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| Sponsor | Barry Gallison |
| Section | GA-Quality |
| Manuals | Plans |

# PL-006-500 Performance Improvement Plan

### I. Purpose

The Performance Improvement (PI) Plan for the North Broward Hospital District (NBHD) (d/b/a Broward Health) defines a system-wide quality management program. Including, the scope, structure, goals, processes, roles, responsibilities, and guiding principles used by the organization for activities supporting patient safety, patient/family engagement, improving patient outcomes and improving overall quality of care. The foundation of the PI Plan is the Mission, Vision, and the Five Star Values, as well as the safety and quality goals of the organization. This plan outlines the collaborative efforts among the Board of Commissioners, Leadership, and Medical and Hospital and Community staff to ensure patient care and services meet or exceed customer expectations.

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### II. Definitions

**MISSION STATEMENT:** The mission of Broward Health is to provide quality health care to the people we serve and support the needs of all physicians and employees.

**VISION STATEMENT:** The vision of Broward Health is to provide world class health care to all we serve.

**FIVE STAR VALUES**

- Accountability for Positive Outcomes
- Valuing Our Employee Family
- Fostering an Innovative Environment
- Collaborative Organizational Team
- Exceptional Service to Our Community

### III. Policy

A. This Performance Improvement Plan involves all of the NBHD facilities and encompasses every process of care and service within the NBHD. Broward Health Medical Center, Broward Health Coral Springs, Broward Health Imperial Point, and Broward Health North and across Broward Health

Ambulatory. Together providing comprehensive acute care and rehabilitation services. Additional services are provided by the Primary Care Facilities, Urgent Care Centers, Hospice and Home Health. The NBHD serves a culturally diverse population and a variety of special needs and services are provided to enhance the quality and safety of the services provided

B. The Board of Commissioners of the NBHD has ultimate responsibility for oversight, direction, and support of the Performance Improvement Program. The Performance Improvement Program is a system-wide planned, comprehensive and ongoing effort to achieve safety and excellence in our structures, processes, and outcomes. The Board of Commissioners, through the District-wide Board Quality Assessment and Oversight Committee (QAOC) will exercise its ultimate overseeing responsibility by receiving and reviewing summaries of organizational performance improvement, risk management, environment of care, nursing services, patient engagement activities, and where applicable, recommending additional PI and Safety initiatives.

## IV. Procedure

The Board of Commissioners delegates the authority to manage the details of the performance improvement activities to the President and Chief Executive Officer of the North Broward Hospital District. The President/CEO of the NBHD therefore extends this authority to the CEO and the Medical Staff Executive Committee of the respective NBHD facilities, who in turn, delegate the hospital performance functions to the Regional Medical Councils and Regional Quality Councils. This is accomplished by systematically collecting aggregating and analyzing the data, comparing the data to established internal and external benchmarks, identification of trends that suggests opportunities for improvement, and implementation of action plans for improvement.

Medical staff and hospitals departments involved in patient care functions measure, aggregate, and assess high volume, high risk and/or problem prone indicators within their areas and identify when a system or process requires an intensive assessment to determine if an opportunity for improvement exists.

Sample sizes are consistent with Joint Commission or data vendors' recommendations when evaluating compliance.

The hospitals and other Broward Health departments then report aggregated outcomes and performance improvement results to the Quality Assessment and Oversight Committee:

Quality Assessment and Oversight Committee ("QAOC")

**Composition**. The QAOC shall consist of three (3) Commissioners who shall be appointed by the Board in accordance with the Bylaws. To further the purposes, goals, and objectives, provide support and/or relevant information, and assist in matters falling within the jurisdiction of the QAOC, the following individuals or their designees shall be required to attend all QAOC meetings: the CEO; two (2) senior corporate members assigned by the CEO; members of Corporate Quality and Risk Management; the Chief Medical Officer or a physician designated by the Chief Medical Officer; one (1) Regional Chief Nursing Officer; the Corporate Safety Officer; the Senior Vice President, Ambulatory Services; the Administrator of Gold Coast Home Health and Hospice; Administrative Vice President, Clinical Services Ambulatory Division; the General Counsel; the Chief Internal Auditor; and the four (4) Regional Chief Executive Officers, Chief Medical Officers, and Quality Services Managers.

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**Duties.** The duties of the QAOC shall include, but not be limited to evaluating the needs and expectations of the individuals served by the District to determine how the District might improve its overall efforts, identify new programs and processes to better assist those individuals served by the District, identify high-volume, high-risk, problem-prone or high-cost processes and recommend methods of improvement, make recommendations regarding patient safety, and to evaluate the impact of patient outcomes. The QAOC should engage and receive input and data from outside regulatory and accrediting agencies, as appropriate, to assist in the performance of its duties. The QAOC shall also perform any other duties as may be requested by the Board from time to time or as provided by law, as provided by Florida Law and applicable federal law, rules and regulations and accreditation standards.

