst and Academic and External Affairs Administrator. |
| Resident Moonlighting | New | Approved as Submitted | New Policy, Vetted by Academic Affiliation Analyst and Academic and External Affairs Administrator. |
| Resident Promotion Appointment Renewal | New | Approved as Submitted | New Policy, Vetted by Academic Affiliation Analyst and Academic and External Affairs Administrator. |

| POLICY NAME | NEW/ REVISED | HPP COMMITTEE DECISION | SUMMARY |
|---|---|---|---|
| Resident Wellness | New | Approved as Submitted | New Policy, Vetted by Academic Affiliation Analyst and Academic and External Affairs Administrator. |
| Blood and Body Fluid Exposure | Revised | Approved as Submitted | Updated reporting exposure process; updated HIV screening timeline to align with CDC guidelines. Vetted by Director Infection Prevention. |
| Communication of Significant Organisms/Infections upon Inter-Facility Transfer | Revised | Approved as Submitted | TJC reference removed. CDC reference added. Grammar changes. Removed section on contacting other facilities if MDRO is identified when receiving patient. Vetted by Infection Prevention Director, Medical Director Inpatient & Outpatient Infectious Disease Services, Laboratory Services Director and CQPS. |
| Clocking In and Out – UGK Timekeeping Systems and Assigned Locations - EVS | New | Approved as Submitted | New procedure. Vetted by EVS Director, Infection Prevention Director, Executive Director of Support Services and HR. |
| Environmental Services Employee - Authorized Break Areas and Times | New | Approved with Revisions | New procedure. Vetted by EVS Director, Infection Prevention Director, Executive Director of Support Services and HR. |
| Environmental Services Employee - Assigned Work Areas | New | Approved as Submitted | New procedure. Vetted by EVS Director, Infection Prevention Director, Executive Director of Support Services and HR. |
| Waste Storage Area Security and Compliance | New | Approved as Submitted | New policy. Vetted by EVS Director, Infection Prevention Director and Executive Director of Support Services. |
| Respiratory Lab - Metabolic and Nutritional Assessment | Revised | Approved as Submitted | Reviewed, updated to reflect current manufacturer guidelines. Vetted by Respiratory Services Director. |
| Respiratory Lab - Pulmonary Function Testing | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Respiratory Services Director. |
| Triaging and Transfer of Patients from Pediatric ED to the Adult ED or Trauma Center | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Director of Critical Care Services of Peds ED, Peds ED MD Director, Adult ED Medical Directors and Pediatric Department. |
| Antipyretic Administration in the Triage for the Febrile Pediatric Patient | Revised | Approved with Revisions | Scheduled review, no changes. Vetted by Director of Critical Care Services for Peds ED, Peds ED MD Director and Pediatric Department. |
| Abdominal Pain/Intrauterine Bleeding in Females After the Age of Menarche | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Director of Critical Care Services for Peds ED, Peds ED MD Director and Pediatric Department. |
| Pediatric Extremity Injury | Revised | Approved with Revisions | Scheduled review, no changes. Vetted by Director of Critical Care Services for Peds ED, Peds ED MD Director and Pediatric Department. |

| POLICY NAME | NEW/ REVISED | HPP COMMITTEE DECISION | SUMMARY |
|---|---|---|---|
| Ultrasound Guided Peripheral IV Guideline | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Clinical Director of Critical Care Services and ED Medical Directors. |
| Ambulation on Discharge in the Adult Emergency Department | Revised | Approved as Submitted | No changes. Vetted by Director of Critical Care Services for Adult ED and ED Medical Directors. |
| Vital Signs Frequency and Addressing Abnormal Vital Signs in the Adult Emergency Department - Guideline | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Director of Critical Care Services for Adult ED and ED Medical Directors. |
| Transfer and Maintenance of Accounts to and from Collection Agency | Revised | Approved as Submitted | Scheduled review, no updates. Vetted by Director Patient Accounting and CFO. |
| Pediatric Gastronomy Tube Care | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by PICU Manager, Maternal Child Services Clinical Director, ACNO and Pediatric Department. |
| Phototherapy Procedures | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by NICU Clinical Manager, Maternal Child Services Director and ACNO. |
| Shaken Baby Syndrome Discharge Education | Revised | Approved as Submitted | Updated wording and references. Vetted by Trauma outreach, Education department, NICU Clinical Manager, Maternal Child Services Clinical Director and ACNO. |
| OB Emergency Response | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by NICU Clinical Manager, Maternal Child Services Director and ACNO. |
| Thermoregulation for Neonates | Revised | Approved as Submitted | Updated weights for weaning and humidity, also added humidity table. Vetted by NICU Clinical Manager, Maternal Child Services Director and ACNO. |
| Burn Consult | Revised | Approved as Submitted | Added Pavement and Friction Burn Guidelines and guideline references. Approved by Burn Medical Director and Burn Program Manager. |
| Burn Diagram Initiation and Utilization | Revised | Approved as Submitted | Scheduled review. No changes. Reviewed by Burn Medical Director and Burn Program Manager. |
| Burn Photography | Revised | Approved as Submitted | Scheduled review. No changes. Reviewed by Burn Medical Director and Burn Program Manager. |
| Burn Psychiatric Consult | Revised | Approved as Submitted | Scheduled review. No changes. Reviewed by Burn Medical Director and Burn Program Manager. |
| Burn Reporting | Revised | Approved as Submitted | Scheduled review. No changes. Reviewed by Burn Medical Director and Burn Program Manager. |

