NOTICE OF MEETING

A Quality Assessment & Oversight Committee meeting will be held on Wednesday, December 16, 2020, immediately following the Audit Committee Meeting, at Broward Health Corporate Spectrum Location: 1700 Northwest 49 Street, Fort Lauderdale, Florida, 33309. The purpose of this committee meeting is to review and consider any matters within the committee’s jurisdiction.

For the most updated information, please check our website as schedules may change for reasons beyond our control: https://www.browardhealth.org/pages/board-calendar

Persons with disabilities requiring special accommodations in order to participate should contact the District by calling 954-473-7481 at least 48 hours in advance of the meeting to request such accommodations.

Any person who decides to appeal any decision of the District’s Board with respect to any matter considered at these meetings will need a record of the proceedings, and for such purpose, may need to ensure that a verbatim record of the proceedings is made which record includes testimony and evidence upon which the appeal is to be based.
QUALITY ASSESSMENT & OVERSIGHT COMMITTEE MEETING
8:00 a.m., September 8, 2020

The Quality Assessment & Oversight Committee of the North Broward Hospital District was held on September 8, 2020, at 8:00 a.m., via WebEx video conference.

1. **NOTICE**

Official notice and agenda of this meeting is attached to the Minutes, as EXHIBIT I and EXHIBIT II, as presented for consideration of the Committee.

2. **CALL TO ORDER**

There being a quorum present, the meeting was called to order by Chair Nancy W. Gregoire at 8:00 a.m.

3. **COMMITTEE MEMBERS**

*Present:* Commissioner Nancy W. Gregoire, Chair
Commissioner, Stacy L. Angier, Vice Chair
Commissioner Ray. T. Berry

*Senior Leadership*
*Additionally Present:* Marie C. Waugh/Commissioner,
Gino Santorio/President/Chief Executive Officer,
Alan Goldsmith/Chief Administrative Officer,
Alex Fernandez/Chief Financial Officer,
Linda Epstein/Corporate General Counsel,
Jerry Del Amo/Deputy General Counsel

4. **GOVERNOR'S EXECUTIVE ORDER ANNOUNCEMENT**

General Counsel delivered the Governor’s Executive Order for the record.

“This public board meeting is being conducted through communications media technology in accordance with the Governor’s Executive Order No. Fla. Exec. Order No. 20-69, as extended by the Governor’s Executive Order No. 20-193. Section §120.54(5)(b)2, Florida statutes. This meeting is open to the public who are able to attend this meeting via telephone conference call. The conference call information is currently posted on Broward Health’s website. All requirements of Florida’s Sunshine Law are still in effect including the memorialization of minutes. While not a requirement under Florida law, we will attempt to record this meeting
and post it on Broward Health’s website for the public and for those who may not be able to attend this live telephone conference.”

5. **PUBLIC COMMENTS**

Chair Gregoire opened the floor for public comments, in which there were none.

6. **APPROVAL OF MINUTES**

Without objection, Chair Gregoire approved the Quality Assessment & Oversight Committee Meeting Minutes for June 17, 2020.

Staff recommendation *carried* without dissent.

7. **CONSENT AGENDA**

Barry Gallison, Director of Risk and Quality Management, requested approval of the quarterly reports listed on the Consent Agenda, as shown below. Mr. Gallison noted that the June 2020 report was delayed due to COVID-19.

- 7.1. Community Health Services: Healthcare for Homeless
- 7.2. Ambulatory - Physician Practice Update
- 7.3. Population Health
- 7.4. Medicare Readmission
- 7.5. Medicare Mortalities
- 7.6. Environment of Care
- 7.7. Sepsis Prevention
- 7.8. Infection Prevention
- 7.9. Hospital Acquired Pressure Injury
- 7.10. Grievances
- 7.11. Patient Satisfaction HCAHPS
- 7.12. Risk Management Quarterly Reports
- 7.13. 2019 Patient Safety Appraisal Reports by Region
- 7.15. 2019 Infection Prevention Appraisal by Region
- 7.16. 2019 Environment of Care Reports by Region

**MOTION** It was *moved* by Commissioner Angier, *seconded* by Commissioner Berry, that:

The Quality Assessment & Oversight Committee of the North Broward Hospital District Approve Items 7.1 through 7.16 on the Consent Agenda, as Presented.
Motion confirmed by roll-call vote:

- **YES** Commissioner Angier, Vice Chair
- **YES** Commissioner Berry
- **YES** Commissioner Gregoire, Chair

Motion *carried* 3/0.

8. **QUALITY AND SAFETY AGENDA** – presented by Barry Gallison, Director, VP Risk and Quality Management

8.1. 2020 Infection Control Plan – presented by Barry Gallison, Director, VP Risk and Quality Management

8.2. 2020 Performance Improvement Plan – presented by Barry Gallison, Director, VP Risk and Quality Management

8.3. 2020 Safety Plan – presented by Barry Gallison, Director, VP Risk and Quality Management

**MOTION** It was moved by Commissioner Berry, seconded by Commissioner Angier, that:

The Quality Assessment & Oversight Committee recommend that the Board of Commissioners of the North Broward Hospital District authorize the District to accept the following annual polices presented as published: GA 006- 200 Patient Safety Plan; PL-006-500 Performance Improvement Plan and 24-Infection Prevention and Control Plan.

Motion confirmed by roll-call vote:

- **YES** Commissioner Angier, Vice Chair
- **YES** Commissioner Berry
- **YES** Commissioner Gregoire, Chair

Motion *carried* 3/0.

8.4. Antimicrobial Stewardship – presented by Dave Lacknauth, Executive Director, Pharmacy Services
- Antibiotic Resistance Cycle
- Antimicrobial Stewardship Program (ASP) Mission Statement
- Broward Health Pharmacy Antimicrobial Stewardship
- Antimicrobial Stewardship Initiatives 2019-2020
*Item 8.6, Readmissions Program, was heard prior to Item 8.5, Gold Coast Home Health & Hospice.

8.6. Readmissions Program – presented by Barry Gallison, Director, VP Risk and Quality Management
- Readmissions July 1, 2016 through June 30, 2019; no difference from national Medicare average.
- Readmission prevention overview.
- Readmissions action plan.
- Broward Health Cost of Readmissions – 2% of Medicare
- Systemwide readmission rates – all payer (Crimson).
  - Heart failure.
  - Chronic obstructive pulmonary disease (COPD).
  - Pneumonia.
  - Acute Myocardial Infarction.

8.7. Gold Coast Home Health & Hospice – presented by Ms. Debra Shockley, Supervisor, Quality Management, Gold Coast

Please note, Mr. Gallison presented as a substitute for Ms. Shockley, due to technical issues.

