Clinical Affairs Subcommittee of the Board of Directors

November 13, 2025

2:00 pm

Live Stream Link

Watch Now:
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UCONN HEALTH

CLINICAL AFFAIRS SUBCOMMITTEE
Board of Directors

Agenda
November 13, 2025
2pm – Virtual Only

Live Stream Link

1.	**Public Comment**		pg 1
2.	**Chair's Remarks**	Cheryl Chase	
	2.1 Welcome		
	2.2 Approval of Minutes: August 14, 2025 **[VOTE]**		pg 2
3.	**Chief Executive Officer's Report**	Dr. A. Agwunobi	pg 6
	3.1 Workplace Violence Update	Deb Abromaitis	
4.	**Quality Report**	Dr. S. Allen	pg 33
5.	**Approvals [VOTES]**		
	5.1 JDH Clinical Quality & Service Performance Improvement Plan – 2026		
6.	**School Reports**		
	6.1 School of Medicine	Dr. B. Liang	
	6.2 School of Dental Medicine	Dr. S. Lepowsky	
7.	**Informational items**		pg 74
	7.1 JDH Medical Board - Quarterly Update		
	7.2 UConn Medical Group Operations - Quarterly Report		
	7.3 Environment of Care Annual Assessment		
8.	**Executive Session**		
	To discuss matters not subject to public disclosure pursuant to Conn. Gen. Stat. §§ 1-210(b)(1), (b)(4), (b)(10), § 19a-17b, and other applicable provisions.		
9.	**Adjourn**		

Peer Review: NOTE: 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 to 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/her designee to receive requests to speak at the Public Comments portion of the Board of Directors Meetings:

Janice Coco
Executive Staff Assistant
Office of Health Affairs | UConn Health
Phone: 860-679-6232
coco@uchc.edu

Chair, Cheryl Chase, called the meeting to order at 2:02 pm.

Present (voting): Cheryl Chase, David Shafer, Joel Freedman, Kevin Staveley-O'Carroll, Leo Wolansky, Richard Barry

1. Public Comment – There was no public comment.

2. Chair's Remarks

2.1 Welcome

Ms. Chase welcomed everyone to the regularly scheduled quarterly meeting and stated the meeting is being recorded. She welcomed Dr. Brian Shames as our new Chief of Medical Staff and commended Dr. Richard Simon for his years of service and leadership.

2.2 Approval of the Minutes: May 8, 2025

The Clinical Affairs Subcommittee approved a motion duly made by Richard Barry and seconded by Joel Freedman to accept the minutes from the Clinical Affairs Subcommittee meeting held on May 8, 2025.

3. Chief Executive Officer's Report

Dr. Agwunobi reiterated the contributions of Dr. Simon and thanked him for his leadership. Dr. Agwunobi reviewed the recent recognitions that UConn Health has received, pointing out the recent Best in America Maternity Hospitals award from Newsweek. He noted that the demand for our maternity services is so strong that we had to pause on accepting new patients recently; we are also looking into our staffing needs to meet those demands. Dr. Agwunobi thanked our OB/GYN team for their hard work and for meeting the needs of our patients. Dr. Agwunobi also told the committee about the 2025 Blue Distinction Center of Excellence that we received for Knee & Hip Replacement services, and mentioned that we also expect to receive this award soon for Spine Surgery.

Dr. Agwunobi gave an update on the 23 new licensed beds that JDH received and how they have been utilized. Specifically, 14 of the 23 new beds have been placed on CT Tower 7 (our overflow Med-Surg Unit). These new beds allow us to place more patients in the hospital on Med-Surg units instead of admitting patients and holding them in the Emergency Department. The remaining nine beds are currently being used in the ED for patients admitted to the hospital, and the future plan is to place these nine additional beds on CT6. Dr. Agwunobi concluded this update by showing how the additional approved beds have stabilized our Med-surg occupancy rate – where our occupancy rate was consistently over 90+%, since the new beds were deployed, we are now tracking at about 80%.

Dr. Agwunobi continued his report by showing that Emergency Room visits, hospital discharges, volume in the Main OR and volume in the UConn Health Surgery Center are all tracking slightly better than budget, and this is good news as our growth continues. Dr. Agwunobi noted that the growth in the Procedure Center is still slightly lower than budget but still higher than last year. We are continuing to look at ways to increase the volume there. The number of encounters and the financials for the UConn Medical Group clinics are ahead of budget by 2.4% so far, and ahead of the prior year by 6.2%. While these numbers show continued growth, they will plateau due to space constraints, and we will continue to discuss ways to alleviate these constraints such as through public/private partnerships.

Dr. Agwunobi also shared with the committee recent and upcoming news about outpatient space and growth. To maximize space utilization and to accommodate growth in a number of clinics (such as OB/GYN, blood draws, surgical services, ENT), additional moves are planned in the Outpatient Pavilion in the coming months. We expanded services and space in our Southington location is August, we are adding same-day internal medicine access to our Avon office in September, and we are moving into a new site in Torrington starting in January 2026.

Dr. Agwunobi concluded his CEO report by mentioning the GUIDE Dementia Care Program. UConn Health was selected as 1 of only 2 sites in Connecticut to participate in the Centers for Medicare and Medicaid Innovation (CMMI) pilot to support patients/caregivers living with Dementia. The Program went so well that a team of surveyors were sent to review our program and we were selected as a mentor for new program track participants.

Dr. Agwunobi turned the presentation over to Dr. Hines to share UConn Health's Joint Commission (TJC) Health Disparities 2024 Annual Report. Dr. Hines explained that the TJC standard to reduce health disparities requires that patients be screened for social determinants/drivers of health (SDoH), which UConn Health first launched for patients admitted to our OB unit and then rolled out JDH-wide in December 2023. Dr. Hines reported on the disparities they found in the rate of postpartum infections among our Latine OB patient cohort, and the action steps we have taken and are taking to address these concerns and to continue to support this population.

4. Quality Reports

Dr. Scott Allen provided the Quality Report to the Committee. He spoke to the Best Maternity Hospital award and said that JDH is the only 5 Star hospital in Connecticut. This award is based on patient experience surveys as well as peers' surveys with reputation being an important aspect for this award.

Dr. Allen reported on two Pay-for-Performance Programs (P4Ps) that we have with payors. Our positive performance under Anthem's P4P program resulted in an increase to our fee-for-service rates, with a projected increase of reimbursement of $1.97M. With regard to Aetna's P4P Program, JDH earned 100% of the target incentive payment of $850,000. As we budgeted for a $450,000 incentive payment, this achievement means an additional $400,000 of revenue for UConn Health. This was the second year in a row that we received 100% of the incentive under Aetna's program.

Dr. Allen continued his report by sharing the Safety Scorecard, noting a few of the key items: Hand hygiene continues to track favorably; CAUTI reporting needs work to get more accurate numbers; and ED metrics remain favorable. Despite having very high volumes, our ED door-to-provider times and length of stay numbers remained fairly consistent; we have done a very good job getting people in and seen in a very busy ED. Regarding the item of Admission Medication Reconciliation Completed within 48 Hours, there has been a slow improvement toward our goal of 80%. To note, we are completing 48-hour admission medication reconciliation for approximately 400 more patients each month compared to two years ago. Although we reported one serious safety event in June, our Serious Safety Event rate went down because other older events rolled off the 12-month rolling average. On the JDH Patient Experience Scorecard we have consistently performed very well throughout all areas, and Dr. Allen noted that Lab, Rehab and Radiology have been consistently green for five quarters. Dr. Allen also mentioned that the Procedure Center's scores have been a bit inconsistent and we will continue to work with leadership in those areas.

Dr. Allen concluded his report with a reminder of the six Performance Improvement Priorities for 2025, noting these are imbedded in the Clinical Quality and Service Improvement Plan that gets updated annually at the November Clinical Affairs Subcommittee meeting. At that meeting there may be recommendations for any changes in these six priorities, as an example we may recommend that the Lab, Rehab and Radiology may be removed as they have been consistent for five quarters. Dr. Allen reminded the committee that the PI priorities that are chosen should have the "SMART" characteristics: Specific, Measurable, Achievable, Relevant and Timed.

5. Approvals

5.1 Appointment of Dr. Alise Frallicciardi as Emergency Medicine Chief of Service
5.2 Appointment of Dr. Konopake as Psychiatry Chief of Service
5.3 JDH Annual Program Leader Designations
5.4 2025 JDH Utilization Management Plan
5.5 JDH Written Scope of Services - 2025

The Clinical Affairs Subcommittee unanimously approved the motion duly made and seconded to approve all five of these approvals under one vote.

6. School Reports

6.1 School of Medicine – No report
6.2 School of Dental Medicine

Dr. Lepowsky gave an oral report. He gave an update on the move of Pediatric Dentistry from West Hartford back to Farmington, which has been delayed because of the complexity of the move. The new date is the first week of October. All patients or guardians of those that have been patients in the last two years have been notified.

Dr. Lepowsky announced the return of Dr. Chang to the role of Residency Program Director of Oral Maxillofacial Surgery. Dr. Lepowsky encouraged the committee to read the article in UConn Today to find out more about Dr. Chang.

Dr. Lepowsky announced a three-year grant from the Delta Dental Foundation to support our efforts to meet the needs of our patients with intellectual delays and developmental disabilities. This is the second consecutive multiyear gift, and we are the only entity to whom they have provided these back-to-back gifts. The first gift is $250,000 and the new gift is $200,000 over the 3 years, which is the largest gift Delta Dental has given to any dental institution. This initiative will allow us to hire a Dental Anesthesiologist to help us expand the scope of services to our patients. Dr. Lepowsky also leveraged this gift to obtain an additional $50,000 gift from the CT Department of Developmental Services.

7. Informational items

Chair Chase directed the subcommittee members' attention to the informational items in the Board book starting on page 142.

8. Executive Session

There was no executive session in this meeting.

9. Adjourn

There being no further business the meeting was adjourned at 3:44 pm.

Respectfully submitted,

Andrea Keilty
Chief of Staff and Liaison to the BOD
UConn Health

Next Regularly Scheduled Meeting: November 13, 2025

CEO Report
Clinical Affairs Subcommittee

Dr. Andrew Agwunobi
November 13, 2025

Areas of Focus

- Recent Recognitions
- Operational Updates
  - Hospital Partnerships
  - Growing Clinical Volume & Capacity
- Payor Negotiations

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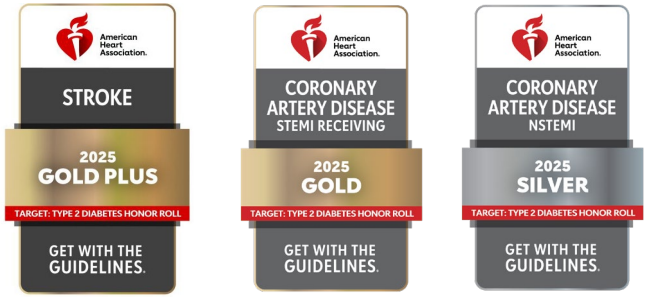
Recent Recognitions

Healthgrades
2026 5 Stars for Treatment of Upper GI, Hip Fracture, Sepsis, and Pneumonia

Forbes
2025 America's Best-in-State Employers in Connecticut



American Heart Association Get With the Guidelines
Nine consecutive years of **Gold Plus** awards for Stroke
Eleven consecutive years of **Gold** awards for STEMI; **Silver** Award for NSTEMI
Also awarded **Silver** in Target: Type 2 Diabetes Honor Roll

Age-Friendly Health Systems
Committed to Care Excellence

Healthgrades
Three consecutive years for Outstanding Patient Experience

The Leapfrog Group
Nine consecutive Straight A's Rating for Patient Safety 2021-2025

Newsweek
America's Best-In-State Hospital, Ranked #2
America's Best Maternity Hospitals
4-year champion World's Best Hospital for Infection Prevention and Patient Experience

2025 Blue Distinction Center+ for Excellence in Spine Surgery

UConn Health has recently been designated a Blue Distinction Center+ for Spine Surgery by Blue Cross Blue Shield.

- Blue Cross Blue Shield Blue Distinction Centers are health care facilities recognized for delivering high-quality care and effective treatments. They meet strict quality standards for patient safety, outcomes, treatment, and better overall patient results. Blue Distinction Centers+ also meet cost measures that address consumers' need for affordable healthcare.
- This program also aims to connect patients with providers who excel in specific specialty areas, ensuring safe and more effective care.
- Last meeting, we announced that UConn Health was designated a Blue Distinction Center for Hip and Knee Replacement and Maternity Care.