| POLICY NAME | NEW/ REVISED | HPP COMMITTEE DECISION | SUMMARY |
|---|---|---|---|
| **Heat Shield** | Revised | Approved as Submitted | Scheduled review. No changes. Reviewed by Burn Medical Director and Burn Program Manager. |
| **Activation Personnel** | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Trauma Program Manager, Clinical Director Critical Care Services and ACNO. |
| **Trauma Surgeon On-Call** | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Trauma Program Manager, Clinical Director Critical Care Services and ACNO. |

**January 7, 2026 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 60 Approved, 3 Retired**

| POLICY NAME | NEW/ REVISED | HPP COMMITTEE DECISION | SUMMARY |
|---|---|---|---|
| Quality Management System: 2026 Quality Assurance and Performance Improvement Program Plan (QAPI) | Revised | Approved as Submitted | Updated to align to organizational performance goals approved by the Governing Board QAPI Priorities; revised reporting schedule. Vetted by Quality/Safety/Regulatory Officer. |
| Patient Safety Plan 2026 | Revised | Approved as Submitted | Reviewed. Removed Joint Commission reference. Changed persons responsible for reporting patient safety events from all clinical staff to all staff. Vetted by Director of Patient Safety. |
| Initial Management for Pediatric Burn Patients | Revised | Approved as Submitted | Scheduled review. No changes. Reviewed by Burn Medical Director, Burn Program Manager and Peds Department. |
| Adult Palliative Care Program | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Emily Brown, Anthony Brando Opimo and ACNO. |
| Adoption | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Care Management Director, ACNO and CFO. |
| Notification to the Guardian's Office of Discharge or Transfer of their Adult Ward | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Care Management Director and CFO. |
| Use of InterQual: Admission and Continued Stay Review | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Care Management Director and CFO. |
| Group Home Placement | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Care Management Director and CFO. |
| Discharge Transportation Assistance | Revised | Approved with Revisions | Updated on-campus transport. Vetted by Care Management Director and CFO. |
| Utilization Management Plan | Revised | Approved as Submitted | Updated to reflect UM Committee meetings to be held at a minimum of 4 times per year. Vetted by Care Management Director. |
| UMCSN Hospital Room & Board | New | Approved as Submitted | New policy. Vetted by Revenue Integrity Analyst and Director, Patient Accounting and Revenue Integrity. |
| Death Certificate Escalation | New | Approved as Submitted | New policy, outlines the current procedure being completed. Vetted by HIM, Med Staff and Nursing. |

| POLICY NAME | NEW/ REVISED | HPP COMMITTEE DECISION | SUMMARY |
|---|---|---|---|
| Drug Diversion – Prevention, Identification, Reporting and Investigation | New | Approved as Submitted | New Policy, vetted by Diversion Committee. |
| Patient's Personal Medications – Storage and Use | Revised | Approved as Submitted | Minor wording changes with "pharmacist" to "pharmacy" or "pharmacy staff member". Added an "arm band" as appropriate identification. Removed the hyaluronate section at OSI as these are devices. Vetted by Pharmacy Services Supervisor and Director of Pharmacy. |
| 340B Drug Pricing Program | Revised | Approved as Submitted | Removed language for advance 340B site eligibility. Corrected typos, clarified language, added MCO language, removed contrast media from exclusion list, added responsibilities of Pharmacy 340B specialists, clarified education requirements. Added recommended language from consultants. Vetted by Director of Pharmacy. |
| Adult Medical Emergency Response Team (MERT) | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Response Team Supervisor, Critical Care Director and ANCO. |
| Central Line Vascular Access Device – Adult | Revised | Approved as Submitted | Added PICC: criteria, contraindications, considerations, procedure, and line placement confirmation. |
| Disclosure of Improper Governmental Action | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Human Resources Director and Chief Human Resources Officer. |
| Benefits Program | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Human Resources Director and Chief Human Resources Officer. |
| Responsibilities of the Chief Human Resources Officer | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Human Resources Director and Chief Human Resources Officer. |
| Nepotism (Hiring of Relatives) | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Human Resources Director and Chief Human Resources Officer. |
| Objectives and Scope – Human Resources | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Human Resources Director and Chief Human Resources Officer. |
| Educational Development Program | Revised | Approved as Submitted | Added LMS testing/education availability in Section D.4. Updated new hire requirements in Section E.5. Clarified |

