Clinical Affairs Subcommittee of the Board of Directors

November 9, 2023

2:00 pm

WebEx link

https://uchc.webex.com/uchc/j.php?MTID=m459e0d24916468886488b2f23ccc266f

Password: Fall2023

Members of the public may join by phone by:
Dialing 1.415.655.0003 and entering access code
263 120 10383 when prompted.

For technical assistance please call 860 679 6232 or 860 679 2594

BOARD OF DIRECTORS
CLINICAL AFFAIRS SUBCOMMITTEE

NOVEMBER 9, 2023
2:00 P.M.

LINK: Clinical Affairs Nov 9, 2023

Password: Fall2023

AGENDA

1	Public Comment		
2	Chair's Remarks		Cheryl Chase
	2.1	Welcome	
	2.2	Approval of Minutes: May 11, 2023 **[vote]**	
3	Chief Executive Officer's Report		Dr. B. Liang
	3.1	Market Perception Study	Hyers / Wallace
4	Quality Reports		Dr. S. Allen
	4.1	JDH Clinical Quality & Service Performance Improvement Plan **[vote]**	
5	Approvals **[vote]**		
	5.1	Environment of Care Annual Assessments	Kevin Higgins
6.	School Reports		
	6.1	School of Medicine	Dr. B. Liang
		6.1.1 GME Annual Quality Improvements by Residents	Dr. W. Miller
	6.2	School of Dental Medicine	Drs. Lepowsky/Saeed
7.	Informational items		
	7.1	JDH Medical Board Quarterly Update	
	7.2	UConn Medical Group Operations Quarterly Report	
8.	Executive Session		
9.	Adjourn		

Post adjournment, the Clinical Affairs Subcommittee will convene in its capacity as a Medical Review Committee to conduct peer review activity under both our medical staff bylaws and Connecticut General Statutes §§ 19a-17b and 19a-17c.

Public Participation at meetings of the Clinical Affairs Subcommittee of the UConn Health Board of Directors

The Clinical Affairs Subcommittee of the UConn Health Board of Directors starts its agenda with Public Comments. The Clinical Affairs Subcommittee shall hear brief oral presentations from members of the public who wish to express their views on issues pending before this committee or on other issues of concern to UConn Health. The agenda for each regular public meeting of the Clinical Affairs Subcommittee shall allot up to thirty minutes for this purpose:

a. Requests to address the Clinical Affairs Subcommittee shall be made to the Chair's designee at least one day prior to the meeting. The actual person who intends to speak must make the request.

b. The Chair of the Clinical Affairs Subcommittee shall recognize each speaker in the order of signing up, shall request the speaker identify himself/herself, and shall ensure adherence to time limits as will permit the orderly progress of the BOD through its agenda. Each speaker will be allotted a time period of three minutes to speak.

c. At a special meeting of the Clinical Affairs Subcommittee, comment by members of the public shall be limited specifically to the subject described in the call of the special meeting. The Clinical Affairs Subcommittee would like to give each constituency an opportunity to speak. Therefore, groups are encouraged to appoint a single spokesperson to present their point of view. The purpose of Public Participation is to hear the views of the public and the Committee will neither ask nor answer questions nor make comments during this portion of the agenda.

The Chair appoints the following person as his designee to receive requests to speak at the Public Comments portion of the Board of Directors Meetings.

Maura Bobinski
Executive Staff Assistant
Office of Health Affairs | UConn Health
Phone: 860-679-6232
mbobinski@uchc.edu

Chair, Cheryl Chase, called the meeting to order at 2:03 pm.

1.1 No public comment

2. Chair's remarks

2.1 Welcome

Ms. Chase welcomed everyone to the regularly scheduled quarterly meeting which was being recorded.

2.2 Approval of Minutes

The Clinical Affairs Subcommittee approved the motion to accept the minutes of the Subcommittee meeting held on February 9, 2023.

3. Chief Executive Officer Report – Dr. Bruce Liang

Dr. Bruce Liang provided a report on current hospital operations. He provided the COVID-19 update to this committee for the last time, due to the continued downward trend of cases at UConn Health and throughout our state. UConn Health has been steadily loosening up COVID restrictions for employees, patients, and visitors over the past several months due to this downward trend. The official end of the COVID-19 public health emergency (PHE) is today, May 11. A workgroup facilitated by our Healthcare Compliance team has reviewed all applicable PHE waivers and taken necessary actions to return to pre-pandemic processes. The average daily census and discharge reports for John Dempsey Hospital continue to exceed budget forecasts. As reported at previous meetings, we are seeing a steep growth of patients seeking care and anticipate needing an additional 1.4 beds every month to keep up with demand. Surgery in main OR, GI and UHSC continues to be at or exceeding budget currently. UConn Medical Group's net patient revenue is ahead of budget by 4.4% and the prior year by 6.7%. The largest growth areas YTD are Dermatology, OB/MFM, and Primary Care when compared to budget. UMG is a busy practice reporting encounters to be 5.5% better than budget and 6.6% ahead of the prior year. The UMG Simsbury practice was relocated to 836 Hopmeadow Road and opened for business on May 5th.

4. Quality Reports

4.0 John Dempsey Hospital/UConn Medical Group – Dr. Scott Allen

Dr. Scott Allen announced that John Dempsey Hospital was recognized with an international designation, as one of the 2023 World's Best Hospitals, recognizing the best medical institutions across 28 countries. In addition, HealthGrades awarded the hospital the 2023 Outstanding Patient Experience Award, the only hospital in Connecticut to achieve this level. For the 5th time in a row, John Dempsey Hospital was awarded an A Safety grade by Leapfrog. Dr. Allen reviewed the Hospital Safety Scorecard metrics and highlighted some key metrics such as Hand Hygiene, CLABSI, CAUTI events – and noted the last serious safety event was January of this year.

5. Approvals

JDH Medical Staff Bylaws require that each Clinical Service of the Medical Staff have a Chief of Service that is responsible for all professional and clinically related activity.

5.1 Anesthesiology Chief of Service – Dr. Leonard Kulicki

5.2 Medicine Chief of Service – Dr. Mark Metersky

The Clinical Affairs Subcommittee unanimously approved the appointments described in Agenda items 5.1 and 5.2 as detailed on the Resolutions in the Board materials on pages 23-27.

5.3 Utilization Review Report

The UCH BOD has delegated authority to this Subcommittee to act on behalf of the Board to approve the JDH Utilization Management Plan, which is designed to ensure effective and efficient utilization of the hospital's resources.

The Clinical Affairs Subcommittee approves the 2022 Utilization Review Report as described in the Resolution in the Board materials on page 28 (Director Rawlins abstained).

6. School Reports

6.1 School of Medicine Update

Dr. Steven Angus provided an overview of the Graduate Medical Education activity reporting four new programs will start in July 2023. Epilepsy, Foot and Ankle Orthopedic Surgery, MSK Radiology and Sleep Medicine join our 70 existing residency and fellowship programs. All residency programs are filled in their respective match. There are 214 incoming trainees starting in June, selected from 3,119 interviewed applicants. 13% of our trainees identify as URiM, and over 55% are female.

6.2 School of Dental Medicine Update

Dr. Sophia Saeed provided an update on the goals set and actions taken after the 2021 inaugural administration of the Patient Safety and Culture Survey. A significant amount of effort was made in the last year to make meaningful changes in areas of weakness. In April 2023 the survey was administered again, and most areas saw improvements, specifically office processes and organizational learning where we met our goals. In operations, the total number of visits remained below budget, but revenue remains favorable. . If we look at gross charges per visit year to date, we are 11% positive to budget with is an improvement from last quarter.

Dean Lepowsky shared the sad news that Dr. Christy Lottinger will be leaving UConn Health later this summer, relocating to New Hampshire. Her remarkable contributions to both our educational and patient care programs have been extraordinary. She is an outstanding educator, receiving the 2023 Excellence Award, and we wish her only the best in the next phase of her professional career.

7. Informational Items

A summary of activities undertaken by the JDH Medical Board over the last quarter is included on page 44, and the UConn Medical Group quarterly Operations Report begins on page 45.

8. Executive Session

A motion was made and seconded to enter executive session to discuss attorney-client privileged communications and other items exempt from public disclosures under the state Freedom of Information Act.

The Clinical Affairs Subcommittee unanimously approved the motion to enter executive session at 3:00pm.

The following guests were invited to attend executive session: A. Keilty, A. Horbatuck, B. Liang, C. Ryan, J. Blumenthal, J. Geoghegan, S. Simpson S. Simpson, R.

Return to public session at 3:35 pm.

There being no further business the meeting was adjourned at 3:36 pm.

Respectfully submitted,

Bruce T. Liang

Bruce T. Liang, MD
Interim Chief Executive Officer, John Dempsey Hospital
Interim Executive Vice President for Health Affairs
Dean, UConn School of Medicine

Voting Members Present: C. Chase, R. Barry, J. Freedman, K. Alleyne, W. Rawlins, T. Ressel, D. McFadden, R. Fuller, L. Wolansky, D. Shafer, C. Lottinger

Absent: n/a

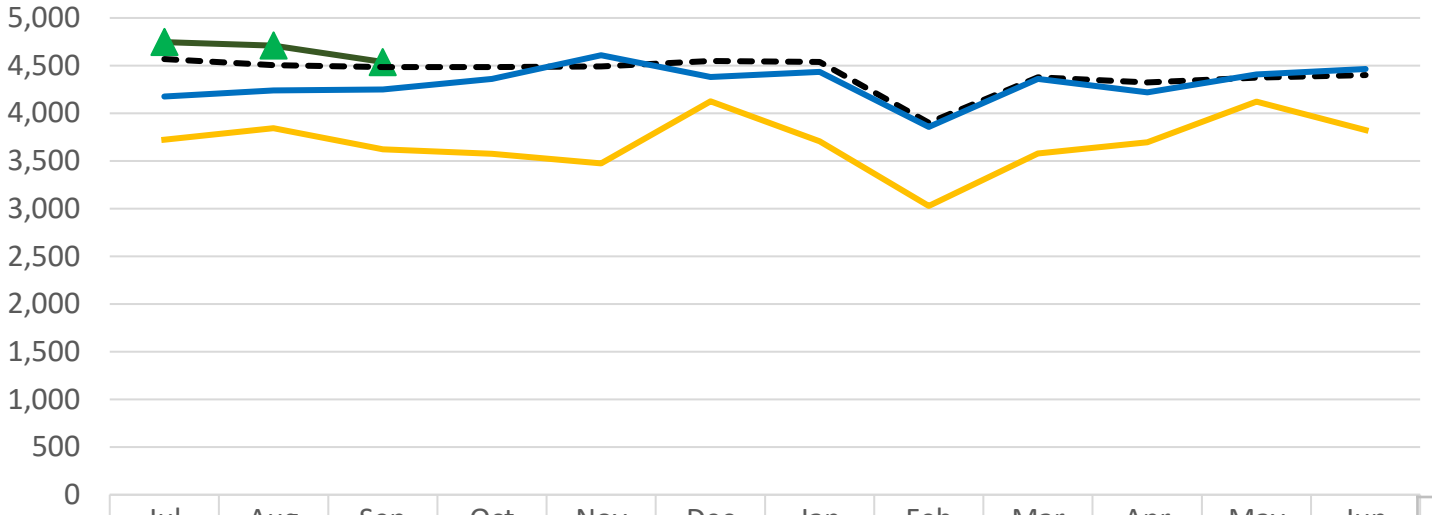
Next Regularly Scheduled Meeting

August 10. 2023

CEO Update November 9, 2023

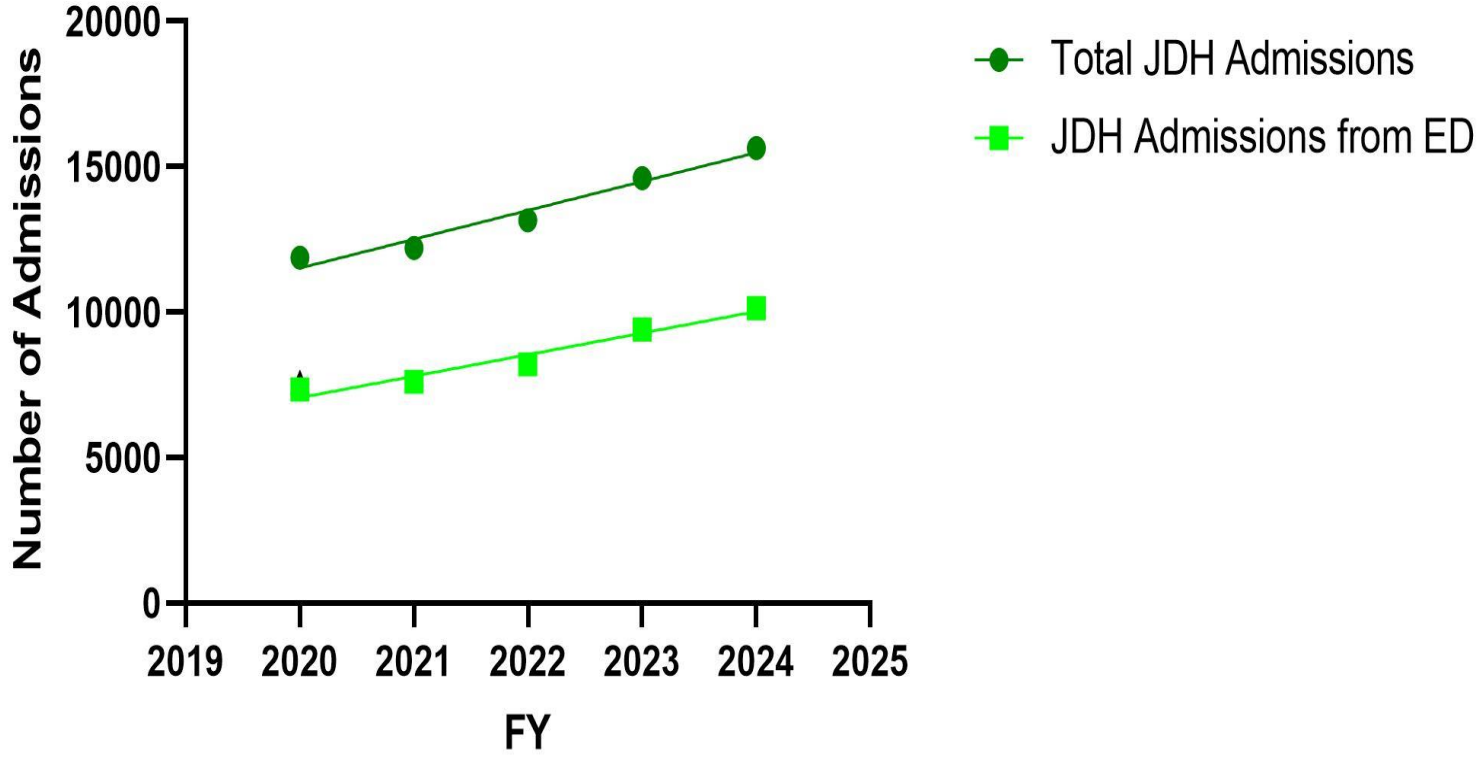
Bruce T. Liang, MD
Interim Chief Executive Officer & EVP for Health Affairs
Dean, School of Medicine

Emergency Room Visits

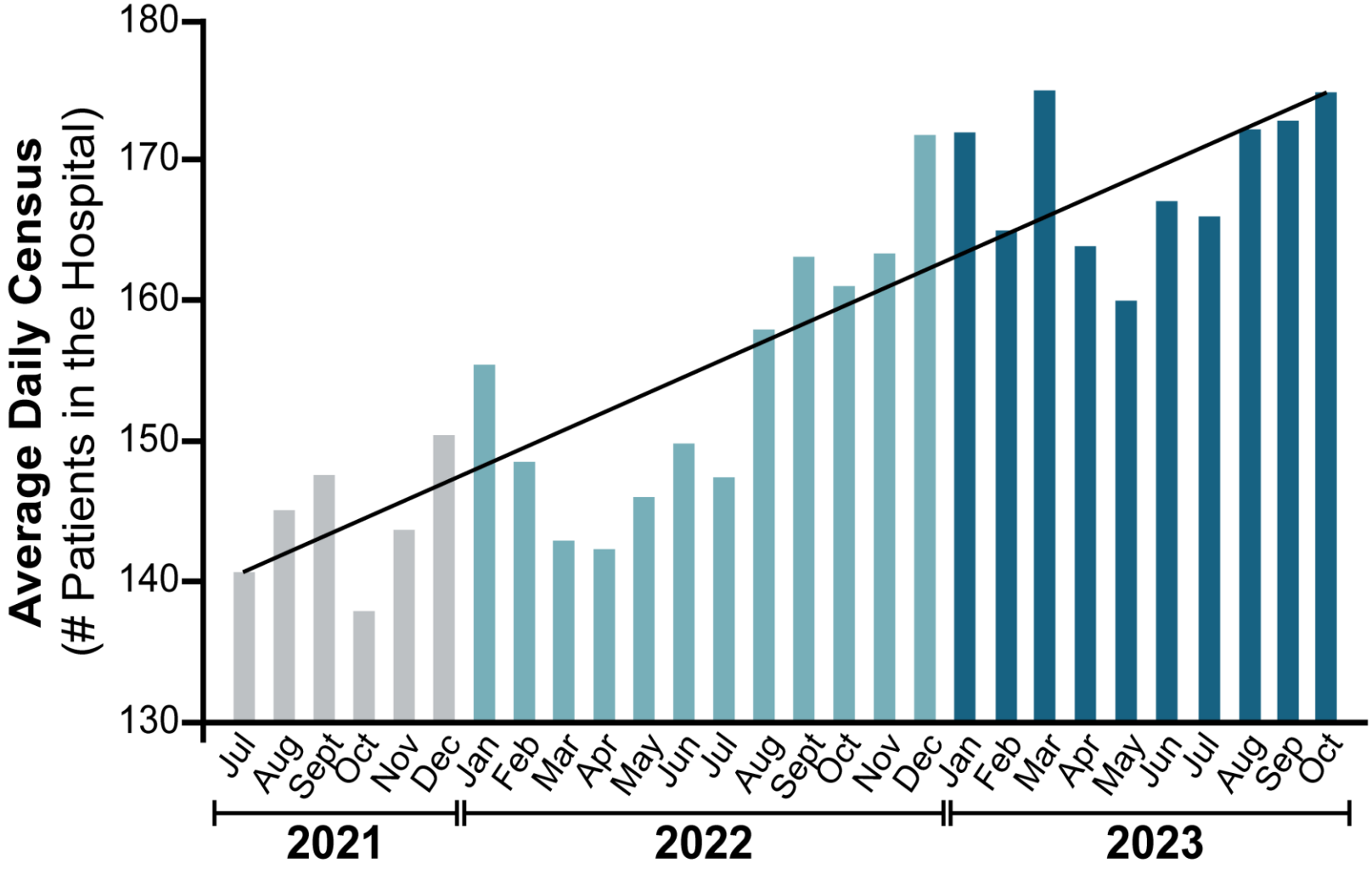


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
2024 Actual	4,746	4,710	4,536										13,992
2024 Budget	4,566	4,503	4,484	4,483	4,491	4,549	4,538	3,899	4,376	4,324	4,374	4,401	52,988
2023 Actual	4,175	4,239	4,249	4,361	4,609	4,381	4,432	3,858	4,360	4,219	4,408	4,462	51,753
2022 Actual	3,723	3,844	3,623	3,575	3,475	4,126	3,706	3,029	3,577	3,696	4,122	3,824	44,320