Anthem

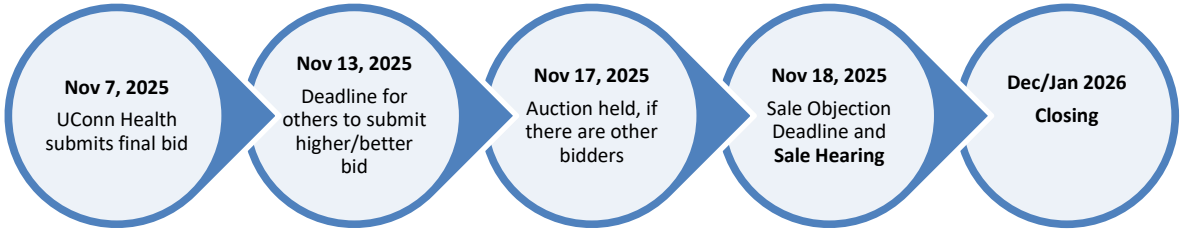
Designated BlueDistinction® Center+ Spine Surgery

Operational Updates

Hospital Partnerships

UConn Health, in partnership with the State, is executing on a new growth strategy to preserve healthcare access in CT and to expand the reach of its award-winning care

- **Waterbury Health**
  - Part of Prospect Holdings, which has been in bankruptcy court in Texas
  - Nov 7 - UCH Bid filed with the court to acquire Waterbury Health & its assets



- **Bristol Health & Day Kimball Health**
  - Discussions underway to develop clinically integrated network

- **Funding Needs** – being addressed in Special Session of the Legislature (Nov 12 & 13)

Growing Clinical Volume & Capacity

UMG, JDH and ED Volumes and Revenues continue to grow

23 New Licensed Beds and Reinterpretation of Observation Bed Counts have helped with Diversions

Strategic Plan being finalized: Clinical Departments' initiatives moving forward

Clinical Strategic Initiatives

We have identified priorities and initiatives through a structured process (Rapid Inclusive Strategic Planning) with Clinical Departments

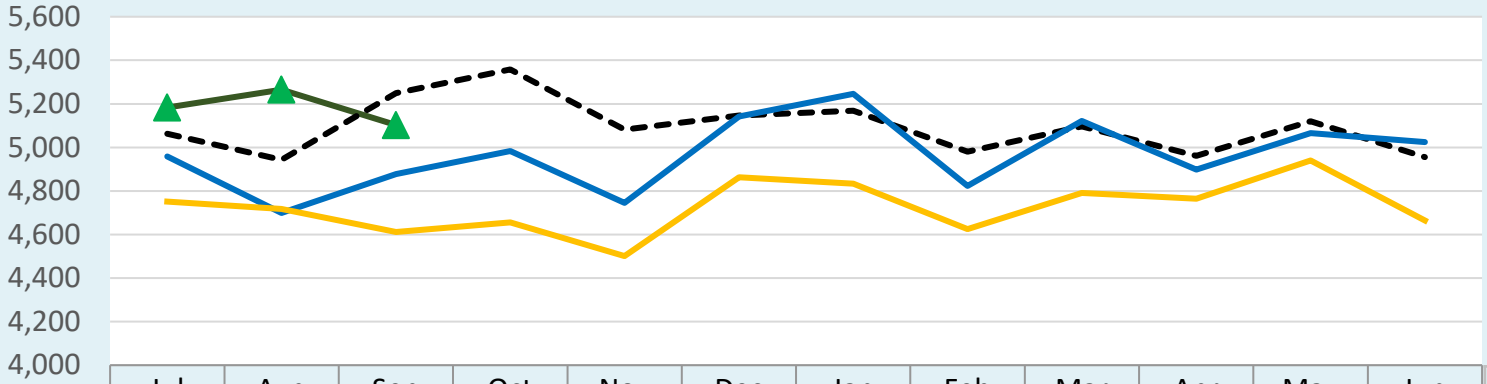
Initiatives Focus on:

- Growth & Financial Strength
- Elevating Surgical & Procedural Excellence
- Growing Access & Ambulatory Footprint
- Building on UConn Health's Areas of Distinction
- Leveraging Innovation

Examples:

- Expand Pharmacy and Infusion Services
- Add Additional Inpatient Psychiatry Beds
- Optimize Peri-Operative Process
- Expand Emergency Department Capacity by opening Low-Acuity Unit
- Grow Esketamine Program
- Establish AI Institute

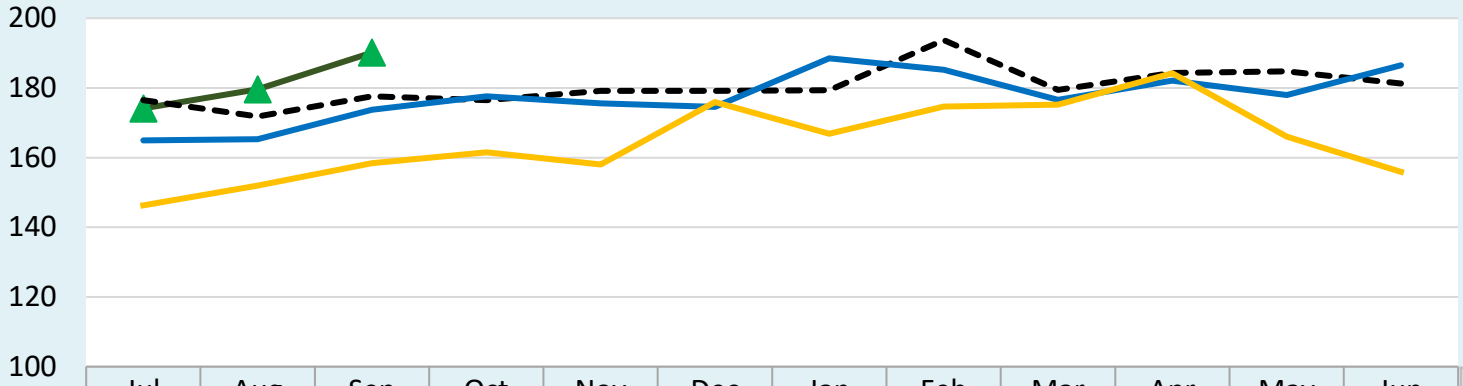
Emergency Room Visits



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
2026 Actual	5,183	5,265	5,103										15,551
2026 Budget	5,063	4,943	5,249	5,358	5,082	5,147	5,169	4,980	5,097	4,961	5,120	4,955	61,124
2025 Actual	4,958	4,699	4,878	4,983	4,745	5,142	5,246	4,823	5,122	4,898	5,066	5,025	59,585
2024 Actual	4,751	4,717	4,612	4,656	4,501	4,863	4,833	4,625	4,791	4,764	4,940	4,664	56,717

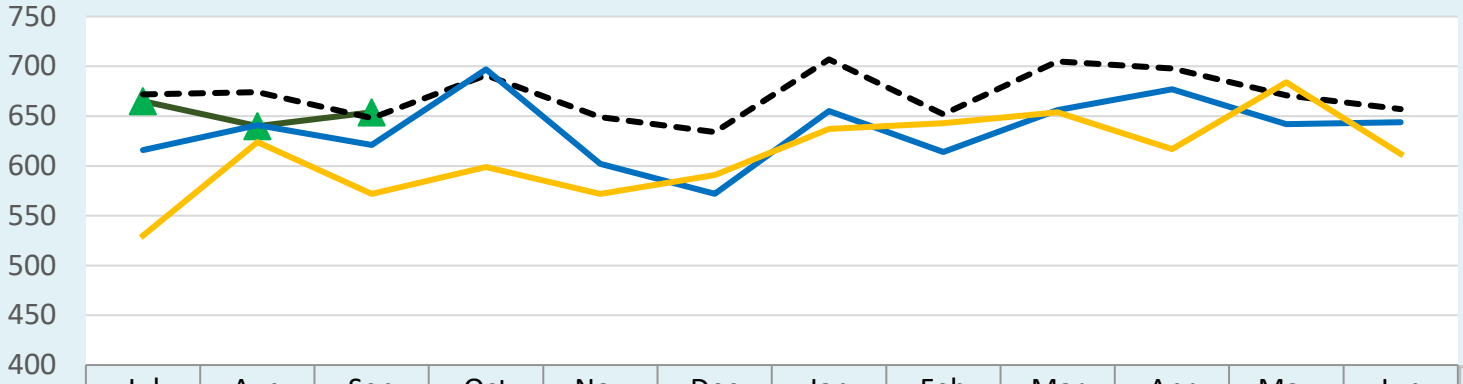
Average Daily Census

Inpatient



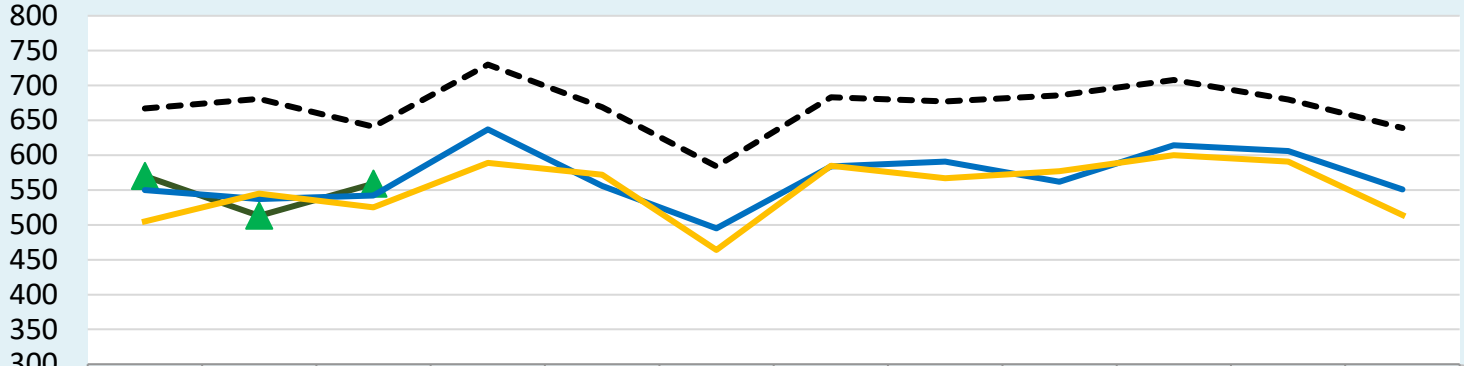
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
2026 Actual	174	180	190										544
2026 Budget	176	172	178	177	179	179	179	194	179	184	185	181	2,163
2025 Actual	165	165	174	178	176	175	188	185	177	182	178	187	2,128
2024 Actual	146	152	158	162	158	176	167	175	175	184	166	156	1,975

JDH - Main OR



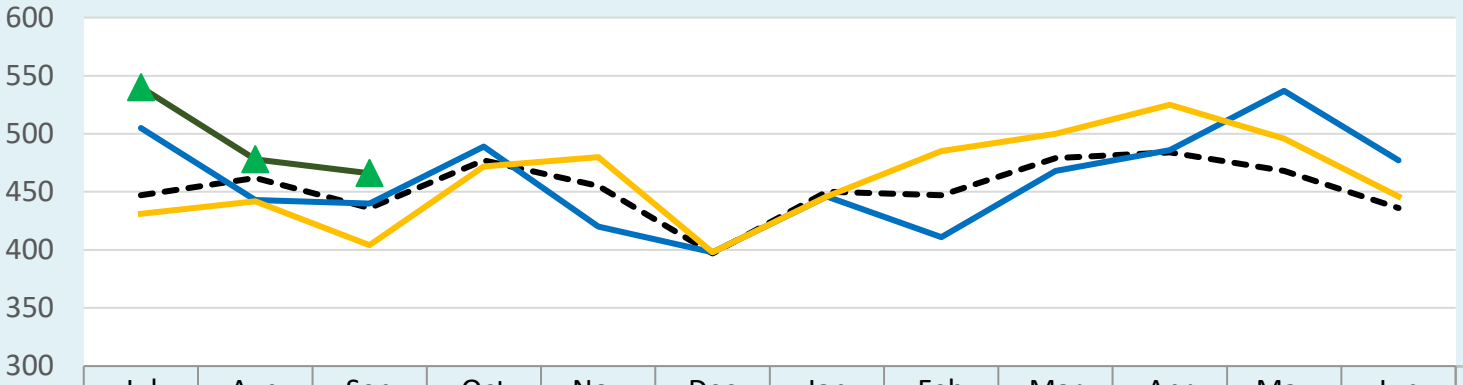
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
2026 Actual	665	640	654										1,959
2026 Budget	672	674	648	691	649	634	707	652	705	698	671	657	8,058
2025 Actual	616	641	621	697	602	572	655	614	656	677	642	644	7,637
2024 Actual	530	624	572	599	572	591	637	643	654	617	684	612	7,335

UHSC - OR



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
2026 Actual	570	513	559										1,642
2026 Budget	667	681	641	730	669	584	683	677	686	708	680	639	8,045
2025 Actual	550	537	542	637	556	495	584	591	562	614	606	551	6,825
2024 Actual	505	545	525	589	572	464	585	567	577	600	591	514	6,634

PROCEDURE CENTER
GI ENDOSCOPY



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
2026 Actual	540	478	466										1,484
2026 Budget	447	462	436	477	455	397	450	447	479	484	468	436	5,438
2025 Actual	505	443	440	489	420	398	446	411	468	486	537	477	5,520
2024 Actual	431	442	404	472	480	398	446	485	500	525	496	446	5,525

UConn Medical Group Financials

September 2025

Encounters

- YTD encounters are ahead of budget by 6.7% & ahead of prior year by 4.4%

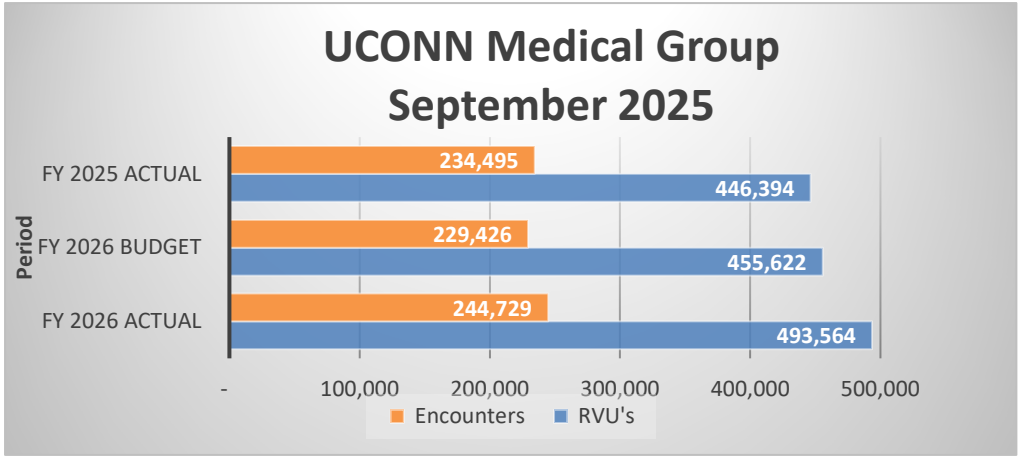
wRVU

- YTD wRVUs are ahead of budget by 8.3% & ahead prior year by 10.6%.