| POLICY NAME | NEW/ REVISED | HPP COMMITTEE DECISION | SUMMARY |
|---|---|---|---|
| | | | scope. Vetted by Chief Human Resources Officer. |
| Employment Eligibility Verification | Revised | Approved as Submitted | Correcting Section A for new hires and adding updated counseling process for renewals in Section B. Removed Section C. Vetted by Chef Human Resources Officer. |
| Substance Abuse | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Human Resources Director and Chief Human Resources Officer. |
| Requesting and Conducting a Classification Audit Study | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Human Resources Director and Chief Human Resources Officer. |
| Employee Health Services | Revised | Approved as Submitted | Updated Policy section to include restrictions for non-compliant health care workers from entering, accessing or performing services within UMC facilities. Vetted by Director of Infection Prevention and Chief Human Resources Officer. |
| Disciplinary Hearing Process | Revised | Approved as Submitted | Revised scope section. Vetted by Chief HR Officer. |
| Progressive Discipline/Corrective Counseling | Revised | Approved as Submitted | Changing from a policy to a procedure. Categorized as a policy in error during the 2022 during formatting changes. Added Scope section. Vetted by Chief HR Officer. |
| Position Classification and Compensation Plans | Revised | Approved as Submitted | Modified Section G to reference Section K in the Recruitment and Selection Program for requirements for new hires. Updated counseling process for existing employees needing renewals. Vetted by Chief Human Resources Officer. |
| Recruitment and Selection Program | Revised | Approved as Submitted | Modified Section J to reference Sections A and B in the Employment Eligibility Verification Policy. Added the updated corrective action process in Section K for existing employees. Vetted by Chief Human Resources Officer. |
| Business Associates | Revised | Approved as Submitted | Converted the prior image listing Business Associate functions and services into an accessible native table, added two supplemental examples reflecting modern vendor types, and created a new "Additional Requirements and Clarifications" section to incorporate non–Business Associate |

| POLICY NAME | NEW/ REVISED | HPP COMMITTEE DECISION | SUMMARY |
|---|---|---|---|
| | | | exceptions, subcontractor flow-down obligations, and the HIPAA-required elements of a Business Associate Agreement. Updated contact language to direct questions to the Privacy Office at privacy@umcsn.com. No other substantive policy changes were made. |
| **Use and Disclosure of PHI for Fundraising or Marketing** | Revised | Approved as Submitted | Updated policy to add new sections on Digital Communications, Prohibition on Use of Tracking Technologies Without Authorization, and Fundraising Opt-Out Requirements; added a procedural requirement for Privacy and Information Security review of digital tools; and added a clarification of remuneration in the Definitions section. No other substantive changes were made. |
| **Informal Disclosures to Family and Friends** | Revised | Approved as Submitted | Manual changed from Compliance & Privacy to just Privacy. Minor formatting and editorial revisions for readability and layout; no other substantive content changes beyond those previously described. |
| **PHI Disclosures for Health Oversight Activities** | Revised | Approved as Submitted | Removed references to procedure and definition language that cited the HIPAA Supported Reproductive Health Care Policy, Privacy Policy, and related reproductive health care definitions to align this policy with updated HIPAA rules on the use and disclosure of PHI containing reproductive health information. These references are now outdated under the revised federal standards. |
| **PHI Disclosures for Law Enforcement** | Revised | Approved as Submitted | Removed references to procedure and definition language that cited the HIPAA Supported Reproductive Health Care Policy, Privacy Policy, and related |