- Home health performance, Q2 2020
  - Processes and outcomes.
- Hospice, Q2 2020
  - Quality – reported measures.
- Rehospitalizations
- Gold Coast HHCAHPS

It was noted that Gold Coast Home Health had consistently been rated as a top provider in the region.

Discussion ensued regarding the organization’s areas of strength and opportunities to improve and mitigate issues. Comments were also made regarding family-patient visitation and communication during the COVID-19 pandemic.

9. ADJOURNMENT

There being no further business on the agenda, the Chair adjourned the meeting at 8:45 a.m.

Respectfully submitted,
Commissioner Marie C. Waugh, Secretary/Treasurer
7.1 AMBULATORY PHYSICIAN PRACTICE UPDATE
# Quality Sprint Summary

Network: **BROWARD HEALTH - API**  
Report Date: **11/16/2020**

<table>
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<tr>
<th>Population</th>
<th>Measure</th>
<th>Total Gaps</th>
<th>Closed Gaps</th>
<th>Open Gaps</th>
<th>Received Pending *</th>
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<tr>
<td>Medicare</td>
<td>OMW - Osteoporosis Management <strong>^</strong></td>
<td>0</td>
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<tr>
<td>Medicare</td>
<td>ART - Rheumatoid Arthritis Management <strong>^</strong></td>
<td>2</td>
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<td>Medicare</td>
<td>SPCR - Statin Therapy for Patients with Cardiovascular Disease (Part C)</td>
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<td>D14 - Statin Therapy for Patients with Diabetes SUPD</td>
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<tr>
<td>Medicare</td>
<td>CDC - Comprehensive Diabetes Care HbA1c Poor Control (&gt;9.0%)</td>
<td>15</td>
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<tr>
<td>Medicare</td>
<td>CDC - Comprehensive Diabetes Care Kidney Disease Monitoring</td>
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<td>2</td>
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<tr>
<td>Medicare</td>
<td>BCS - Breast Cancer Screening</td>
<td>22</td>
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<td>21</td>
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<td>Medicare</td>
<td>AWV - Annual Wellness Visit</td>
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<tr>
<td>Medicare</td>
<td>CBP - Controlling High Blood Pressure</td>
<td>112</td>
<td>5</td>
<td>107</td>
<td>9</td>
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<tr>
<td>Medicare</td>
<td>CDC - Comprehensive Diabetes Care Eye Exam</td>
<td>22</td>
<td>7</td>
<td>15</td>
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<tr>
<td>Medicare</td>
<td>COL - Colorectal Cancer Screening</td>
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<td>40</td>
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<td>Medicare</td>
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<td><strong>Total</strong></td>
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<td><strong>284</strong></td>
<td><strong>23</strong></td>
<td><strong>261</strong></td>
<td><strong>11</strong></td>
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<td><strong>%</strong></td>
<td></td>
<td><strong>100%</strong></td>
<td><strong>8%</strong></td>
<td><strong>92%</strong></td>
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**COMMUNITY CARE PLAN (CCP) – BHPG HEDIS 2020**

**3RD QTR REPORT CARD**

**BROWARD HEALTH PHYSICIAN GROUP**

YTD HEDIS Report Card  
Report For October, 2020

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<th>Type</th>
<th>Performance Measure</th>
<th>Performance Measure Description</th>
<th>Num</th>
<th>Den</th>
<th>Score</th>
<th>66.67%</th>
<th>66.67th needed</th>
<th>75%</th>
<th>75th needed</th>
<th>90%</th>
<th>90th needed</th>
<th>66.67% Weight</th>
<th>75th Weight</th>
<th>90th Weight</th>
<th>Weighted Total</th>
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<td>MMA, 5-11 years</td>
<td>Medication Management for People with Asthma, 5 to 11 Years</td>
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<td>1</td>
<td>0.00%</td>
<td>33.14%</td>
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<td>0</td>
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<tr>
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<td>MMA, 12-18 years</td>
<td>Medication Management for People with Asthma, 12 to 18 Years</td>
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<td>0</td>
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<td>533</td>
<td>57.22%</td>
<td>85.97%</td>
<td>143</td>
<td>149</td>
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<td>AWC, Total</td>
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<td>66.00%</td>
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<td>4.00</td>
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<td>BCS, Total</td>
<td>Breast Cancer Screening</td>
<td>13</td>
<td>30</td>
<td>48.83%</td>
<td>62.34%</td>
<td>6</td>
<td>6</td>
<td>68.84%</td>
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<td>0.25</td>
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<td>CAP, 12-19 years</td>
<td>Children’s Access to Primary Care – 12 to 19 Years</td>
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<td>8</td>
<td>100.00%</td>
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<td>(1)</td>
<td>94.75%</td>
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<td>CAP, 7-11 years</td>
<td>Children’s Access to Primary Care – 7 to 11 Years</td>
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<td>Family Practice</td>
<td>CBP, Total</td>
<td>Controlling High Blood Pressure</td>
<td>25</td>
<td>90</td>
<td>27.78%</td>
<td>65.50%</td>
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<td>32</td>
<td>71.04%</td>
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<tr>
<td>Family Practice</td>
<td>CCS, Total</td>
<td>Cervical Cancer Screening</td>
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<td>258</td>
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<td>45</td>
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<td>CDC, A1c &lt;8% Good Control</td>
<td>Comprehensive Diabetes Care – HbA1c &lt;8% Control</td>
<td>13</td>
<td>47</td>
<td>27.66%</td>
<td>54.53%</td>
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<td>59.49%</td>
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<td>Comprehensive Diabetes Care – Blood Pressure Control (&lt;140/90)</td>
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<td>47</td>
<td>25.53%</td>
<td>60.37%</td>
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<td>21</td>
<td>77.50%</td>
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<td>CDC, Eye Exam</td>
<td>Comprehensive Diabetes Care – Eye Exam</td>
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<td>47</td>
<td>27.66%</td>
<td>62.26%</td>
<td>16</td>
<td>16</td>
<td>64.23%</td>
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<td>CDF, 12-17 years</td>
<td>Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF)</td>
<td>0</td>
<td>14</td>
<td>0.00%</td>
<td>30.00%</td>
<td>4</td>
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<td>Screening for Depression and Follow-Up Plan: Age 18 and older (CDF)*</td>
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<td>401</td>
<td>23.69%</td>
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<td>25</td>
<td>65</td>
<td>50.00%</td>
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<td>CHL, Total, Adult</td>
<td>Chlamydia Screening – 21 to 24 Years</td>
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<td>67.02%</td>
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<td>CHL, Total, Peds</td>
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<td>33.33%</td>
<td>59.45%</td>
<td>1</td>
<td>6</td>
<td>69.75%</td>
<td>1</td>
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<td>4.00</td>
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<td>CIS, Combo 10</td>
<td>Childhood Immunizations Status – Combo #10</td>
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<td>38.44%</td>
<td>(0)</td>
<td>(0)</td>
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<td>IMA, Combo 2</td>
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<td>35.52%</td>
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<td>46.72%</td>
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<tr>
<td>Family Practice</td>
<td>WIS, 6- Visits</td>
<td>Well Child Visits – Birth to 15 months (6 + Visits)</td>
<td>7</td>
<td>13</td>
<td>53.85%</td>
<td>69.59%</td>
<td>2</td>
<td>2</td>
<td>72.62%</td>
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<tr>
<td>Family Practice</td>
<td>W34</td>
<td>Well Child Visits – 3 to 6 Years</td>
<td>14</td>
<td>23</td>
<td>60.87%</td>
<td>77.06%</td>
<td>4</td>
<td>4</td>
<td>83.70%</td>
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<td>0.50</td>
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Please refer to disclaimer on cover page

