Governing Board

Clinical Quality and Professional Affairs Committee

June 20, 2016 3:00 PM
ProVidence Suite
Trauma Building, 5th Floor
800 Hope Place, Las Vegas, NV
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 on Monday, June 20, 2016, commencing at 3:00 p.m. at the UMC Trauma Building, ProVidence Suite (5th Floor), 800 Hope Place, Las Vegas, Nevada to consider the following:

SECTION 1. OPENING CEREMONIES

CALL TO ORDER

1. Public Comment

PUBLIC COMMENT. This is a period devoted to comments by the general public about items on this agenda. If you wish to speak to the Committee about items within its jurisdiction but not appearing on this agenda, you must wait until the “Comments by the General Public” period listed at the end of this agenda. Comments will be limited to three minutes. Please step up to the speaker's podium, clearly state your name and address and please spell your last name for the record. If any member of the Committee wishes to extend the length of a presentation, this will be done by the Chair or the Committee by majority vote.
2. Approval of minutes of the regular meeting of the UMC Clinical Quality and Professional Affairs Committee meeting on April 18, 2016. (For possible action)

3. Approval of Agenda. (For possible action)

SECTION 2. BUSINESS ITEMS

4. Receive a report from Dr. John Fildes, Chair, UMC Trauma on the status of the Southern Nevada Trauma System in “Voice of the Physician” (For possible action)

5. Approve and recommend approval by the Governing Board the amended Medical and Dental Staff Bylaws of University Medical Center of Southern Nevada; as accepted and voted on by the Medical Executive Committee and General Medical Staff on April 26, 2016. (For possible action)

6. Receive a report on current HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) scores, reviewing trended data as well as benchmarks and initiatives for improvement (For possible action)

7. Receive an update on ICARE4U educational update. (For possible action)

8. Receive a report on the 'Top 5' Priorities for Quality and Patient Safety with a review of action plans and initiatives for performance improvement (For possible action)

9. Receive a report on the Leapfrog initiative with a focus on Medication reporting, performance initiatives and patient safety (For possible action)

10. Receive an update on the CMS Star Rating (For possible action)

11. 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

A period devoted to comments by the general public about matters relevant to the Committee’s jurisdiction will be held. No action may be taken on a matter not listed on the posted agenda. Comments will be limited to three minutes. Please step up to the speaker’s podium, clearly state your name and address and please spell your last name for the record.

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 AND COUNTY COUNSEL.

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 18, 3:00 p.m.

The University Medical Center Governing Board Clinical Quality and Professional Affairs Committee met in the ProVidence Conference Room, Trauma Building, 5th floor, Las Vegas, Clark County, Nevada, on Monday, April 18, 2016, at the hour of 3:00 p.m. The meeting was called to order at the hour of 3:00 p.m. by Chair Jeff Ellis and the following members were present, which constituted a quorum of the members thereof:

**CALL TO ORDER**

**Board Members:**

Present:
- Jeff Ellis, Chair
- Renee Franklin
- Laura Lopez-Hobbs
- Donald Mackay, M.D.
- Mike Saltman
- John White

Absent:
- Mike Saltman (excused)

Also Present:
- Kurt Houser, Chief Operating Officer
- Stephanie Merrill, Chief Financial Officer
- Danita Cohen, Executive Director, Strategic Development and Marketing
- Mary Brann, DNP, MSN, RN, Executive Director, Compliance
- Shana Tello, Director of Medical Staff Services
- Halley Hammond, Director of Patient Experience
- Patti Stopka, RN, BSN, Assistant Director, Center for Quality and Patient Safety
- Terra Lovelin, Administrative Assistant/Board Secretary
SECTION 1. OPENING CEREMONIES

ITEM NO. 1  PUBLIC COMMENT

Chair Ellis 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 22, 2016.  (For possible action)

FINAL ACTION: A motion was made by Member Mackay that the minutes be approved as recommended. 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.

Kurt Houser, Chief Operating Officer, introduced Jenny Caca, Associate Administrator of Clinical Quality and Performance Improvement.

SECTION 2. BUSINESS ITEMS

ITEM NO. 4  Receive a report from Dr. Alan Greenberg, Infectious Disease physician, on the current state of ID and the challenges and opportunities for UMC and Las Vegas. (For possible action)

DOCUMENT(S) SUBMITTED: PowerPoint presented

DISCUSSION: Dr. Alan Greenberg presented an overview on infectious diseases and the impact on UMC.

He has worked with the hospital to help design and plan responses to external infectious disease threats, like H1N1 and Ebola. Another important responsibility of the Infectious Disease service is planning for internal threats, like hospital acquired infections.

One of the big risks to healthcare workers is exposure to TB and other blood related diseases. His number one call at night is blood exposure incidences.

Dr. Greenberg also discussed the protocol in place to ask patients who present flu like symptoms, if they have traveled out of the country recently. This protocol
has helped decrease external threats and isolate those who present symptoms to ensure that they do not spread disease to others.

