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Sponsor	Barry Gallison: Vice President, Clinical Quality & Risk Management
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 and equity 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, Medical, Hospital and Community staff to ensure patient care and services meet or exceed customer expectations.

II. Definitions

MISSION STATEMENT: Exceptional care. Extraordinary compassion. Everyday excellence.

VISION STATEMENT: To be the champion for a healthier community.

FIVE STAR VALUES

A. Acts with Compassion
B. Always Growing
C. Accountable to Self and Others
D. Action Oriented
E. Ally to Colleagues

III. Policy

A. This Performance Improvement Plan (PIP) involves all of the NBHD facilities and encompasses every process of care and service within the NBHD. Broward Health Medical

Center (BHMC), Broward Health Coral Springs (BHCS), Broward Health Imperial Point (BHIP), and Broward Health North (BHN) and across Broward Health Ambulatory including Broward HealthPoint. Together, providing comprehensive care across the continuum: acute care, rehabilitation services and primary and community health care. Additional services are provided by the Primary Care Facilities, Specialty Clinics, and Urgent Care. 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 for all people. NBHD promotes an inclusive environment where every individual has a fair and just opportunity to attain their highest level of health.

B. The Board of Commissioners of the NBHD has ultimate responsibility for oversight, direction, and support of the Performance Improvement Program (PIP). The PIP 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 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/Chief Executive Officer of the NBHD. The President/CEO 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 data, comparing data to established internal and external benchmarks, identification of trends suggesting opportunities for improvement, and implementation of action plans for improvement.

Medical staff and hospitals departments involved in patient care functions measure, aggregate, and assess low 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 may then report aggregated outcomes and performance improvement results to the Quality Assessment Oversight Committee:

Quality Assessment 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 designee may be required to attend 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; 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 Directors.

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 low-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: define the problem*
    - *M: measure the problem*
    - *A: analyze the problem*
    - *I: improve the process*
    - *C: control the process*
- PDSA/PDCA
    - *P: plan*
    - *D: do*
    - *S: study/Check*
    - *A: act*
- 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:

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

- Improved Center for Medicare and Medicaid Services (CMS) Value Based Purchasing (VBP), Inpatient Quality Reporting (IQR), Hospital Acquired Conditions (HAC) and Readmission Reduction Penalty (RRP) outcomes.
- Improved CMS STAR ratings.
- Continued journey to a high reliable organization
- Improved continuous readiness for regulatory surveys.
- Increased Leapfrog Hospital Survey scores and robust processes.
- Improved clinical integration across the continuum of care.
- Demonstrated compliance with required Social Determinants of Health 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.

Infection Control, including antimicrobial stewardship.

Sepsis management.

Use of restraint and seclusion.

Medication management system including Antibiotic Stewardship.

Written annual action plan on how to address at least one identified health care disparity in an identified patient population.

Activities of Enterprise-wide Quality Programs:

Actions:

Review Environment of Care Quarterly and Annual reports.

Approval of the Annual Strategic Plan -Performance Improvement Plan for Quality.

Review of a High Reliability Organization Assessment and Action plan.

Review of a Leapfrog Survey Gap Analysis.

Review of the Culture of Safety Survey results.

Review of publicly reported CMS STAR ratings.

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 Complaint and Grievance Policy.

V. Related Policies

VI. Regulation/Standards

The Joint Commission Hospital Accreditation Performance Improvement standards, 2023/2024

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

AHCA ASPEN page 139/146, 1/22/2022 version; Title QAPI

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

Attachments

PL-006-500 Attachment - State requirement re.PNG

Approval Signatures

Step Description	Approver	Date
	Barry Gallison: Vice President, Clinical Quality & Risk Management	02/2024

Martin Hynes: Regional Director, Clinical Quality Services-BHMC	02/2024
Donna Diel: Regional Director, Clinical Quality Services-BHCS	02/2024
Christopher LaRue: Regional Director, Clinical Quality Services-BHN	02/2024
Donna Williamson: Regional Director, Clinical Quality Serivces-BHIP	02/2024