COMMUNITY CARE PLAN - the health plan with a heart - WWW.CCPCORES.ORG
HUMANA MEDICARE HMO 2020 3RD QTR
IPMG GROUP

Quality/Stars Report

Quality Stars Summary  BHGP IMPERIAL POINT MEDICAL GR (80904267) (Center: 000101415_80904267)
10/09/2020 01:15 PM EDT
Overall Star Level: 3.88  HEDIS Star Level: 2.92  Patient Safety Star Level: 5.00
 Aggregate Pass %: 74.48%  Patient Experience Rating: -  Open Opportunities: 261
Overall Medication Adherence: 93.50%  Active Patients: 356  Eligible Opportunities: 1,023
Patients w/ Open Opportunities: 166

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Pass % PYTD</th>
<th>% PFY</th>
<th>% Passing</th>
<th>Eligible</th>
<th>Open Opp</th>
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<td>Breast Cancer Screening</td>
<td>72</td>
<td>75</td>
<td>76</td>
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<td>83</td>
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<td>Care for Older Adults: Functional Status Assessment</td>
<td>41</td>
<td>70</td>
<td>80</td>
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<td>Care for Older Adults: Medication Review</td>
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<td>Colorectal Cancer Screening</td>
<td>71</td>
<td>63</td>
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<td>110</td>
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<td>Comprehensive Diabetes Care: HbA1c Poor Control</td>
<td>65</td>
<td>84</td>
<td>87</td>
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<td>Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis</td>
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</table>

Sources: Anvita, Versoend, Pharmacy Analytics, Humana-Conducted Comment VAT Calls
# Humana Medicare HMO 2020 3rd Qtr

## Narvez Group

### Quality/Stars Report

**Quality Stars Summary**
- BHPG Narvez L Fernando (80904267) (Center: 000107047_80904267)
- Overall Star Level: 3.96
- HEDIS Star Level: 3.28
- Patient Safety Star Level: 4.75

**Aggregate Pass %:** 82.05%
**Patient Experience Rating:** Open Opportunities: 131
**Overall Medication Adherence:** 90.11%
**Active Patients:** 240
**Eligible Opportunities:** 730
**Patients w/ Open Opportunities:** 31

## Measures with 5 Star Level

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<th>PYTD %</th>
<th>PFY %</th>
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<td>100</td>
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</table>

**Access to Care**
- 
- 
- 
- 

**Coordination of Care**
- 
- 
- 
- 

**Patient Discussion**
- 
- 
- 
- 

Sources: Anvita, Verscend, Pharmacy Analytics, Humana—Conducted Comment VAT Calls
The following data shows metrics for HEDIS measures that indicate a potential care opportunity. Metrics include assigned and/or attributed Medicare Advantage members specific to the MA-PCPI, which are not included in the M&IR ACO Program.

### Annual Care Visit (ACV)

| Total MA-PCPI Patients | 481 | 69 | 412 |

### Quality Measures

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Eligible Members</th>
<th>Compliant Members</th>
<th>Non-Compliant Members</th>
<th>Current Rate</th>
<th>4 STAR Threshold % Target</th>
<th># of Members to Achieve 4 STAR Threshold</th>
<th>5 STAR Threshold % Target</th>
<th># of Members to Achieve 5 STAR Threshold</th>
<th>Quality Rating</th>
<th>MA-PCPI Weight</th>
<th>MA-PCPI Weighted Quality Rating</th>
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<tbody>
<tr>
<td>C01 - Breast Cancer Screening</td>
<td>102</td>
<td>77</td>
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<td>75%</td>
<td>76.0%</td>
<td>2</td>
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<td>83.0%</td>
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<td>89%</td>
<td>94.0%</td>
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<td>98.0%</td>
<td>21</td>
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<tr>
<td>C13 - Diabetes Care - Eye Exam</td>
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<td>10</td>
<td>85.0%</td>
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<tr>
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<td>C15 - Diabetes Care - Blood Sugar Controlled</td>
<td>70</td>
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<td>71%</td>
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<td>87.0%</td>
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<td>6</td>
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<td>95.0%</td>
<td>3</td>
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<td>3</td>
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<tr>
<td>D11 - Medication Adherence for Hypertension (RA) antagonists</td>
<td>180</td>
<td>163</td>
<td>17</td>
<td>91%</td>
<td>93.0%</td>
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<td>98.0%</td>
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<td>204</td>
<td>188</td>
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<td>92%</td>
<td>93.0%</td>
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<td>98.0%</td>
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<td>D14 - Statin Use in Persons with Diabetes</td>
<td>68</td>
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<td>91%</td>
<td>93.0%</td>
<td>0</td>
<td>85.0%</td>
<td>0</td>
<td>5</td>
<td>3</td>
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<tr>
<td>C21 - Statin Therapy for Patients With Cardiovascular Disease**</td>
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<td>94.0%</td>
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<td>89.0%</td>
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**Current Year Average Star Rating**: 3.3

**Prior Year Final Average Star Rating**: 3.89

**Average Star Rating Year over Year Change**: -0.59
## UNITED 2020 3rd QTR QA MEDICARE INCENTIVE MEASURES CLOSURES MONTH OVER MONTH TREND