Currently in the news is the Zika virus and Dr. Greenberg explained that the virus was identified over 60 years ago and is a mosquito-borne illness. The most common symptoms are fever, skin rash and muscle and joint pain, much like the flu. The World Health Organization (WHO) explains this as an explosive spread. Our role is to work with transplant services and the blood bank to ensure that people infected are not donating organs or having blood transfusions.

Dr. Mackay asked if Zika and MERS are detectable by antibodies and Dr. Greenberg replied that the detection is very difficult; there is a five to seven day latency period before antibody is made.

Mr. Houser added that Dr. Greenburg is leaving us in June after ten years and we are sorry to see him go.

FINAL ACTION: None taken.

ITEM NO. 5 Receive a report on current HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) scores, reviewing trended data as well as benchmarks and initiatives for improvement (For possible action)

DOCUMENT(S) SUBMITTED: PowerPoint: HCAHPS Report Key Drivers

DISCUSSION: Hailey Hammond, Director of Patient Experience went over four of our 2016 HCAPS key drivers:

1. How often our doctors listen carefully to our patients
   -Continuing ICARE4U sessions, focus on doctors sitting down with patients at eye level, increase HCAPs education and recognizing the good things the doctors are doing

2. How often did nurses treat you with courtesy and respect?
   -Continuing ICARE4U sessions and focusing on particular concepts by pulling the model apart and really focusing on the defining the principals, recognizing the staff via rounding’s and observations.

3. How often was your pain well controlled?
   -Using the white boards as a communication tool and possible nursing initiative to create pain management brochure to educate patients on realistic pain management.

4. After you pressed the call button, how often did you get help as soon as you wanted it?
   -Tent cards with nursing contact information and hourly rounding, use of our volunteers to help round on the patients to focus on the non-medical needs they have; 40 volunteers have just been on boarded specifically in the ER, to help with comfort items.
Our scores in these particular drivers are moving forwarded.

Shana Tello, Director of Med staff added that doctors are now getting reports to see where they are at. The first Hospitalist meeting occurred and the doctors went over their scores and then took them back to their groups. The HCAPS scores have been added to a report card that they receive every six months.

It was brought up that there is a need to make sure there are chairs in every room so the doctors can sit down with their patients.

FINAL ACTION: No action taken.

ITEM NO. 6 Receive an update on ICARE4U educational update. (For possible action)

DOCUMENT(S) SUBMITTED: None submitted

DISCUSSION: Danita Cohen, Executive Director of Strategic Development and Marketing explained the various ways that they are keeping the ICARE4U program alive and motivating the employees.

There are posters, emails and UMC posts regarding the principals. Danita and the team are also rounding with candy to help motivate and recognize employees.

Multiple awards are also given out to encourage everyone to embrace the model.

The distribution of the ICARE4U cards have actually gone up which is a great thing.

FINAL ACTION: No action taken.

ITEM NO. 7 Receive a report on the “Top 5” Priorities for Quality and Patient Safety, with a focus on Sepsis and PS14, reviewing actions plans and initiatives for performance improvement. (For possible action)

DOCUMENT(S) SUBMITTED: “Top 5” Update

DISCUSSION: Mary Brann, Executive Director of Compliance presented the top 5 priorities for Quality and Patient Safety.

1. PSI 4
2. Sepsis
3. Pressure Ulcers
4. CLABSI
5. Hand Hygiene
PSI 4: Death among surgical inpatients with serious treatable conditions.
-DVT/PE
-Pneumonia
-Sepsis
-Cardiac arrest
-GI bleed/hemorrhage

Patty and Paige are having weekly coding and quality meetings to review questionable cases. Also, weekly mortality meetings are being held to discuss if there are any documentation and quality issues.

A PSI 4 working group has been established that includes a physician who looks at cases should anyone have any questions.

Patti Stopka, Assistant Director, Center for Quality and Patient Safety explained that Sepsis is a Core Measure from CMS.

Core Measures are bundles of Evidence Based care which has shown to result in better outcomes for patients. The new measure set started October 2015. Sepsis is the leading cause of death in U.S hospitals and strikes 750,000 Americans each year.

A Sepsis Action Plan has been created and includes the following:

- 1 FTE Sepsis Program Manager
- Education
  -Nursing: Mandatory 2 hour education course on how they can recognize sepsis cases immediately.
  -Physician/resident/leadership: May 10 and 11, Sepsis Summit.
- Champions
  -Administrative champion: Kurt Houser
  -Physician Champion: JD McCourt and Hindu Shigamitsu
  -Resident Champion: Christopher McNicoll
- Revenue Cycle
  -Identification of record coded sepsis
  -Review of records prior to dropping bills

In December 2015, we had 111 patients coded with Sepsis in one month so it was clear something needed to be done.