The organization's appropriate individuals, departments and disciplines, work collaboratively in the effort to reduce and prevent errors and enhance quality, safety, and performance. Broward Health uses several improvement processes and methodologies, including, but not limited to:

- Six Sigma (DMAIC)
  - ***D*** *efine the problem*
  - ***M*** *easure the problem*
  - ***A*** *nalyze the problem*
  - ***I*** *mprove the process*
  - ***C*** *ontrol the process*
- PDSA/PDCA
  - ***P*** *lan*
  - ***D*** *o*
  - ***S*** *tudy/Check*
  - ***A*** *ct*
- Rapid Cycle Improvement
- Performance Improvement Teams
- Failure Mode and Effects Analysis
- Root Cause Analysis

The Quality Improvement Program includes but is not limited to the goals/metrics/activities:

1. **Goals:**

Performance Improvement will drive a culture of safety and high quality outcomes as evidenced by:

- Improved CMS Value Based Purchasing, Hospital Acquired Conditions and Readmission Reduction Penalty outcomes.
- Improved CMS STAR ratings.
- Improved continuous readiness for regulatory surveys.
- Increased Leapfrog Hospital Survey scores and robust process.
- Improved clinical integration across the continuum of care.

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- Demonstrated compliance with required data collection and subsequent action planning.

**Metrics(as required by regulatory bodies and/or as determined by Broward Health) related to and may include :**

Value Based Purchasing, Readmissions Reduction Program, Hospital Acquired Conditions as defined by the Center for Medicare and Medicaid Services

Operative or other procedures placing patients at risk of disability or death. All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses. Adverse events related to using moderate or deep sedation or anesthesia.

The use of blood and blood components and all reported and confirmed transfusion reactions.

The results of cardiac resuscitations.

Significant medication errors.

Quality improvement activities including at least clinical laboratory services, diagnostic imaging services, dietetic services, nuclear medicine services, emergency services, respiratory services, and radiation oncology services.

Patient Engagement scores and plans.

Patient thermal injuries that occur during magnetic resonance imaging exams. Incidents where ferromagnetic objects unintentionally entered the magnetic resonance imaging (MRI) scanner room- Injuries resulting from the presence of ferromagnetic objects in the MRI scanner room.

Infection Control including antimicrobial stewardship, and sepsis management.

Use of restraint and seclusion.

Medication management system including Antibiotic Stewardship.

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**Activities of Enterprise wide Quality Programs:**

Home Care.

**Actions:**

Review Environment of Care Quarterly and Annual reports.

Approval of the Annual Strategic Plan for Quality.

Review of a High Reliability Organization Assessment and Action plan.

Review of a Leapfrog Survey Gap Analysis and Action Plans.

Review of the Culture of Safety Survey results.

Review of publicly reported CMS STAR ratings.

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Review evaluations of contracted services.

Approval of Utilization Review Plans.

Approval of Infection Control Annual Reports including Hand Hygiene.

Approval of Patient Safety Annual Report.

Approval of Annual Environment of Care Reports.

Approval of Complaint and Grievance Policy.

**V. Related Policies**

**VI. Regulation/Standards**

The Joint Commission Hospital Accreditation Performance Improvement standards, 2018/2019

CMS Conditions of Participation 482.21 (e) Quality Assessment and Performance improvement Program

AHCA ASPEN page 123/250, 9-27-16 version; Title QUALITY IMPROVEMENT - System

Statute or Rule 59A-3.271(1), FAC

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## Attachments

State requirement re result of autopsy.PNG

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| | Barry Gallison: VP, CLINICAL QUAL & RISK MGMT | 04/2022 |
| | Janet Dougherty: Reg Dir, Clin Quality Scs-BHMC | 04/2022 |
| | Maria Belyea: DIR, CLIN SVCS/ CLINICAL MGR-GC | 04/2022 |
| | Donna Williamson: Reg Dir, Clin Quality Scs-BHIP | 04/2022 |
| | Christopher LaRue: Reg Dir, Clin Quality Scs-BHN | 04/2022 |

## Older Version Approval Signatures

| Approver | Date |
| --- | --- |
| Andrew Ta: EVP, CHIEF MEDICAL OFFICER | 05/2021 |
| Barry Gallison: VP, CLINICAL QUAL & RISK MGMT | 05/2021 |
| Kimberly Cerri: REG MGR, QUAL,ADMIN,PAT SAF-CS | 05/2021 |
| Janet Dougherty: REG DIR, QUAL/EPI/PAT SAFE-BG | 05/2021 |
| Donna Williamson: REG MGR, QUL/EPI/PS/PE-BHIP | 05/2021 |
| Andrew Ta: EVP, CHIEF MEDICAL OFFICER | 07/2020 |
| Barry Gallison: CORP DIR, RISK & QUALITY | 06/2020 |
| Kimberly Cerri: REG MGR, QUAL,ADMIN,PAT SAF-CS | 06/2020 |
| Donna Williamson: REG MGR, QUL/EPI/PS/PE-BHIP | 06/2020 |
| Janet Dougherty: REG DIR, QUAL/EPI/PAT SAFE-BG | 06/2020 |
| Jesusa Alfonso: REG MGR, QUAL/EPI/PAT SAFE-NB | 06/2020 |
| Lee Ghezzi: SVP, QUALITY & CASE MGMT | 05/2019 |
| Andrew Ta: EVP, CHIEF MEDICAL OFFICER | 05/2019 |
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| Andrew Ta: EVP, CHIEF MEDICAL OFFICER | 07/2018 |
| Lee Ghezzi: SVP, QUALITY & CASE MGMT | 07/2018 |
| Denise Payne: REG MGR, QUAL/EPI/PAT SAFE-NB | 07/2018 |