### Quality Care Incentive Measures

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Eligible Members</th>
<th>Compliant Members</th>
<th>Non-Compliant Members</th>
<th>Current Rate</th>
<th>4 STAR Threshold % Target</th>
<th># of Members to Achieve 4 STAR</th>
<th>5 STAR Threshold % Target</th>
<th># of Members to Achieve 5 STAR</th>
<th>Quality Rating</th>
<th>MA-PCP/Weight</th>
<th>MA-PCPI Weighted Quality Rating</th>
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<tr>
<td>C12-Osteoporosis Management in Women who had a Fracture</td>
<td>-</td>
<td>-</td>
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<td>-</td>
<td>≥53.0%</td>
<td>-</td>
<td>≥73.0%</td>
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<td>C16-Rheumatoid Arthritis Management**</td>
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<td>≥81.0%</td>
<td>2</td>
<td>1</td>
<td>0</td>
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<tr>
<td>C19-Medication Reconciliation Post Discharge</td>
<td>40</td>
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<td>35</td>
<td>13%</td>
<td>≥75.0%</td>
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<td>≥86.0%</td>
<td>30</td>
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<table>
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<th>Month-Over-Month</th>
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<th>Sep 2020</th>
<th>Trend</th>
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<tr>
<td>Total MA-PCP/Patients</td>
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<th>Sep 2020</th>
<th>Trend</th>
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<tbody>
<tr>
<td>Total MA-PCP/Patients</td>
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<td>481</td>
<td>+15%</td>
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### Quality Measure

<table>
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<tr>
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<td>C02-Colorectal Cancer Screening</td>
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<tr>
<td>C07-Adult BMI Assessment</td>
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<td>→</td>
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<td>C13-Diabetes Care - Eye Exam</td>
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<td>C14-Diabetes Care - Kidney Disease Monitoring</td>
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<tr>
<td>C15-Diabetes Care - Blood Sugar Controlled</td>
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<td>D10-Medication Adherence for Diabetes Medications</td>
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<td>D11-Medication Adherence for Hypertension (BAS antagonists)</td>
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<td>↓</td>
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<td>D12-Medication Adherence for Cholesterol (Statins)</td>
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<td>D14-Statin Use in Persons with Diabetes</td>
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<td>2.78</td>
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# CarePlus HealthPlan MA HMO Part C & Part D 2020 3rd QTR

## HEDIS 2021 Reporting Year

Administrative Results Only - Vendor Performance
Part-C Data Processed From 1/1/2020 - 9/30/2020
Part-D Data Processed From 1/1/2020 - 10/16/2020

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<th>Current Status</th>
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<th>Star Minimum Threshold %</th>
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<td>1</td>
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</tr>
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<tr>
<td>Care in Older Adults - Advance Care Planning**</td>
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*Inverse Measure - Lower Rate is Better - Rate represents % of GAPs
**Display Measure - Star Values Calculated Using NCQA® Percentiles as a base

Total Star Eligible Measures: 20

Weighted Average Star Rating: 2.40

*NOTE: There are additional measures included above that are not STAR measures. These measures are NOT included in the weighted average. These can be identified by their blank values for the "Weight.*
**MEDICA PART D MEASURES 2020 3RD QTR**

# of Eligible Measures: 13  
Current Membership: 37

---

**Medica Healthcare**  
**NORTH BROWARD HSPTL DIST**

---

**Stars Scorecard**  
**Measurement Year 2020**

---

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<thead>
<tr>
<th>Measure Description</th>
<th>Eligible Population</th>
<th>Compliant Population</th>
<th>% Compliant</th>
<th>Stars</th>
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<td>Statin Use in Persons with Diabetes (SUPD)</td>
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<td>5</td>
<td>100%</td>
<td>*****</td>
<td>-1</td>
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<tr>
<td>Cholesterol (Statins)</td>
<td>13</td>
<td>11</td>
<td>84.62%</td>
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<td>89%</td>
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## MEDICA PART C 2020 3RD QTR

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<tr>
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<td>100%</td>
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<td>86%</td>
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<tr>
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<tr>
<td><strong>Care For Older Adults (COA)</strong></td>
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<td>98%</td>
<td>1</td>
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<tr>
<td>Plan All-Cause Readmissions (PCR)</td>
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### TOTAL PART C & D

**Average Star Rating**

3.22
# of Eligible Measures: 15
Current Membership: 716

Collection Period Through 10/9/2020

Preferred Care Partners
NORTH BROWARD HSPTL DIST

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<tr>
<th>Measure Description</th>
<th>Eligible Population</th>
<th>Compliant Population</th>
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<th>Population Needed</th>
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<td>Statin Use in Persons with Diabetes (SUPD)</td>
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<td>110</td>
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<td>86%</td>
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<td>Cholesterol (Statins)</td>
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<tr>
<td>Hypertension (ACEI &amp; ARB)</td>
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<td>296</td>
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Average Star Rating Part D: 4.00
# PREFERRED CARE PARTNERS MEDICARE
## 2020 3rd Qtr Part C

### Part C (HEDIS, NCQA)

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<th>Rating</th>
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<th>Percentage</th>
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<td>71</td>
<td>29</td>
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<td>1</td>
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<td>73%</td>
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<tr>
<td>Statin Therapy for Patients With Cardiovascular Disease (SPC)</td>
<td>34</td>
<td>29</td>
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<td>1</td>
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### Care For Older Adults (COA)

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<th>Count</th>
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<th>Rating</th>
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### Comprehensive Diabetes Care (CDC)

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<td>Eye Exam</td>
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<td>Kidney Disease Monitoring</td>
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### Informational

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<th>Percentage</th>
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<td>57.94%</td>
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<td>94%</td>
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<td></td>
<td>1</td>
<td>1</td>
</tr>
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<td>Plan All-Cause Readmissions (PCR)</td>
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### Total Part C & D

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Average Star Rating: 3.16
7.2 POPULATION HEALTH UPDATE ACCOUNTABLE CARE ORGANIZATION
# Cigna - Quality