**FINAL ACTION:** No action taken.
ITEM NO. 8  Receive a report on the Quality Award program initiated at UMC. (For possible action)

DOCUMENT(S) SUBMITTED: PowerPoint

DISCUSSION: Ms. Brann updated the committee on the UMC Quality Star Program.

The Quality Star Champions Award is awarded to a unit or department that demonstrates an improvement in one of our five initiatives then maintains the improvement for a quarter. The department/unit is given a banner for the quarter to display and a pin for all involved.

The Quality Star Program is awarded to individuals making a significant contribution to quality in their area of expertise. The individual receives a certificate and a pin. We have awarded 13 pins to date.

FINAL ACTION: No action taken

ITEM NO. 9  Receive an update on the CMS Star Rating and a response from Vizient in preparation for its release. (For possible action)

DOCUMENT(S) SUBMITTED:  
- CMS Overall Hospital Star Rating Preview

DISCUSSION: Mary Brann gave an overview on Vizient's review of star rating.

Vizient found the following:

- The star ratings will come out on the 21st of this month but the improvements that have been made won't be reflected for a couple of years

- Non-Medicare patients are not represented

- It adds layers of analytics that are difficult to understand or reproduce.

- Caring for underserved populations are not accounted for in their risk adjustment

In response to a Vizient consultation we looked at some things that they pointed out.
1. PSI 4
2. Top 5 costs per DRG
3. Ambulatory
4. Documentation improvement
5. Patient flu vaccination and VTE-1
We were selected as a site for the Vizient Performance Improvement Advisor program for 2016. There is no charge for 2016 and only 30 sites nationwide were selected.

**FINAL ACTION:** No action taken.

**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.

Member Franklin mentioned a hospital in New Jersey that is giving their patients the ability to request a refund for a service that they don’t feel is up to their standard.

**COMMENTS BY THE GENERAL PUBLIC:**

At this time, Chair Ellis 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 4:42 p.m., Chair Ellis adjourned the meeting.

**MINTUES PREPARED BY:** Terra Lovelin, Administrative Assistant

**APPROVED:**
The SNTS is working well

- There have been NO INCIDENTS where patients or EMS could not access a trauma center in a timely manner
- All local, regional, and national benchmarks are met or exceeded

The data does not support the need for new trauma centers

Doubling the number of trauma centers at one time is unwise and dangerous
The level 1 academic trauma center is an essential asset of the trauma system. A trauma system should not try to grow by dismantling the Level 1 center to create an oversupply of Level 3 trauma centers. Needs based assessment and population studies must be used to identify the need and location of new centers from the American College of Surgeons Position Statement.
The injury pyramid

The millions of deaths that result from injuries represent only a small fraction of those injured. Tens of millions of people suffer injuries that lead to hospitalization, emergency department or general practitioner treatment, or treatment that does not involve formal medical care. The relative numbers of fatal and non-fatal injuries are often graphically depicted in the form of a pyramid. In addition to the severity of an injury, there are a number of factors that vary by country and that determine the "shape" of the pyramid, such as access to health care services, or the quality of the data available.
All hospitals treat injured patients **BUT NOT ALL** hospitals are trauma centers from the American Trauma Society
The work of a Level 1 or 2 center

- **Level 1**
  - Care of seriously injured patients with physiologic or anatomic abnormalities and all others
  - Research, prevention, teaching & training

- **Level 2**
  - Care of seriously injured patients with physiologic or anatomic abnormalities and all others. They only provide the clinical component.
The work of a Level 3 center

- Care of stable patients with serious mechanisms of injury or special considerations
- These patients are awake, alert and have stable vital signs
- These patients are transported without lights & sirens at travel at posted street speeds
The work at St Rose Level 3 center

- St Rose sees about 2 patients per day or 60 (50-70) per month
- 85% of patients are discharged or transferred
- Less than 4 patients per year are admitted directly to the OR or ICU
- Only 15% or about 10 patients per month are admitted

SNHD data
UMC is a unique Level 1

- Purpose built for high volume & acuity
- It is a stand alone center
- 20,025 sq feet = 4 ¼ basketball courts
- 11 resuscitation beds
- 3 dedicated ORs
- 14 bed closed ICU
- CT, angio, radiology, blood bank, pharmacy, and lab
UMC trains new doctors

- 100\textsuperscript{th} General Surgeon trained in NV
- Emergency medicine
- Plastic Surgery
- ENT
- Orthopedic Surgery is new and needs the historic volumes to be successful
- UNLV needs this training center to succeed
- ALL students and residents are welcome to rotate here
UMC trains the military

- There are active duty residents in surgery and emergency medicine
- The SMART program provides sustainment training between deployments
UMC provides injury prevention and research

- Areas like child abuse, pedestrian safety, drunk driving, seat belt use, interpersonal violence, suicide, and many more
- Taught ATLS and DMEP to more than 700
- Has published over 100 articles and book chapter
- Over $12 million in research grants
- Lectured at the national & international level
UMC Trauma Admission Volume

Data Source: UMC Trauma Registry Adult Patients
UMC Trauma Admission Volume

Data Source: UMC Trauma Registry Adult Patients

August 2005
Sunrise Level II and St. Rose Level III
UMC Trauma Admission Volume

August 2005
Sunrise Level II
and St. Rose
Level III

August 2005
Step 4
Criteria
Adopted

Data Source:
UMC Trauma
Registry Adult Patients
Clark County Population

Data Source: Clark County Demographics
Clark County Population

Total Trauma Field Triage Criteria

Data Source: Clark County Demographics & SNHD TFTC
All patients
An important question...