Emergency Department and JDH Admissions

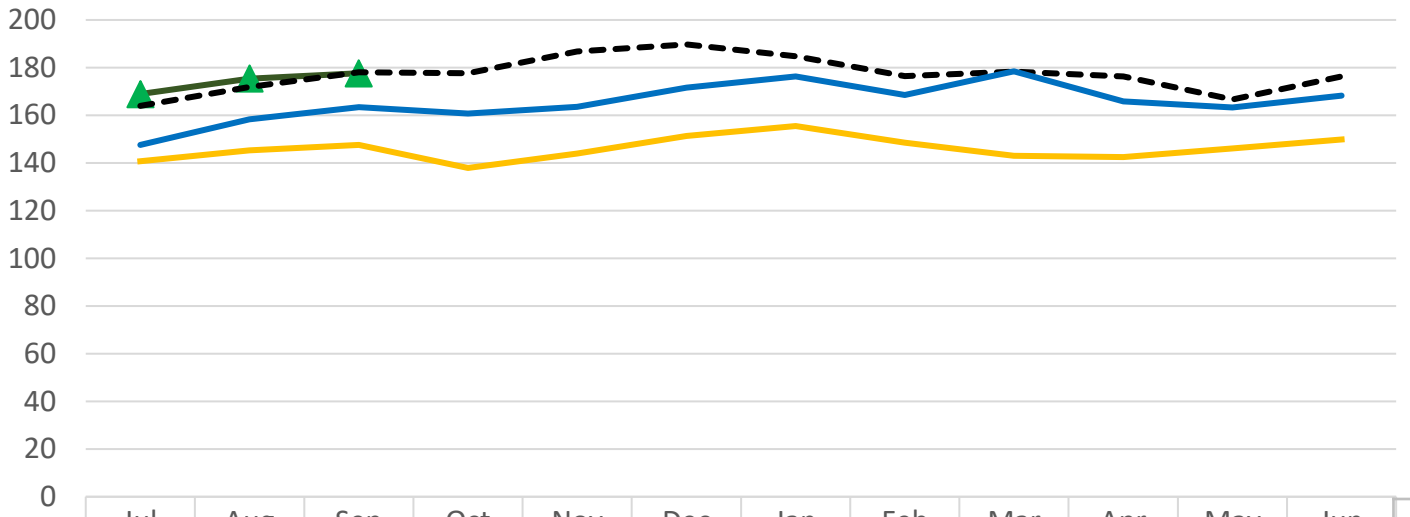


Steep Growth of Patients Seeking Care at UConn Health Each Month



UCONN HEALTH

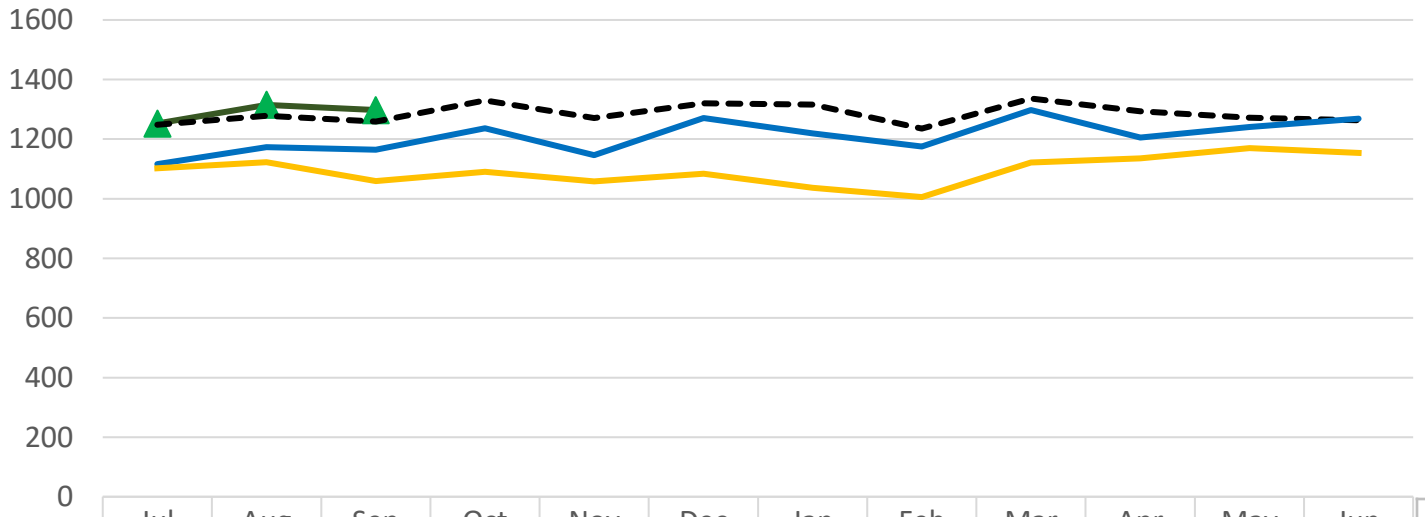
Average Daily Census
including OBS/OEXT



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
2024 Actual	169	175	178										522
2024 Budget	164	172	178	178	187	190	185	176	178	176	167	176	2,126
2023 Actual	148	158	163	161	164	172	176	168	178	166	163	168	1,986
2022 Actual	141	145	148	138	144	151	155	149	143	143	146	150	1,752

Discharges

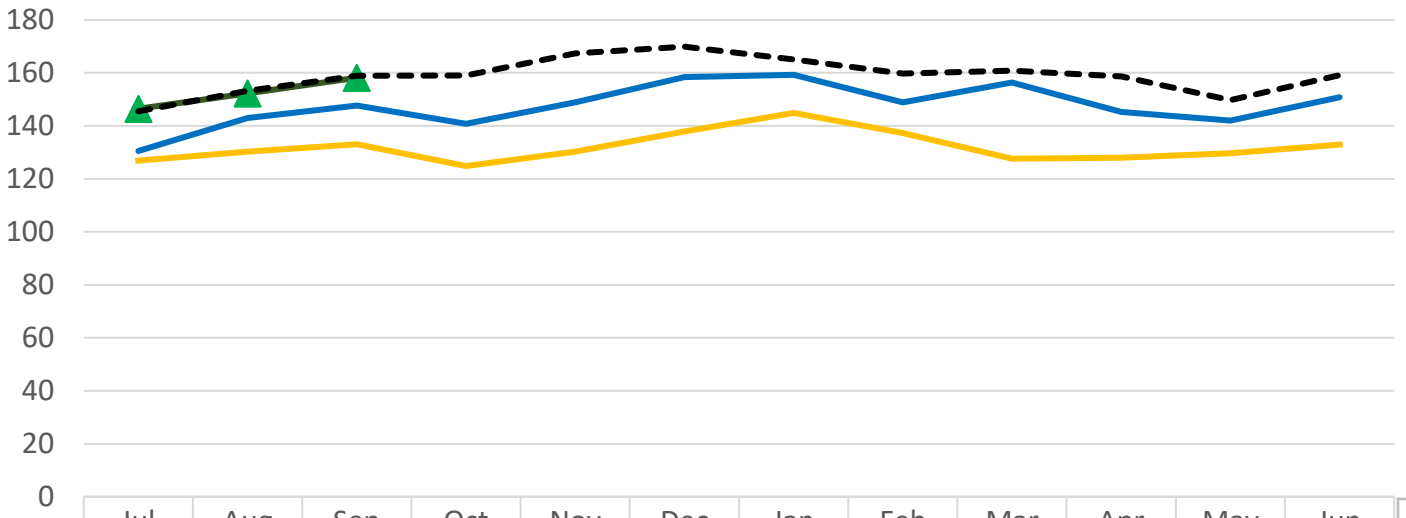
including OBS/OEXT



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
2024 Actual	1252	1315	1297										3,864
2024 Budget	1248	1278	1259	1329	1270	1320	1315	1236	1336	1293	1272	1264	15,419
2023 Actual	1116	1173	1164	1236	1146	1271	1219	1175	1297	1205	1241	1268	14,511
2022 Actual	1102	1122	1059	1090	1058	1084	1037	1006	1121	1135	1170	1154	13,138

Average Daily Census

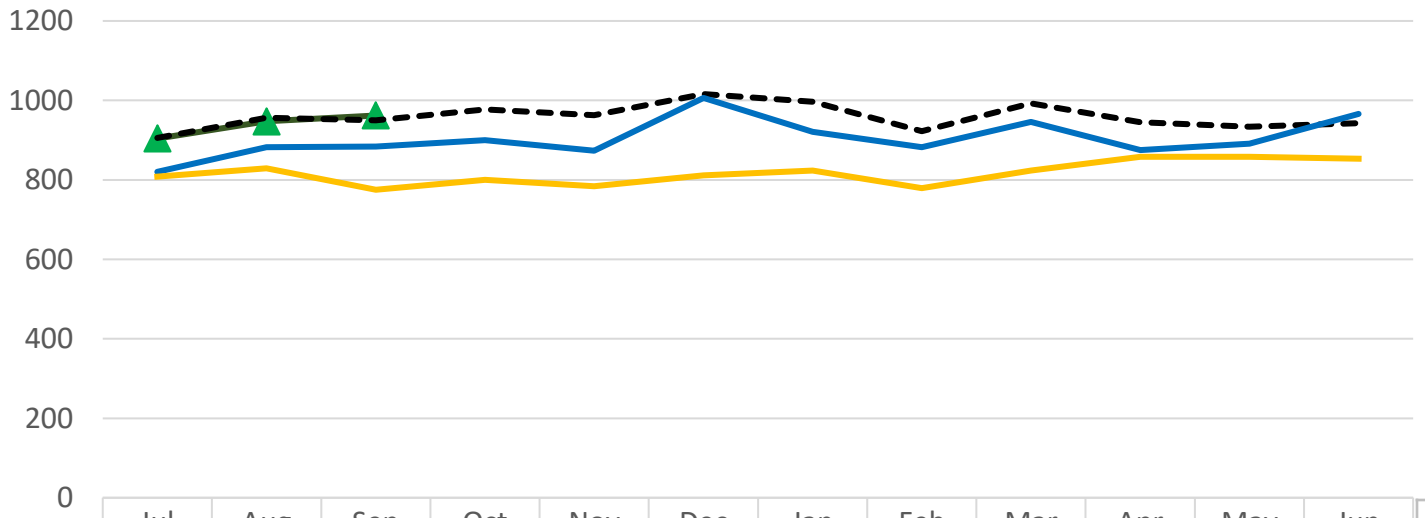
Inpatient



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
2024 Actual	146	152	158										457
2024 Budget	146	153	159	159	167	170	165	160	161	159	150	159	1,907
2023 Actual	130	143	148	141	149	158	159	149	156	145	142	151	1,771
2022 Actual	127	130	133	125	130	138	145	137	128	128	130	133	1,583

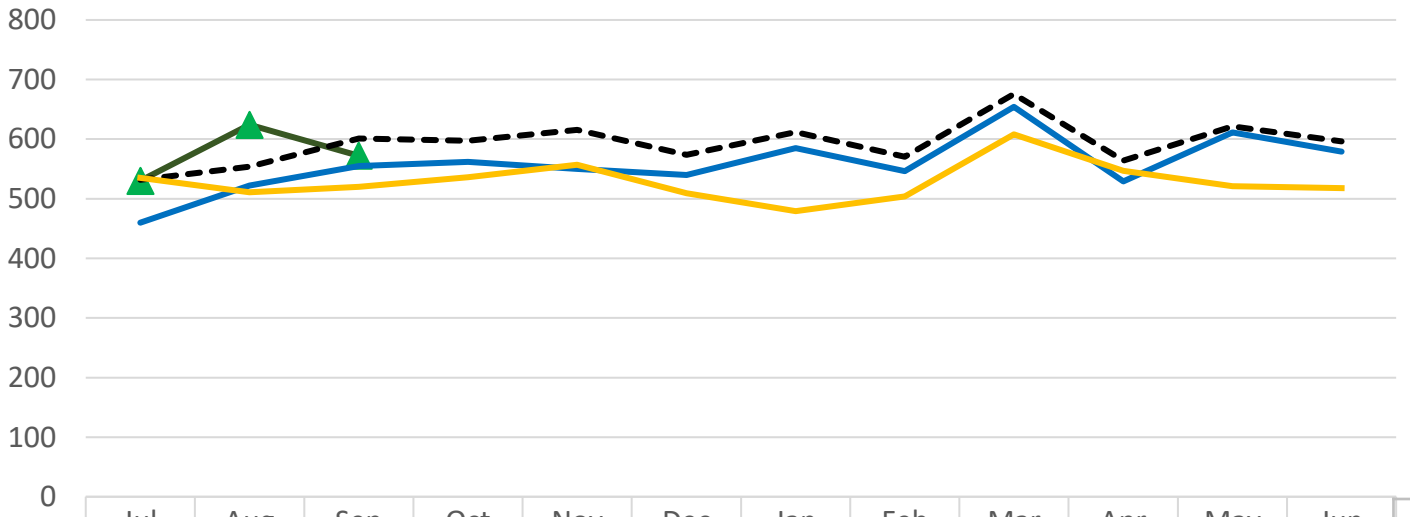
Discharges

Inpatient



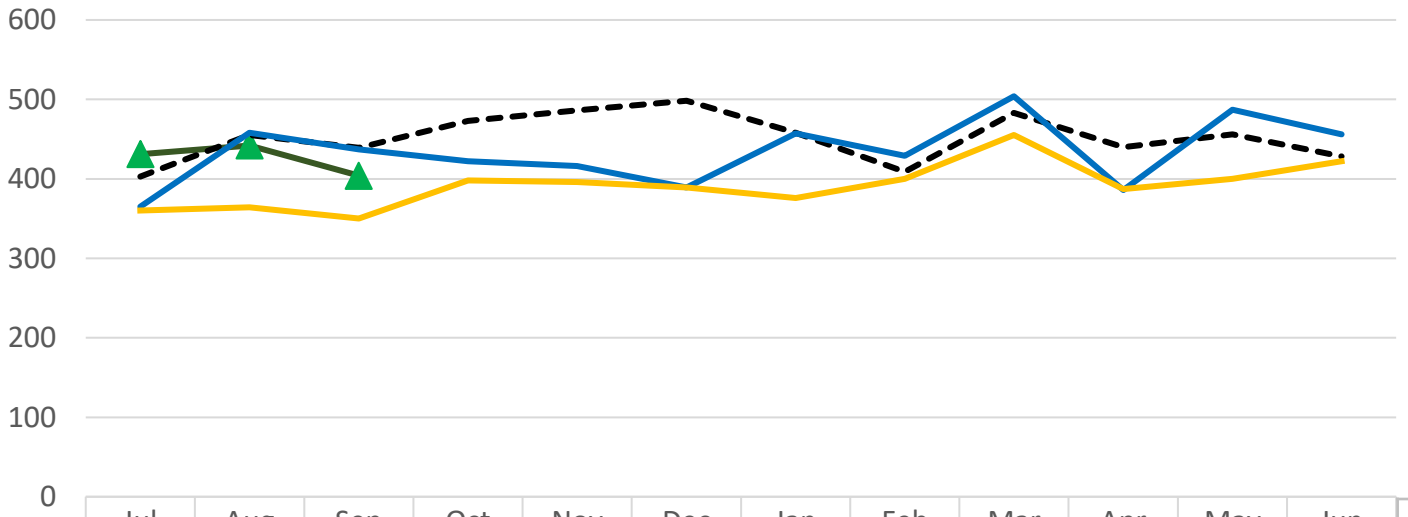
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
2024 Actual	904	947	962										2,813
2024 Budget	905	956	950	977	962	1016	997	922	993	945	933	943	11,499
2023 Actual	820	882	884	900	873	1006	921	882	946	875	891	966	10,846
2022 Actual	808	829	775	800	784	811	823	779	823	858	858	853	9,801