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<td>71.2%</td>
<td>72.9%</td>
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<td>34.0%</td>
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<td>53.2%</td>
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<td>88.7%</td>
<td>88.9%</td>
<td>88.0%</td>
<td>91.2%</td>
<td>91.6%</td>
<td>91.9%</td>
<td>93.1%</td>
<td>91.1%</td>
<td>88.1%</td>
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<tr>
<td>Diabetes - Poor HbA1c control</td>
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<td>85.4%</td>
<td>85.9%</td>
<td>90.2%</td>
<td>90.7%</td>
<td>94.2%</td>
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<td>91.1%</td>
<td>89.7%</td>
<td>88.8%</td>
<td>89.9%</td>
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<tr>
<td>Diabetes - Good HbA1c control</td>
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<td>70.4%</td>
<td>74.7%</td>
<td>76.1%</td>
<td>77.5%</td>
<td>76.6%</td>
<td>80.7%</td>
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<td>78.9%</td>
<td>86.6%</td>
<td>79.2%</td>
<td>82.9%</td>
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<td>71.7%</td>
<td>66.5%</td>
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<td>82.6%</td>
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<td>75.5%</td>
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<td>N/A</td>
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<td>95.9%</td>
<td>96.3%</td>
<td>98.4%</td>
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<td>96.9%</td>
<td>96.3%</td>
<td>96.7%</td>
<td>100.0%</td>
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<td>80.6%</td>
<td>83.8%</td>
<td>95.0%</td>
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<td>31.6%</td>
<td>25.7%</td>
<td>34.3%</td>
<td>36.1%</td>
<td>45.9%</td>
<td>69.4%</td>
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<td>67.7%</td>
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<td>73.5%</td>
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<td>58.8%</td>
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<tr>
<td>Generic Dispensing Rate</td>
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<td>79.3%</td>
<td>85.7%</td>
<td>85.9%</td>
<td>85.7%</td>
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## Florida Blue - Quality

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<th>Aug-17</th>
<th>Nov-17</th>
<th>Feb-18</th>
<th>May-18</th>
<th>Aug-18</th>
<th>Dec-18</th>
<th>Feb-20</th>
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<td>75.9%</td>
<td>64.2%</td>
<td>65.4%</td>
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<td>Cervical Cancer Screening</td>
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<td>73.3%</td>
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<td>65.4%</td>
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<td>Diabetes - HgA1c Completed</td>
<td>88.0%</td>
<td>91.7%</td>
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<td>91.7%</td>
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<td>Diabetes - Nephropathy</td>
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**Important to note that the Benchmark being used in 2020 marks an increase from previous years, which causes previous quarters to appear not to meet.**
# HOME HEALTH CMS IQIES

## Broward Health Home Health

<table>
<thead>
<tr>
<th>Processes &amp; Outcomes</th>
<th>CMS</th>
<th>Q1 CY 20</th>
<th>Q2 CY 20</th>
<th>Q3 CY 20</th>
<th>Q4 CY 20</th>
<th>YTD</th>
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<tbody>
<tr>
<td>Managing Daily Activities</td>
<td>CMS</td>
<td>Jan</td>
<td>Feb</td>
<td>Mar</td>
<td>Apr</td>
<td>May</td>
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<tr>
<td>Improvement in Ambulation - Locomotion</td>
<td>CMS Target Rolling 79.9% *Star Rating</td>
<td>94.1</td>
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<td>CMS Target Rolling 81.4% *Star Rating/YBP</td>
<td>94.1</td>
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<td>84</td>
<td>90.2</td>
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<td>Improvement in Bathing</td>
<td>CMS Target Rolling 82.6% *Star Rating/YBP</td>
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<td>Improvement in Dyspnea</td>
<td>CMS Target Rolling 83.2% *Star Rating/YBP</td>
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<td>88.5</td>
<td>92</td>
<td>90.3</td>
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## HOME HEALTH CMS IQIES

<table>
<thead>
<tr>
<th>Managing Pain and Treating Symptoms</th>
<th>1st Qtr CY 2020</th>
<th>2nd Qtr CY 2020</th>
<th>3rd Qtr CY 2020</th>
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</tr>
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<tr>
<td>Improvement in Management of Oral Medications</td>
<td>CMS Target Rolling 78.2% VBP</td>
<td>93.8</td>
<td>85</td>
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<tr>
<td>Preventing Harm</td>
<td></td>
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<tr>
<td>Timely Initiation of Care</td>
<td>CMS Target Rolling 95.4% *Star Rating</td>
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<tr>
<td>Drug Education on all medications provided to patients/caregiver during all episode of care (EOC)</td>
<td>CMS Target Rolling 99% *Star Rating</td>
<td>98</td>
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<tr>
<td>Discharged to Community</td>
<td>CMS Target Rolling 72.5% VBP</td>
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## HOME HEALTH HHCAHPS

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<tr>
<th></th>
<th>National Average</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
<th>JUL</th>
<th>AUG</th>
<th>SEP</th>
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</thead>
<tbody>
<tr>
<td>HHCAHPS % of patients who reported that their HH team gave care in a professional way</td>
<td>CMS Target Rolling 88%</td>
<td>88.2</td>
<td>68</td>
<td>93</td>
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<tr>
<td>HHCAHPS % of patients who reported that their HH team communicated well with them</td>
<td>CMS Target Rolling 85%</td>
<td>81</td>
<td>48</td>
<td>97.6</td>
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<td>88</td>
<td>86</td>
<td>81</td>
<td>76.3</td>
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<tr>
<td>HHCAHPS % of patients who reported that their HH team discussed meds, pain and home safety with them</td>
<td>CMS Target Rolling 83%</td>
<td>88.2</td>
<td>55</td>
<td>84</td>
<td>72</td>
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<td>61</td>
<td>88.2</td>
<td>55</td>
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<tr>
<td>HHCAHPS % of patients who gave their HH agency a rating of 9 or 10</td>
<td>CMS Target Rolling 84%</td>
<td>71</td>
<td>46</td>
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<td>78</td>
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<td>HHCAHPS % of patients who reported YES, they would definitely recommend HH agency</td>
<td>CMS Target Rolling 78%</td>
<td>65</td>
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<td>50</td>
<td>71</td>
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24
# HOSPICE

## Broward Health Hospice

### Processes & Outcomes

<table>
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<tr>
<th></th>
<th>Q1 CY 20</th>
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<th>Q3 CY 20</th>
<th>Q4 CY</th>
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<tr>
<td><strong>Infection Control - IPU</strong></td>
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<td>0.00%</td>
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<td>21</td>
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<td><strong>Pain Management - IPU</strong></td>
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<td><strong>Infection Control - Home</strong></td>
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## HOSPICE

### HOSPICE Quality Reported Measures

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<tr>
<th>Hospice Home Visits When Death is Imminent</th>
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<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
<th>JUL</th>
<th>AUG</th>
<th>SEP</th>
<th>YTD</th>
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</thead>
<tbody>
<tr>
<td><strong>A - 3 days</strong></td>
<td><strong>Avg # visits</strong></td>
<td>5</td>
<td>7</td>
<td>4.5</td>
<td>5.75</td>
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<td><strong>B - 7 days</strong></td>
<td><strong>Avg # visits</strong></td>
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<td>11.67</td>
<td>8</td>
<td>9.5</td>
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# HOSPICE