Why did so many hospitals become interested in becoming trauma centers?

- More patients are insured
- The rate of SELF PAY has **decreased** to 9-11%
- Trauma centers can charge **activation fees**
- Trauma centers can charge **out of network** fees
- It increases the volume of patients seen in the Emergency Department
Better funding means trauma center shortage may become a glut

By Steven Ross Johnson | November 28, 2015

For the past 20 years, MetroHealth Medical Center has been the sole provider of Level 1 adult trauma care for the metropolitan Cleveland area’s 2 million residents.

Located on the city’s west side, Cuyahoga County-owned MetroHealth operates one of the busiest trauma centers in the country. Its specialized facility and highly trained clinical staff handle more than 3,000 sudden and serious injuries a year, including gunshots, stabbings, falls and motor-vehicle accidents. “Emergencies come first here,” said Dr. Jeffrey Claridge, director of the trauma division at MetroHealth.

But his center is about to face some stiff competition. Next month, Case
A way forward...

- Needs-Based Trauma Center Designation Consensus Conference was convened by the American College of Surgeons Committee on Trauma in August 24-25, 2015
- HCA participated
- They developed a Needs Based Assessment of Trauma Systems tool (NBATS)
- That tool can be applied in a way that is relevant to southern Nevada
American College of Surgeons NBATS analyzes these six domains

- Population trends
- Median transport times
- Lead Agency/System Stakeholder/Community Support
- Severely injured patients (ISS > 15) discharged from acute care facilities not designated as Level I, II, or III trauma centers.
- Level I Trauma Centers
- Numbers of severely injured patients (ISS > 15) seen in trauma centers (Level I and II) already in the TSA
Needs Based Assessment Task Force

- Will use the NBATS tool
- Will use the American College of Surgeons Trauma Systems document for guidance
- Must assess the impact on existing centers
- Must assess applicant preparedness
- Must focus on patient needs
I will ask the Board of Health to

- Uphold the findings of the Office of EMS and Trauma Systems of the Southern Nevada Health District (SNHD)
  - “that the three applicants have not demonstrated unmet need for additional trauma services, and therefore cannot recommend authorization to seek designation as a center for the treatment of trauma.”
I will ask the Board of Health to

- Uphold the decision of the Regional Trauma Advisory Board (RTAB) of the SNHD
  - to not support the applications of the three hospitals
I will ask the Board of Health to

- Direct the RTAB to continue the work of the Needs Based Assessment Task Force
  - in a manner that is focused on patient need
  - in a manner that is relevant to Southern Nevada
  - and will include all three applicant hospitals and additional community stakeholders.
Medical Staff Services
Conflict of Interest Statement Policy

Medical Staff/APP Member’s Name:

Medical Staff Services Department or Committee Title:

This Statement is filed for:

☐ Credentialing Purposes (New or Renewal)
☐ Annual or New Officer, Department Chief or Committee Chair
☐ Update
☐ IRB Submission

Policy:

It is the policy of UMC Medical Staff that all staff members granted membership and/or privileges including those providing contracted services to the organization shall act in good faith to fulfill their responsibilities. In order to achieve this goal, all staff members and practitioners shall voluntarily fully and openly disclose any actual or potential conflict of interest at the time they arise in the course of providing or directing patient care, conducting the affairs of the organization, or providing services to the organization.

Conflict of Interest documents, where there is evidence of a reported conflict, will be published on the University Medical Center Website, www.umcsn.com. Additionally, signatures of Providers of conflicts published on the internet may be redacted from the scanned version of the Conflict of Interest prior to publication of such on the UMCSN website. This may be done by the Provider sending a request to the Medical Staff Office.

Definitions:

For the purposes of the policy, an actual or potential conflict of interest is present when an actual or potential conflict exists between an individual’s duty to act in the best interests of UMC and the patients we serve and his or her desire to act in a way that will benefit only him or herself or another third party. Although it is impossible to list every circumstance giving rise to a conflict of interest, the following will serve as a guide to the types of activities that might cause conflict of interest and to which this policy applies.