JDH - Main OR



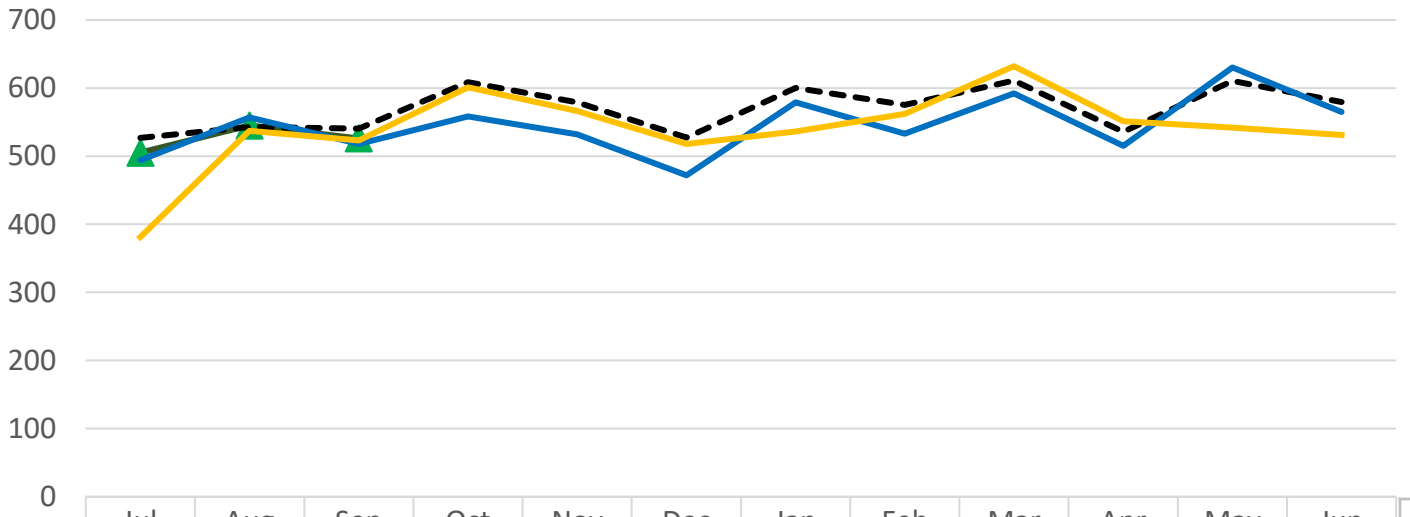
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
2024 Actual	530	624	572										1,726
2024 Budget	532	554	601	597	616	573	611	570	676	564	622	596	7,111
2023 Actual	460	522	555	562	550	540	585	546	654	529	611	579	6,693
2022 Actual	535	511	520	536	557	509	479	504	608	547	521	518	6,345

PROCEDURE CENTER
GI ENDOSCOPY



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
2024 Actual	431	442	404										1,277
2024 Budget	403	455	439	473	486	498	458	409	483	440	456	428	5,428
2023 Actual	365	458	437	422	416	389	457	429	504	386	487	456	5,206
2022 Actual	360	364	350	398	396	389	376	400	455	387	400	422	4,697

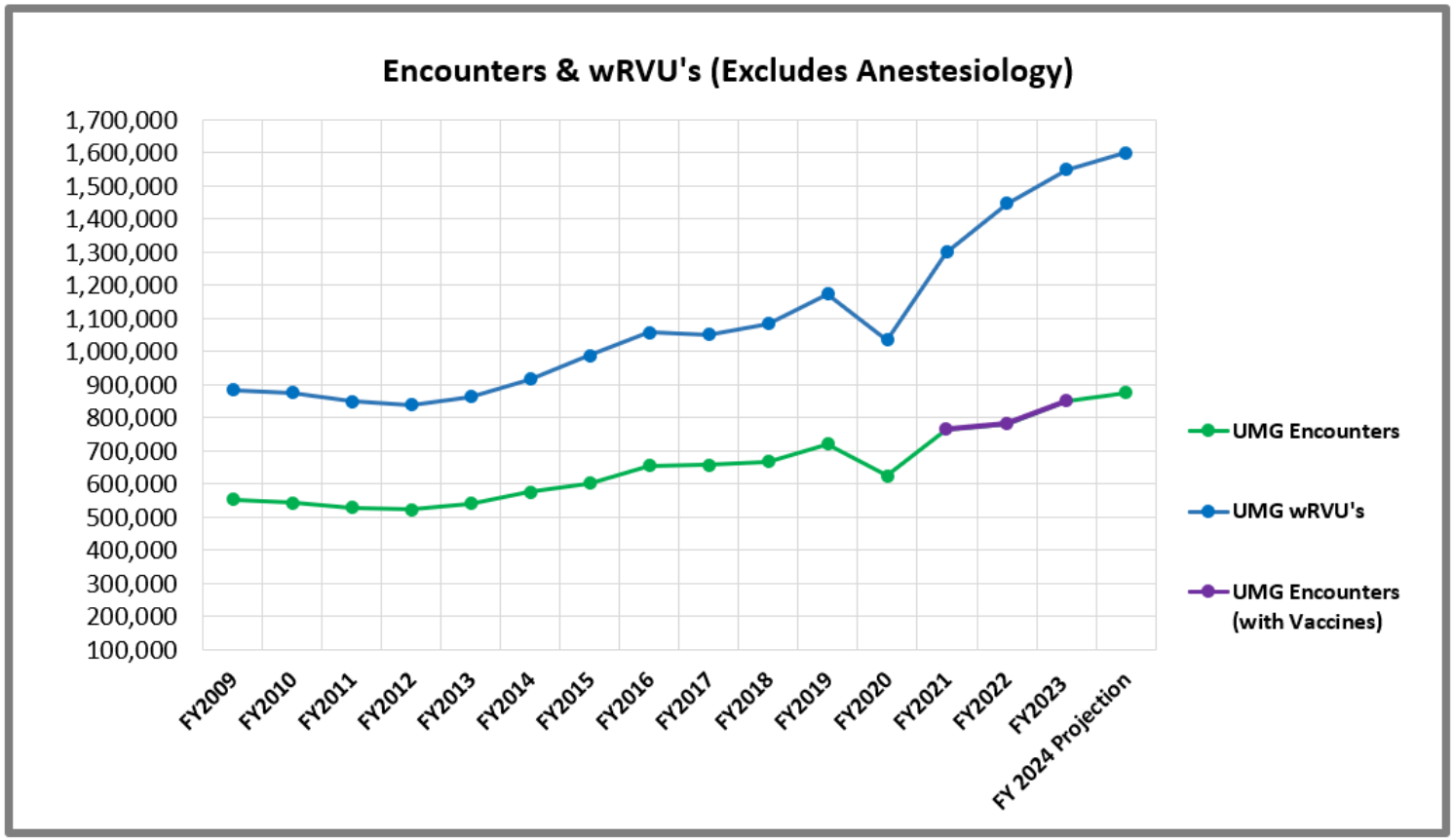
UHSC - OR



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
2024 Actual	505	545	526										1,576
2024 Budget	527	543	541	608	579	527	600	575	611	536	610	579	6,835
2023 Actual	494	557	518	558	532	472	579	533	592	515	630	565	6,545
2022 Actual	381	537	523	601	566	518	536	562	632	551	542	531	6,480

UConn Medical Group

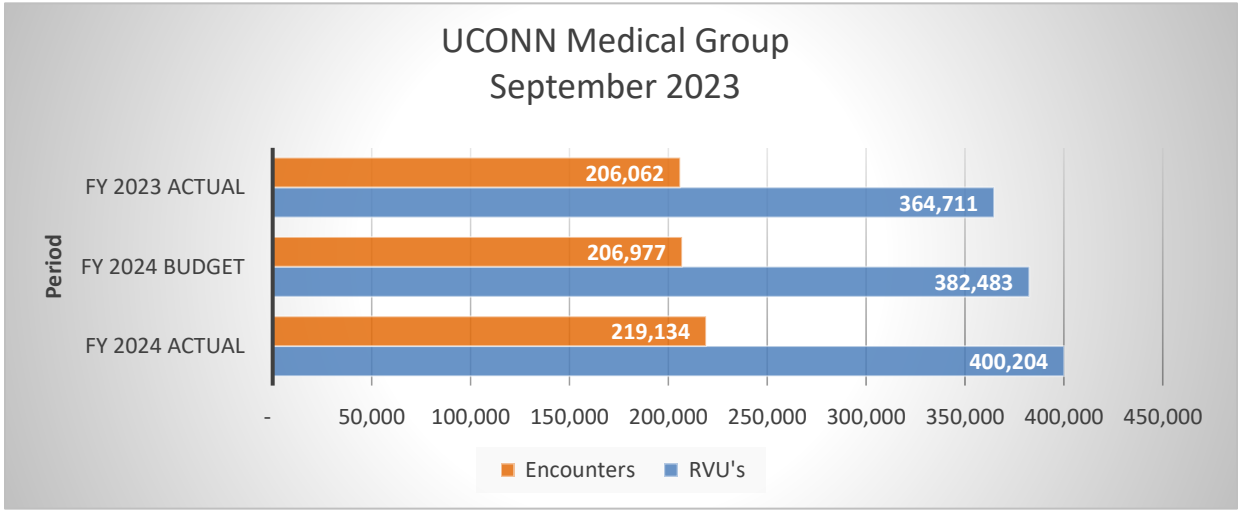
Statistical Graph



	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024 Projection	As of Sept 2023
UMG Encounters	553,016	542,611	529,703	523,570	540,574	575,416	602,923	655,234	656,848	667,009	719,760	625,310	686,166	782,695	850,412	876,536	219,134
UMG wRVU's	883,919	875,441	848,932	839,310	863,044	915,822	987,303	1,057,267	1,050,731	1,084,289	1,174,160	1,035,563	1,300,162	1,446,597	1,550,265	1,600,816	400,204
Vaccines	-	-	-	-	-	-	-	-	-	-	-	-	78,329	41,865	6,263	-	-

NOTE: FY 20 & 21 COVID
FY 24 vaccine moved to clinics

UMG Encounters & wRVU's



Encounters:

- YTD encounters are ahead of budget by 5.9% and ahead of prior year by 6.3%

wRVU's:

- YTD wRVU's are ahead of budget by 4.6% and ahead of prior year by 9.7%

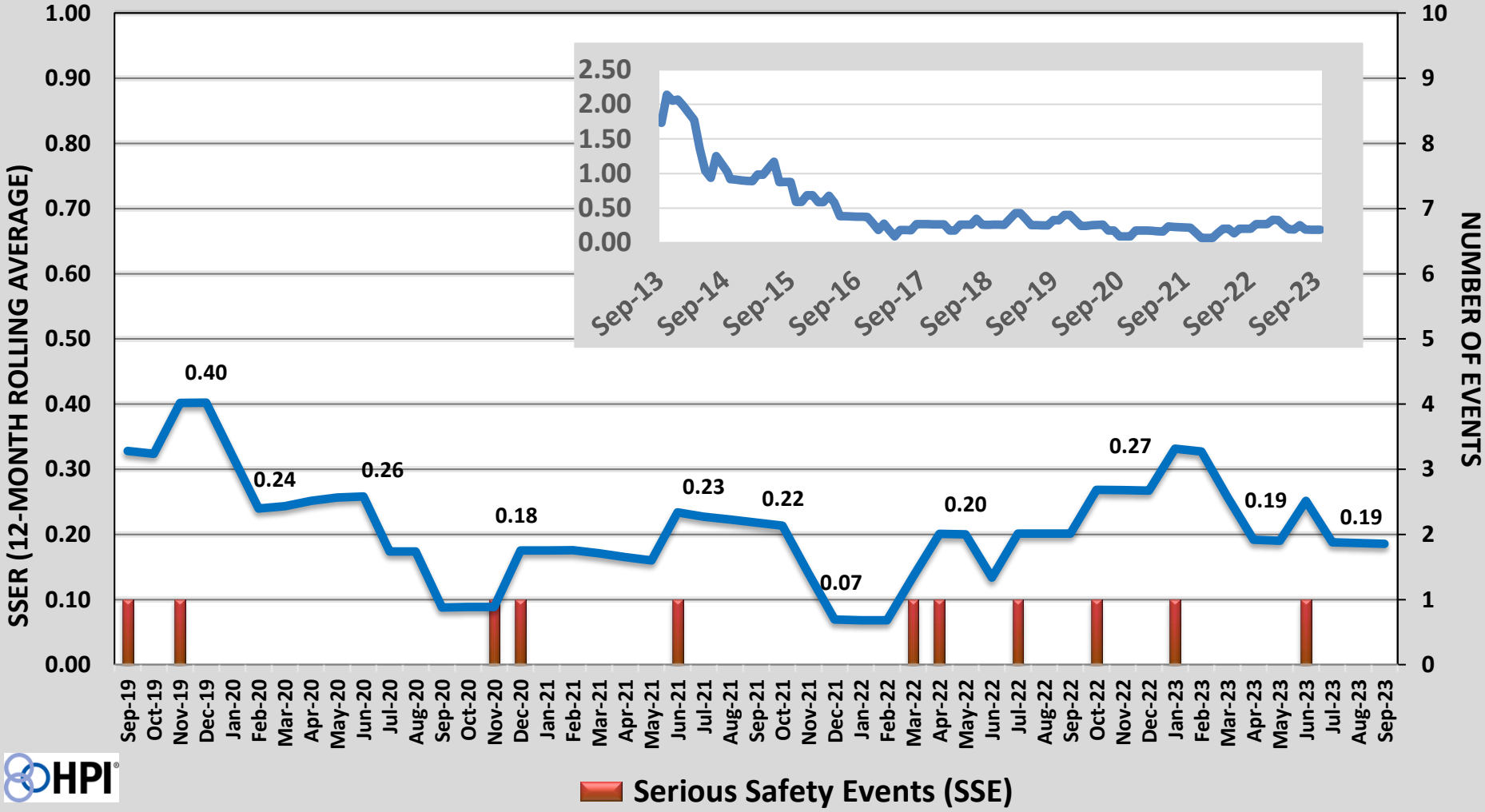
Revenues:

- YTD net revenues are ahead of budget by 4% and ahead of prior year by 8.3%
- Largest growth areas for YTD period are; MOHS, DermPath and Neurology when compared to budget

	FY 2024 Actual	FY 2024 Budget	FY 2023 Actual	Budget	vs PY
RVU's	400,204	382,483	364,711	4.6%	9.7%
Encounters	219,134	206,977	206,062	5.9%	6.3%
Net Revenue	34,173,307	32,865,330	31,552,773	4.0%	8.3%

Quality Report

Serious Safety Event Rate (SSER): 12-Month Rolling Average
Serious Safety Events
per 10,000 Adjusted Patient Days



JDH Scorecard

Meaure Group	Service/Unit	Metric	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Current Target	Warning Range	Red Flag
Safety & Quality	All Hospital Units	Serious Safety Event Rate - events/10,000 pt days, rolling average (End of Quarter)	0.20	0.27	0.26	0.25		<0.1	0.1- 0.25	>0.25
		Hand Hygiene Inpatient: Before	95%	91%	87%	90%	89%	≥97%	94%-97%	<94%
		CAUTI - # events	4	1	5	1	1			
		CAUTI Standardized Infection Ratio (Half-year)	2.099	1.327	2.498	0.622	0.546	<0.75	0.75-1.00	>1.00
		CLABSI - # events	0	0	3	1	0			
		CLABSI Standardized Infection Ratio (Half-year)	0	0	1.604	0.638	0	<0.75	0.75-1.00	>1.00
		C.diff - # events	6	4	1	3	1			
		C.diff Standardized Infection Ratio	0.750	0.478	0.118	0.385	0.109	<0.75	0.75-1.00	>1.00
		Falls with Harm/1000 Patient days (NDNQI): # Quarters > mean of AMC's/Last 8 Quarters	5	4	4	4		>4 of 8 quarters	4 of 8 quarters	<4 of 8 quarters
		Hospital-Acquired Pressure Injury (Stage 2+) (NDNQI): # Quarters > mean of AMC's/Last 8 Quarter	8	8	8	8		>3 of 7 Quarters	3 of 7 Quarters	<3 of 7 Quarters
		Mortality index (Vizient® Risk Adjusted]: Observed/Expected Ratio [Percentile vs. CCMC Peer grou	0.86	0.90	0.72	0.65	0.66	>75th	50th - 75th	<50th
		Admission Medication Reconciliation Completed <24 hours	72.9%	71.7%	73.4%	71.9%	73.8%	>90%	80%-90%%	<80%
		30-Day All-Cause Readmission Rate: Percentile vs. All CT Hospitals	8.2%	8.9%	8.5%	8.9%		>75	50-75	<50
	Anesthesiology	Adverse event rate	0.16%	0.03%	0.14%			<0.20%	0.20-0.30%	>0.30%
	Diagnostic Imaging	% of Vrad radiologists with miss rate >2%	0.87%	0.59%	0.90%	0.71%		<2.00%	2.00-4.00%	>4.00%
		% of UConn radiologists with miss rate >2%	0.43%	0.24%	0.51%	0.00%		<2.00%	2.00-4.00%	>4.00%
	Emergency Medicine	Door to provider (min)	28	35	27	29	31	<30 min	31-40 min	>40 min
		Length of Stay (min)	246	251	249	244	247	<240 min	240-300 min%	>300 min
		Left Without Being Seen Rate	1.04%	0.92%	0.85%	0.72%	0.98%	<1.0%	1.0-2.0%	>2.0%
		72-Hour Return to ED with Admission Rate	0.92%	1.10%	1.06%	1.15%	1.04%	<1.00%	1.00-3.00%	>3.00%
		Stroke: Median Door to CT Scan Time (min)	18.7	14.6	15.6	16.0	19.3	<26 min	26-40 min	>40 min
	Laboratory Medicine	Critical Value Notification - Inpatient (Within 15 min)	99.1%	98.8%	98.7%	99.0%		>98%	90-98%	<90%
		Critical Value Notification - ED (Within 30 min)	99.8%	100.0%	100.0%	99.0%		>98%	90-98%	<90%
	OB/GYN	PC-02: Nulliparous women with a term, singleton baby in vertex position delivered by C-section	50.0%	27.3%	21.4%	20.6%		<24%	24-30%%	>30%
		PC-05: Exclusive Breast Milk Feeding	57.9%	44.7%	64.6%	47.1%		>70%	50-69%%	<50%
		Acute Treatment of Hypertension within 60 min	71%	71%	82%			>80%	50-80%%	<50%
	Surgery	SSI Colon - # CMS events	0	0	0	1				
		SSI Colon - CMS Standardized Infection Ratio		0.0				<0.75	0.75-1.00	>1.00