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<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
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<th>AUG</th>
<th>SEP</th>
<th>OCT</th>
<th>NOY</th>
<th>DEC</th>
<th>YTD</th>
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<td>OCT</td>
<td>NOV</td>
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# HOSPICE HSCAHPS

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<th>MAR</th>
<th>APR</th>
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<th>JUL</th>
<th>AUG</th>
<th>SEP</th>
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<td>Getting Timely Care</td>
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<td>29</td>
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<td>Treating Family Member with Respect</td>
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<td>Recommend Hospice</td>
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<td>100</td>
<td>80</td>
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7.4 READMISSIONS
Readmission Prevention Overview

- Patient admit
- Risk assessment performed in EHR
- Discern Alert w/ risk factor
- Enter patient care plan with visibility across care providers
- Refine patient set with readmissions dashboard
- Manage high risk patients in workflow
- Manage outcomes with easy to identify status metrics
- Performance Reporting

- Essential roles:
  - Physicians
  - Nurses
  - Case Managers
  - Readmission Preventionists

- Targeted conditions:
  - Acute Myocardial Infarction (AMI)
  - Community-Acquired Pneumonia (CAP)
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Chronic Heart Failure (CHF)

- All-cause high risk assessment:
  - Identify 30 day readmits
  - Identify high risk procedures
  - Knee/Hip Replacement
  - Coronary Artery Bypass Graft

BOOST Ps assessment
**Discharge Process**

- D/C education to patient & caregiver
- Follow up appointment made by CM on COPD, CHF Readmitted patients.
- COPD discharge med packets: ABX, Rescue inhaler and Medrol dose packs.

**High Risk Readmissions**

- Readmission Assessments implemented in Cerner.
- High Risk Daily census sent to CM staff daily.
- Implementation of discharge disposition with readmission.
- CM & CMO Disease specific readmissions teams: CHF, COPD, AMI - Intense Analysis data drill down of opportunities.

**Transition of Care**

- Readmission follow up calls.
- CM referrals to Pop Health via Ensocare.
- CHF task force with collaboration with Duke university study.
- COPD task force.
- Centralized appointment center for follow up care.
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<tr>
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<th>FY21 Potential Max Penalty</th>
<th>FY 20 Actual Penalty</th>
<th>FY21 Estimated Penalty</th>
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BHMC COST OF READMISSIONS
3% OF MEDICARE
BHCS COST OF READMISSIONS 3% OF MEDICARE

### Actual FFY 2020 Performance

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### Actual FFY 2021 Performance

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BHN COST OF READMISSIONS 3% OF MEDICARE

Actual FFY 2020 Performance

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National Budget Neutrality Modifier: 0.9576

% Full-Benefit Dual Eligible: 18.41%

National Quintile: 3

SDS Impact (Breakout): ($10,000)

Actual FFY 2021 Performance

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<th>Actual Adj. Factor</th>
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<th>Est. Revenue Subject to Adj.</th>
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<th>Max Penalty (3.0%)</th>
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National Budget Neutrality Modifier: 0.9613

% Full-Benefit Dual Eligible: 18.23%

National Quintile: 2

SDS Impact (Breakout): ($20,000)

Condition Chart:
- [ ] Condition Revenue
- [x] Est. Impact

Actual FFY 2020 Performance

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Actual FFY 2021 Performance

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BHIP COST OF READMISSIONS 3% OF MEDICARE
Medicare Readmissions

Medicare Average:
No difference from National Average for all hospitals and following diagnoses: HF, COPD, PN, AMI
Readmissions 07/01/2016 – 06/30/2019
## Readmissions - Medicare

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BH SYSTEMWIDE HEART FAILURE

% 30 Day Readmits w/ Excludes (Any APR-DRG) - System-AllPhysicians

Broward Health
19.14%

National Observed
Rate 21.7%
BH SYSTEMWIDE
CHRONIC OBSTRUCTIVE PULMONARY DISEASE

% 30 Day Readmits w/ Excludes (Any APR-DRG) - System-AllPhysicians

Broward Health
Rate 17.28%

National Observed
Rate 19.6%
BH SYSTEMWIDE PNEUMONIA

% 30 Day Readmits w/ Excludes (Any APR-DRG) - System-AllPhysicians

Broward Health
Rate 12.48%

National Observed
Rate 16.6%
BH SYSTEMWIDE
ACUTE MYOCARDIAL INFARCTION

% 30 Day Readmits w/ Excludes (Any APR-DRG) - System-AllPhysicians

Broward Health
Rate 9.64%

National Observed
Rate 15.7%
7.5 MEDICARE MORTALITIES
AMI Medicare Mortalities 3rd Q 2020
Hospital Compare CMS benchmark 13.6%

Mortality Rate (with Exclusions) - System-All Physicians

BHMC

Mortality Rate (with Exclusions) - System-All Physicians

BHN

Mortality Rate (with Exclusions) - System-All Physicians

BHCS

BHMC: 0/6
BHN: 0/7
BHIP: 0/1
BHCS: 0/2
HF Medicare Mortalities 3rd Q 2020
Hospital Compare CMS benchmark 12.0%

Mortality Rate (with Exclusions) - System-All Physicians

BHMC

Mortality Rate (with Exclusions) - System-All Physicians

BHN

BHCS

0/19

-0.32σ

0/12

-0.14σ

0/6

-0.11σ

1/108

0.59σ
CABG Medicare Mortalities 3rd Q 2020

Hospital Compare CMS benchmark 3.3%

BHMC

Mortality Rate (with Exclusions) - System-All Physicians

- Result
- Comparison

-1.0
-0.63σ
0.0
1.0

0/9
7.6 ENVIRONMENT OF CARE
An RFP for an electronic Emergency notification system was released.

Each vendor conducted an oral presentation to the selection committee.

Based on the scores by the committee members, Everbridge received the highest score and was awarded the contract.

The Regional Leaders in conjunction with the Emergency preparedness department will review the functionality and effectiveness of the platform to ensure contractual requirements are met.