“Key Definitions:

Material Financial Interest means includes, but is not limited to:
• An employment, consulting royalty, licensing, equipment or space lease, services, arrangement or other financial relationship;
• An ownership interest;
• An interest that contributes more than 5% to a member’s annual income or the annual income of a family member;
• A position as a director, trustee, managing partner, officer or key employee, whether paid or unpaid.

“Family Member” means a spouse or domestic partner, children and their spouses, grandchildren and their spouses, parents and their spouses, grandparents and their spouses, brothers and sisters and their spouses, nieces and nephews and their spouses, parents-in-law and their spouses. Children include natural and adopted children. Spouses include domestic partners.

“Ownership” includes ownership through sole proprietorships, stock, stock options, partnership or limited partnership shares, and limited liability company memberships. It is not required that ownership in diversified funds that are not
controlled by you or an immediate family member be reported.

“Personal Interests” mean those interests that arise out of a member’s personal activities or the activities of a family member.

### A. Disclosures of Material Financial and Personal Interests:

- [ ] I have no conflicts to report

### B. Ownership:

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Do you (or does a family member) have an ownership interest in any company that provides goods or services to the Hospital, or otherwise does business with the Hospital? If yes, please list below, using additional sheets if necessary.

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<th>Name of Person (Self or Family Member)</th>
<th>Name of Company</th>
<th>Percent of Ownership</th>
<th>Type of Services Provided by the Company</th>
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### C. Compensation Arrangements:

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Do you (or does a family member) have an employment, consulting or other financial arrangement (including, without limitation, an office or space lease, royalty or licensing agreement, or sponsored research agreement or pre-clinical research agreements) with a company that provides goods and services to the Hospital or otherwise does business with the Hospital? If yes, please list below, use additional sheet if necessary.

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<th>Name of Company</th>
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### D. Business Positions:

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Are you (or is a family member) an officer, director, trustee, managing partner, officer or key employee of a company that provides goods and services to the Hospital or otherwise does business with the Hospital? If yes, please list below, use additional sheet if necessary.

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<th>Name of Person (Self or Family Member)</th>
<th>Name of Company</th>
<th>Business Position or Title</th>
<th>Percentage of Annual Compensation (includes mtg. stipends &amp; Travel reimbursement)</th>
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This final rule requires applicable manufacturers of drugs, devices, biologicals, or medical supplies covered by Medicare, Medicaid, or CHIP to report annually to the Secretary certain payments or transfers of value provided to physicians or teaching hospitals ("covered recipients"). In addition, applicable manufacturers and applicable group purchasing organizations (GPOs) are required to report annually certain physician ownership or investment interests. The Secretary is required to publish applicable manufacturers' and applicable GPOs' submitted payment and ownership information on a public website.

UMC Physicians, who are employed, affiliated with contract with or utilize the services of UMC for their patients are required under UMC bylaws to know and abide by all applicable federal regulations related to their position. While this summary is presented for condensed reference due to the specificity of much of the material, a link is being provided to the official Federal Register related to 42 CFR Part 403. It is this material that physicians and Advanced Practice Professionals (APPs) are required to know. [https://www.federalregister.gov/regulations/0938-AR33/transparency-reports-and-reporting-of-physician-ownership-of-investment-interests-cms-5060-f](https://www.federalregister.gov/regulations/0938-AR33/transparency-reports-and-reporting-of-physician-ownership-of-investment-interests-cms-5060-f).

If an issue that gives rise to an actual or potential conflict of interest will not be considered by a deliberate or decision-making body, the individual shall make the disclosure to the person or committee to whom the individual is accountable in the Medical Staff structure. It shall be the responsibility of the individual or committee to which the disclosure is made to determine whether and to what extent the person making the disclosure may participate in consideration of the issue.

Conflict of Interest Disclosure Statements submitted will be reviewed by the Chief of Staff and the Corporate Compliance Officer. If further review is necessary, the Disclosure statement will be forwarded to the Medical Executive Committee and/or the Board of Hospital Trustees.

I certify that the information hereby submitted is accurate and complete as of the date stated below, and that I shall provide written notice within 30 days to the Medical Staff of any changes to the information, after such date.

Print Name:

Date:

Signature:

FOR MEDICAL STAFF OFFICE

Memo Completed/Submitted to Chief(s):

COI Scanned Internet:

COI Sent to Compliance Officer:

Transparency Reports and Reporting of Physician Ownership of Investment Interests (CMS-5060-F)

MEC: 03/23/10, 09/28/10, 04/26/11, 05/24/11, 04/23/13, 4/26/16
BOT: 04/20/10, 01/12/11, 06/21/11, 06/18/13, 00/00/16
In the space below, please list, in a legible fashion, all conflicting interests as defined in the Conflict of Interest Policy (MSS-361).

The listing of conflicts will not preclude an individual's participation in Medical Staff Services activities unless determined by the Medical Executive Committee to be a significant conflict of interest as described in the Conflict of Interest Policy (MSS-361).