Hand Hygiene (HH) Literature

JAMA Internal Medicine

Makhni, et.al. 2021

- HH compliance before pandemic = 54.5%
- Implemented Automated hand hygiene monitoring system in 37% of inpatient beds
- Peak HH compliance = 92.8% but quickly returned to 56% within 4 months

BMJ Journals

BMJ Open Quality

Poulose, et.al. 2022

- Multi-faceted HH improvement project 2014-2017
- HH compliance 53%→80%

AJIC American Journal of Infection Control

Wang, et.al. 2021

- Review of 7 studies of HH during COVID pandemic
- Before patient contact HH compliance = 68%
  - Nurses = 80%
  - Other staff = 60%

AJIC American Journal of Infection Control

Zen and Yee, 2023

- Implemented electronic dashboard displaying unit HH rates in 2018
- Baseline rate = upper 80's%
- Post-intervention: Sustained rates at or above 95%

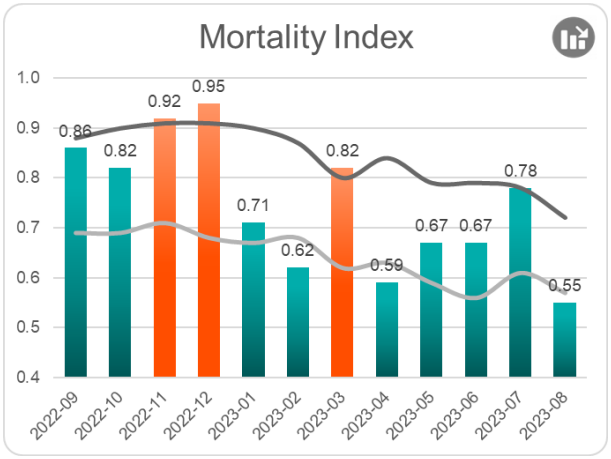
Mortality Index

Mortality Index = Observed/Expected

- Lower is better
- Source = Vizient
- Peer group = Complex Care Medical Centers

Mortality

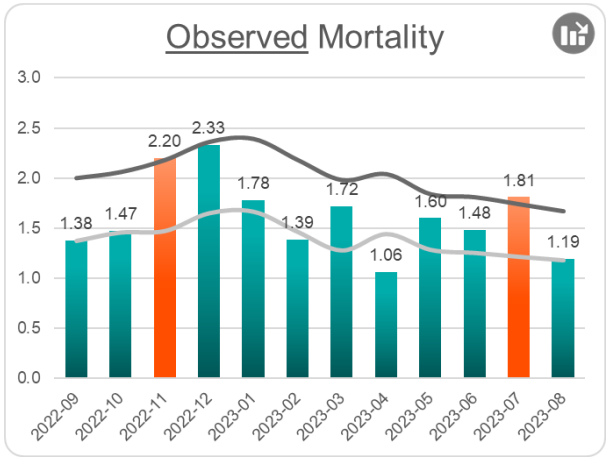
- Mortality Index monthly view



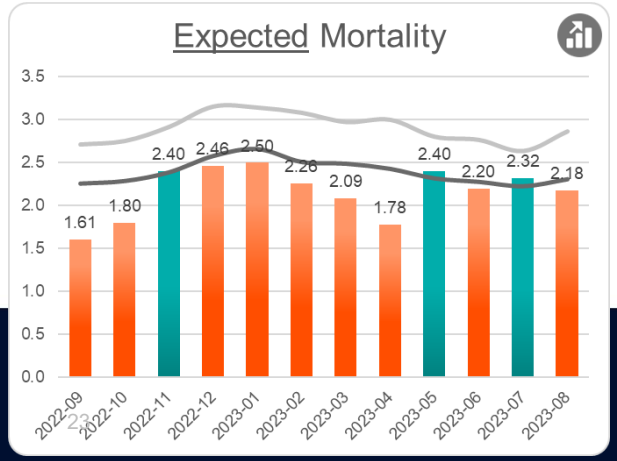
Lower is better

50th percentile

75th percentile



Lower is better



Higher is better

UCONN HEALTH

Patient Experience

Measure Group	Service/Unit	Metric	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Current Target	Warning Range	Red Flag
Patient Experience	Inpatient Units	HCAHPS Likelihood to Recommend: % Top Box	78.1%	75.4%	81.6%	82.4%	83.9%			
		HCAHPS Likelihood to Recommend: **CT Hospitals Percentile Ranking**	95	82	99	99	99	>75	50-75	<50
		HCAHPS Likelihood to Recommend: **All Press Ganey Database Percentile Ranking**	81	73	89	88	91	>75	50-75	<50
	Emergency Department	ED CAHPS: Likelihood to Recommend ER: % Top Box	67.4%	63.3%	72.8%	72.9%	69.6%			
		ED CAHPS: Likelihood to Recommendthe ER: **CT state ER/ED's Percentile Ranking**	68	51	72	67	58	>75	50-75	<50
		ED CAHPS: Likelihood to Recommend ER: **40K-50K Percentile** (* = 30-40K)	87	82	91	95	86	>75	50-75	<50
	All UMG and JDH Outpatient Clinics, Urgent Care Centers	CG CAHPS: Recommend the Provider Office: % Top Box	91.0%	91.9%	93.3%	93.6%	93.7%			
		CGCAHPS: Recommend this Provider Office: **AHA Region 1 Facilities Percentile Ranking**	39	63	87	84	81	>75	50-75	<50
		CG CAHPS: Recommend the Provider Office: **National Facilities Percentile Ranking**	38	52	70	69	69	>75	50-75	<50
	Main OR, UConn Health Surgery Center, Procedure Center (GI)	OAS CAHPS: Recommend Facility: % Top Box	90.1%	87.2%	89.5%	91.6%	91.3%			
		OASCAHPS: Recommend Facility: **Facilities in CT Percentile Ranking**	88	46	64	71	77	>75	50-75	<50
		OAS CAHPS: Recommend Facility: **All Press Ganey Database Percentile Ranking**	77	58	71	83	80	>75	50-75	<50
	Lab, Rehab, Radiology	Press Ganey Targeted Survey: Likelihood to Recommend: **% Top Box**	83.8%	84.5%	86.7%	86.3%	86.9%			
		Press Ganey Targeted Survey: Likelihood to Recommend: **AHA Region 1 Percentile Ranking**	42	48	65	64	66	>75	50-75	<50
		Press Ganey Targeted Survey: Likelihood to Recommend: **All Facilities Percentile Ranking**	48	48	66	60	63	>75	50-75	<50

Patient Experience: Lab, Rehab, Radiology

Measure Group	Service/Unit	Metric	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Current Target	Warning Range	Red Flag
Patient Experience	LAB	Press Ganey Targeted Survey: Likelihood to Recommend: **% Top Box**	83.3%	84.9%	86.2%	86.1%	87.8%			
		Press Ganey Targeted Survey: Likelihood to Recommend: **AHA Region 1 Percentile Ranking**	37	50	62	61	75	>75	50-75	<50
		Press Ganey Targeted Survey: Likelihood to Recommend: **All Facilities Percentile Ranking**	43	52	63	58	70	>75	50-75	<50
	Rehab	Press Ganey Targeted Survey: Likelihood to Recommend: **% Top Box**	90.9%	84.5%	93.1%	92.9%	92.1%			
		Press Ganey Targeted Survey: Likelihood to Recommend: **AHA Region 1 Percentile Ranking**	99	48	99	99	99	>75	50-75	<50
		Press Ganey Targeted Survey: Likelihood to Recommend: **All Facilities Percentile Ranking**	95	49	98	97	94	>75	50-75	<50
	Radiology	Press Ganey Targeted Survey: Likelihood to Recommend: **% Top Box**	83.2%	83.7%	86.5%	85.8%	84.8%			
		Press Ganey Targeted Survey: Likelihood to Recommend: **AHA Region 1 Percentile Ranking**	36	40	64	58	35	>75	50-75	<50
		Press Ganey Targeted Survey: Likelihood to Recommend: **All Facilities Percentile Ranking**	42	43	65	55	44	>75	50-75	<50

CMS Star Rating: January 2024

Willingness to Recommend this Hospital — Q2 (2022) - Q1 (2023)

★★★★★ Linear Score (1 - 100): 91

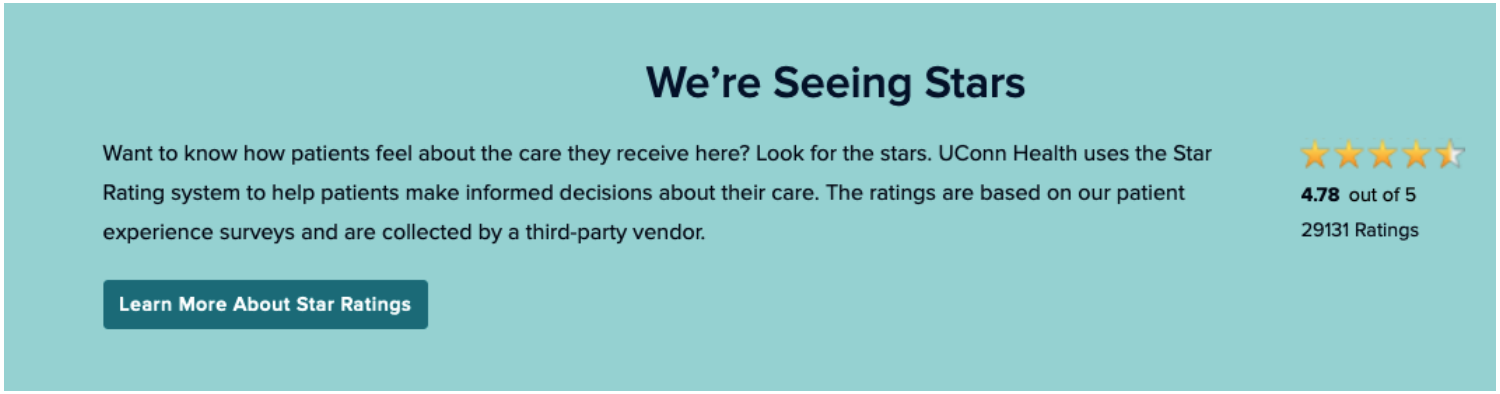
	Facility	State	National
Definitely Yes Patients who reported YES, they would definitely recommend the hospital	78%	67%	69%
Probably Patients who reported YES, they would probably recommend the hospital	17%	26%	25%
Definitely No Patients who reported NO, they would probably not or definitely not recommend the hospital	5%	7%	6%

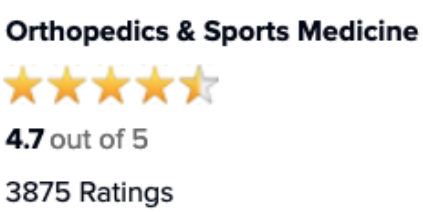
CMS Care Compare website: https://www.medicare.gov/care-compare

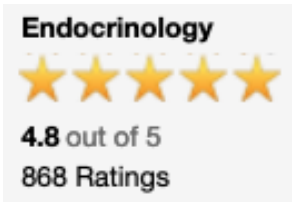
NRC Star Ratings

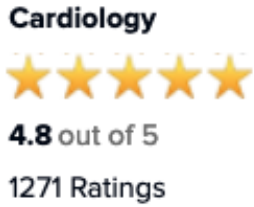
- UConn Health star rating = 4.78
- Not all clinical areas have star ratings yet

UConn Health website main page:









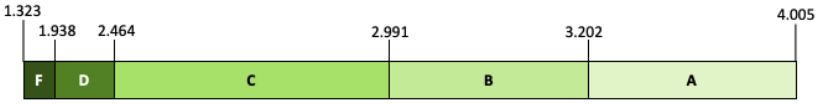
Leapfrog Hospital Safety Grade: Fall 2023

University of Connecticut Health Center, John Dempsey Hospital (07-0036)
263 Farmington Avenue, Farmington, CT 06032-3802

My Score	My Letter Grade
3.3906	TBD
More Information	

Grade	Safety Grade Criteria *(at or above cut point)*	Percentage of Hospitals
A	≥ 3.202	30%
B	≥ 2.991	24%
C	≥ 2.464	39%
D	≥ 1.938	7%
F	< 1.938	<1%

Higher is Better

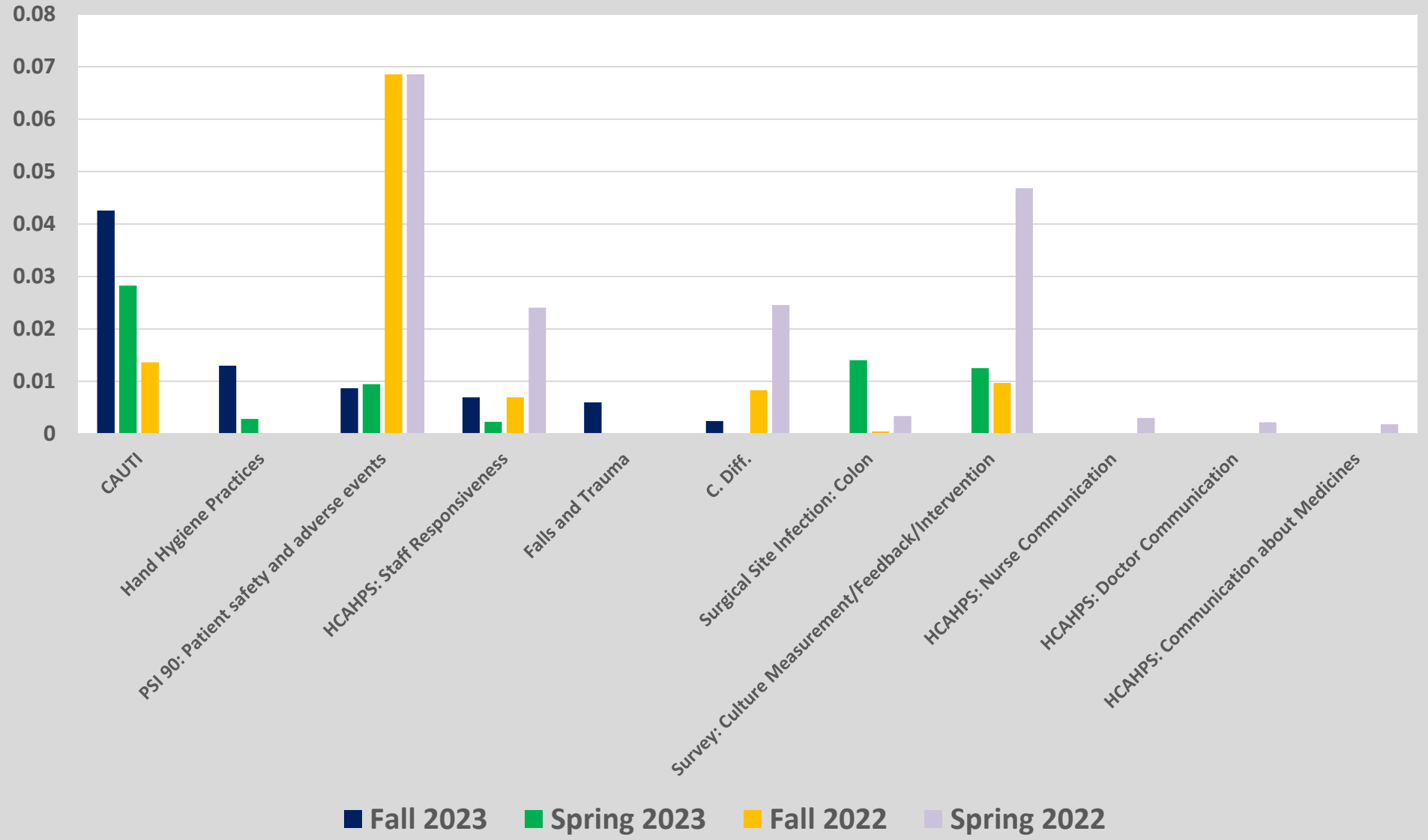


Scorecard

Process Measures	Culture of Safety	Doctors order medications through a computer
		Safe medication administration
		Specially trained doctors care for ICU patients
		Effective leadership to prevent errors
		Staff work together to prevent errors
		Enough qualified nurses
		Handwashing
	Patient Experience	Communication with nurses
		Communication with doctors
		Responsiveness of hospital staff
		Communication about medicines
		Communication about discharge
Outome Measures	Miscellaneous	PSI 90: Patient safety and adverse events composite
		Air or gas bubble in the blood (embolism)
		Falls and trauma
	Infections	Infection in the blood (CLABSI)
		Infection in the urinary tract (CAUTI)
		Surgical site infection after colon surgery
		MRSA Infection
		C. diff. Infection
	Surgical	Retained foreign object
		PSI 4: Death rate among surgical inpatients with serious treatable conditions

UCONN HEALTH

Leapfrog Negative Contributions to Raw Score



Leapfrog Hospital Safety Grade

Metric	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Current Target	Warning Range	Red Flag
CAUTI - # events	1	2	4	1	5	1	1			
CAUTI Standardized Infection Ratio (Half-year)	1.031	1.308	2.099	1.327	2.498	0.622	0.546	<0.75	0.75-1.00	>1.00

Data period for Fall 2023 Grade : Q1 2022 – Q4 2022

John Dempsey Hospital Clinical Quality and Service Improvement Plan

CMS Requirement

§ 482.21 Condition of Participation: Quality Assessment and Performance Improvement Program

The hospital must develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

TJC Requirement

PI.02.01.01

EP1: Performance improvement priorities established by hospital leaders are described in a written plan that includes the following:

- The defined process(es) needing improvement, along with any stakeholder (for example, patient, staff, regulatory) requirements, project goals, and improvement activities

EP 2: Leadership reviews the plan for addressing performance improvement priorities at least annually and updates it to reflect any changes in strategic priorities and in response to changes in the internal or external environment.

John Dempsey Hospital Clinical Quality and Service Improvement Plan

Significant Proposed Revisions/Updates

Section IV:
Updated description of The **Patient and Family Advisory Council** to state it is now supported by the Vice President for Patient Experience.