A 28 day implementation plan has been provided by Everbridge. Implementation will begin immediately upon final execution of the contract.
NEW EMERGENCY NOTIFICATION SYSTEM IMPLEMENTATION
(TRANSITION FROM READY-OP TO EVERBRIDGE)

WHAT ARE WE GETTING

Mass Notification and Incident Communications
• Rapidly communicate with ALL staff with a single click of a button.
• Activate emergency response teams, notify executive leadership and impacted staff with a single click of a button.
• Automated communication workflows
• 100+ Multi-modal notification end-points
• Everbridge Network to access situational intelligence & notifications shared by other public and private groups

Geo-Intelligent
• GIS-based Message Targeting
• Send messages to recipients in a specific geographic region
• Specify target locations with user friendly drawing tools, or even upload shape files
• Search for, view the locations of, and send alerts to specific contact types
• Highlight functional needs populations, fire districts, alert type subscribers, and more
• Load, geo-code, and manage contact data within a single interface and in real-time

A mobile SOS feature, which provides a mobile alert button that employees can activate to send messages and video to the security center if they feel threatened via mobile device.
Quality
KEY QUALITY DRIVER: Improve negatively performing trends

People
KEY PEOPLE DRIVER: Keep our employees and patients safe

Finance
KEY FINANCE DRIVER: Reduce the direct, indirect and total occupational injury cost

KEY GROUP EOC PI INITIATIVE

Occupational Injury Reduction - Slip, Trip and Falls – 2016 – Garnett Coke
Missing Patient Property – 2017 – Susan Newton
Safe Patient Handling - 2018 – Michael Huempfner
**KEY GROUP – PI INITIATIVE**

*(ACHIEVE 10% YEAR OVER YEAR REDUCTION IN THE NUMBER OF PATIENT HANDLING INJURIES)*

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**Regional Annual Injury Total**

- **BHMC**: 20, 30, 32, 34
- **BHIP**: 2, 3, 5, 13
- **BHCS**: 2, 7, 10, 15
- **BHN**: 4, 8, 11, 14

**Percentage of All Injuries**

- 2013: 47%, 11%
- 2014: 44%, 12%
- 2015: 25%, 9%
- 2016: 29%, 8%
- 2017: 26%, 10%
- 2018: 26%, 7%
- 2019: 25%, 7%
- 2020: 30%, 7%

**Percentage of All Cost**

- 2013: 47%, 11%
- 2014: 44%, 12%
- 2015: 25%, 9%
- 2016: 29%, 8%
- 2017: 26%, 7%
- 2018: 26%, 7%
- 2019: 30%, 7%
- 2020: 30%, 7%
Analysis
When compared to calendar year 2019 in total, there is an optimistic downward (positive) trend in the number of injuries for calendar year 2020. During 2019, there were 72 compensable patient handling injuries reported by worker’s comp; year to date; 2019, 33 compensable injuries have been reported, reflecting a 54% reduction. Conversely, the organization is on target to exceed the compensable costs when compared to 2019. Through the first 9 months of calendar year 2020, the organization has incurred $413,604 for patient handling injuries as reported by Worker’s Comp, compared to all of calendar year 2019. The costs incurred per patient handling injury have increased by 49%, between calendar year 2019 and calendar year 2020, going from $6332 up to $12,533. A number of factor contribute to the cost increase, including but no limited to, severity of the injury, medical intervention required and cost of medical care.

The analyses also revealed that patient handling injuries represented 7% of all injuries during calendar year 2020, compared to 10% in 2019; a 3% decline. From a cost perspective, patient handling injuries represents 30% of the directly incurred injury costs in 2020, compared to 25% in 2019.

Action Plan:
The subgroup, which is comprised of the Michael Leopold, David Obrien, Michael Huempfner, Garnett Coke and a Nursing leader(s) will further analyze cost to identify actionable plans.
Finance

Analysis
Year to Date; CY2020, the organization continues to experience a downward (positive) trend in the number of compensable slip, trip and fall injuries. To date, there were 58 reported injuries, compared to 121 during calendar year 2019. The decrease in the total numbers reflect a 52% decline when compared to all of calendar year 2019. Additionally, when compared to calendar year 2019, the organization continues to experience a reduction in the cost directly incurred for compensable slip, trip and fall incidents. In calendar year 2019, the organization directly incurred $780,834 as reported by Worker’s Comp, compared to $3354,961 year to date; calendar year 2020; a 57% reduction.

Action Plan:
The Committee recommended a re-invigorated implementation of strategies that have been effective previously, in coordination with the marketing department.
ENVIRONMENT OF CARE PERFORMANCE REPORT –
(ACHIEVE 10% YEAR OVER YEAR REDUCTION IN THE NUMBER OF MISSING PATIENT’S PROPERTY)
Quality
KEY QUALITY DRIVER: Improve negatively performing trends

People
KEY PEOPLE DRIVER: Keep our employees and patients safe

Finance
KEY FINANCE DRIVER: Reduce the direct, indirect and total occupational injury cost

CHIEF OPERATING OFFICERS
OPPORTUNITIES & ACTION PLAN REPORT

BHMC – DAVID O’BRIEN
ANALYSES & ACTION PLAN:

During the reporting period (Q3CY20), the performance monitor related to OSHA Recordable Injury Rate negatively performed when compared to Threshold. Though the overall number of compensable injuries decreased by 8 (56 ↓ 48) resulting in a rate decreased by 3.82 (11.13 ↓ 7.31), the performance rate exceeded the threshold by 1.3.

When compared to Q2CY,2019, BHMC experienced increases in the number of struck-by and slip, fall incidents, while experience decreases in other incident categories, of special note, is the number of exposure injuries, where the hospital reduced the total from 24 in Q2 to 5 in Q3.
ANALYSES & ACTION PLAN:

During the reporting period (Q3CY20), the performance monitor related to Contaminated Needle Stick Rate negatively performed when compared to Threshold. The overall number of needlestick injuries decreased by 2 (16 ↓ 14) resulting in a rate decreased by 0.77 (3.29 ↓ 2.52). When compared to other Broward Health Regions, BHMC’s rate of contaminated needle stick is on par with two of the three sister hospitals.

BHMC Managers provides re-education and reviewed correct procedures to prevent injuries and Safety Officer had Smiths-Medical team return June and July for re-education on their blood collection devices. Additional rounding in August when in-servicing the new safety lancet device.
ANALYSES & ACTION PLAN:

During the reporting period (Q3CY20), the performance monitor related to the amount of biomedical waste generated setting negatively performed. During the period, BHMC generated 3,487 (82,919 ↓ 79,432) pounds less than the previous calendar quarter; however, the performance showed a rate increase of .13 0.09 (1.50 ↑ 1.63), resulting in a .3 negative rate performance.

The rate increase is directly attributable to the increased generation of pharmaceutical waste consistent with EPA regulations as well as the specific protocol established by the CDC for managing COVID-19 related waste.
ANALYSES & ACTION PLAN:

During the reporting period (Q2CY20), the performance monitor related to the amount of biomedical waste generated setting negatively performed. During the period, BHMC generated 3,487 (82919 ↓ 79432) pounds less than the previous calendar quarter; however, the rate, which compares the weight generated to the number of adjusted patient days exceeded the threshold by .3.