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<td>MEC: 09/28/10, 02/22/11, 04/26/16</td>
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<td>BOT: 04/19/11, 00/00/16</td>
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2016 HCAHPS Key Drivers

June 2016
## 2016 HCAHPS Key Drivers

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<th>Key Driver</th>
<th>Goal</th>
<th>Jan-16</th>
<th>Feb-16</th>
<th>Mar-16</th>
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<tr>
<td>How often did doctors listen carefully to you?</td>
<td>76.23</td>
<td>62.13</td>
<td>66.67</td>
<td>59.24</td>
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<tr>
<td>How often did nurses treat you with courtesy and respect?</td>
<td>83.13</td>
<td>69.37</td>
<td>74.36</td>
<td>65.82</td>
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<td>How often was your pain well controlled?</td>
<td>60.21</td>
<td>55.02</td>
<td>54.78</td>
<td>53.70</td>
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<td>After you pressed the call button, how often did you get help as soon as you wanted it?</td>
<td>59.46</td>
<td>46.56</td>
<td>52.31</td>
<td>40.91</td>
</tr>
</tbody>
</table>
Top Initiatives:

• ICARE4U sessions for all Physicians and Residents (new Residents 6/28/16)

• Continued focus on educating doctors sitting down to be at eye level (new visuals in Physician lounge and dictation rooms)

• Continued HCAHPS education (providing individual scores, physician impact committee, physician champions and report cards)

• Recognition from Medical Leadership for positive comments and increased HCAHPS scores

How often did doctors listen carefully to you?

- [Line graph showing data points for Jan-16, Feb-16, and Mar-16. The graph shows a general trend of stability with minor fluctuations.]
Top Initiatives:

• ICARE4U as a standing agenda item in all unit/department meetings

• Narrowed focus on identifying themselves to patients and visitors and utilizing the communication board

• Increased HCAHPS education (providing unit scores, and comments comparing across units)

• Daily rounds Med/Surg 4th, 5th, 1500 floors to assist in validation and reinforcement of ICARE4U principles

• ICARE4U Take 5 Series - Courtesy and Respect conducted on Med/Surg 4th, 5th, and 1500 floors

• Recognition from leadership and ICARE Champions through rounding and peer to peer observation
Top Initiatives:

• Nurse Managers validate and reinforce continued use of whiteboards and pain scale (focused efforts on 3W/3S and Med/Surg 5N/5S)

• Utilization of best practices of hourly rounding and beside shift report to help assess, manage, and discuss expectations/needs for pain on IMC 3S/3W, Med/Surg 4th, 5th, 1500 floors

• Continued focus on ICARE4U Principle A- Asking about pain and pain management in clinical areas
Top Initiatives:

• Utilization of best practices of hourly rounding and beside shift report to help assess, manage, and discuss expectations/needs for pain on IMC 3S/3W, Med/Surg 4th, 5th, 1500 floors

• Nurse Managers validate and reinforce continued use of whiteboards and pain scale (focused efforts on 3W/3S and Med/Surg 5N/5S)

• Daily rounds Med/Surg 4th, 5th, 1500 floors to assist in validation and reinforcement of ICARE4U principles

• Use of volunteers to round on patients for non-medical needs

After you pressed the call button, how often did you get help as soon as you wanted it?
Top 5 Update 6.2016

Mary Brann DNP, MSN, RN
2016 Infection Control CLABSI Reduction Initiatives
UMC Adult Hospitalwide CLABSI (Raw Data)

- CLABSI Ad Hoc Committee began – March 2015
- Daily Review of all Blood Culture results and CLABSI analysis began – January 2016
- RCA with manager and staff RNs with unit based action plan – January 2016
- MaxZero needless connectors rolled out – March 2015
- IP rounding continues with one-on-one education, prevalence information to manager for reviews
  - Best practice, appropriate indication
The Joint Commission Targeted Solutions Tool (TST) Hand Hygiene program began
- 1500 & 3 West – April 3, 2015
- 3 South & CVCU/CCU – August 4, 2015
  - Pending analysis of these 4 units to determine effectiveness
- Upcoming units
  - 5 North/5 South & TICU
- Quality Week – focus on Hand Hygiene with Hospitalwide treat cart – March 16th, 2016
- You’ve been Spotted program/Pulse Articles
  - Message from Mason 5/29/2015
- IPs rewarding positive infection control behaviors to staff with Starbucks tokens – March 2016
- New Database created & went live 1/1/2016
PSI 4

Death among surgical inpatients with serious treatable conditions.