Revenues

- Largest Growth Areas for YTD period with charges/stats are Dermatology, OB, Cancer Center, Radiology when compared to budget.

- YTD net patient revenues are ahead of budget by 0.1% & ahead of prior year by 2.7%.

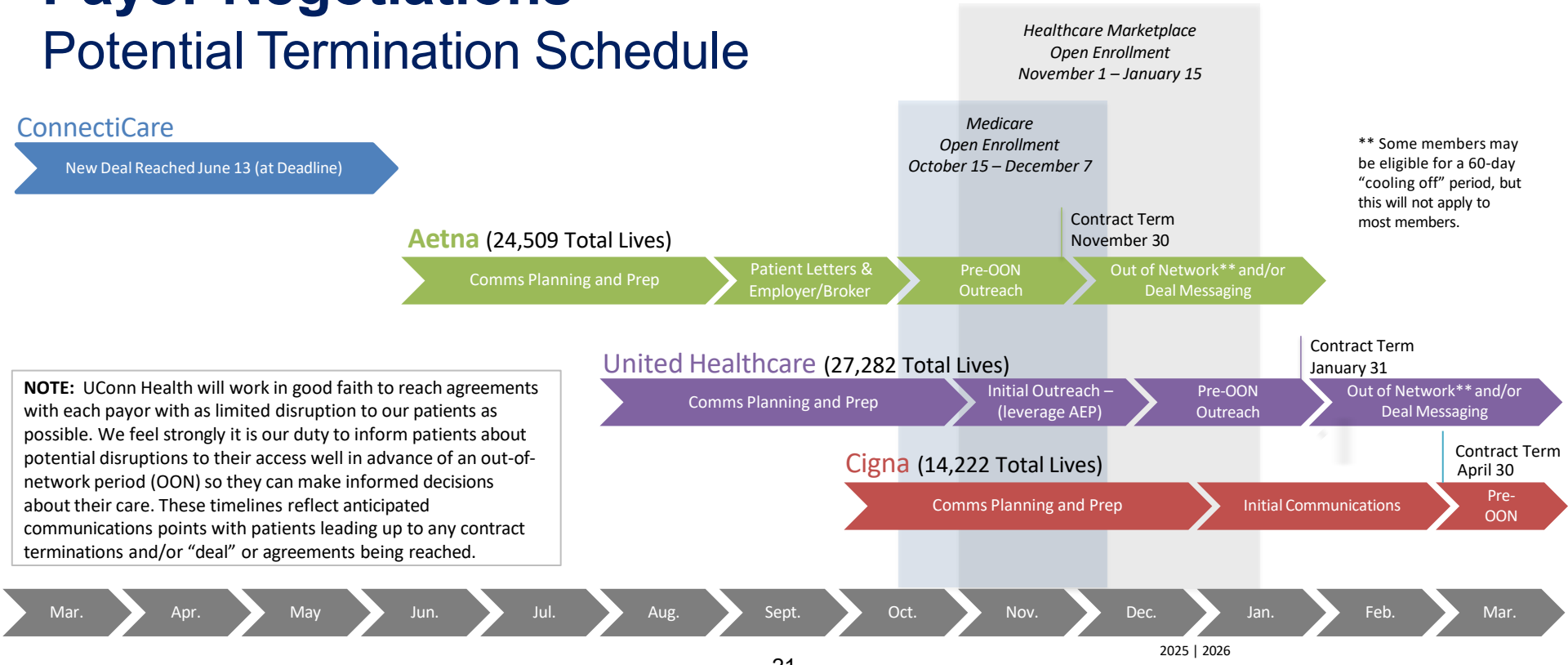


	FY 2025 Actual	FY 2026 Budget	FY2025 Actual	vs Bud	vs PY
Encounters	244,729	229,426	234,495	6.7%	4.4%
RVUs	493,564	455,622	446,394	8.3%	10.6%
Net Patient Revenue	39,391,420	39,338,442	38,372,608	0.1%	2.7%

Payor Negotiations

Payor Negotiations

Potential Termination Schedule



NOTE: UConn Health will work in good faith to reach agreements with each payor with as limited disruption to our patients as possible. We feel strongly it is our duty to inform patients about potential disruptions to their access well in advance of an out-of-network period (OON) so they can make informed decisions about their care. These timelines reflect anticipated communications points with patients leading up to any contract terminations and/or "deal" or agreements being reached.

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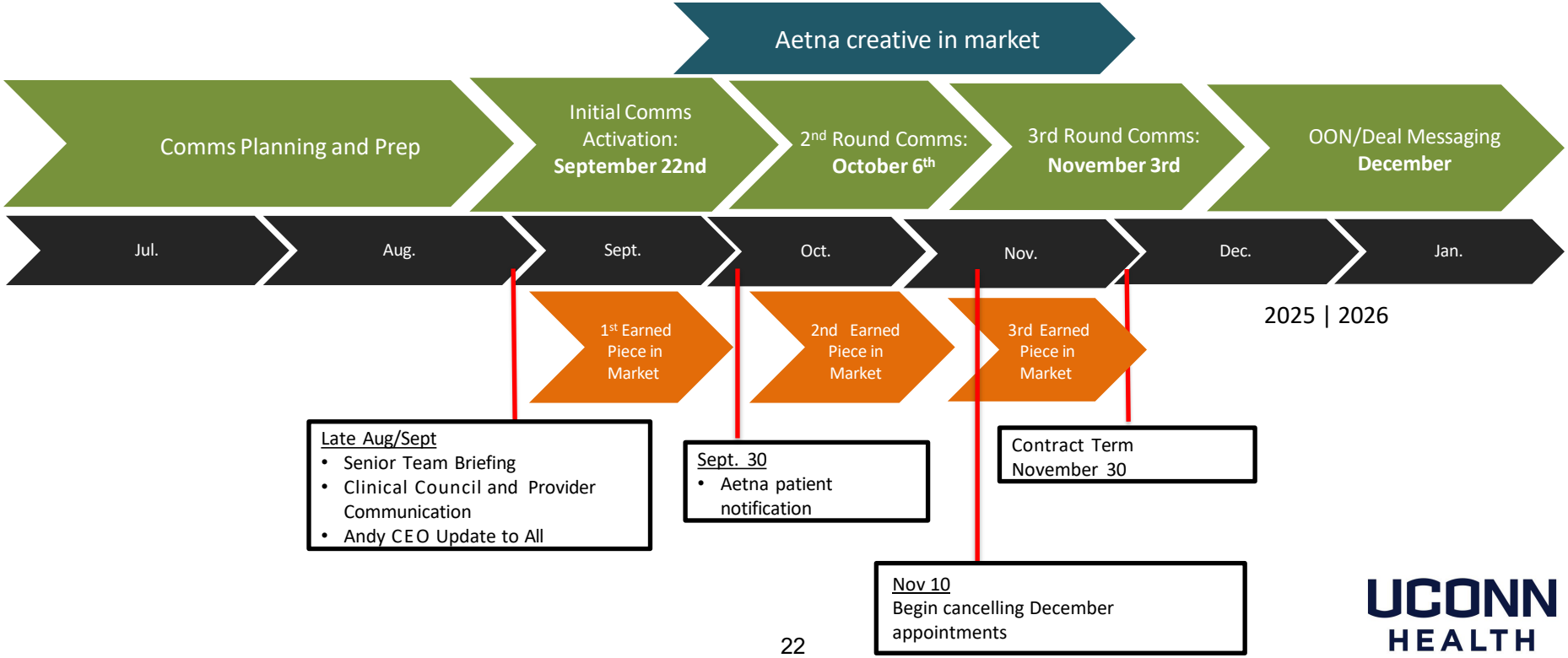
Aetna Communications Plan



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Workplace Violence 2025 Update

Debra Abromaitis, Assistant Vice President
Accreditation and Regulatory Affairs

November, 2025

UCONN HEALTH

WORKPLACE VIOLENCE(WPV) DEFINITION

The Joint Commission (TJC)

An act or threat occurring at the workplace that can include any of the following: Verbal, written, or physical aggression; threatening, intimidation, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; or physical assaults involving staff, patients or visitors.

UConn Health

Any violent act or threat of violence directed at persons at work involving workforce members, patients, or visitors. Violent acts or threats of violence includes, but is not limited to, physical assaults, threats (verbal, non-verbal or written), harassment and/or intimidation.

WPV TJC REGULATION

- The hospital has a workplace violence prevention program led by a designated individual and developed by a multidisciplinary team that includes the following:

  - Policies and procedures to prevent and respond to workplace violence

  - A process to report incidents in order to analyze incidents and trends

  - A process for follow up and support to victims and witnesses affected by workplace violence, including trauma and psychological counseling, if necessary

  - Reporting of workplace violence incidents to the governing body

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WPV BY YEAR

YEAR	NUMBER OF INCIDENTS
2015	16
2016	19
2017	16
2018	21
2019	66
2020	41
2021	66
2022	114
2023	143
2024	89
2025 (9 months)	120

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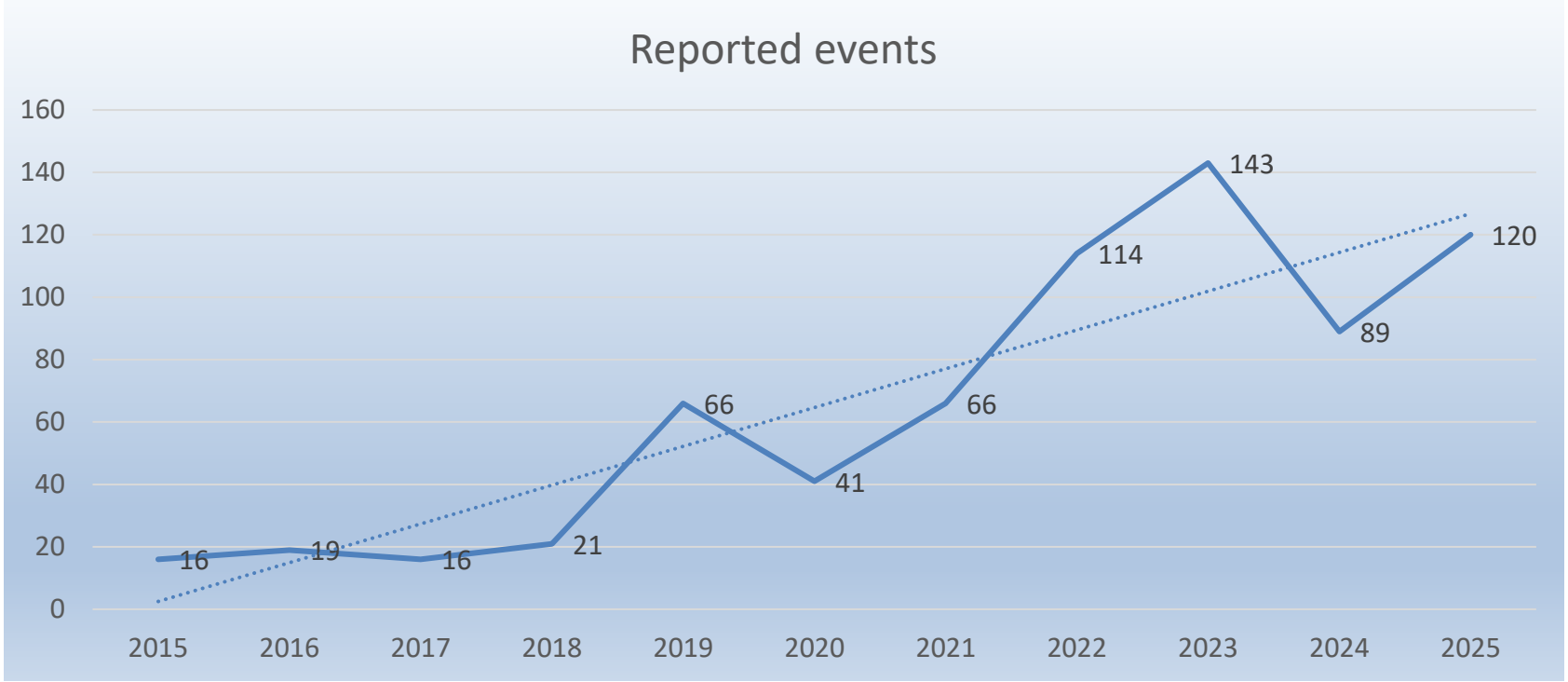
WPV BY YEAR