| POLICY NAME | NEW/ REVISED | HPP COMMITTEE DECISION | SUMMARY |
|---|---|---|---|
| | | | reproductive health care definitions to align this policy with updated HIPAA rules on the use and disclosure of PHI containing reproductive health information. These references are now outdated under the revised federal standards. No other substantive policy changes were made. |
| **PHI Disclosures for Other Specialized Activities** | Revised | Approved as Submitted | Removed language to the Disclosures to Coroners or Medical Examiners and Reference sections to reference HIPAA Support of Reproductive Health Care Privacy policy to align with updated HIPAA rules concerning uses and disclosures of PHI containing reproductive health care. The Regulator Requirement was vacated by the court. Additional minor formatting and editorial revisions for readability and layout; no other substantive content changes beyond those previously described. |
| **Assessment for PHI Compromise & Notification** | Revised | Approved as Submitted | Replaced: "For breach events where contact information for 10 or more individuals is insufficient, substitute notice must be provided in accordance with 45 CFR 164.404." with "If UMC has insufficient or out-of-date contact information that precludes written notice for 10 or more individuals, UMC must provide substitute notice in accordance with 45 CFR § 164.404(d)(2)(ii) (90-day website posting or major print/broadcast media notice, plus a toll-free number active for at least 90 days)." For more complete regulatory alignment.<br>Replaced: "Alternative forms of notification, such as via email or phone, may be used if an address is outdated or circumstances justify it. However, alternative methods should not replace letter notification." with "Alternative methods may be used to supplement written notification when an address is out-of-date or circumstances warrant additional outreach. Email may be used only if the individual has agreed to receive electronic notices and has not withdrawn that agreement (45 CFR § 164.404(d)(1)). However, alternative methods are supplemental and do not replace the required written letter notification." |

| POLICY NAME | NEW/ REVISED | HPP COMMITTEE DECISION | SUMMARY |
|---|---|---|---|
| | | | Changed: Additional References Added. Changed: Manual from Compliance & Privacy to Privacy. Minor formatting and editorial revisions for readability and layout; no other substantive content changes beyond those previously described. |
| **Access, Use, and Disclosure of PHI for Treatment** | Revised | Approved as Submitted | Manual changed from Compliance & Privacy to just Privacy. Minor formatting and editorial revisions for readability and layout. Clarified the policy's scope for treatment-related access, use, and disclosures, including care coordination, consultations, referrals, and continuity of care, consistent with HIPAA treatment provisions. (45 C.F.R. § 164.506(c); 45 C.F.R. § 164.501.) Added staff-friendly procedural guardrails for verifying the identity and authority of external requesters, including escalation for unusual or questionable requests. (45 C.F.R. § 164.514(h).) Added an explicit Special Categories and Exceptions section highlighting psychotherapy notes and 42 C.F.R. Part 2 Substance Use Disorder records, with direction to escalate as needed. (45 C.F.R. § 164.508(a)(2); 42 C.F.R. Part 2.) Added guidance permitting time-sensitive treatment disclosures (for example, phone coordination) when needed to avoid delaying patient care, with documentation and verification expectations. (45 C.F.R. § 164.506(c); 45 C.F.R. § 164.514(h).) Added language to clarify that clinicians/staff can provide patients or personal representatives with limited, immediate copies of select care-continuity documents, with required two-identifier identity verification and confirmation that the records match the correct patient. Vetted by Privacy Officer. |
| **HIPAA Compliance Policies & Procedures** | Revised | Approved as Submitted | Standard review. Chief Information Officer removed from information security policy responsibility. Change: Removed "Leadership and" replaced it with Committee. "If either the Privacy Officer or ISO determines the need for a new policy or procedure, or a material change to an existing policy or procedure, they shall coordinate with the appropriate UMC leadership Committee to ensure proper consideration and approval." Revised to incorporate Nevada state requirements; clarify applicability to workforce |