Section VIII:
Updated performance improvement (PI) priorities

- Kept the same priorities, but made them more specific and measurable
- Changed the admission medicine reconciliation timeframe from 24 to 48 hours

Performance Improvement Priorities 2024

1. Achieve a Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Rate target of 0.5 with a goal of zero
2. Achieve a target of 7/8 quarters better than benchmark group of NDNQI academic medical centers for Falls with Moderate harm, Major harm or Death with a goal of 8/8 quarters
3. Achieve an inpatient/before hand hygiene compliance rate of >92% with a goal of >95%
4. Achieve a within-48 hours Admission Medication Reconciliation rate >80% with a goal of >90%
5. Achieve >75th percentile compared to all national hospitals in the Press Ganey database for Outpatient and Ambulatory Surgery (OAS) CAHPS Recommend Facility rate with a goal of >90th percentile
6. Achieve >75th percentile compared to all national hospitals in the Press Ganey database for LAB, Rehab, & Radiology Targeted Survey Likelihood to Recommend rate with a goal of >90th percentile

TO: Clinical Affairs Subcommittee of the UConn Health Board of Directors

FROM: Bruce T. Liang, Interim CEO, John Dempsey Hospital

DATE: November 9, 2023

SUBJECT: JDH Clinical Quality & Service Improvement Plan

Recommendation:

That the Clinical Affairs Subcommittee of the UConn Health Board of Directors accepts and approves the attached 2024 Clinical Quality & Service Improvement Plan for John Dempsey Hospital.

Background:

The John Dempsey Hospital Clinical Quality and Service Improvement Plan outlines the structure that JDH uses to achieve safe, timely, effective, efficient, equitable and patient-centered care. The Center for Medicare & Medicaid Services (CMS) and The Joint Commission (TJC) require hospital leaders to establish priorities and to ensure that quality assessment and improvement efforts are addressed and approved by the institution's governing body.

The recommended changes to the JDH Clinical Quality & Service Improvement Plan have been approved by the Medical Board and the Quality Assessment and Performance Improvement (QAPI) Committee.

Significant proposed revisions/updates include:

- Section IV: Updated description of The **Patient and Family Advisory Council** to state that it is now supported by the Vice President for Patient Experience.

- Section VIII: Updated performance improvement (PI) priorities
  - Kept the same priorities, but made them more specific and measurable
  - Changed the admission medicine reconciliation timeframe from 24 to 48 hours

The 2024 Performance Improvement Priorities include:

1. Achieve a **Catheter-Associated Urinary Tract Infection** (CAUTI) Standardized Infection Rate target of 0.5 with a goal of zero
2. Achieve a target of 7/8 quarters better than benchmark group of NDNQI academic medical

centers for **Falls with Moderate harm, Major harm or Death** with a goal of 8/8 quarters
3. Achieve an inpatient/before **hand hygiene** compliance rate of >92% with a goal of >95%
4. Achieve a within-48 hours **Admission Medication Reconciliation** rate >80% with a goal of >90%
5. Achieve >75th percentile compared to all national hospitals in the Press Ganey database for **Outpatient and Ambulatory Surgery (OAS) CAHPS Recommend Facility rate** with a goal of >90th percentile
6. Achieve >75th percentile compared to all national hospitals in the Press Ganey database for **LAB, Rehab, & Radiology Targeted Survey Likelihood to Recommend rate** with a goal of >90th percentile

Attachment: John Dempsey Hospital Clinical Quality & Service Improvement Plan 2024 – tracked changes version.

John Dempsey Hospital Clinical Quality and Service Improvement Plan 2024

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Reviewed/Approved:
Quality Assessment and Performance Improvement Committee: 6/21/22
Medical Board: 7/12/22
Clinical Affairs Subcommittee: 8/11/22
Board of Directors:

TABLE OF CONTENTS

I. Purpose

II. Scope

III. Goals

IV. Leadership, Authority and Responsibility

V. External Resources

VI. Prioritization of Performance Improvement Initiatives

VII. Data Sources

VIII. JDH Performance Improvement Priorities

IX. Performance Improvement Teams

X. Performance Improvement Methodology

XI. Communication

XII. Retention of Data and Reports

XIII. Confidentiality, Peer Review, and Morbidity & Mortality Review

XIV. Evaluation of the JDH Performance Improvement Plan

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REFERENCES

JOHN DEMPSEY HOSPITAL MEDICAL STAFF BYLAWS

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John Dempsey Hospital Clinical Quality and Service Improvement Plan

I. PURPOSE

The purpose of the UConn John Dempsey Hospital (JDH) Clinical Quality and Service Improvement Plan is to insure the design, systematic monitoring, analysis and improvement in performance of all its services related to quality of care, the reduction of medical errors, and the patient/family experience. This activity serves to increase the overall value of health care and supports the JDH mission, vision, values, and goals within the overall context of UConn Health. The Clinical Quality and Service Improvement Plan is integral to the JDH Quality Assessment and Performance Improvement system.

II. SCOPE

The JDH Clinical Quality and Service Improvement Plan encompasses all settings and services that operate under the JDH license. This includes both inpatient and ambulatory sites, whether providing direct patient care or in a supportive role.

III. GOALS

The JDH Clinical Quality and Service Improvement Plan serves to establish the structure of how JDH achieves safe, effective, efficient, timely, and equitable patient-centered care. JDH, in partnership with our teaching programs, strives to achieve customer-focused, value-driven care in an academic environment through a multidisciplinary approach to the implementation of best practices and evidence-based medicine. The Plan supports the promotion of a culture of safety leading with the goal of reducing adverse events.

The aims of the program include:

- **Quality** - Provide the highest quality care. Be regionally and nationally recognized for having the highest levels of patient safety and for consistently integrating best practices and assimilating the most current medical knowledge into the care we provide. Develop innovative and transferable models for patient care. Be the healthcare provider of choice by delivering the highest levels of patient satisfaction and cost-effective care.
- **Safety -** Continuously improve patient safety in all settings. Establish a culture of open communication, transparency, and high reliability. Strive for zero harm.
- **Academic Connections -** Be distinguished through enhanced engagement of graduate medical education in the patient safety activities of the organization.

Specific objectives include:

A. To foster a culture where quality, safety, service, and improved performance are

embraced by all members of the organization using a collaborative, interdisciplinary approach.

B. To prioritize Performance Improvement (PI) projects and commit necessary resources for monitoring, analysis and improvement.

C. To maintain a uniform methodology for organizational performance measurement and improvement activities using "Plan-Do-Study-Act" (PDSA), as well as lean methodology, in a planned, systematic, hospital-wide approach.

D. To utilize internal and external comparative data bases, benchmarks, and focused studies for identifying performance improvement opportunities.

E. To provide on-going education and training to enhance the technical and professional expertise for organizational performance improvement that support engagement of staff, residents, and providers in improving organizational performance at all levels.

F. To achieve and maintain compliance with federal, state, The Joint Commission, Accreditation Council for Graduate Medical Education, and other regulatory bodies as it relates to clinical quality and service performance improvement.

G. To conduct an annual evaluation of the organizational framework of the JDH Performance Improvement Plan.

IV. PERFORMANCE IMPROVEMENT LEADERSHIP, AUTHORITY AND RESPONSIBILITY

A. **Board of Trustees:** The Board of Trustees (BOT) bears the ultimate responsibility for ensuring safe, high quality care and promotion of performance improvement through review of the Clinical Quality and Service Improvement Plan. The Board of Trustees has delegated the responsibility and accountability to the Board of Directors.

B. **Board of Directors:** The Board of Directors (BOD) is accountable to the BOT to review the activities of the Medical Staff particularly as they pertain to the quality of care as reflected in reports of the monthly meetings of the Medical Board. The BOD has delegated the responsibility and accountability for clinical quality and service performance improvement activities to the Clinical Affairs Subcommittee of the Board of Directors.

C. **Clinical Affairs Subcommittee**: The Clinical Affairs Subcommittee (CAS) is accountable to the BOD to review the findings of the performance improvement process and make recommendations and policy changes for the resolution of problems in patient care. The CAS has delegated the responsibility and accountability for performance improvement activities to the John Dempsey Hospital (JDH) Quality Assessment/Performance Improvement (QAPI) Committee.

D. **The John Dempsey Hospital (JDH) Quality Assessment/Performance Improvement (QAPI) Committee** is accountable for making decisions on improving organizational performance initiatives related to clinical quality and service that JDH will support each year, including administration, operations, and associated finances. The QAPI Committee

incorporates JDH's clinical strategic plan and program development and compliance with regulatory requirements into their decision-making strategy. The Committee analyzes and tracks quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service, and operations in order to improve health outcomes, identify and reduce medical errors, and improve efficiency and costs. The JDH Chief Medical Officer leads the QAPI Committee. Members include the Chief Executive Officer, the Vice President for Quality and Patient Care Services/Chief Nursing Officer, and the JDH Chief of the Medical Staff.

Grievance Committee is a subcommittee of QAPI Committee and is headed by the Vice President of Patient Experience who reports directly to the JDH CEO. The Grievance Committee reviews all complaints that are not resolved to the satisfaction of the patient or the patient's advocate by the staff present, guides the Patient Relations Department in providing written responses to unresolved grievances after the initial Patient Relations response to the patient or the patient's advocate, investigates grievances, as appropriate, and facilitates an appropriate resolution.

The **Patient and Family Advisory Council** reports to the QAPI Committee and is supported by the Vice President for Patient Experience. This is a group of patients and family members of patients who serve to provide feedback to the Vice President of Patient Experience, Vice President for Quality and Patient Care Services/Chief Nursing Officer, and Chief Medical Officer regarding the patient perspective on clinical care at JDH and to help identify opportunities for improvement.

E. **Medical Board:** The Medical Board is the senior executive committee for the Medical Staff. It is accountable to the CAS to establish systems to monitor the accuracy, confidentiality and availability of organizational improvement; to coordinate and implement the professional and organizational activities and policies of the clinical services and medical staffs; and to establish the structure of the assessment of medical staff organizational improvement activities.

The following Hospital subcommittees report to Medical Board: Cancer Committee; Transfusion Committee; Pharmacy, Therapeutics and Medication Safety Committee; Operating Room Committee, Medical Ethics Committee, and the Utilization Management Committee. The Medical Board subcommittees are organized and charged with the goal of coordinating and monitoring activities related to the quality of patient care, identifying and implementing performance improvement initiatives related to the committee's clinical focus or area of expertise, and reporting these activities to the Medical Board.

F. The **JDH Senior Team** includes the Chief Executive Officer, the Vice President for Quality and Patient Care Services/Chief Nursing Officer/Chief Operations Officer, the Chief Medical Officer, and the JDH Chief of the Medical Staff. The JDH Senior Team prioritizes and commits resources for performance improvement initiatives and is dynamic in nature to ensure the timely response to internal and external changing influences. These resources

include technical guidance**,** facilitation**,** and assistance to the hospital staff, medical staff, and relevant committees, subcommittees, departments, and services. The JDH leaders promote performance improvement through data analysis, staff feedback, development of clinical accountability, as well as development of clinical policies and protocols, and general education regarding performance improvement methods.

- The **Vice President for Quality and Patient Care Services/Chief Nursing Officer/Chief Operations Officer** is a member of UConn Health Senior Leadership team with operational, financial and fiscal oversite of UConn Health Nursing Department, APRNs and PAs, Epidemiology, Clinical Quality, Professional Practice, Cancer Services, Social Work, Case Management, Hospital Ambulatory Services, Procedural including all ORs and OB Services, Patient Support, Nursing Research, Magnet Journey and co-chairs Safety Huddle. Additional responsibilities included but are not limited to: directing performance improvement activities with areas of responsibility; ensures safe nurse staffing levels utilizing NDNQI benchmarks, all Nursing Practice Policy and Procedures and the 24/7 operation of al nursing units to ensure patient safety. This individual is also a Clinical Faculty member of UConn School of Nursing who works in partnership with the Dean of UConn School of Nursing related to Professional Practice.

  The **Nursing Director of Epidemiology** reports to the Vice President for Quality and Patient Care Services/Chief Nursing Officer/Chief Operations Officer**.** The Director is responsible for identifying and reporting to State and Federal regulatory bodies on a large number of measurements associated with infection prevention and post-exposure therapy. The Director and his/her staff are all Infection Prevention Specialists and play a key role in educating clinical staff on universal protocols. The Director serves as the JDH representative to the State of Connecticut Department of Epidemiology. It is the responsibility of the Nursing Director of Epidemiology to maintain the Infection Control Manual.

  The **Nursing Director of Professional Practice & Clinical Excellence** reports to the Vice President for Quality and Patient Care Services/Chief Nursing Officer/Chief Operations Officer and oversees the framework for educating staff in response to regulatory requirements as well as changes needed to ensure that patients receive the highest quality of care. **Clinical Nurse Specialists** and **Clinical Educators** report to the Nursing Director of Professional Practice and are deployed to specific departments to serve as a resource for staff and management. The Nursing Director helps research and determine best practices for patients at JDH. The Clinical Nurse Specialists serve on various committees to help oversee implementation of these best practices.

  The **Nursing Director of Critical Care, Quality and Advanced Practice** reports to the Vice President for Quality and Patient Care Services/Chief Nursing Officer/Chief Operations Officer. The Director works collaboratively with the Chief Medical Officer in helping to lead continuous improvement programs throughout the organization and to develop a culture of continuous improvement. The Director oversees adverse event investigation, including Apparent Cause Analyses and Root Cause Analyses and co-chairs the Safety Intelligence™ Review Committee. The Director also oversees members of the quality department responsible for data abstraction, including, Core Measures, external benchmarking registries, and pay-for-performance. The Director supports the

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unit-based Safety Coaches program. This program ensures that each JDH inpatient and outpatient area has Safety Coaches trained in the science of High Reliability, reinforcing our Safety Program within the individual JDH units.

The **Chief Medical Officer** is the Chair of the Quality Assesment and Performance Improvement Committee and is responsible for ensuring that the JDH Medical Staff and all residency programs are operating within the requirements of the state, federal and other regulatory agencies. The Chief Medical Officer (CMO) investigates patient complaints and quality of care concerns and analyzes both internal performance metrics as well as pay-for-performance and external hospital safety scorecards to identify opportunities for improvement. The CMO works closely with the Graduate Medical Education Programs to promote resident reporting of safety concerns and participation in adverse event analysis. The CMO co-chairs both Safety Huddle and the Safety Intelligence™ Review Committee. Inpatient unit **Medical Directors** indirectly report to the CMO as part of the unit-based approach to improving clinical quality and service.

Deleted: The **Patient and Family Advisory Council** is supported by the Vice President for Quality and Patient Care Services/Chief Nursing Officer. This is a group of patients and family members of patients who serve to provide feedback to the Vice President for Quality and Patient Care Services/Chief Nursing Officer regarding the patient perspective on clinical care at JDH and to help identify opportunities for improvement.¶ ¶

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V. EXTERNAL RESOURCES

JDH utilizes external resources to assist in its goal of achieving Safe, Effective, Efficient, Timely, Patient-centered, and Equitable care. Some examples of external resources used include:

a. Connecticut Hospital Association (CHA) – JDH has contracted with CHA to provide data sources and benchmarking and has partnered with CHA for purposes of participating in quality improvement initiatives to achieve best practice. UConn Health also participates in the CHA Patient Safety Organization.
b. Press Ganey – JDH has contracted with Press Ganey to administer the program for the collection of Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys, including Hospital (HCAHPS), Clinician and Group (CGCAHPS), Emergency Department (EDCAHPS) and Outpatient Ambulatory Surgery (OASCAHPS) surveys. Healthcare Performance Improvement (HPI), now part of Press Ganey, remains a consultant for assistance in high reliability training and efforts to eliminate all-cause harm to patients. All employees and providers receive initial training built by HPI upon starting employment.
c. Vizient – JDH has contracted with Vizient for use of the Clinical DataBase product that allows for access to data and benchmarking.

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VI. PRIORITIZATION OF PERFORMANCE IMPROVEMENTS INITIATIVES

Assessment and prioritization of performance improvement initiatives are made by the JDH Senior Team and the QAPI Committee. These initiatives are based on input and recommendations from members of the JDH management team as well as other groups, departments, and functional units within JDH, including the medical staff and Clinical Service Chiefs. Establishment of priorities, selection, and commitment of resources by the JDH Senior Team shall take into account:

a. The degree to which the performance improvement opportunity reflects the organization's vision and strategic plan

b. The degree to which the performance improvement opportunity reflects customers' feedback on their priorities with respect to needs and expectations
c. The degree of adverse impact on patient care that can be expected if the improvement opportunity remains unresolved
d. The duration of the performance improvement opportunity
e. The resources required to pursue the performance improvement opportunity
f. The number and type of services affected by the performance improvement opportunity
g. The degree to which the performance improvement opportunity affects one of the patient-care, organizational functions, or the dimensions of performance identified in The Joint Commission standards
h. The degree to which the performance improvement opportunity reflects a high volume, high risk, or problem-prone process
i. The degree to which the performance improvement opportunity pertains to clinical resource management, cost management, risk management and /or quality control issues
j. Recommendations from various groups, such as medical staff committees.