Reported events
160
140
120
100
80
60
40
20
0
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
16
19
16
21
66
41
66
114
143
89
120

2024 DPH WPV REPORT

Calendar Year 2024 Workplace Violence Incidents John Dempsey Hospital License #65

Area	Location Where Incident Occurred	Reportable Incidents
Care coordination	Inpatient units	6
Float Pool	Inpatient unit	1
Nursing Administration	Nursing administration	1
CT 7th floor	Med Surg	1
CT 5th floor	Department of Corrections	2
CT 2nd floor	Out Patient Cardiology	1
CT 2nd floor	Lab	1
CT 1st floor	Psychiatry	23
CT Main Floor	Nuclear Medicine	1
CT Ground Floor	Labor and Delivery	1
CT Ground Floor	OB	1
UT Basement	Emergency Department	24
UT 1st Floor	Intensive Care Unit	2
UT 2nd Floor	Intermediate Unit	3
UT 3rd Floor	Medicine Unit	5
UT 4th floor	Medicine Unit	4
UT 5th Floor	Surgical Unit	4
UT 5th Floor	Rehab	1
UT 6th Floor	Oncology Unit	4
10 Talcott	Out Patient Psychiatry	1
21 South Road	Dermatology	2
TOTAL		89

2025 REPORTS SUBMITTED (through September)

- Human Resources Reports 63 reports
- Safety Intelligence Reports 32 reports
- Police Reports 20 reports
- Behavioral Health Reports 6 reports

- Operator behavioral calls 301 calls

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OPERATOR CALLS (Through September)

MONTH	OPERATOR BH CALLS	REPORTER
January	26	Operator
February	35	Operator
March	29	Operator
April	48	Operator
May	19	Operator
June	47	Operator
July	33	Operator
August	30	Operator
September	34	Operator
October		Operator
November		Operator
December		Operator

UCONN HEALTH

EXAMPLES OF WORKPLACE VIOLENCE

- **Threats**
- **Verbal abuse**
  - Racial
  - Sexual
  - Hostility
  - Intimidation
  - Called 23 times in 10 minutes
- **Destructive**-Attempted to break glass at nurse's station
- **Physical**
  - Staff slapped
  - Kicked in face
  - Punched in face
  - Kicked in stomach (pregnant)
  - punched firefighter in face
  - spit in eye of CNA
  - fighting staff
  - Pulled hair
  - Hit staff
  - Threw ice at nurse
  - Lunged at phlebotomist
  - dug nails in employee hand
  - Threw used equipment at phlebotomist and punched in stomach
  - Threw tissue boxes at staff

UCONN HEALTH

NEXT STEPS

- Drills
- Security assessment-panic buttons
- Threat Assessment Team review
- Increased response to support victims and witnesses affected by WPV when report is filed
- Implement EPIC charting to document past WPV Behavior
- CPI Training
- Psych visitor wanding expanded
- WPV Category in Safety Reporting system

Quality Report

Scott Allen, MD

November 13, 2025

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Newsweek America's Best in State Hospitals 2026

- Ranks the top 800 U.S. hospitals
- Scoring:

Metric	% of Total Score
Quality	50%
Reputation	30%
Patient Experience	15%
Patient-Reported Outcome Measures	5%

UCONN HEALTH

Newsweek Best in State Hospitals: Connecticut

- https://rankings.newsweek.com/americas-best-state-hospitals-2026

State Rank	Hospital	City	State	PROMs	Patient experience award
1	Yale New Haven Hospital	New Haven	Connecticut		
2	Midstate Medical Center	Meriden	Connecticut		
3	UConn John Dempsey Hospital	Farmington	Connecticut		✓ *
4	Hartford Hospital	Hartford	Connecticut		
5	Griffin Hospital	Derby	Connecticut		

*JDH was the only CT hospital to be recognized with the Patient Experience Award the last 2 years

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Leapfrog Hospital Safety Grade: Fall 2025

- 3,000 general acute-care hospitals graded twice annually
- Scoring based on 22 national patient safety measures from the Centers for Medicare & Medicaid Services (CMS), the Leapfrog Hospital Survey, and other supplemental data
- 2 Domains - each weighted 50%

DOMAIN	MEASURE
Process / Structural	Computerized Physician Order Entry (CPOE)
	Bar Code Medication Administration (BCMA)
	ICU Physician Staffing (IPS)
	Safe Practice 1: Culture of Leadership Structures and Systems
	Safe Practice 2: Culture Measurement, Feedback, & Intervention
	Total Nursing Care Hours per Patient Day
	Hand Hygiene
	Nurse Communication
	Doctor Communication
	Staff Responsiveness
	Communication about Medicines
	Discharge Information
Outcome	Foreign Object Retained
	Air Embolism
	Falls and Trauma
	Central Line-Associated Bloodstream Infection (CLABSI)
	Catheter-Associated Urinary Tract Infection (CAUTI)
	Surgical Site Infection: Colon
	Methicillin-Resistant *Staph. Aureus*
	C. Difficile infection
	Death rate among surgical inpatients with serious treatable complications
	CMS Medicare PSI 90: Patient safety and adverse events composite

Leapfrog Hospital Safety Grade: JDH

Grade embargoed until November 13

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JDH Scorecard

Meaure Group	Service/Unit	Metric	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	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)	0.19	0.18	0.12	0.11	0.17	0.16	0.27	0.21	0.37	<0.10	0.10- 0.25	>0.25
		Hand Hygiene Inpatient: Before	89%	89%	95%	96%	93%	95%	98%	98%	95%	>95%	92-95%	<92%
		CAUTI - # events	1	2	2	3	2	1	1	3	1			
		CAUTI Standardized Infection Ratio (Half-year)	0.546	1.053	0.760	0.000	0.687	0.333	0.368	1.273	0.361	<0.75	0.75-1.00	>1.00
		CLABSI - # events	0	2	0	2	1	2	2	2	0			
		CLABSI Standardized Infection Ratio (Half-year)	0	1.160	0.000	1.049	0.482	1.099	0.852	0.833	0.000	<0.75	0.75-1.00	>1.00
		C.diff - # events	1	5	3	5	1	5	5	4	6			
		C.diff Standardized Infection Ratio	0.109	0.541	0.309	0.557	0.096	0.530	0.470	0.413	0.593	<0.75	0.75-1.00	>1.00
		Falls with Harm/1000 Patient days (NDNQI): z-score vs. All Facilities	-0.36	-0.03	0.28	-0.40	-0.56	-0.53	-0.18	-0.07		<25th percentile	25th-50th percentile	>50th percentile
		Hospital-Acquired Pressure Injury (Stage 2+) % of Patients (NDNQI): z-score vs. All Facilities	-0.17	-0.25	-0.26	-0.45	-0.23	-0.25	-0.48	-0.35		<25th percentile	25th-50th percentile	>50th percentile
		Mortality index (Vizient®): Observed/Expected Ratio - Percentile rank vs. CCMC Peer group	63	80	53	66	63	64	86	91		>75	50-75	<50
		30-Day All-Cause Readmission Rate: Percentile vs. Vizient® All hospital group				52	57	25	27			>75	50-75	<50
		Admission Medication Reconciliation Completed Within 48 hours	56.2%	60.4%	63.2%	65.0%	65.9%	72.3%	70.6%	74.8%	78.8%	>90%	80%-90%	<80%
	Anesthesiology	Adverse event rate	0.15%	0.12%	0.10%	0.06%	0.04%	0.08%	0.28%	0.06%	0.06%	<0.20%	0.20-0.30%	>0.30%
	Diagnostic Imaging	% of Vrad radiologists miss rate	0.71%	0.96%	0.64%	0.53%	0.88%	0.63%	0.69%	0.21%	0.21%	<2.00%	2.00-4.00%	>4.00%
		% of UConn radiologists miss rate	0.00%	0.00%	1.28%	0.10%	0.41%	0.00%	0.00%	0.34%	0.16%	<2.00%	2.00-4.00%	>4.00%
	Emergency Medicine	Door to provider (min)	31	33	38	33	34	32	37	31		<30 min	31-40 min	>40 min
		Length of Stay (min)	247	253	256	254	252	250	262	251		<240 min	240-300 min%	>300 min
		Left Without Being Seen Rate	0.98%	1.71%	1.68%	1.12%	0.91%	1.02%	1.94%	0.98%		<1.0%	1.0-2.0%	>2.0%
		72-Hour Return to ED with Admission Rate	1.04%	1.05%	1.04%	1.03%	1.19%	1.19%	0.87%	1.03%		<1.00%	1.00-3.00%	>3.00%
		Stroke: Median Door to CT Scan Time (min)	19.3	16.0	18.5	18	20	20	21	20	18	<26 min	26-40 min	>40 min
	Laboratory Medicine	Critical Value Notification - Inpatient (Within 15 min)	91.9%	98.7%	99.2%	99.2%	99.0%	98.6%	99.3%	99.0%	99.4%%	>98%	90-98%	<90%
		Critical Value Notification - ED (Within 15 min) *(Within 30 min)	96.0%*	99.5%*	100%*	99.7%*	99%*	99.0%*	98.6%	99.0%	99.5%%	>98%	90-98%	<90%
	OB/GYN	PC-02: Nulliparous women with a term, singleton baby in vertex position delivered by C-section	31.6%	24.0%	31.1%	22.2%	24.0%	41.4%	21.3%	36.4%		<24%	24-30%%	>30%
		PC-05: Exclusive Breast Milk Feeding	47.2%	65.8%	59.8%	56.1%	60.6%	48.4%	47.3%	43.7%%		>70%	50-69%%	<50%
		Acute Treatment of Hypertension within 60 min	78%	76%	83%	76%	83%	89%	92%			>80%	50-80%%	<50%
	Surgery	SSI Colon - # CMS events	2	0	1	1	0	1	3	2				
		SSI Colon - CMS Standardized Infection Ratio		0.000		0.909	1.594	0.548	2.606	3.088		<0.75	0.75-1.00	>1.00
	Cardiology	Heart Failure - CMS 30-day readmission rate: Percentile Rank vs. Vizient® All hospitals	18	37	71	55	66	35	58	69		>75	50- 75	<50

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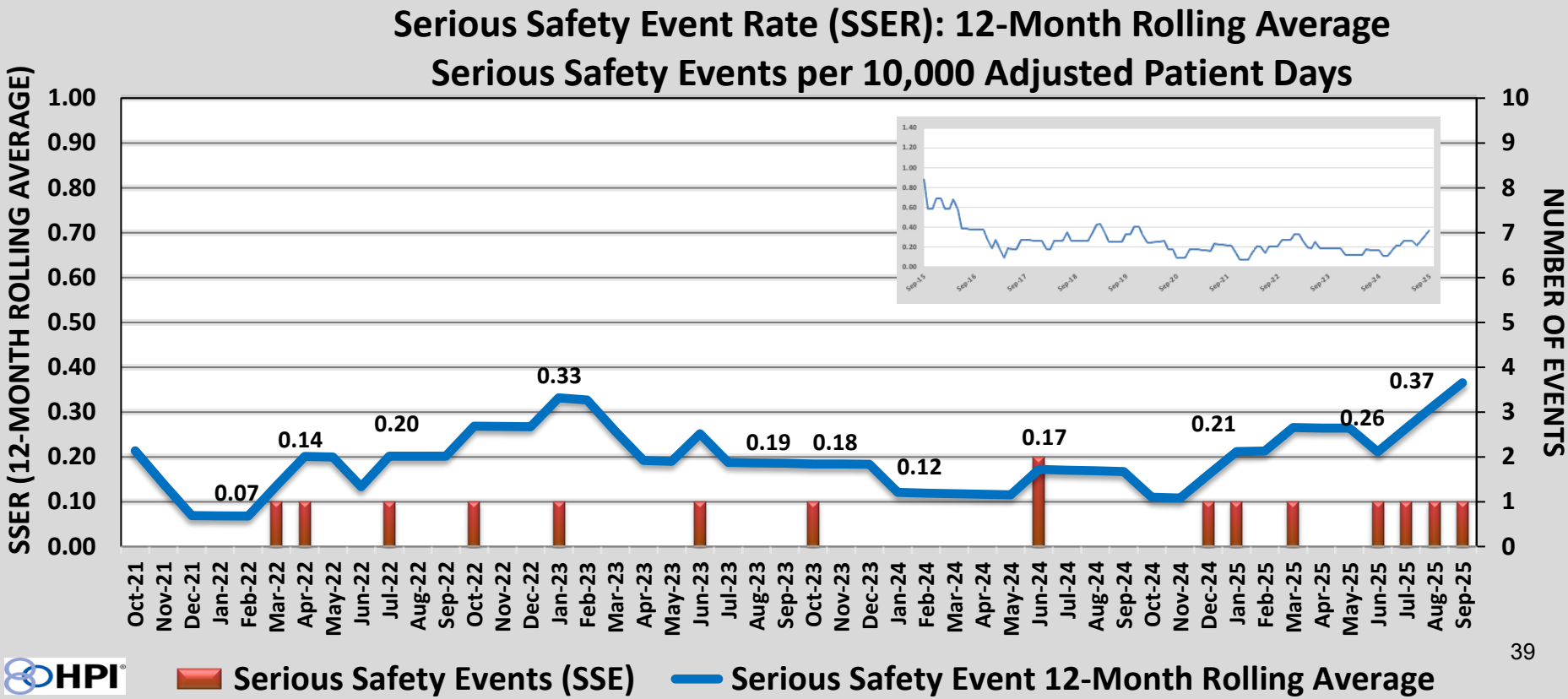
Serious Safety Event Rate