• DVT/PE
• Pneumonia
• Sepsis
• Cardiac arrest
• GI bleed/hemorrhage
PSI-04 Cases at UMC for the Most Recent 5 Quarters, Risk-Adjusted by Vizient

<table>
<thead>
<tr>
<th>Discharge Quarter</th>
<th>1Q15</th>
<th>2Q15</th>
<th>3Q15</th>
<th>4Q15</th>
<th>1Q16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>6</td>
<td>13</td>
<td>10</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Denominator</td>
<td>63</td>
<td>75</td>
<td>66</td>
<td>70</td>
<td>85</td>
</tr>
<tr>
<td>Observed Rate per 1,000</td>
<td>95.24</td>
<td>173.33</td>
<td>151.52</td>
<td>128.57</td>
<td>176.47</td>
</tr>
<tr>
<td>Expected Rate per 1,000</td>
<td>123.86</td>
<td>94.24</td>
<td>105.70</td>
<td>126.46</td>
<td>122.17</td>
</tr>
</tbody>
</table>

Initiatives:
- Review by Quality of all cases coded as HAC/PSI
- CPQS review of mortality cases.
- Review of potential PSIs forwarded for peer review began 3/25/16
- Attendance at CDI Conference and receipt of strategies to address PSIs/HACs
- Challenge: Identification of cases concurrently

Decrease in CDI staff
Sepsis

Nationally:

• Sepsis is the leading cause of death in U.S. hospitals (4 in 10 hospital deaths)
• Strikes 750,000 Americans each year
• Mortality rate of 28%–50%
• $20.3 million/year in hospital costs alone

CDC.gov

• Post – op sepsis (PSI 13)
**Sepsis Reviews**: Reviewing Lactic acids >2 in order to do concurrent review of septic patients. Identification of current patients challenging.

**Sepsis Committee**: Multidisciplinary team continued work on evidence based order sets

**Lab Call Backs** 1/10/2016: Laboratory began calling the floor on critical lactic acid values >2 to the ED

**Physician Peer Review** 2/10/2016: Weekly peer review and education by physician

**ED and inpatient adult Severe Sepsis and Septic Shock order set** 4/5/2016 – Sepsis screening – Staff education – Resident education

**Sepsis Symposium** 5/11/2016

**Staff Coordination**: approval of RN to provide more concurrent oversight and enforcement

**IT Support**: Investigating opportunities with software to assist in concurrent identification and patient management
INPATIENT MORTALITY - SEPSIS

Analysis: Continue to review sepsis mortality for core measure compliance
PI nurse for sepsis coordination and improvement
Need in depth analysis of sepsis mortality cases to identify opportunities for documentation severity of illness on admission

<table>
<thead>
<tr>
<th>Quarter</th>
<th>1Q15</th>
<th>2Q15</th>
<th>3Q15</th>
<th>4Q15</th>
<th>1Q16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>51</td>
<td>45</td>
<td>41</td>
<td>39</td>
<td>72</td>
</tr>
<tr>
<td>Denominator</td>
<td>406</td>
<td>345</td>
<td>328</td>
<td>367</td>
<td>436</td>
</tr>
<tr>
<td>Observed Rate</td>
<td>12.56%</td>
<td>13.04%</td>
<td>12.50%</td>
<td>10.63%</td>
<td>16.51%</td>
</tr>
<tr>
<td>Expected Rate</td>
<td>9.42%</td>
<td>9.46%</td>
<td>7.82%</td>
<td>6.89%</td>
<td>8.99%</td>
</tr>
<tr>
<td>Mortality Index</td>
<td>1.33</td>
<td>1.38</td>
<td>1.60</td>
<td>1.54</td>
<td>1.84</td>
</tr>
</tbody>
</table>
Pressure Ulcer Prevalence Trending (PSI 3)

Patients with Facility-Acquired Wounds (Excluding Stage 1)

- Dec'14: 2.7%
- Mar'15: 3.9%
- Jun'15: 3.9%
- Sep'15: 3.8%
- Feb'16: 4.6%

Actions: Mobile media capture piloted in BCU; roll out in ED
Two CWONs with new days/hours to cover 7 days a week.
Continuous updating of action plan for improvement by PSO and CWONs
1:1 just in time teaching/coaching through rounding on challenged nursing units
The Leapfrog Group

- Nonprofit group that coordinates a nationwide hospital survey
- Survey results publicly report hospital performance
- Survey is voluntary
- Survey results released two times per year
- Hospitals assigned a letter grade (safety score) based on results
# Infection in the Blood during ICU Stay (CLABSI)

<table>
<thead>
<tr>
<th>Trend</th>
<th>Current Score</th>
<th>Fall 2015</th>
<th>Average Score</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.852</td>
<td>0.983</td>
<td>0.437</td>
<td>RCA’s, PI teams, daily rounds, CLABSI team</td>
</tr>
</tbody>
</table>

# Infection in the Urinary Tract during ICU Stay (CAUTI)

<table>
<thead>
<tr>
<th>Trend</th>
<th>Current Score</th>
<th>Fall 2015</th>
<th>Average Score</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.030</td>
<td>1.730</td>
<td>0.945</td>
<td>IC Committee focus, daily rounds, nurse removal protocol</td>
</tr>
</tbody>
</table>