| POLICY NAME | NEW/ REVISED | HPP COMMITTEE DECISION | SUMMARY |
|---|---|---|---|
| | | | members involved in HIPAA policy lifecycle activities; add governance cross-reference to "Policy, Procedures, Protocols and Guideline Management"; refine Privacy Officer and Information Security Officer responsibilities to PHI/ePHI (removed Payment Card Industry references); replace "Procedure" with a concise HIPAA/PHI-focused policy lifecycle section aligned to the 3-year review standard; and update documentation/retention language to reflect intranet archival continuity while deferring retention to Hospital System and Clark County requirements and meeting or exceeding HIPAA minimums. |
| **IRB Policies and Procedures Manual** | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Director Clinical Research and Compliance. |
| **Syphilis Testing Requirements in Pregnancy** | New | Approved as Submitted | New policy. Vetted by Maternal Child Director, Critical Care Services Director and Legal. |
| **Pediatric and Adult Emergency Department Activations** | Revised | Approved as Submitted | Scheduled Review. "Must" changed to "should" in #3. Language added regarding Pediatric Emergency Medicine Fellow. Reviewed by Trauma Surgery, Adult, Pediatric Emergency Medicine, and Peds Department. |
| **Trauma Overload** | Revised | Approved as Submitted | Scheduled Review. Language regarding the MACC added to Policy letter "E". Clarification added to Procedure letter "E" as to the individuals requiring notification. Reviewed by ACNO, Trauma Surgery, Emergency Medicine, TICU/Trauma ED Nursing Leadership, and Emergency Preparedness. |
| **Labeling Medications and Solutions On and Off the Sterile Field** | Revised | Approved with Revisions | Added 4-hour beyond use under policy. Vetted by Perioperative Services Manager, Medical Director of Surgical Services, Pharmacy and ACNO. |
| **Patients Presenting with Complaint of Dysuria, Patients 3 Years of Age and Older** | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Peds ED Supervisor, Dr. Trautwein and Peds Department. |
| **Pediatric Wheezing** | Revised | Approved as Submitted | Annual review. No changes. Vetted by Clinical Director of Critical Care Services, Dr. Trautwein and Peds Department. |
| **Pediatric Vomiting** | Revised | Approved as Submitted | Annual review, no changes. Vetted by Clinical Director of Critical Care Services, Dr. Trautwein and Peds Department. |

| POLICY NAME | NEW/ REVISED | HPP COMMITTEE DECISION | SUMMARY |
|---|---|---|---|
| Pediatric Testicular Pain | Revised | Approved as Submitted | Annual review, no changes. Vetted by Clinical Director of Critical Care Services, Dr. Trautwein and Peds Department. |
| Pediatric Stridor | Revised | Approved as Submitted | Removed "oral" steroids from page 1 Exclusion Criteria #3. Added maximum dose when using protocol for oral dexamethasone. Vetted by Clinical Director of Critical Care Services, Peds ED Medical Director and Peds Department. |
| Controlling Access to/from Security Sensitive Areas | Revised | Approved as Submitted | Minor verbiage changes throughout policy. Verbiage related to blood irradiator removed. Added Medical staff office, Supply Warehouse and loading docks. Vetted by Public Safety Manager and Director of Public Safety. |
| Honeywell Alarm Signals | Revised | Approved as Submitted | Policy reviewed, no changes. Vetted by Public Safety Manager and Director of Public Safety. |
| Identifying Individuals Entering the Hospital | Revised | Approved as Submitted | Verbiage changes to overall policy to help with flow and clarity. Additions made to "Employees" section to include badge replacement and termination of access. Revisions to "Students". UMC no longer issued to students, they are to use their institutions ID and have them visible at all times. Added: Med Staff Office, Warehouse, and Loading docks. Vetted by Public Safety Manager and Director of Public Safety. |
| Use of Lockers | Revised | Approved as Submitted | Minor grammar changes. Vetted by Public Safety Manager, Director of Public Safety and Risk Management. |
| Payroll and Timekeeping | Revised | Approved as Submitted | Revisions to align with the transition from Kronos to UKG. Vetted by Assistant Controller and CFO. |
| Reference Ranges | Revised | Approved with Revisions | Updated Adult chemistry reference intervals for the following: BNP, Gentamicin – random, Gentamicin – trough, Haptoglobin, Iron, Levetiracetam, Lithium. Updated pediatric chemistry reference interval for Alk Phos 0-1 week. Removed reference intervals for TEG 5000 testing, Ictotest, and Malaria stain as these tests are no longer performed at UMC. Updated entire Molecular section to include all new testing. Updated "Reference Intervals" to "Reference Ranges". Vetted by Assistant Director Laboratory Services. |
| Adult Massive Transfusion | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Assistant Director Laboratory Services. |

| POLICY NAME | NEW/ REVISED | HPP COMMITTEE DECISION | SUMMARY |
|---|---|---|---|
| Timed Collections for Therapeutic Drug Monitoring | Revised | Approved as Submitted | Updated Vancomycin, acetaminophen, acetylsalicylic acid sections per Pharmacy recommendations and updated all units from ug to mcg. Vetted by General Laboratory Services Manager and Laboratory Services Director. |
| Non-Blood Specimen Collection for Routine Testing and Culture | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by General Laboratory Services Manager and Laboratory Services Director. |
| Avoximeter 1000E – Whole Blood Oximeter | New | Approved as Submitted | New policy. Vetted by Dr. Jeremy Kilburn. |

# 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:**<br><br>**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
February 2, 2026

Agenda Item #

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