Quarterly Admission Medication Reconciliation

- Quarterly rates:

Metric	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Target	Goal
Admission Medication Reconciliation Completed Within 48 hours	**65.0%**	**65.9%**	**72.3%**	**70.6%**	**74.8%**	**78.8%**	**>80%**	**>90%**

- Tracking and Performance Improvement started in July 2023: 48hr completion rate = 54.2%
- Current quarter represents a **45**% improvement over time
- Both August and September were >80% (above target)

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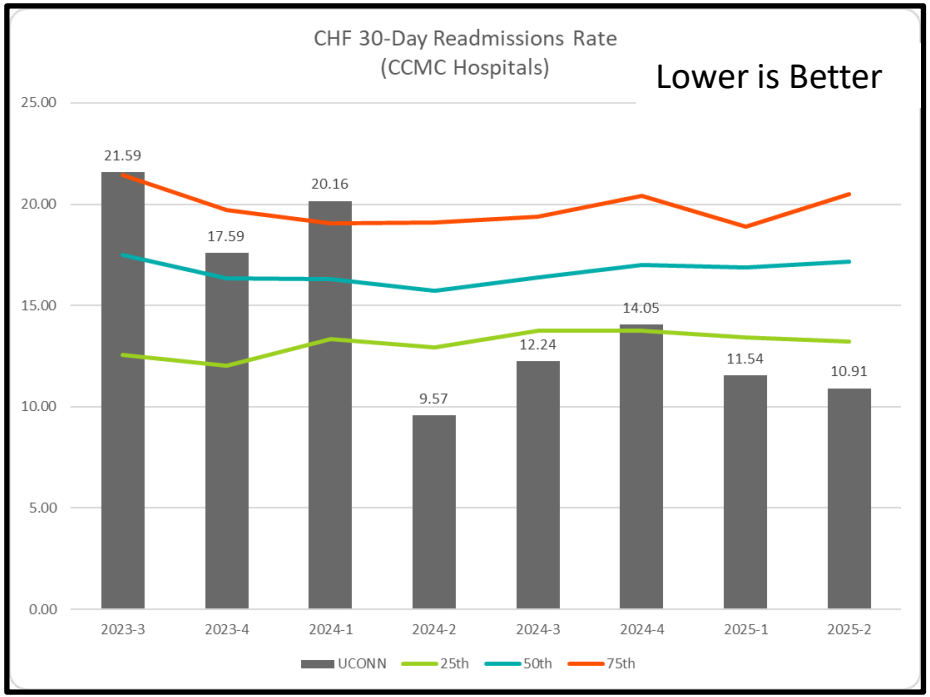
Heart Failure 30-Day Readmission Rate

- Important P4P and Readmission Reduction Program measure



Source: Vizient

CCMC Hospitals = Complex Care Medical Centers

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Patient Experience (PX) Scorecard

Patient Experience	Inpatient Units	HCAHPS Likelihood to Recommend: % Top Box	82.0%	82.7%	82.1%	76.3%	82.6%	83.1%			
		HCAHPS Likelihood to Recommend: **CT Hospitals Percentile Rank**	93	98	94	82	99	99	>75	50- 75	<50
		HCAHPS Likelihood to Recommend: **All Press Ganey Database Percentile Rank**	86	88	87	71	86	87	>75	50- 75	<50
	Emergency Department	ED CAHPS: Likelihood to Recommend ER: % Top Box	72.0%	68.5%	73.6%	64.7%	72.3%	64.1%			
		ED CAHPS: Likelihood to Recommendthe ER: **CT state ER/ED's Percentile Rank**	59	58	85	59	58	26	>75	50- 75	<50
		ED CAHPS: Likelihood to Recommend ER: >50k visits (*= 40k-50k) **Percentile Rank**	80*	77*	73*	68*	81	54	>75	50- 75	<50
	All UMG and JDH Outpatient Clinics, Urgent Care Centers	CG CAHPS: Recommend the Provider Office: % Top Box	94.0%	94.7%	94.6%	94.6%	94.5%	94.8%			
		CGCAHPS: Recommend this Provider Office: **AHA Region 1 Facilities Percentile Rank**	84	87	86	83	81	87	>75	50- 75	<50
		CG CAHPS: Recommend the Provider Office: **National Facilities Percentile Rank**	70	79	78	77	74	77	>75	50- 75	<50
	Main OR, UConn Health Surgery Center, Procedure Center (GI)	OAS CAHPS: Recommend Facility: % Top Box	90.2%	92.7%	87.8%	93.2%	90.3%	90.9%			
		OAS CAHPS: Recommend Facility: **Facilities in CT Percentile Rank**	71	79	37	73	47	52	>75	50- 75	<50
		OAS CAHPS: Recommend Facility: **All Press Ganey Database Percentile Rank**	74	88	58	89	74	78	>75	50- 75	<50
	Outpatient Oncology	Press Ganey Targeted Survey [ON]: Likelihood of Recommending Services: % Top Box	92.5%	92.7%	91.6%	91.9%	92.6%	94.4%			
		Press Ganey Targeted Survey [ON]: Likelihood of Recommending Services: **All Facilities Percentile F**	76	77	65	66	73	85	>75	50- 75	<50
	Lab, Rehab, Radiology	Press Ganey Targeted Survey: Likelihood to Recommend: **% Top Box**	88.5%	89.7%	90.2%	89.8%	89.4%	90.9%			
		Press Ganey Targeted Survey: Likelihood to Recommend: **AHA Region 1 Percentile Rank**	79	94	90	82	78	93	>75	50- 75	<50
		Press Ganey Targeted Survey: Likelihood to Recommend: **All Facilities Percentile Rank**	75	84	83	79	77	86	>75	50- 75	<50

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Service/Unit Specific PX Performance

Measure Group	Service/Unit	Metric	Q2 2924	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Current Target	Warning Range	Red Flag
Patient Experience	LAB	Press Ganey Targeted Survey: Likelihood to Recommend: **% Top Box**	87.5%	89.9%	91.0%	89.2%	89.5%	90.8%			
		Press Ganey Targeted Survey: Likelihood to Recommend: **AHA Region 1 Percentile Rank**	70	97	97	79	79	92	>75	50- 75	<50
		Press Ganey Targeted Survey: Likelihood to Recommend: **All Facilities Percentile Rank**	65	84	89	75	77	85	>75	50- 75	<50
	Rehab	Press Ganey Targeted Survey: Likelihood to Recommend: **% Top Box**	96.7%	93.9%	88.8%	93.1%	92.0%	91.3%			
		Press Ganey Targeted Survey: Likelihood to Recommend: AHA Region 1 Percentile Ranking	99	57	74	97	99	94	>75	50- 75	<50
		Press Ganey Targeted Survey: Likelihood to Recommend: **All Facilities Percentile Rank**	9	55	73	96	93	88	>75	50- 75	<50
	Radiology	Press Ganey Targeted Survey: Likelihood to Recommend: **% Top Box**	88.1%	89.2%	91.0%	90.5%	88.2%	90.4%			
		Press Ganey Targeted Survey: Likelihood to Recommend: **AHA Region 1 Percentile Ranking**	75	84	97	89	62	91	>75	50- 75	<50
		Press Ganey Targeted Survey: Likelihood to Recommend: **All Facilities Percentile Ranking**	70	79	89	85	66	83	>75	50- 75	<50

Measure Group	Service/Unit	Metric	Q2 2924	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Current Target	Warning Range	Red Flag
Patient Experience	Procedure Center	OAS CAHPS: Recommend Facility: % Top Box	87.5%	92.4%	83.3%	89.8%	87.7%	90.1%			
		OAS CAHPS: Recommend Facility: **Facilities in CT Percentile Rank**	70	78	11	52	33	49	>75	50- 75	<50
		OAS CAHPS: Recommend Facility: **All Press Ganey Database Percentile Rank**	65	87	32	69	56	72	>75	50- 75	<50
	UHSC	OAS CAHPS: Recommend Facility: % Top Box	96.7%	93.9%	89.4%	96.1%	92.7%	91.9%			
		OAS CAHPS: Recommend Facility: **Facilities in CT Percentile Rank**	99	82	49	92	72	61	>75	50- 75	<50
		OAS CAHPS: Recommend Facility: **All Press Ganey Database Percentile Rank**	99	92	68	98	88	84	>75	50- 75	<50
	Main OR	OAS CAHPS: Recommend Facility: % Top Box	88.0%	91.6%	90.6%	92.9%	90.7%	90.9%			
		OAS CAHPS: Recommend Facility: **Facilities in CT Percentile Rank**	75	70	53	70	48	52	>75	50- 75	<50
		OAS CAHPS: Recommend Facility: **All Press Ganey Database Percentile Rank**	70	83	75	87	77	78	>75	50- 75	<50

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CMS Hospital Star Rating

- www.Medicare.gov Care Compare website
- Based on publicly-reported measures
- 1-5 Star rating 
  - Overall Star Rating = quality
  - Patient Survey Rating = patient experience

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CMS Star Rating: Scoring Methodology

- Annual release in July
- 47 total measures
- Must have a minimum of three measure groups (one of which must be the Mortality or Safety of Care group) with at least three measures in each of the three groups to receive an Overall Star Rating
- Hospitals put into peer groups based on the number of measure groups in which they have at least three measures
- Hospital summary scores within each peer group are categorized with a Star Rating between one and five stars

Measure Groups
Mortality
Safety
Readmission
Patient Experience
Timely & Effective Care

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CMS Star Rating Scoring

Measure Group	# of Measures	Weight
Mortality	7	22%
Safety	8	22%
Readmission	11	22%
Patient Experience	8	22%
Timely & Effective Care	13	12%

July 2025 Report: https://data.cms.gov/provider-data/topics/hospitals/overall-hospital-quality-star-rating/#measure-included-by-categories

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CMS Star Rating: Score Distribution

National Star Distribution

Overall rating	# of hospitals	% of Total
1 star	233	8.1%
2 stars	661	22.9%
3 stars	939	32.5%
4 stars	767	26.5%
5 stars	291	10.1%

July 2025 Report: https://data.cms.gov/provider-data/topics/hospitals/overall-hospital-quality-star-rating/#measure-included-by-categories

Regional Star Distribution

Hospital	Overall	Pt. Survey
UConn JDH	3	4
Hospital of Central CT	2	3
Bristol Hospital	2	3
St. Francis Hosp & Med Ctr	2	2
Hartford Hospital	4	3
Middlesex Hospital	3	3
Griffin Hospital	4	4
Yale	3	3

https://www.medicare.gov/care-compare/?redirect=true&providerType=Hospital

Identified Measures For Improvement

Measure Group	Measure	CMS Care Compare	Vizient
Mortality	30-day death rate for heart failure patients	x	x
Safety	CAUTI		x
Readmission	Heart failure excess days in acute care (EDAC)	x	
	AMI excess days in acute care (EDAC)		x
	Admissions visits for patients receiving OP chemo		x
	ED visits for patients receiving OP chemotherapy		x
Patient Experience	Responsiveness of hospital staff	x	x
Timely & Effective Care	Average time patients spent in the emergency department before being sent home	x	x
	Appropriate follow-up for normal colonoscopy	x	x
	Percent of healthcare workers vaccinated against influenza	x	x
	Percentage of patients who were prescribed 2 or more opioids or an opioid and benzodiazepine concurrently at discharge	x	x

Performance Improvement Priorities

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Performance Improvement (PI) Priorities: 2025