VII. DATA SOURCES

Data used to drive performance improvement focuses on measures relating to patient safety, regulatory requirements, and organizational functions. Data sources include, but are not limited to:

a. Clinical outcomes
b. Processes of care, such as Core Measures
c. Staffing levels and effectiveness
d. Healthcare providers' opinions and needs
e. Infection prevention practices and surveillance
f. Clinical audits
g. Needs, expectations and feedback from customers
h. Utilization management
i. Performance measures related to accreditation and other regulatory requirements
j. Apparent Cause and Root Cause Analyses
k. Morbidity and Mortality reviews
l. Comparative benchmarking utilizing sources such as Vizient and Connecticut Hospital Association
m. External scorecards such as Leapfrog

VIII. JDH PI PRIORITIES

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Top PI Priorities for 2024:

1. Achieve a Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Rate target of 0.5 with a goal of zero.
2. Achieve a target of 7/8 quarters better than benchmark group of NDNQI academic medical centers for Falls with Moderate harm, Major harm or Death with a goal of 8/8 quarters.
3. Achieve an inpatient/before hand hygiene compliance rate of >92% with a goal of >95%

4. Achieve a within-48-hours admission medication reconciliation rate >80% with a goal of >90%
5. Achieve >75th percentile compared to all national hospitals in the Press Ganey database for Outpatient and Ambulatory Surgery (OAS) CAHPS Recommend Facility rate with a goal of >90th percentile
6. Achieve >75th percentile compared to all national hospitals in the Press Ganey database for LAB, Rehab, & Radiology Targeted Survey Likelihood to Recommend rate with a goal of >90th percentile

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Achieve zero Falls with injury (NDNQI Moderate harm, Major harm or Death)¶
Improve hand hygiene compliance rate¶
Improve admission medication reconciliation rate¶
Improve Outpatient and Ambulatory Surgery (OAS) CAHPS Recommend Facility rate¶
Improve Press Ganey LAB, Rehab, & Radiology Targeted Survey Likelihood to Recommend rate¶

Additional PI Priorities:

a. Creating a culture of safety through our Connecticut Hospital Association - High Reliability journey
b. Full or exceptional performance in all the governmental accrediting agency standards, including The Joint Commission, the State Department of Public Health, or any other regulatory body
c. Full achievement of National Patient Safety Goals
d. Improvement in patient perception of safety (via patient experience surveys)
e. Improvement in staff perception of safety (via Safety Culture Survey)
f. Medication safety

IX. PERFORMANCE IMPROVEMENT TEAMS

Performance Improvement Teams shall be empowered by the JDH Senior Team and/or the QAPI Committee to identify, assess, and initiate process and outcome measures and actions to improve organizational performance. In addition, performance improvement teams may also be formed under the direction of medical staff committees, clinical services, the Nursing Department, or any of the ancillary departments. Such teams may be comprised of or be represented by:

1. Department/Unit/ Point of Service
2. Discipline-Specific Service
3. Cross Functional/ Interdisciplinary Services
4. Committees

X. PERFORMANCE IMPROVEMENT METHODOLOGY

As a performance improvement opportunity is identified, an overall planned, systematic, and organization-wide approach to performance improvement is used. The PDSA model, along with lean methodology, is endorsed and follows the sequence of: review/gather data; identify issues/problem statement; analyze data; develop and implement actions to address issues; and monitor performance.

- **Plan** the improvement with identifying a goal or purpose and defining success metrics
- **Do** the data collection
- **Study** the results
- **Act** to form a strategy to improve the process

Employees are empowered to eliminate waste in their departments, participate in hospital-wide process improvement initiatives, and teach other employees about Lean methodology.

XI. COMMUNICATION

Performance improvement relies upon interactive, open communication paths that are freely and continuously used. To achieve the exchange of ideas and information required to establish and maintain a continuously improving organization, communication between all committees and organizational groups responsible for performance improvement is critical.

Formal liaisons are identified for each performance improvement team/group. The Chief Medical Officer is the liaison between the Clinical Affairs Subcommittee (CAS), the Medical Board, the QAPI Committee, and the Graduate Medical Education Programs. The JDH Chief of the Medical Staff is Chair of the Medical Board and is also a member of the QAPI Committee. Both are members of the JDH Senior Team. Medical staff, Nursing, and ancillary services are all represented at the QAPI committee. Communications include information on the overall Performance Improvement Plan, designated performance measures, reviews and reports of performance improvement activities and findings, action plans, changes in direction or philosophy, assessment activities, and requests for guidance.

Other methods of communication to providers, residents, and staff include: Broadcast messages, departmental and unit-level dashboards, the UConn Health organizational scorecard, and the Friday Flyer newsletter. The hospital continuously develops a performance measurement system (scorecard) utilizing clinical measures that represent a targeted percentage of the hospital patient population. The performance measurement system includes the timely submission of data related to the selected clinical measures, receipt of comparative data, and ongoing review and performance improvement as indicated. This data supplies the JDH Senior Team with information needed to ensure that future Performance Improvement Initiatives focus on key areas functioning at less than the desired goal.

XII. RETENTION OF DATA AND REPORTS

Minutes, reports and related data shall be kept in their original form for minimum of five years (or longer depending upon State and other requirements). Any disposal of records will be in accordance with UConn Health policies and procedures and State recordkeeping requirements.

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XIII. CONFIDENTIALITY AND PEER REVIEW

Certain medical staff committees and the QAPI Committee function in some of their activities as a Medical Review Committee conducting both peer review and morbidity and mortality review as defined in the Connecticut state statute Sec. 19a-17b. (Formerly Sec. 38-19a), as amended from time to time. When acting as a Medical Review Committee, these designated committees participate in the evaluation of the quality and efficiency of health services ordered and performed. Proceedings of peer review and morbidity and mortality activities, including data and information gathering and analyses and reporting by authorized individuals for the primary purpose of these review activities, as well as minutes and other documents from meetings or portions of meetings addressing peer and morbidity and mortality review, shall be kept strictly confidential.

Deleted: and morbidity and mortality review in accordance with Connecticut state statute Sec. 19a-25. (Formerly Sec. 19-6a)

To ensure the confidentiality, the following will be observed:

a. Names of individuals are withheld from all study/review report forms.

b. All individuals are identified by alpha and/or numeric codes.

c. All Performance Improvement and Peer Review Data, reports and minutes, are accessible only to those participating in the program and on a "need to know" basis utilizing the reporting mechanism specified in section IV of this Plan, the Rules and Regulations of the Medical Staff, and the Policies and Procedures in the Hospital Administrative Manual. All other requests for information from the program shall be in writing, stating the purpose and intent of the request, and shall be addressed to Legal Counsel.

Deleted: or Director of Risk Management

d. The peer review and/or morbidity and review portion(s) of the medical staff committee and department meeting minutes is clearly indicated and may be separated from the business portion of the activity. Minutes including peer review and/or morbidity and review content are maintained in a secure location within the hospital administration suite.

XIV. EVALUATION OF THE PERFORMANCE IMPROVEMENT PLAN

The effectiveness of the Performance Improvement Plan is evaluated continuously with special emphasis upon data received after significant improvement efforts that assess progress toward accomplishing program objectives. Data that reflect outcomes as well as key process measures of performance improvement efforts are collected and analyzed via the performance measurement system (scorecard), surveys, interviews with key individuals, and discussions at the Medical Board, the Quality Department, and QAPI Committee as well as the Clinical Affairs Subcommittee.

Environment of Care Annual Assessments

TO: Clinical Affairs Subcommittee of the UConn Health Board of Directors

FROM: Kevin Higgins, Director of Environment of Care & Radiation Safety

DATE: November 9, 2023

SUBJECT: Environment of Care Management Plan

Recommendation: That the Clinical Affairs Subcommittee of the UConn Health Board of Directors accept and approve the 2023 UConn Health John Dempsey Hospital (JDH) Assessments of the Environment of Care Management Plan.

Background: UConn Health takes a proactive approach to managing the Environment of Care as it relates to quality of care and patient safety.

As part of this process, annual assessments are conducted to review the objectives, scope, performance, and effectiveness in the following six required management plans for JDH:

- Safety
- Security
- Hazardous Materials and Waste
- Fire Safety
- Medical Equipment, and
- Utilities

The annual assessments review:

- Risk points that have been mitigated during this 12 month period
- Risk points where progress is being made towards mitigation
- Risk points where the plan of attack needs revision for successful mitigation, and
- New risk points that have been identified during this period

UConn Health has completed these assessments for 2023 and has determined that the management plans are effective at reducing risks within the JDH's environment of care.

Best practice provides that these annual assessments be brought before the Board for review and approval.

Attachments: Annual Evaluations of Effectiveness (6)

2023 Annual Assessment of Management Plan Effectiveness

Safety Sub-Committee

Section/EP	Summary	Risk Point	Process to Mitigate Risk	Goal	Measure	Met/Not Met	Progress to Date	Work to be Done
02.01.01 EP-1	The hospital implements its process to identify safety risks associated with the environment of care.	Failure to implement the process could lead to safety risks going undetected and therefore increase risk of injury.	Morning huddle, safety sub-committee meeting, ECRI product recall review, workplace injury review, and mandating a discussion of safety at the beginning of all meetings are examples of the processes used to mitigate risk.	Robust risk mitigation process.	Are these processes active? Are they identifying risks and actions to mitigate those risks?	Met	Morning huddle takes place 365 days/year. Safety sub-committee consistently meets monthly and as risks are identified, they are placed on the sub-committee risk assessment.	
02.01.01 EP-3	The hospital takes action to minimize or eliminate identified safety risks in the physical environment.	Failure to take action could result in increased risk.	Safety Sub-Committee and its risk assessment.	Risks are identified and acted on in a timely manner.	This is measured by how long items remain unresolved on the risk assessment.	Met	The committee feels most items are being addressed in a timely manner. Very few have to be escalated to upper management. Now work orders placed for EOC will be monitored/tracked for progress/closure to each sub committee	Have FAMIS WO tracking system launch to each sub-committee to track/report more effectively
02.01.01 EP-5	The hospital maintains all grounds and equipment.	Improperly or inadequately maintained grounds could lead to increased slips, trips, falls, and workplace injuries.	The grounds department within Facilities is responsible for maintaining grounds. In addition, the EOC rounding team walks the grounds looking for issues needing attention.	Zero workplace injuries due to inadequately maintained grounds.	Workplace injury report, morning huddle, etc.	Met	Hiring in progress for additional HR staff to represent Workers Compensation division.	On board of new HR staff as needed for Workers Compensation
02.01.01 EP-11	The hospital responds to product notices and recalls.	Failure to respond to product recalls could result in a recalled product being used on a patient and put that patient at risk.	Each month the ECRI report is shared at the sub-committee meetings. Risk are mitigated for equipment and products	All risks identified and mitigated	ECRI reports/recalls	Met	Product recalls identified and addressed, products removed or replaced as needed. Equipment is checked and taken out of circulation when necessary. Replacement equipment is purchased or existing equipment repaired as required.	
02.01.01 EP-14	The hospital manages magnetic resonance imaging (MRI) safety risks associated with the following: - Patients who may experience claustrophobia, anxiety, or emotional distress - Patients who may require urgent or emergent medical care - Patients with medical implants, devices, or imbedded metallic foreign objects (such as shrapnel) - Ferromagnetic objects entering the MRI environment - Acoustic noise	Failure to properly screen patients may result in injury of patient, others or death to patient or others (staff)	Every MRI patient is screened prior to entering the active magnet zone	Zero safety events in MRI involving patient, staff and/or equipment, personal effects.	Staff to follow explicit procedures for screening patients. Appropriately designated zones in the MRI unit department	Met	Staff are following the proper screening procedure/process on all MRI patients	Continue reviewing any new updates or edits to the department MRI screening policy/procedures to remain compliant.

2023 Annual Assessment of Management Plan Effectiveness

Safety Sub-Committee

Section/EP	Summary	Risk Point	Process to Mitigate Risk	Goal	Measure	Met/Not Met	Progress to Date	Work to be Done
02.01.01 EP-16	The hospital manages magnetic resonance imaging (MRI) safety risks by restricting access of everyone not trained in MRI safety or screened by staff trained in MRI safety from the scanner room and the area that immediately precedes the entrance to the MRI scanner room, by making sure that these restricted areas are controlled by and under the direct supervision of staff trained in MRI safety. And by posting signage at the entrance to the MRI scanner room that conveys that potentially dangerous magnetic fields are present in the room. Signage should also indicate that the magnet is always on except in cases where the MRI system, by its design, can have its magnetic field routinely turned on and off by the operator.	Staff not following the proper screening procedure/process for MRI patients.	Clearly identify all zones in the MRI department to keep patients and staff safe from injury and risk, Be sure the department policy/procedure is adhered to for all MRI patients	Zero safety events	Rounding in MRI to observe the patient screening process and ensure staff can speak to the safety zones in the unit as well as contraindications during screening patient.	Met	Process/procedures in place and all MRI zones in the departments are identified appropriately.	
02.01.03 EP-1	The hospital develops a written policy prohibiting smoking in all buildings. Exceptions for patients in specific circumstances are defined. Note: The scope of this EP is concerned with all smoking types—tobacco, electronic, or other.	Failure to have a written policy could encourage people to smoke.	The grounds department within Facilities is responsible for maintaining grounds. In addition, the EOC rounding team walks the grounds looking for evidence of smoking. Increased number of posted reminder signs identifying a smoke-free campus. Police are able to issue citations for individuals found smoking on campus.	No smoking on campus	Rounding by EOC tracer teams, police patrol, employees encouraged to remind persons on campus that it is indeed smoke free. Grounds crew continues to report evidence of smoking to the Safety Sub Committee.	Not met	1 citation issued No increased evidence of smoking	Continue to educate staff and visitors about smoke free campus, issue citations to people not abiding by the policy.
02.01.03 EP-4	Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient room, no sources of ignition are within the site of intentional expulsion (within 1 foot). When other oxygen delivery equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area of administration (within 15 feet). Solid fuel–burning appliances are not in the area of Administration. Nonmedical appliances with hot surfaces or	Failure to remove smoking materials from patients receiving treatment on campus. Sources of ignition are in close proximity to oxygen delivery system.	Remove smoking materials when patient arrives or before treatment. Ensure the surfaces surrounding the treatment area are free from ignition sources and nonmedical surfaces are not near the administration mechanism	Zero safety incidences. Zero damage to property.	Rounding by EOC tracer teams to patient rooms to ensure the equipment is properly placed in the room. Review policy with staff regarding smoking material removal.	Met		

2023 Annual Assessment of Management Plan Effectiveness

Safety Sub-Committee

Section/EP	Summary	Risk Point	Process to Mitigate Risk	Goal	Measure	Met/Not Met	Progress to Date	Work to be Done
	sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion.							
02.01.03 EP-6	The hospital takes action to maintain compliance with its smoking policy.	Failure to comply places campus at risk of fire and continued smoking on campus	Signage, staff intervention when others are non-compliant. Police citations	Zero evidence of smoking on campus	Reports from grounds, Police Department and safety sub-committee	Not Met	1 citation issued	Continue vigilance and rounding

2023 Annual Assessment of Effectiveness – Security Management Plan

Chapter / Element of Performance	Item summary	Risk Point	Management Process to Mitigate	Goal	Measure	Goal Met / Not Met	Progress to date	Work to be done	Comments
EC 02.01.01, EP1	Assess and measure risk based on collected data	Organization is unaware of risks and potential for injuries.	Discussion of risk assessment during monthly meetings.	Incorporate, track, and assess monthly statistics pertaining to Workplace Violence as per the new Joint Commission guidelines.	Security reports during WPV Committee meetings.	Met	Reports provided in WPV Committee meetings.	None	
EC 02.01.01, EP17	The hospital conducts an annual worksite analysis related to its workplace violence prevention program.	Unknown or unaddressed risks pertaining to workplace violence	Workplace violence worksite analysis.	Work with the JDH Workplace Violence Committee to ensure compliance with Joint Commission guidelines pertaining to Worksite Analysis.	Worksite analysis approved by WPV Committee.	Met	Worksite analysis approved by WPV Committee.		
EC 04.04.01, EP15	Hospital evaluates the effectiveness of the management plan within the prescribed timeframe	Management plan does not properly outline objectives or scope of work needed to ensure compliance and minimize risk.	Annual assessment of management plan effectiveness.	Evaluate the Security Management Plan within the prescribed timeframe.	Annual assessment is created and presented to EOC Committee for approval.	Met	Evaluation complete/approved by EOC Committee in October.	None	

2023 Annual Evaluation of Effectiveness – Hazardous Materials and Waste Management Plan

Chapter/ Element of Performance	Item summary	Risk Point	Management Process to Mitigate	Goal	Measure	Goal Met/ Not Met	Progress to date	Work to be done	Comments
EC 02.01.01, EP-7	The hospital minimizes risks associated with selecting and using hazardous energy sources (lasers)	Risk of injury to staff and patient	Policy/ procedures and training	Review/revise/implement a laser safety/MRI safety program	SABA compliance	met	Materials have been developed	Incorporate into SABA and assign to appropriate individuals	
EC 02.02.01 EP-1	Hospital maintains written inventory of hazardous materials	Inaccurate inventory	Annual update of inventory	Chemical inventory database remains current.	Rounds/ Tracers	Met	Inventory updated on 8/15/23.		
EC 02.02.01 EP-5	The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals	Improper storage may place patients and staff at risk.	HazMat Program	Proper storage, handling, transporting and use of hazardous chemicals are consistently observed	Observed during rounds and tracers	Met		Continue assessing during environmental rounds and audits (Lab Med)	
EC 02.02.01 EP-8	The hospital minimizes risks associated with disposing of hazardous medications	Waste streams not segregated properly resulting in improper disposal	Segregation of hazardous and pharmaceutical waste streams, separate containers, etc.	Pharmaceutical waste segregation and handling program goals are met (main campus & off-sites)	Waste streams are segregated at point of disposal and on rounds	Not Met		Continue assessing during environmental rounds has revealed a lack of training.	Contract renewal 1/1/2024
EC 02.02.01 EP-18	Radiation workers are checked periodically for the amount of radiation exposure.	Failure to monitor could lead to overexposure	Dosimetry program	Radiation dosimetry return rate meets goals	Badge return rate metric reported to QAPI	Met	Badge return rates are consistently above 95%	Continue tracking and reporting badge return rate to RSC and QAPI.	