# Surgical Site Infection after Colon Surgery

<table>
<thead>
<tr>
<th>Trend</th>
<th>Current Score</th>
<th>Fall 2015</th>
<th>Average Score</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.433</td>
<td>1.392</td>
<td>0.959</td>
<td>Colon bundle, CHG, 1:1 with surgery</td>
</tr>
</tbody>
</table>

# MRSA Infection

<table>
<thead>
<tr>
<th>Trend</th>
<th>Current Score</th>
<th>Fall 2015</th>
<th>Average Score</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td>1.634</td>
<td>N/A</td>
<td>0.890</td>
<td>IC Committee, CHG, Screening</td>
</tr>
</tbody>
</table>
# Dangerous Bed Sores

<table>
<thead>
<tr>
<th>Trend</th>
<th>Current Score</th>
<th>Fall 2015</th>
<th>Average Score</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Change</td>
<td><strong>0.83</strong></td>
<td><strong>0.83</strong></td>
<td><strong>0.32</strong></td>
<td>Wound care team, weekly rounds, staff education, documentation</td>
</tr>
</tbody>
</table>

# Death from Treatable Serious Complications

<table>
<thead>
<tr>
<th>Trend</th>
<th>Current Score</th>
<th>Fall 2015</th>
<th>Average Score</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>↑</strong></td>
<td><strong>167.33</strong></td>
<td><strong>167.28</strong></td>
<td><strong>118.06</strong></td>
<td>‘PSI-4’</td>
</tr>
</tbody>
</table>

# Collapsed Lung

<table>
<thead>
<tr>
<th>Trend</th>
<th>Current Score</th>
<th>Fall 2015</th>
<th>Average Score</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Change</td>
<td><strong>0.48</strong></td>
<td><strong>0.48</strong></td>
<td><strong>0.39</strong></td>
<td>Review of cases, documentation initiatives, CDI</td>
</tr>
</tbody>
</table>

# Serious Breathing Problem (post-op resp. failure)

<table>
<thead>
<tr>
<th>Trend</th>
<th>Current Score</th>
<th>Fall 2015</th>
<th>Average Score</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Change</td>
<td><strong>24.29</strong></td>
<td><strong>24.29</strong></td>
<td><strong>12.05</strong></td>
<td>Review of cases, documentation initiatives, CDI</td>
</tr>
</tbody>
</table>
### Dangerous Blood Clot

<table>
<thead>
<tr>
<th>Trend</th>
<th>Current Score</th>
<th>Fall 2015</th>
<th>Average Score</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Change</td>
<td>7.13</td>
<td>7.13</td>
<td>4.18</td>
<td>CDI, documentation initiatives, physician education</td>
</tr>
</tbody>
</table>

### Surgical Wound Splits Open

<table>
<thead>
<tr>
<th>Trend</th>
<th>Current Score</th>
<th>Fall 2015</th>
<th>Average Score</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Change</td>
<td>1.94</td>
<td>1.94</td>
<td>1.70</td>
<td>CDI, documentation initiatives, physician education</td>
</tr>
</tbody>
</table>

### Accidental Cuts and Tears

<table>
<thead>
<tr>
<th>Trend</th>
<th>Current Score</th>
<th>Fall 2015</th>
<th>Average Score</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Change</td>
<td>3.8</td>
<td>3.8</td>
<td>1.80</td>
<td>Review after coding, CDI, documentation initiatives, physician education</td>
</tr>
</tbody>
</table>
Medication Reconciliation

Addition of SI reporting to Orientation - Jun 2016
Peer Review
Ongoing Staff Education and Reinforcement – Just Culture
• Most prevalent drug classes – antimicrobials, antibiotics and Opiates
• Project started 3Q 15 aimed and increased ADR reporting
• ADR’s entered into SI system and reviewed by Pharmacy Department
• Analyzed for Trends and modifications suggested
49% response rate

Areas of focus:
- Team work within and across units
- Manager promotes Patient Safety
- Organization offers Continuous Improvement
- Overall Perceptions of Patient Safety
- Staffing
- Handoffs
- Non-punitive Response to Errors
Culture of Safety Survey

FAVORABLE RESPONSE AREAS

- People support one another
- Work together as a team
- Actively working to improve patient safety
- Treat each other with respect
- Manager does not overlook patient safety problems
- Manager says good work when job is done safely

AREAS FOR IMPROVEMENT

- Staff worry that their mistakes are kept on file
- Units do not coordinate well
- Not enough staff
- Things ‘fall between the cracks’ when transferring
- Problems occur in the exchange of information
- Staff feel mistakes held against them
COS – Actions Taken

- Management Survey Review
- IT Solutions and EPIC
- ICARE4U
- Employee Events
- SI In-services – Just Culture
- Pursuit of Magnet
- Nursing Re-structure
- Leadership Rounding