Priority	Rationale
Achieve an **Inpatient/Before Hand Hygiene** compliance rate of >92% with a goal of >95%	• Hand hygiene is essential for reducing hospital-acquired infections (HAI) • JDH HAI rate remains above target
Achieve a **Catheter-Associated Urinary Tract Infection** (CAUTI) Standardized Infection Rate target of 0.5 with a goal of zero.	• Costly HAI • JDH rate above national mean • Impacts negatively on scoring for P4P programs
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.	• 2nd highest DPH reportable event for state of CT • Most frequent DPH reportable event for JDH • Significant morbidity for falls with hip fracture • Metric important for Magnet designation
Achieve a **Within-48 hours Admission Medication Reconciliation** rate >80% with a goal of >90%	• About half of patients discharged from the hospital experience medication errors or unintentional medication discrepancies. • Accurate admission med rec reduces both inpatient and discharge medication errors, and reduces readmissions
Achieve >75th percentile compared to all Vizient hospitals for **Heart Failure 30-day Readmission Rate** with a goal of >90th percentile.	• Rate above [worse than] Vizient and CMS peer groups • Important for P4P programs • Contributes to Readmission Reduction Program penalty
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	• Patient experience in ancillary services critical to population health • Performance was not consistently top 25%

PI Priorities 2026: Revision

Performance for Lab/Rehab/Radiology Patient Experience:

Service/Unit	Metric	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Current Target	Warning Range	Red Flag
Lab, Rehab, Radiology	Press Ganey Targeted Survey: Likelihood to Recommend: **% Top Box**	88.5%	89.7%	90.2%	89.8%	89.4%	90.9%			
	Press Ganey Targeted Survey: Likelihood to Recommend: **AHA Region 1 Percentile Rank**	79	94	90	82	78	93	>75	50- 75	<50
	Press Ganey Targeted Survey: Likelihood to Recommend: **All Facilities Percentile Rank**	75	84	83	79	77	86	>75	50- 75	<50

Recommendation: Remove Lab/Rehab/Radiology Patient Experience as a PI Priority

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Choosing a PI Priority: Metric Characteristics

Replacement metric should have the following characteristics:

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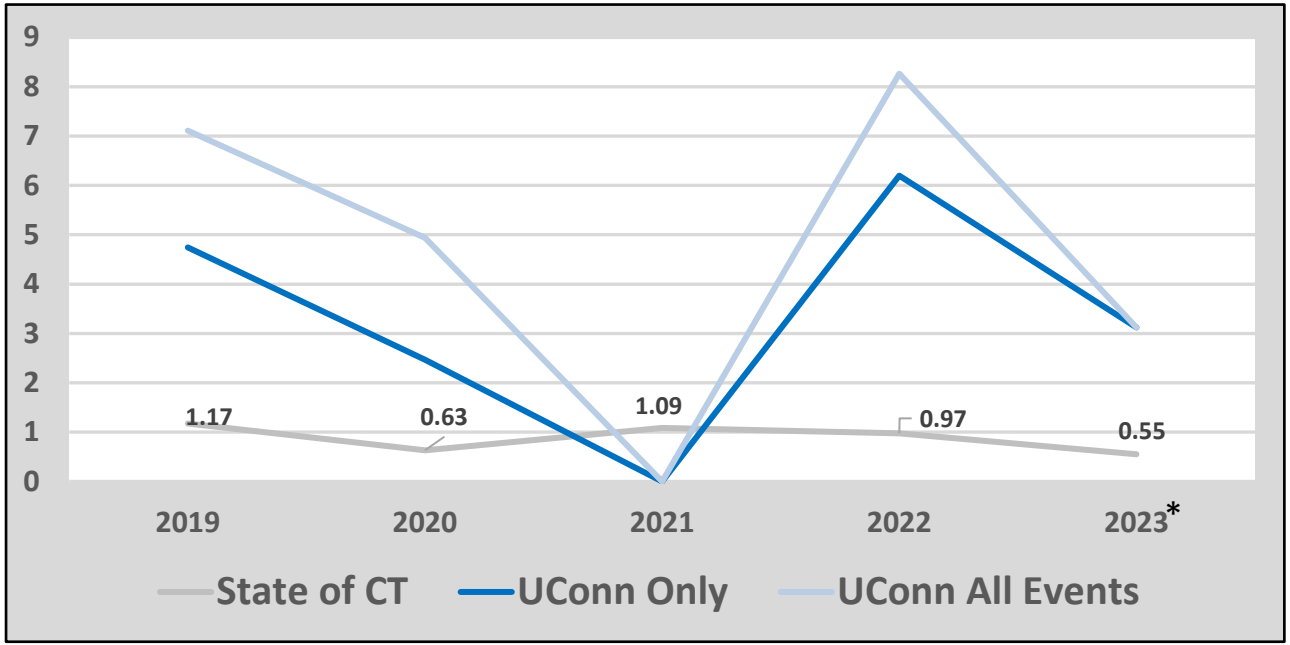
Retained Items – DPH Reportable Rate per 100,000 Patient Days

Recommended Priority: Achieve a DPH-reportable retained object rate of <1.6 per rolling 100,000 patient days with a goal of zero.

Note: FY 2024 patient days = 62,548 →

1 event/63,000 =

1.6 event/100,000 patient days



* 2023 patient days in error (TBD)

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Performance Improvement Priorities 2026: Proposed Revisions

	Priority	Rationale
Revise	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. Change to: *Achieve a z-score target that is better than the benchmark group of ALL Facilities in the NDNQI database for **Falls with Moderate harm, Major harm or Death** with a goal of the top 25%*	• 2nd highest DPH reportable event for state of CT • Most frequent DPH reportable event for JDH • Significant morbidity for falls with hip fracture • Metric important for Magnet designation
Remove	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	• Patient experience in ancillary services critical to population health • Performance was not consistently top 25%
Add	*Achieve a DPH-reportable **Retained Object Rate** of <1.6 per rolling 100,000 patient days with a goal of zero.*	• JDH is an outlier for retained object rate compared to other CT hospitals • Significant morbidity associated with retained objects

JDH Clinical Quality and Service Improvement Plan 2026: Proposed Revisions

IV.D. The John Dempsey Hospital (JDH) Quality Assessment/Performance Improvement (QAPI) Committee

- Add Safety Huddle as a new subcommittee.
- Add descriptions of the existing QAPI subcommittees: Behavioral Intervention Committee and Resuscitation Review Committee
- Change the name of **Patient and Family Advisory Council** to **Patient, Family, and Community Council** to better reflect the purpose of the committee to include representative members of our community.

IV.F. The **Nursing Senior Director of Critical Care, Quality and Advanced Practice** role has been changed to **Associate Vice President Nursing Operations and Quality**

VIII. The JDH Performance Improvement Priorities

- Remove the Press Ganey LAB, Rehab, & Radiology Targeted Survey Likelihood to Recommend rate based on consistent high level of performance
- Modify Falls with Moderate harm, Major harm or Death to using a z-score and benchmarked against all NDNQI facilities
- Add a new priority: Retained Object Rate

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Approvals

- JDH Clinical Quality & Service Performance Improvement Plan - 2026

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

FROM: Dr. Andrew Agwunobi, CEO, John Dempsey Hospital

DATE: November 13, 2024

SUBJECT: JDH Clinical Quality & Service Improvement Plan 2026

Recommendation:

That the Clinical Affairs Subcommittee of the UConn Health Board of Directors accepts and approves the attached 2026 Clinical Quality & Service Improvement Plan for John Dempsey Hospital, including the updated Performance Improvement Priorities.

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 Quality Assessment and Performance Improvement (QAPI) Committee of the hospital.

Substantive proposed revisions/updates include:

- **IV.D.** The John Dempsey Hospital (JDH) Quality Assessment/Performance Improvement (QAPI) Committee
    - Add descriptions of the existing QAPI subcommittees: Behavioral Intervention Committee and Resuscitation Review Committee.
    - Change the name of Patient and Family Advisory Council to *Patient, Family, and Community Council* to better reflect the purpose of the committee to include representative members of our community.
    - Add Safety Huddle as a new subcommittee.

- **IV.F.** Change the Nursing Senior Director of Critical Care, Quality and Advanced Practice role to *Associate Vice President Nursing Operations and Quality*

- **Performance Improvement Priorities:**

  The QAPI Committee has also recommended the following updates to **JDH's Performance Improvement Priorities for 2026**. Priority 6 below is a new recommendation for 2026:

  Retain 4 Priorities:

  1. Achieve a Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Rate target of 0.5 with a goal of zero

  2. Achieve an inpatient/before hand hygiene compliance rate of >92% with a goal of >95%

  3. Achieve a within-48-hours admission medication reconciliation rate >80% with a goal of >90%

  4. Achieve >75th percentile compared to all Vizient hospitals for Heart Failure 30-day readmission rate with a goal of >90th percentile

  Modify 1 Priority:

  5. 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.

     Recommend Changing to:

     Achieve a z-score target that is better than the benchmark group of ALL Facilities in the NDNQI database for Falls with Moderate harm, Major harm or Death with a goal of the top 25%

  Remove 1 Priority:

  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

  Adding a New Priority:

  6. Achieve a DPH-reportable Retained Object Rate of <1.6 per rolling 100,000 patient days with a goal of zero.

Attachment: John Dempsey Hospital Clinical Quality & Service Improvement Plan 2026 (*tracked changes* version)

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John Dempsey Hospital Clinical Quality and Service Improvement Plan

2026

Deleted: 5

Reviewed/Approved:
Quality Assessment and Performance Improvement Committee: 10/28/24
Board of Directors Clinical Affairs Subcommittee: 12/5/24

TABLE OF CONTENTS

REFERENCES

JOHN DEMPSEY HOSPITAL MEDICAL STAFF BYLAWS

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, patient safety, 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 outpatient 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 relies upon the John Dempsey Hospital (JDH) Quality Assessment/ Performance Improvement (QAPI) Committee to make recommendations to CAS related to performance improvement measures and activities.

D. **The John Dempsey Hospital (JDH) Quality Assessment/Performance Improvement (QAPI) Committee:** The QAPI Committee is accountable for making decisions on improving organizational performance initiatives related to clinical quality, patient safety, 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, the Chief Quality Officer, and the JDH Chief of the Medical Staff.

The JDH Safety Huddle is a subcommittee of QAPI comprised of a large group of managerial staff from all hospital clinical services and departments who briefly review safety events and operational challenges each business day morning. Issues are identified and followed to ensure problems are addressed. Apparent Cause Analysis or Root Cause Analysis of specific events may be assigned. It is co-chaired by the **Vice President for Quality and Patient Care Services/Chief Nursing Officer/Chief Operations Officer** and the **Chief Medical Officer.**

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The UConn John Dempsey Hospital (JDH) Behavioral Intervention Committee is a subcommittee of QAPI that oversees the Behavioral Intervention team and its service. It monitors the behavioral intervention practice, reviews use of violent restraints and cases for missed early warning opportunities, and recommends policy and procedure changes regarding appropriate patient care. It is co-chaired by the Medical Director and Nurse Manager of the inpatient psychiatric unit.

The UConn John Dempsey Hospital (JDH) Resuscitation Review Committee is a subcommittee of QAPI that oversees the Rapid Response (Medical Emergency), "Code Blue" (Medical Emergency – Cardiac), and Stroke response team. It monitors the rapid response practice and identifies opportunities for best practice or implementation of evidence-based guidelines. The committee also identifies cases involving potential failure to rescue and those needing further Morbidity & Mortality review by the appropriate clinical service. It is co-chaired by the Associate Vice President of Nursing Operations and Quality who is also a member of the QAPI Committee.

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 **UConn John Dempsey Hospital (JDH) Palliative Medicine and Supportive Care Committee** is a subcommittee of QAPI that oversees the inpatient Palliative Medicine and Supportive Care program. It monitors the palliative care practices, develops educational initiatives, and recommends policy and procedure changes regarding appropriate patient care. It is co-chaired by the Director of the Hospitalist Service who is also a member of the QAPI Committee.

The **Patient, Family and Community Council** reports to the QAPI Committee and is supported by the Director 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.

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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, but is not limited to, the Chief Executive Officer, the Vice President for Quality and Patient Care Services/Chief Nursing Officer/Chief Operations Officer, the Chief Medical Officer, the Chief Pharmacy 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; ensuring safe nurse staffing levels utilizing NDNQI benchmarks, approving all Nursing Practice Policy and Procedures and overseeing the 24/7 operation of all 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 **Associate Vice President of Nursing Operations and Quality** is a new position that reports to the Vice President for Quality and Patient Care Services/Chief Nursing Officer/Chief Operations Officer. The Critical Care Nursing Director role reports to the AVP. The AVP of Nursing Operations and Quality works collaboratively with the Chief Medical Officer and Chief Quality Officer in helping to lead continuous improvement programs throughout the organization and to develop a culture of continuous improvement. The AVP provides oversight over the Quality Department and the Quality Department Manager who oversees adverse event investigation, including Apparent Cause Analyses and Root Cause Analyses, and who co-chairs the Safety Intelligence™ Review Committee. The Manager also oversees members of the Quality

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Department responsible for data abstraction, including, Core Measures, external benchmarking registries, and pay-for-performance. The AVP supports the 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.