2023 Annual Evaluation of Effectiveness – Fire Safety Management Plan

Chapter/ Element of Performance	Item summary	Risk Point	Management Process to Mitigate	Goal	Measure	Goal Met/ Not Met	Progress to date	Work to be done	Comments
02.03.01 EP 1	The hospital minimizes the potential for harm from fire, smoke, and other products of combustion	Ineffective fire doors could result in spread of smoke or fire.	Review completion of work orders involving fire doors deemed out of compliance	Monitor fire door maintenance and compliance during subcommittee meetings	Review of meeting minutes	Not Met	Reviewed during Facilities updates in meeting. Stopped specifically asking for this information as weekly rounding identified less doors out of compliance during year.	Continue reviewing doors during weekly rounding to ensure compliance and continue asking for update during meetings to prevent complacency.	
02.03.01 EP 1	The hospital minimizes the potential for harm from fire, smoke, and other products of combustion	Improper documentation and records could lead to items being missed and risk increased	Update documents to current standards	Update binders to reflect 2022 and early 2023 TJC documentation requirements	Review of binders	Met	Updated language and matrices included in binders	Continue to update as TJC requirements change	
02.03.03 EP 7	The hospital conducts fire drills for operating rooms/surgical suites.	During emergencies, people could forget what to do.	Training and education specific to risks in this specialty area	Increase participation of licensed practitioners (LP) in annual in-person training and fire drill.	Review of attendance records	Met	Only a few more LPs attended the multiple offerings of education and drills.	Work with OR admin and educators to identify methods to increase LP participation. Looking for greater participation and need to quantify.	
02.03.03 EP 7	The hospital conducts fire drills for operating	During emergencies, people could	Training and education specific to	Monitor for compliance of OR fire	Review of vendor drill and	Met	FD and FMU personnel attended each drill and obtained	Continue this effective education and drill process.	

	rooms/surgical suites.	forget what to do.	risks in this specialty area	drills/evacuation drills	education records		records from vendor who provided education and conducted drills. Added documents to drill binder.		

2023 Annual Evaluation of Effectiveness – Medical Equipment Management Plan

Chapter/ Element of Performance	Item summary	Risk Point	Management Process to Mitigate	Goal	Measure	Goal Met/Not Met	Progress to date	Work to be done	Comments
EC.02.04.03 EP3,4	The hospital inspects, tests, and maintains all equipment. These activities are documented. Required activities and associated frequencies for maintaining, inspecting, and testing of medical equipment must have a 100% completion rate	Use of unsafe equipment and/or poor reliability	Monthly reviews of PM % completed	Maintain all applicable PMs at 100% completion rate	PM compliance Metric	Met	PM Compliance to Date 100%	None	N/A
EC.02.04.01 EP5	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's activities and frequencies for inspecting, testing, and maintaining the following items must be in accordance with manufacturers' recommendations:	Injury to patients	Laser Safety Program	Launch Laser Safety SABA modules and deploy to clinical staff	Program Created	Met	Program Launched in 2023	None	N/A
EC. 02.04.01, EP3	The Hospital Manages Medical Equipment Risks	Injury to patients.	FMEA document completed	Perform a utility-related or a medical device–related Failure Modes and Effects Analysis or Root Cause Analysis by Dec 2023	FMEA Completed	Not Met	FMEA has been assigned	FMEA will be complete by end of year.	N/A
EC. 02.04.01, EP3	The Hospital Manages Medical Equipment Risks	Malfunctioning equipment	Cybersecurity Program	Create program to address software patching of medical devices (High Risk and Non-High Risk) to improve safety from cybersecurity standpoint.	Create Medical Device Cybersecurity Program	Met	Used Medigate to define Cybersecurity High Risk and shared on monthly basis during EOC medical equipment meeting.	Continue to manage medical device Cybersecurity risk by using Medigate and with the Cybersecurity Program	N/A

UCONN HEALTH
UCONN JOHN DEMPSEY HOSPITAL

2023 Annual Evaluation of Effectiveness – Utilities Management Plan

Chapter/ Element of Performance	Item summary/JC Requirement	Risk Point	Management Process to Mitigate	2023 Goal	Measure	Goal Met/ Not Met	Progress to date	Work to be done	Comments
EC.02.02.05 EP4. 6	The hospital inspects, tests, and maintains the following: High and non-high risk utility system components on the inventory.	Revise preventative maintenance schedules to assure 100% of EOC PMs completed on time	Reschedule preventative maintenance work orders over 3-month period	Revise schedules to assure compliance	Review open work order log weekly to assure assigned work orders complete on time.	Met	Complete	Manage work order reports. Report completion rates to Utilities Management Sub Committee.	Schedules include grace period days as weekly and monthly reports are managed
EC.02.05.01 EP10, 13	The hospital manages risks associated with its utility systems. The hospital has written procedures for responding to utility system disruptions. The hospital responds to utility system failure.	Main chiller plant has one pump system offline and introduces concern if other pumps fail. Chiller system supplies significant portion of campus including childbirth and nicu areas.	Smaller chiller can be run to pick up load of inpatient area	Replace main chilled water pump in central plant.	New pump system installed and commissioned.	Not Met	Pump has been installed.	Commission pump/manage project turnover.	Track progress through the Utilities Management Sub Committee
EC.02.05.01 EP10, 13	The hospital manages risks associated with its utility systems. The hospital has written procedures for responding to utility system disruptions. The hospital responds to utility system failure.	Loss of chiller in University Tower carries risk of interruption of patient care and possible hospital diversion	Temporary arrangement for emergency chiller has been identified by Facilities and on-call contractor	Develop emergency response plan and project for emergency chiller arrangement.	Piping system and valves installed for tie-in. Power source for chiller identified.	Not Met	Tie in location and landing space for temp chiller identified	Tie in the connections over the winter after the chilled water system is offline.	Track progress through the Utilities Management Sub Committee
EC.02.05.01 EP16	In non–critical care areas, the ventilation system provides required pressure relationships, temperature, and humidity.	Humidity requirements for sterile storage are expected in non-critical areas that were not designed to meet more stringent requirement.	Manage sterile storage items in locations. Dehumidifiers accepted as interim solution at dermatology	Install new heat pumps in 21 South Road storage rooms	No humidity alarms or manageable controls to keep below threshold	Met	Project Complete	Facilities team commissioned the controls. Utilize dehumidifiers where appropriate as temporary.	Humidity has been maintained with only occasional spikes below 65% during extreme weather periods.
02.05.01 EP23	Power strips in a patient care vicinity are only used for components of movable electrical equipment assemblies used for patient care. These power strips meet UL 1363A or UL 60601-1.	We use UL1363A for patient room vicinity which would also be good within room. Review other power strips that must meet UL1363A. Risk point should be simply that that our policy is inclusive of requirement	Implement new requirements. Inspect patient rooms during rounding.	Update policy and review UL rating on devices. The in-room UL is less restrictive than the patient care vicinity device. Include other EP notes 1-3 in policy	Reviewing rooms during EOC rounds	Met	Policy was edited and re-written with appropriate UL rating on devices permitted in respective areas.	Continue to round areas for appropriate power strips.	Rounds teams have not found a non-rated power strip in a patient vicinity for months.
EC.02.05.02	Hospitals should consider incorporating basic practices for water monitoring within their water management programs	Building F hot water tanks create risk of bacterial growth and distribution to higher risk area.	Plumbing shop superheats the water monthly which is acceptable method to control	Renovate the hot water system with on demand heat exchangers to remove the risks of the old tank system	Hot water temperature exposure during the monthly tank superheat procedure	Not Met	Design of system complete. Contractor selected. Project initiated.	Complete project.	Track progress through the Utilities Management Sub Committee

School of Medicine

GME Annual Quality Improvements

Engaging Residents, Fellows and Faculty in Patient Safety at UConn Health

Wendy A. Miller, MD, FACP
Associate Professor of Medicine
Quality and Safety Education Officer
Assistant Designated Institutional Official
Office of Graduate Medical Education

ACGME Common Program Requirements

- Residents, fellows and faculty must:
  - Actively participate in patient safety systems and contribute to a culture of safety
  - Know their responsibilities in reporting/how to report patient safety events at the clinical
  - Participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses/other activities that include analysis, as well as formulation and implementation of action plans

ACGME Common Program Requirements. Effective July 1, 2022. Accessed 10.7.2022.
https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency_2022v3.pdf

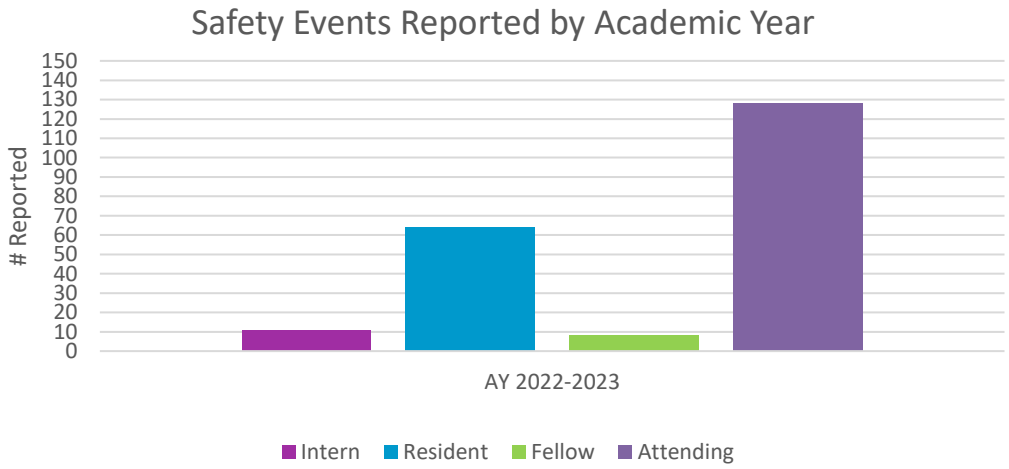
Patient Safety Educational Program

- 2017 implemented a Patient Safety Educational Program for incoming residents and fellows
  - Culture of Safety; Safety Event Reporting; Safety Event Analysis using Apparent Cause Analysis (ACA); Action Plan Development
- 2018 began assigning incoming residents and fellows safety event reports to analyze through the Apparent Cause Analysis (ACA) process
- 2020 Patient Safety Faculty Experts were chosen to participate in an ongoing faculty development program designed to provide them with the requisite knowledge and skills to teach and mentor their trainees in patient safety

Participating Programs

JDH Patient Safety Faculty Experts 2023-2024	
Program	Patient Safety Faculty Expert
Residencies	
Anesthesiology	TBD
Dermatology	Campbell Stewart, MD, FAAD
Emergency Medicine	Danielle Mailloux, MD
Internal Medicine	Jennifer Baldwin, MD
Neurosurgery	Ian McNeill, MD
Neurology	Neha Prakash, MD
Obstetrics & Gynecology	Alex West, MD
Orthopaedic Surgery	Scott Mallozzi, MD
Otolaryngology	Todd Falcone, MD
Physical Medicine & Rehabilitation	Snehal Naik, MD
Primary Care Internal Medicine	Snehal Naik, MD
Psychiatry	Gregory Barron, MD
Radiology	Marco Molina, MD
Surgery	Jillian Fortier, MD
Urology	Brooke Harnisch, MD
Fellowships	
Cardiology	Peter Robinson, MD
Endocrinology	Parvathy Madhavan, MD
Gastroenterology	Roopi Bath, MBBS
Hematology & Oncology	Victoria Forbes, MD
Infectious Disease	Mary Snayd, MD
Nephrology	TBD
Pulmonary	Jose Soriano, MD

Safety Events Reported by Residents and Fellows



	AY 2022-2023
Intern	11
Resident	64
Fellow	8
Attending	128

Resident and Fellow Education/Simulated ACA

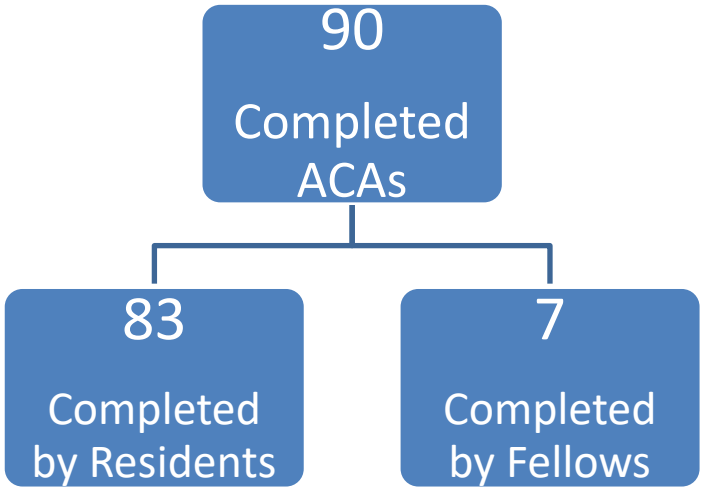
2022-2023	Total n	Educated (n/%)	Completed a Sim Case (n/%)
Residents			
PGY1's and Residents new to the institution	164	160/98%	149/91%
Residents above the PGY 1 level or new to the institution level	379	92/24%	71/19%
Fellows			
First Year Fellows	27	24/89%	18/67%
Upper Year Fellows	39	31/79%	23/59%

Resident and Fellow ACA Participation

2022-2023	Total n	Participated in Real ACA (n/%)
Residents		
PGY1's and Residents new to the institution	164	158/96%
Residents above the PGY 1 level or new to the institution level	379	68/18%
Fellows		
First Year Fellows	27	18/67%
Upper Year Fellows	39	20/51%

ACAs Completed by Residents and Fellows

2022-2023



Resident and Fellow Action Plans Implemented

Total Number of Action Plans Implemented	
2022-2023	56

Informational Items

UCONN HEALTH

TO: Members of the Clinical Affairs Subcommittee of the UConn Health Board of Directors

FROM: Richard Simon, M.D., Medical Board Chair

DATE: November 9, 2023

SUBJECT: JDH Medical Board Report

The following is a summary of the major activities of the JDH Medical Board for May 2023 through October 31, 2023.

POLICY/OTHER ISSUES

1. Reviewed the requirement that Chiefs of Service have practitioner-specific data on file that supports their approval of any Special Privilege listed on the practitioner's privilege list.
2. Reviewed clinical revenue and expense contracts presented by Berri T. Gerjuoy, J.D., Vice President, Contracts Department.
3. Approved changes to the Clinical Standing Order Set for Newborn Admission.
4. Approved additions to the Critical Results Policy to include "any positive stains" and "any positive cultures of normally sterile body fluids".
5. Approved a new policy, "Medical Staff: Gifts, Non-Monetary Compensation, and Incidental Medical Staff Benefits".
6. Established a new, institution-wide, "UConn Health Lab Utilization Committee" as a subcommittee of the Utilization Management Committee with inpatient and outpatient workgroups.
7. Approved changes to the History and Physical Policy as it relates to CMS standards allowing for a patient assessment instead of a full history and physical for low-risk patients undergoing a low-risk procedure.
8. Proposed a change to the Medical Staff Bylaws extending the timeframe for obtaining board certification in order to comply with new state statute. Issue will be voted on at the Annual Medical Staff Meeting.
9. Approved the addition of Optometrists to the Professional Staff.

CREDENTIALING ACTIVITY

Type of Application or Evaluation	Total
Initial Appointment	87
Reappointment	211
Temporary Privileges	28
Applications for a Change in Privileges	16
Focused Professional Practice Evaluations	47
Ongoing Professional Practice Evaluations	404

TO: **UConn Health Board of Directors / Clinical Affairs**

FROM: **Anne Horbatuck, RN, BSN, MBA**
Chief Operating Officer, University Medical Group
Vice President, Ambulatory Operations

Denis Lafreniere, MD, FACS
Professor and Chief, Division of Otolaryngology, Head and Neck Surgery,
Associate Dean of Clinical Affairs

DATE: **November 9, 2023**

SUBJECT: **UConn Medical Group (UMG) / Ambulatory Operations Report**

PROGRESS ON AMBULATORY ORGANIZATIONAL GOALS and INITIATIVES

Brief highlights for Q1 FY24:

Operational Updates

- **COVID-19 Vaccination Policy:** UConn Health continues to align with the CDC changes and recommendations for vaccine administration. This requirement applies to workforce members regardless of whether they work on site or remotely, unless the individual qualifies for an exemption, or a deferral as provided by our policy and procedure. Booster shots are strongly recommended for those eligible but are not mandated at this time.

- **Vaccine Administration and Testing:** The Public Health Emergency (PHE) ended on May 11th, 2023. With the end of the PHE, the guidelines and recommendations around testing changed resulting in a need to shift our process. The team started working on this right away, developing new Epic flows, decommissioning the drive through testing site in Garage 1 as of August 1, 2023 and shifting the care to the PCP's and special identified clinics (ID, Pulmonary, Urgent Cares, etc.) Our employees continue to call the COVID call center and have access to testing in OPPV 1st floor in the Pedestrian site to keep our workforce operational and safe. In the future we will be transitioning this testing to our Employee Health area.

- **Masking policy updates**: Effective June 27, 2023, masks have been optional in all UConn Health facilities. This includes all UConn Health inpatient settings the emergency department, procedural settings, outpatient clinics and dental clinics, urgent cares, hallways, cafes/cafeteria, and UConn Health shuttle buses. However, masks continue to be required in all locations for any individual (employee, learner, patient) who has Flu /COVID signs or symptoms. Must consult with our COVID call center for specifics.

    - **As of October 23, 2023 we updated our Institutional masking protocol due to increased COVID-19 in our community**, and we are seeing increased cases among employees and patients. The health and safety of our patients, learners, faculty and staff is our highest priority, therefore, we are updated our institutional mask protocols.

      Masks will be required in the following circumstances:
      - During all direct, patient-facing interactions in ambulatory and inpatient settings
      - In any location, for any individual at UConn Health (employee, learner, patient) who has signs or symptoms of respiratory illness.* (*Employees should not come to work sick. Those with

respiratory symptoms should call the COVID-19 Call Center for guidance on evaluation and testing)
- For any individual in any area of UConn Health with a known, recent (within the last 10 days) high-risk exposure to COVID-19
- Patients with symptoms that may be due to respiratory illness should wear a mask at all times while in the facility. For all other patients and visitors masking is recommended.
- Additional masking requirements may be implemented in specific units, clinics or departments under direction from local leaders and UConn Health leadership in consultation with Infection Prevention and COVID-19 Call Center leaders.