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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 co-chairs both Safety Huddle and the Safety Event Review Committee. Inpatient unit **Medical Directors** indirectly report to the CMO as part of the unit-based approach to improving clinical quality and service.

The **Chief Quality Officer** (CQO) assists in investigating patient complaints and quality of care concerns and also analyzes both internal performance metrics as well as pay-for-performance and external hospital safety scorecards to identify opportunities for improvement. The CQO reports to the CMO. The CQO works closely with the Graduate Medical Education Programs to promote resident reporting of safety concerns and participation in adverse event analysis.

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.

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

Top PI Priorities for 2025:

1. Achieve a Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Rate target of 0.5 with a goal of zero.

2. Achieve a z-score target that is better than the benchmark group of ALL Facilities in the NDNQI database for Falls with Moderate harm, Major harm or Death with a goal of of the top 25%.

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 Vizient hospitals for Heart Failure 30-day readmission rate with a goal of >90th percentile.

6. Achieve a DPH-reportable retained object rate of <1.6 per rolling 100,000 patient days with a goal of zero.

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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, the UConn Health Lifeline, 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.

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.

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 JDH Policies and Procedures. 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 the Office of General Counsel.

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 either in a limited-access electronic file or 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.

Informational Items

- JDH Medical Board Update
- UMG Operations Update
- Annual Assessment of the Environment of Care Management Plans

UCONN HEALTH

UCONN HEALTH

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

FROM: Brian Shames, MD

DATE: November 13, 2025

SUBJECT: JDH Medical Board Report

The following is a summary of the major activities of the John Dempsey Hospital Medical Board from August 1, 2025 through October 31, 2025.

POLICY/OTHER ISSUES

1. Approved revisions to the policy on Death of a Patient.
2. Approved an updated JDH Utilization Management Plan.
3. Approved a new Enteral Tube Policy which replaces the retired policy called Tube Feedings/Enteral Nutrition (Adult).
4. Approved a Bylaws change to Article XI.3.D. which allows a Chief of Service to be a member of the Affiliated Staff.
5. Approved OPPE metrics for Geriatric APPs, Maternal Fetal Medicine physicians and APPs, Surgical Oncology physicians, and Psychiatry physicians and APPs.
6. Approved an updated History & Physical Policy.

CREDENTIALING ACTIVITY

Type of Application or Evaluation	Total
Initial Appointment	58
Reappointment	142
Temporary Privileges	36
Applications for a Change in Privileges	8
Focused Professional Practice Evaluations	16
Ongoing Professional Practice Evaluations	348
Delegated Credentialing Audits	1

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

FROM: Anne Horbatuck, RN, BSN, MBA
Chief Operating Officer, UConn 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 13, 2025

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

UPDATES ON AMBULATORY ORGANIZATIONAL GOALS and INITIATIVES

Brief highlights for Q1 FY26:

Operational Updates:

Respiratory Illness Protocol Update: Our employees continue to have access to COVID-19 testing through our clinics and Employee Health areas, helping to keep our workforce safe and operational. Vaccine administration and testing protocols remain unchanged at this time.

As of November 3rd, 2025 the COVID call line that was managed, most recently by Employee Health, is being discontinued. Based on the DPH guidelines we are updating our UConn Health Return-to-work protocols for *healthcare personnel* with *suspected or confirmed* respiratory virus infection. This includes individuals who test positive for Influenza, RSV and SARS-CoV-2. Moving forward, COVID will be treated like any other respiratory illness. For staff/ others calling out sick, they will follow the department's standard call-out procedures.

Canton Drive-Through Flu Clinic
On Saturday, October 18, the Canton clinical team successfully hosted a drive-through flu clinic at the Canton site. The event was well organized and efficiently executed, resulting in the administration of 293 flu vaccinations. This initiative reflects our continued commitment to accessible, community-based preventive care and was a strong example of teamwork and patient-centered service delivery.

New Alzheimer's Disease Medication: The FDA has granted full approval for Lecanemab, an anti-amyloid antibody, for the treatment of Alzheimer's disease in patients with mild cognitive impairment or mild dementia due to Alzheimer's disease. The UConn Geriatric and Healthy Aging Clinic, under the Alzheimer's clinical direction of Dr. Maghaydah and Dr. Zdanys, began administering the new medication in April 2024. This detailed process requires a multidisciplinary team approach, involving

the Geriatrics Clinic, Geriatric Psychiatry, Infusion Center, IT/Epic, Radiology (MRI, PET, Lumbar Punctures), Emergency Department, Pharmacy, Finance, Pre-certification, Data Tracking, and more. Once a patient is approved to receive the medication, administration will occur every two weeks for 18 months, along with additional exams and procedures. As of October 21, 2025, there are 55 geriatric patients actively enrolled in Lecanemab therapy plans, with an additional 12 patients in the approval process awaiting start dates.

Quality

The quality and patient safety team's Falls Champions program continues to meet monthly to review ambulatory falls, discuss mitigation strategies and share best practices. Screening for fall risk in ambulatory practices is steady at 94% for the past three quarters. The focus for the committee is on implementing interventions for patients at risk. The group has identified process improvements to increase patients' proactive use of wheelchairs for those identified as a fall risk. The team is working closely with Volunteer Services and the Patient & Family Community Council to implement proposed changes.

Fig.1. Ambulatory Patient Fall Volume

CY24 Fall Volume				CY25 Fall Volume		
Q1	Q2	Q3	Q4	Q1	Q2	Q3
13	9	19	15	17	13	14

In August 2025, the ambulatory quality and patient safety team along with nursing education launched an internal employee and patient-facing campaign, "Do the Two", to remind all patient-facing teams to confirm the patient's name and date of birth during every encounter, every time. This initiative is in response to patient identification errors trending in the top three categories of safety incident in the past year. The initiative aims to reduce patient identification errors by increasing patient and staff awareness. The campaign includes buttons, flyers, posters and reminders on closed circuit monitors throughout the health system. During the launch week the team visited practices, hosted pop-up trivia events with games and prizes and was featured in the HUB to spread the word and promote staff engagement.

Fig. 2. Ambulatory Patient Safety Scorecard

Ambulatory Patient Safety Scorecard													
	Measures	FY Q3			FY Q4			FY Q1			Target		
		Jan '25	Feb '25	Mar '25	Apr '25	May '25	Jun '25	July '25	Aug '25	Sept '25			
Ambulatory Clinics	Monthly Falls Screening	91%	92%	93%	93%	93%	93%	94%	94%	94%	>90%	70-89.9%	<70%
	Number of Mislabeled Specimens	0	0	0	1	1	1	0	0	1	<=2	<=3	>4
	Date of last serious safety event	1/8/2025					6/9/2025						
	Patient experience: Recommend this provider's office to your friends and family	94.62%	93.83%	95.17%	94.76%	94.40%	94.45%	94.68%	94.75%	94.95%	>=60	50-59	<50

UMG & JDH leadership are working to combine the Workplace Violence committees into one committee with representation from inpatient, outpatient and administrative areas. This joint committee structure will ensure that education, interventions and reporting are consistently implemented across all areas. The group is also working on opportunities in regards to a safety assessment across the areas including leadership, police and this committee. Deb Abromaitis serves as the chair of the Workplace Violence committee and will be updating the policy to reflect the newly merged committee structure.

Performance Improvement

The winner of the Primary Care Quality Improvement Contest was Southington Internal Medicine. The practice improved the total of 7% points on the quality metrics. Among all practices, the biggest improvement was seen on the Breast Cancer Screening and Depression Screening metrics. Storrs Family Medicine improved by 3% and Southington Internal Medicine improving by 2% on the Breast Cancer Screening measure. Southington Internal Medicine and East Hartford Internal Medicine improved by 3% and Geriatrics by 2% on Depression Screening metric.

Kidney health evaluation for patients with diabetes should be performed annually. Custom care gap/health maintenance topic was created in Epic to allow providers for easy, one-click ordering of the relevant blood and urine tests. Kidney health evaluation measure is included in several value-based contracts. Evaluating kidney health as a health maintenance topic directly supports better performance on healthcare quality measures and supports chronic disease management of patients.

Monthly Population Health Quality Improvement Office Hours for support staff at the primary care clinics spanned various topics and encouraged cross-disciplinary collaboration. Topics included reinforcing patient identification, fall risk screening, abuse screening and mandated reporting and patient experience.

Patient Satisfaction

This quarter, the Medical Practice achieved a Likelihood to Recommend Top Box Score of 94.8%, based on 11,978 returned surveys, an increase of 0.3 percentage points from last quarter. We now rank in the 87th percentile in AHA Region I (up from 81st) and the 77th percentile nationally (up from 74th). Additionally, 98.4% of patients rated their likelihood to recommend as Good or Very Good.

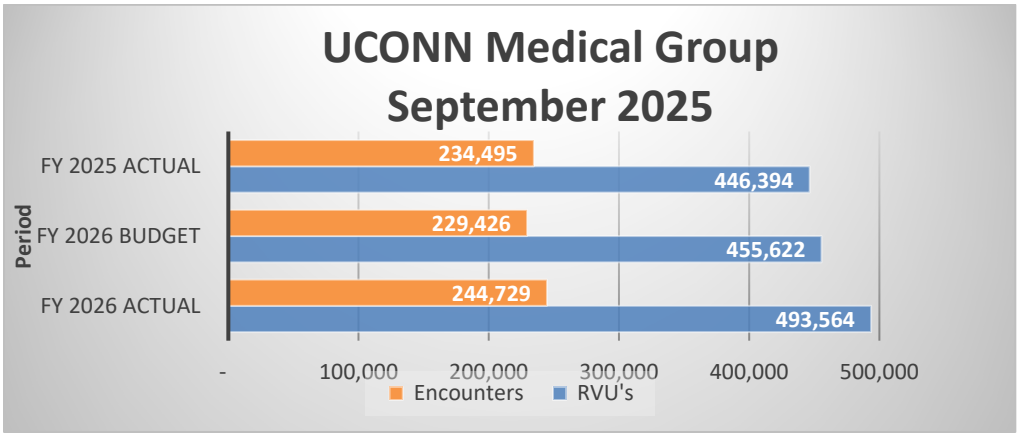
Patient Experience Scorecard Trends

- **Improved Response Times:**
  - After-hours phone responses answered same day: ↑ **4.85%**
  - During-hours phone responses answered same day: ↑ **1.83%**
- **Slight Declines in Service Perception:**
  - Helpfulness of clerks/receptionists: ↓ **0.25%**
  - Ability to get appointments as needed: ↓ **0.51%**
  - Staff collaboration in patient care: ↓ **0.55%**

Likelihood to Recommend

Quarter	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	
Time Period	July - Sept	Oct - Dec	Jan - March	April - June	July - Sept	Oct - Dec	Jan - March	April-June	July-Sept	Oct - Dec	Jan - March	April-June	July-Sept	Trend
n	4062	9113	13745	13064	12492	9866	14288	12706	12480	12721	12711	12309	11978	
Top Box Score	90.99%	91.93%	93.31%	93.58%	93.70%	94.01%	94.14%	94.02%	94.67%	94.60%	94.56%	94.54%	94.80%	
Percentile Rank	39	63	87	84	81	91	87	84	87	86	83	81	87	

Finance



Encounters

- YTD encounters are ahead of budget by 6.7% & ahead of prior year by 4.4%

wRVU

- YTD wRVU's are ahead of budget by 8.3% & ahead prior year by 10.6%

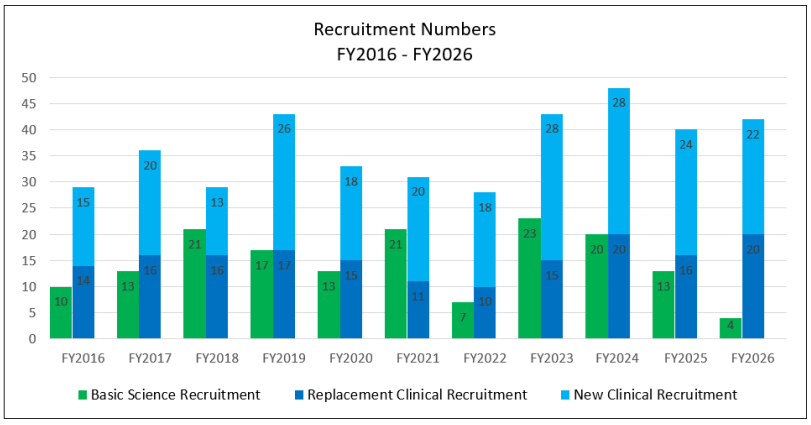
Revenues

- Largest Growth Areas for YTD period with charges/stats are Dermatology, OB, Cancer Center, Radiology when compared to budget
- YTD net patient revenues are ahead of budget by 0.1% & ahead of prior year by 2.7%

Faculty Expansion

We have significant faculty growth in FY26, with 42 clinical faculty hires scheduled to date. Of these, 22 are new positions and 20 are replacements. Additionally, 4 basic science faculty hires are expected, all of which are new positions except one replacement.

The distribution of the 42 clinical faculty departments is as follows: Anesthesiology(1), Cancer Center(2), Cardiology(1), Dermatology (Mohs)(1), Emergency Medicine(1), Endocrinology(2), ENT(2), Family Medicine (3), Geriatrics(1), Hospitalist(4), Infectious Diseases(2), Internal Medicine(4), Pulmonary and Critical Care (1), Nephrology(1), Neurology(1), Occupational and Environmental Medicine(1), Psychiatry(7), Pulmonary and Critical Care)(1), Radiology(3), Speech and Language Pathology(1), Urology(1), Vascular(1)



	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	Total
Basic Science Recruitment	**10**	**13**	**21**	**17**	**13**	**21**	**7**	**23**	**20**	**13**	**4**	**162**
Clinical Recruitment	**29**	**36**	**29**	**43**	**33**	**31**	**28**	**43**	**48**	**40**	**42**	**402**
New	15	20	13	26	18	20	18	28	28	24	22	232
Replacment	14	16	16	17	15	11	10	15	20	16	20	170

Space and Growth

This is a very exciting time for growth and expansion of services. In ***Q2 of FY24***, we reported that we moved the first group in a series of moves under what we are calling the "domino expansion" in the Outpatient Pavilion. This plan allows for growth in key areas such as OBGYN/Women's Health, all of the Surgical specialties, Internal medicine, Geriatrics & Healthy aging, to name a few.

- **Brain & Spine Institute - complete**
  located at 5 Munson Road, is now open. The neurology clinic and blood draw services have been operational in this space since January 22, 2024. The Cranial Neurosurgery and Comprehensive Spine Center completed their relocation on April 29 along with UConn Health Imaging (UHI).

- **Blood Draw Relocation - complete**
  area previously located on the third floor of the Outpatient Pavilion has been relocated to the first floor, alongside the newly designated rooms for Medication Therapy Management. This relocation has enabled ease of access, the expansion of patient care capacity by creating additional bays to better accommodate patient needs.

- **PT/OT move to MSI - complete**
  The physical therapy which and occupational therapy, which was located on OP3, were consolidated in the Musculoskeletal Institute (MSI) on the first floor, when we covered the pool area that was not being utilized.

- **The Women's Center for Motion & Performance - complete**
  Directed by Dr. Katherine Coyner and Dr. Allison Schafer from the Department of Orthopedic Surgery, opened April 2024. This virtual center is dedicated to treating musculoskeletal injuries in active women of all ages through an integrated, multidisciplinary approach. The center's patient-centric model collaborates with various services, including Orthopedics, Neurology, Physical Therapy, Behavioral Health, Nonoperative Sports Medicine, Internal Medicine, Osteoporosis, and Weight Management. To date, over 2,522 women have been treated under this program, with an additional 281 scheduled for future appointments.

- **Southington Clinic Expansion - complete**
  Plans to expand our Southington clinic space at 1115 West Street have been successfully completed in July and our new space officially opened July 25, 2025. An additional 5,000 sq ft was added to the lower level of the building, allowing specialty services—including ENT, Dermatology, Obstetrics and Gynecology, Pulmonary, Endocrinology, and Nephrology—to relocate from the second floor, increasing exam rooms by four. This expansion also enables our existing Primary Care practice on the second floor to expand.

- **Avon Primary Care Expansion – now open**
  Primary care services have expanded into the town of Avon through the conversion of two exam rooms on the upper level of the existing facility at 2 Simsbury Road. This newly designated space supports emergent care visits (ECV) for established internal medicine patients requiring timely medical attention. The new space officially opened on August 29, 2025.

- **OB/GYN Clinics Relocated to 3rd Floor of Outpatient Pavilion - Complete**
  The Obstetrics and Gynecology clinics have successfully completed their large construction and relocation from the 8th floor to the 3rd floor of the Outpatient Pavilion. Phase 1 began with the High-Risk Pregnancy unit (Maternal Fetal Medicine) moving in July 2024. Phases 2 and 3 involved construction to accommodate the Obstetrics and Gynecology and MIGS (Minimally Invasive Gynecological Surgery) clinics, which officially joined the High-Risk Pregnancy unit on the 3rd floor on September 19, 2025. These services are now co-located with Urology, Radiology, and the High-Risk Pregnancy unit. This move allowed for expansion of the needed OB services.

- **Torrington Clinical Expansion – Coming February 2026**
  A new clinical facility located at 507 East Main Street in Torrington is set to be leased, enabling the relocation and expansion of the existing single-physician primary care practice currently operating in the area. The current 2,000-square-foot practice will transition into a significantly larger, state-of-the-art space totaling over 10,500 square feet across two floors. This expansion will enhance primary care services and introduce a range of specialty services, including Orthopedics, Pulmonary, Vascular Surgery, Endocrinology, Cardiology, Obstetrics and Gynecology, Radiology, and Blood Draw services. The Campus Planning Department is overseeing the build-out of the new space, with construction having commenced in July 2025 and an anticipated opening in February 2026.

- **Institute of Sports Medicine (ISM) Hartford Location – Nearing Completion**
  Ongoing implementation to build out ISM Hartford location in People' Bank Arena (formerly the XL Center) co run by Dr. Cory Edgar (UConn Health) and Dr Laurie Devaney (UConn). This 5,500 sq ft area is operated under a partnership with UConn Hartford who took over responsibility for space two years ago. Once operational in Fall of this year, ISM-Hartford will provide state-of-the-art motion assessment, injury prevention and return-to-play services for athletes throughout Connecticut and New England. This location will be the cornerstone of the ISM as we continue to look at strategic opportunities to expand in the future. The site is expected to begin seeing patients at the beginning of 2026.

Cheers / Access

UConn Health began implementation of CHEERS, Epic's Customer Relationship Management (CRM), Schedule Optimization, and Campaigns modules in late January 2023. There are three modules for CHEERS include:

Schedule/Template/Referral Optimization: As the largest component, this portion of the project involves faculty, online scheduling options to increase access, template review and consistency, patient flow opportunities to get the right patient to the right provider, and customer satisfaction. This allows for detailed review of each schedule / template.

Call Management: Aimed at assisting the call centers in accessing information and scheduling to improve efficiency of triage and patient experience.

Campaigns: As part of the ongoing CHEERS initiative, six key outreach campaigns—Medicare Annual Wellness Visit, FIT Testing, Schedule Screening Mammograms, Diabetes Education, HEP Annual Visit Scheduling, and the Flu Clinic—were actively promoted throughout 2025 to support preventive care and patient engagement. Below is the progress to date:

- Medicare Annual Wellness Visit - Targeting patients with a UConn PCP who are due for their annual wellness visit, this campaign offers scheduling via MyChart or phone. To date, 1,251

patients have scheduled appointments (36.5%) and 581 have completed visits (17%) out of 3,426 outreached.

- FIT Testing - Patients with open FIT orders were encouraged to complete their colorectal cancer screenings. The campaign has achieved a 24.7% response rate, with 385 patients submitting specimens outreaching out of 1,559.
- Schedule Screening Mammograms - Eligible patients were invited to schedule screening mammograms. The campaign resulted in 1,228 scheduled appointments (15.3%) and 857 completed visits (10.7%) from a total outreach of 8,011 patients.
- Diabetes Education - This campaign focuses on patients in the Diabetes Registry without upcoming primary care appointments, encouraging them to schedule visits for diabetes management. So far, 709 patients have scheduled appointments (29%) and 408 have completed visits (16.7%) out of 2,449 outreached.
- HEP Annual Visit Scheduling - Patients due for their annual visits were offered the opportunity to schedule via MyChart or phone. To date, 102 patients have scheduled appointments (12%) and 29 have completed visits (3.4%) out of the total outreach.
- Flu Clinic -This campaign targeted patients living near Canton, offering flu clinic appointments via MyChart. The campaign is now complete, with 167 patients scheduling appointments (0.5% of those outreached). Notably, 51% of those scheduled appointments were directly attributed to the campaign.

- Along with these campaigns we utilize this platform to assist with our payor strategy messaging, and marketing opportunities.

These campaigns remain a vital part of the CHEERS initiative's commitment to proactive, preventive healthcare and continue to drive meaningful patient engagement and access across the system.

Nuance DAX CoPilot Implementation Update

UConn Health recently concluded its pilot of the Nuance Microsoft DAX CoPilot, an AI-powered ambient listening solution integrated with Epic. The pilot, which launched on March 26, 2025, involved 30 physicians across 25 departments using Epic Haiku on their iPhones to convert patient-provider conversations into clinical notes. Designed to reduce documentation time and enhance provider-patient interaction and satisfaction, assist with provider burn out, increase billing in Ambulatory Clinics. The project included virtual kickoff sessions and template training, with feedback collected at 45- and 60-days post-implementation. Providers reported significant time savings in charting, improved accuracy in capturing patient details, provided better coding and praised the customizable note templates and the after-visit summary feature. The tool was described as easy to use, with accurate summaries and strong support throughout the pilot phase.

Following the overwhelmingly positive feedback, UConn Health has launched Phase 1 of the broader rollout, which includes the Internal Medicine, Orthopedics, and Dermatology departments, as well as participants in the Scribe Program. Currently, 60% of Phase 1 providers are up and running with DAX. Licenses are available to MDs, APRNs, PAs, residents, and fellows. This implementation also includes where possible the elimination of an in person or virtual scribe.

Phase 2 will expand access to the Cancer Center, starting Nov 3rd and will go big bang on Nov 17th, 2025. Few noted barriers have been identified:

- Android users are unable to enroll until a future version release, expected in January 2026.

- Residency programs have expressed hesitation in allowing lower-level trainees to use the tool.
- Scribe users have been reluctant to adopt DAX due to its current inability to place orders; however, order entry functionality is expected to be available November 4th.

Despite these challenges, providers who are actively using DAX CoPilot have shared positive feedback, citing improved workflow efficiency, reduced documentation burden, and enhanced note quality.

MyChart

This quarter, MyChart activations have increased to 78%. This excellent accomplishment is attributed to the efforts of the quality group and clinics, as well as the implementation of EPIC's Campaigns and Hello World initiatives. Remarkable progress has been made since the start of the program, when activation rates were below 16%.

Few Newsworthy Accolades this Quarter

Huntington's Disease Program Recognition: UConn Health's Huntington's Disease program received national recognition from the Huntington's Disease Society of America (HDSA) as a Center of Excellence in both 2024 and 2025. The program delivers multidisciplinary care, including psychiatry, neurology, and social work in a single visit, enhancing patient experience and outcomes. The CT Chapter of HDSA was also honored as Chapter of the Year.

Multiple Sclerosis Patient Sees Bright Future
https://today.uconn.edu/2025/07/multiple-sclerosis-patient-sees-bright-future/

Early Adopters Embracing AI Transcription Tool
https://today.uconn.edu/2025/09/early-adopters-embracing-ai-transcription-tool/

UConn Health Recognized Nationally for Huntington's Disease Care in Connecticut
https://today.uconn.edu/2025/09/connecticuts-only-huntingtons-disease-society-of-america-center-of-excellence-at-uconn-health/

Correcting a Deadly Error
https://today.uconn.edu/2025/09/correcting-a-deadly-error/

Rebuilding Spines, Restoring Lives: How UConn Health's Dr. Singh Helps Patients Stand Tall Again
https://today.uconn.edu/2025/09/rebuilding-spines-restoring-lives-how-uconn-healths-dr-singh-helps-patients-stand-tall-again/

Blue Cross Blue Shield Blue Distinction Center + in Spine Surgery;

2025 JOHN DEMPSEY HOSPITAL
ANNUAL ASSESSMENT
of the
ENVIRONMENT OF CARE MANAGEMENT PLANS

UConn Health takes a proactive approach to the management of the Environment of Care. The 2025 Environment of Care is broken into six sub-committees. Each sub-committee creates a management plan. At the end of the year, management plans are assessed to determine their effectiveness.

Some of the accomplishments include:

- Safety
  - Monitored ECRI recalls for applicability to John Dempsey Hospital
  - Monitored and reduced expired products found in storage and medicine rooms
- Security
  - Increased security presence in high-risk units
  - Reduced likelihood of contraband entering the inpatient Psychiatry unit for visitors using handheld metal detectors and lockers
- Fire Safety
  - Revised OR fire drills and fire safety training process to all staff including providers
  - Ensured all required fire inspections were completed on time
- Hazardous Materials and Waste
  - Revised pharmaceutical waste segregation and handling processes for offsite locations
  - Achieved a radiation dosimetry return rate > 90%
- Medical Equipment
  - Identified all battery powered medical devices
  - Created plan/process to update aged hospital bed mattresses
- Utilities
  - Relocated University Tower sand filter tank
  - Installed University Tower emergency chilled water connection

2025 Goals we continue to strive to complete include:

- Completing CPI training for all staff in high risk areas
- HUGS security system to be replaced

The annual assessments review:

- Risk points that have been mitigated during the calendar year
- Risk points where progress is being made toward mitigation
- Risk points where the plan of attack needs revision for successful mitigation; and
- Risk points that have been identified during this period.

Respectfully submitted,

Kevin Higgins
Director of Environment of Care & Radiation Safety