It is anticipated that these mask protocol changes will be time-limited and will be revised as respiratory virus transmission in the local community decreases. Our COVID-19 Policy Workgroup will continue to monitor COVID-19 and respiratory virus conditions and will provide updated communication with further changes.

- **COVID-19 Vaccination:** UConn Health continues to make large strides against COVID-19 with administering the COVID-19 vaccine and adhering to ever changing recommendations from the CDC. We continue to meet with senior leadership, Infection Disease /Prevention and the COVID Call Center team to adjust to the changes, review our policies and guidelines to stay current and consistent with other local hospitals. https://health.uconn.edu/coronavirus/

  - On October 17, 2023**,** UConn Health began offering our workforce and learners the newly approved COVID-19 vaccine (Moderna). The new COVID-19 vaccine is being offered at the Outpatient Pavilion's first floor vaccine clinic and in the Occupational Health Services Clinic. The new vaccine is also available to established patients in PCP and clinics across campus.

- **COVID 19 Call Center -** Since the start of COVID, we have continued to answer calls from employees who have either been exposed to or have symptoms of COVID-19. We have continued to track, assess, provide guidance scheduling of tests, contact trace for these groups. We also provide guidance with home self-swab tests and track those in our data as well.

- **Influenza Vaccine -** This year's flu vaccine became available campus-wide on September 15th. UConn Health's vaccine supply is quadrivalent (it covers four influenza strains). UConn Health is following the CDC recommendation and providing the high-dose vaccine for those 65 and older. Vaccines are available to established patients in primary care clinics and available to the public via a drive-through flu clinic scheduled Oct. 21st at the Canton site. This excellent drive through vaccinated over 325 people. UConn Health workforce, learners and volunteers are able to receive their vaccines by appointment at Employee/Student Health Services, or by attending one of several flu clinics scheduled in October and November on campus or by identifying a mobile immunizer in their work area.

- **Policy Migration –** On October 1st, UConn Health launched a new searchable, cloud-based Policy Manager software which will serve as the single source for all UConn Health standards documents making procedures, guidelines, and protocols available across the institution. The software allows for automated policy approval workflows and will streamline the process for review, revision and approvals for stakeholders and committees. A new Policy Template has been approved and is available in the software as well.

Population Health Program Outcomes

Figure 1. Population Health Clinical Outcome Scorecard

Population Health Program	Metric	Reporting Period					Trend	Notes
		FY23 Average (July '22-Jun '23)	FY24 Q1 (Jul-Sept)	FY24 Q2 (Oct-Dec)	FY24 Q3 (Jan-Mar)	FY24 Q4 (Apr-Jun)		
Transitional Care Management	Appointment Adherence	78%	82%				↑	Target rate 80%
	30- Day Readmission Rate	13.5%					TBD	Readmission rate not available at time of report
Care Coordination	Patients Referred to Social Work	-	191					New data on social work referral volume
	Patients Referred- SDOH	87	80				↓	Top referral requests- transportation, housing, and food resources
ED High Utilizer Outreach	Total High Utilizer Outreach	387	353				↓	High utilizer defined as 3 or more ED visits in 60 day period.
	Engagement Rate	47%	36%				↓	Percentage of patients reached by a Community Health Specialist following an ED visit

- This quarter, appointment adherence for Transitional Care Management visits increased, exceeding the target rate. The adherence rate correlates to the readmission rate of this population, so the increase is encouraging. The volume of ED high utilizers continued to decrease this quarter. Frequent outreach to this population, screening for social determinants of health and reconnecting patients to their primary care provider are some of the interventions used to manage this patient population. The engagement rate for ED high utilizers was lower than average this quarter which may have been related to some telephone issues resulting in the outbound calls to patients showing as "Private". These issues have been resolved and we hope to see the ED engagement rate recover accordingly.

- In March of 2023, two ambulatory social workers were hired and transitioned from the JDH department of Care Coordination to the Population Health Department. They provide centralized social work support to over 40 ambulatory practices and manage patient safety concerns, behavioral health needs, skilled nursing facility placement, advance care planning and more. This quarter we will begin sharing data on the volume of referrals to social work in the table above.

- Readmission work continues with the interdisciplinary team to address systemic issues and trends. Recently, leadership has begun investigating the option of a post-discharge clinic to manage patients who are at high-risk for readmission and may not have established provider relationships in the community. This model would include a multi-disciplinary approach using nurses, pharmacists, and advanced practice providers as well remote patient monitoring technology to drive reductions in readmission and improved patient outcomes. Dr. Celi, Chair of the Department of Medicine is leading these efforts.

Performance Improvement

- The Gastroenterology process improvement report was shared with physician and operational leadership. The report findings and process improvement steps were discussed with the GI team during a division meeting in May. The improvement steps will include modifications to referral work queue processing to identify urgent cases that need to be prioritized for office visit scheduling, review of the scheduling templates, new process for routine, low-risk, colonoscopy screening as well as optimization of procedure scheduling, including prioritizing of urgent cases and addressing procedure no-shows and cancellations in a timely manner. The new process for routine colonoscopy screening will involve a screening questionnaire sent to patients via MyChart (patient portal) to assess their risk. Low risk patients will be scheduled for a screening colonoscopy procedure without the need for office visit. Working sessions with APRNs to develop screening questionnaire were conducted. Practice identified the need to hire additional RN to help with triaging of urgent cases and streamlining of colonoscopy screening procedures. Position was approved, a candidate has been hired and will start in clinic on Oct. 20, 2023.

In addition, meetings were held with the OR leadership to improve GI procedure scheduling process and develop workflow for procedure confirmation two weeks prior to a scheduled procedure to avoid cancellations and ensure the backfilling of cancelled spots with urgent cases. New pre-procedure outreach call process is set to launch Nov. 1, 2023.

Patient Experience

- In this quarter UMG in collaboration with the Office of Patient Experience began a series of patient experience trainings with practices that have the most opportunity to improve their patient experience scores. The trainings include a brief overview of the survey process, education on basic terminology, review of the practice performance and a deeper dive into two questions with the highest priority index (identified by PG Fusion as driving practice's performance so improvement in these areas has the highest impact on raising the overall score). The trainings are attended by all members of the care team, including front desk staff, MAs, RNs, clinicians, and practice management. In FY23 Q4 trainings were conducted with West Hartford Internal Medicine, East Hartford Internal Medicine, and Torrington Internal Medicine teams. In the upcoming quarter, trainings are scheduled for Orthopedics, Rheumatology, Podiatry, and Geriatrics care teams. The goal is to meet with all ambulatory practices by the end of FY24.

Quality

- This quarter UMG implemented an Ambulatory Good Catch program to recognize UConn Health ambulatory staffers who report a "Near Miss" event or safety situation that could have resulted in patient harm. The program emphasizes the importance of identifying and reporting concerns so that together we can strive to provide the safest environment possible for our patients.

- July 30, 2023, marked the end of the Million Hearts Self-Monitored Blood Pressure grant program. At the end of the award period, 212 BP cuff-kits and education material were disseminated to high-risk mothers. Six women were admitted to the hospital post-delivery after recognizing preeclampsia symptoms and contacting their provider. The funding allowed for the purchase of 1000 cuff kits. Distribution and education will continue in inpatient and ambulatory settings to continue this important program. Efforts are underway with the UConn Health pharmacy department to develop a sustainable solution to bill for the BP monitors when allowable under the patient's insurance plan as well a potential grant opportunity with the UConn Health Foundation to offset the cost share to the patient.

- This quarter we continued our primary care Quality Improvement contest, and we recognized the practice with the most improvement quarter over quarter across all measures. The winner was East Hartford Internal Medicine. The final QI winner will be determined at the end of December and will reflect the highest overall performance for the year.

- Press Ganey survey results for this quarter indicate upward trending across outpatient practices within several focus area Top Box scores when compared to last quarter including physician communication quality and office staff quality. Telemedicine feedback has shown upward trending as well in the areas of access, care provider and telemedicine technology. Most notable was the patient's likelihood to recommend with a new high top box rating of 94.82%.

Likelihood to Recommend

Time Period	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023
n	4062	9113	13745	13064	12492	1815
Top Box Score	90.99%	91.93%	93.31%	93.58%	93.70%	94.82%
Percentile Rank	39	63	87	84	81	88

Pay for Performance (P4P) / Population Health Q1 Financial Incentives

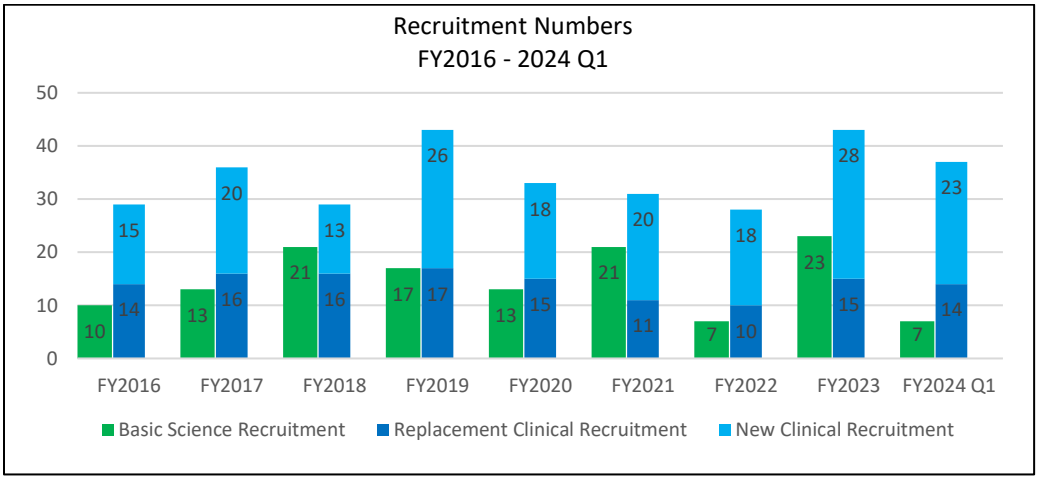
- Aetna Commercial Pay for Performance
- Aetna Medicare Advantage Valu-Based Care Program
- Anthem's Value-Based Care Program - EPHC (Enhanced Personal Health Care) Care Coordination
- DSS Medicaid Obstetrics Pay for Performance
- United Healthcare MA-PCPi Quality Care Bonus Payment
- Wellcare Medicare Advantage P4P
- Optum In Office Assessment Program

Total incentives earned for FY24 Q1- $670,309

Growth and Development

Significant growth is anticipated for FY24 with 37 clinical faculty hires scheduled with 23 of these new and 14 of those replacements. We also expect seven basic science faculty.

- The breakdown of the 23 new clinical positions is as follows: 4 General Internal Medicine, 2 General Surgery, 2 Hospitalist, 2 Hospitalist/Nocturnist, 2 Maternal Fetal Medicine, 1 Cancer Center, 1 Dermatology, 1 Emergency Medicine, 1 General OBGYN, 1 Geriatrics, 1 Hospitalist OBGYN, 1 Neurology, 1 Psychiatry, 1 Pulmonary and Critical Care, 1 Radiology, 1 Surgery/Cancer Center



Space

- Space continues to be a challenge as we grow our practices. Early in the FY23 Q2 we expanded our Surgical specialties in our **West Hartford** location. This allowed for patient convenience, direct referrals from Internal Medicine and allowed to decant the space in the Outpatient Pavilion. Services include General Surgery, Vascular Surgery, Urology and Plastics.

- We opened our new location in **Simsbury, CT** at **836 Hopmeadow Street** on May 8th, 2023. This includes Internal Medicine, Orthopedic Surgery and specialists. In addition, this site has radiology and blood draw station.

- The new **Laser Center** located within our Dermatology suite at 21 South Road in our Dermatology suite opened on May 22nd 2023. We were fortunate to receive a donation of over $1 million dollars in equipment from Dr. M. Perez. With the new equipment being added to our present lasers, a specific UMG location has been established within the suite. Grand opening will be scheduled in the near future.

- In addition to the above space enhancements, we are working on a growth and "domino" plan to optimize the Outpatient Pavilion, with a financially focused, service line approach to grow specific areas. The first move involved relocating the **Geriatrics and Healthy Aging** to a new leased space at 21 South Road Farmington. The new 10,000 square foot space allows for the expansion of our existing geriatric clinic and includes targeted specialty services with the opportunity to provide coordinated care for our older adult patient population. The rotating specialties include Geriatric Psychiatry, Osteoporosis, Neurology, Nutrition, Urology, Vascular Surgery as well as Audiology for hearing testing. The space also provides a new blood draw area for full-service patient care. The new UConn Geriatrics and Healthy Aging clinic opened its doors on October 23rd.

- The new **5 Munson Road** building construction is underway with a new target occupancy date of January 2024 for Neurology to move in and then mid March for the spine group, which requires radiology.. The new space will comprise of the UConn Health Brain and Spine Institute. This includes clinical components from Neurology, Comprehensive Spine, and Neurosurgery/cranial. In addition there will be radiology at this location.

- Plans to expand our **Southington** clinic space at 1115 West Street are also underway. An additional 5,000 sq ft of space will be added to the lower level of the building to allow for specialty services (ENT, Dermatology, OB/GYN Pulmonary, Endocrinology and Nephrology) to move down and grow by 4 exam rooms. This will allow our existing Primary Care practice on the second floor to expand to accommodate the 3 new physicians to be hired post-construction.

CHEERS

UConn Health began implementation of CHEERS, Epic's Customer Relationship Management (CRM) suite in February 2023. UConn Health is one of five Epic customers chosen to implement this complete product. They have implemented each component separately, but they are integrated so have moved to this new platform. The three modules for CHEERS include.

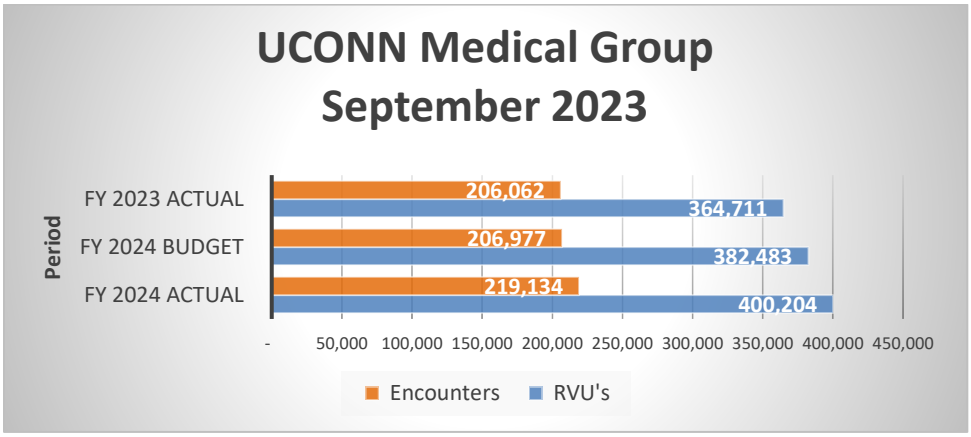
- Schedule/Template/Referral Optimization – largest component and will involve faculty, online scheduling options, template review and patient flow opportunities for access and increase revenues.

(Completed phase 1: Ortho, IM, FM, Derm. Phase 2 starts November and will include Endo/Osteo, Diabetes Education and Ophthalmology)

- Call Management - to assist the call centers in accessing information and scheduling to improve efficiency of triage and patient experience

- Campaigns - will focus on marketing healthcare opportunities to targeted patient populations

FINANCE



Encounters:

- YTD encounters are ahead of budget by 5.9% and ahead of prior year by 6.3%

wRVUs:

- YTD wRVUs are ahead of budget by 4.6% and ahead of prior year by 9.7%

Revenues:

- YTD net revenues are ahead of budget by 4% and ahead of prior year by 8.3%
- Largest growth areas for YTD period are: MOHS, DermPath and Neurology when compared to budget

MyChart

Oct 2023, we have seen an **increase to 58% active** patients. This is an excellent accomplishment, and we will continue to focus on additional growth. This will also be a part of the CHEERS initiative for patient engagement and Campaigns. Each month our numerator and denominator increase, keeping in mind that when we started our MyChart we were less than 16%.

Some Newsworthy Accolades

- Dr. George K UConn Health Elected to Elite Group of Researchers https://today.uconn.edu/2023/10/dr-george-kUConn Health-elected-to-elite-group-of-researchers/
- Medical Assistants Vital to UConn Health Patient Care https://today.uconn.edu/2023/10/medical-assistants-vital-to-uconn-health-patient-care/
- UConn's First Global Oncology Program https://today.uconn.edu/2023/09/uconns-first-global-oncology-program/
- A 3D-Printed Solution for the Spine https://today.uconn.edu/2023/09/a-3d-printed-solution-for-the-spine/
- UConn Health Redesignated a HEART Safe Campus https://today.uconn.edu/2023/09/uconn-health-redesignated-a-heartsafe-campus/
- Excellence Finds its Root in a Profound Desire to Make a Positive Impact on Others' Lives https://today.uconn.edu/2023/08/excellence-finds-its-root-in-a-profound-desire-to-make-a-positive-impact-on-others-lives/
- Keeping Sports From Becoming a Dangerous Game -https://today.uconn.edu/2023/08/keeping-sports-from-becoming-a-dangerous-game/
- Chronic Leg Swelling Mystery Solved by Innovative UConn Interventional Cardiologist https://today.uconn.edu/2023/08/chronic-leg-swelling-mystery-solved-by-innovative-uconn-interventional-cardiologist/
- Population Health Team Exhibits Leadership at Multiple Levels https://today.uconn.edu/2023/07/population-health-team-exhibits-leadership-at-multiple-levels/
- UConn Health Professor Victoria Forbes Nominated for International Teaching Award https://today.uconn.edu/2023/07/uconn-health-professor-victoria-forbes-nominated-for-international-teaching-award/
- Patient Group Honors Dr. Peter Albertsen as Pioneer in Prostate Cancer Management https://today.uconn.edu/2023/07/patient-group-honors-dr-peter-albertsen-as-pioneer-in-prostate-cancer-management/