The analysis also shows that the cost of managing BHMC exceeded the contracted cost by $25,379.67. The increase in cost is directly associated with the increased generation of pharmaceutical waste consistent with EPA regulations.
Quality

KEY QUALITY DRIVER: Improve negatively performing trends

People

KEY PEOPLE DRIVER: Keep our employees and patients safe

Finance

KEY FINANCE DRIVER: Reduce the direct, indirect and total occupational injury cost
ANALYSES & ACTION PLAN:

During the reporting period (Q3CY20), the performance monitor related to Contaminated Needle Stick Rate negatively performed when compared to Threshold. The overall performance was negative for needle stick injuries with BHN experiencing a 40% (5 ↑ 7) increase. However, there was a 4.17 rate decrease in the number and rate of OSHA Recordable Injuries overall. BHN during the first quarter in 2020 experienced a performance rates below the established threshold. However, in the Q2 needle stick injuries dropped 50%, with only an increased of 2 incidents in Q3. When compared to other Broward Health Regions, BHN’s rate of contaminated needle stick remains on par with other sister hospitals.

Regional and organization-wide’ Managers provides re-education and reviews correct procedures to prevent needle stick injuries and Safety Officer continues to work with companies who provide needles to conduct additional educational in-services. The Safety Officer is also conducting accident prevention education during new employee orientation.
Quality
KEY QUALITY DRIVER: Improve negatively performing trends

People
KEY PEOPLE DRIVER: Keep our employees and patients safe

Finance
KEY FINANCE DRIVER: Reduce the direct, indirect and total occupational injury cost

REGIONAL ENVIRONMENT OF CARE OPPORTUNITIES & ACTION PLAN REPORT

BHCS – MICHAEL LEOPOLD
ANALYSES & ACTION PLAN:

During the reporting period (Q3CY20), the performance monitor related to OSHA Recordable Injury Rate negatively performed when compared to Threshold. Though the overall number of compensable injuries decreased by 1 (16 ↓ 15), resulting in a rate decreased by 2.15 (8.28 ↓ 6.13), the performance rate exceeded the threshold by .12.

When compared to Q2CY, 2019, BHCS experienced decreases in all incident categories, except Struck-By incidents, which increased by 2.
ANALYSES & ACTION PLAN:

During the reporting period (Q3CY20), the performance monitor related to Contaminated Needle Sticks negatively performed when compared to Threshold. BHCS experienced the same amount of contaminated needle sticks as they did in Q2CY’20 (6), at the same time, BHCS increased the number of calculable work hours from 386,359 to 489,283. As a result, BHCS experience a 0.86 reduction in the rate of injury when compared to the previous measurable period.

When compared to other Broward Health Regions, BHCS’ rate of contaminated needle stick is on par with two of the three sister hospitals.

The overall performance continues a show a negative performance trend in reducing the total number of contaminated needle stick injuries. BHCS will coordinate with the other hospitals to develop and implement strategic initiative to reduce the number and rate of contaminated needle sticks.
During the reporting period (Q3CY20), the performance monitor related to the amount of biomedical waste generated setting negatively performed. During the period, BHCS generated 7,767 (34,345 ↑ 42112 ) pounds more than the previous calendar quarter; resulting in a rate decrease of 0.09 (2.31 ↓ 2.22); however the performance exceeded the established threshold by 0.62

The increase in cost is directly associated with the increased generation of pharmaceutical waste consistent with EPA regulations as well as the specific protocol established by the CDC for managing COVID-19 related waste.
Quality

**KEY QUALITY DRIVER:** Improve negatively performing trends

People

**KEY PEOPLE DRIVER:** Keep our employees and patients safe

Finance

**KEY FINANCE DRIVER:** Reduce the direct, indirect and total occupational injury cost

REGIONAL ENVIRONMENT OF CARE OPPORTUNITIES & ACTION PLAN REPORT

BHIP– NETONUA “TONI” REYES
ANALYSES & ACTION PLAN:

During the reporting period (Q3CY20), the performance monitor related to OSHA Recordable Injury Rate negatively performed when compared to the threshold. BHIP experienced a 55% (22 ↑34) and a 7.0 rate increase in the number and rate of OSHA Recordable Injuries; however, BHIP continues to experience inconsistent performance rates that over the most recent 4 calendar quarters. The specific increase in rate and total numbers is directly attributable to occupational exposure to COVID-19.

The overall performance shows a positive performance in reducing the total number of injuries. BHIP will continue its reduction efforts through the exposure prevention, contaminated needle stick reduction and assault reduction initiatives.
ANALYSES & ACTION PLAN:

During the reporting period (Q3CY20), the performance monitor related to contaminated needle stick rate negatively performed when compared to the threshold. BHIP experienced a 100% (2 ↑4) increase in the number of injuries and a 1.11 (1.31 ↑2.42) rate increase; however, BHIP continues to experience inconsistent performance rates that over the most recent 4 calendar quarters.

The overall performance shows a positive performance in reducing the total number of injuries. BHIP will continue its reduction efforts through the exposure prevention, contaminated needle stick reduction and assault reduction initiatives.
7.7 SEPSIS PREVENTION
Comparative Report: Quality Performer-Wide for Proportion Measures
Facility: 11367
Interval of Analysis: Quarter
Discharge Dates: 01/01/2017 to 09/30/2020
Measure: SEP-1
Measure Description: Sepsis

Facility #11367  SEP-1: Sepsis

- Facility Rate
- 95th Percentile
- 90th Percentile
- 75th Percentile
- 50th Percentile
- 25th Percentile
Think. Treat. Stop Sepsis
Through A Multidisciplinary Team Approach

Evan Boyar, MD, Keith Foster, MD, Dana Cordero, Jesusa Alfonso, Tina Rodriguez, Joann Franklin, Raji Nair, Joseph Guastaferro, Mary Scott. Broward Health North Hospital, Deerfield Beach, Fl.

Aim
By June 30, 2020, Broward Health North’s SEP-1 Severe Sepsis and Septic Shock compliance will increase by 30%.

Measurement of Improvement
Sep-1 Severe Sepsis and Septic Shock Compliance rate equal to or above 70%.

Strategy for Change
At Broward Health North, we strive to provide quality care in a safe and compassionate environment. By increasing SEP-1 Severe Sepsis and Septic Shock compliance through a multidisciplinary team approach, we seek to improve patient outcome, increase patient satisfaction and foster inter-departmental collaboration.

Results
Our SEP-1 Severe Sepsis and Septic Shock compliance rate captured in the last CMS star rating report was 53% (National rate: 57%). The timeframe was from 1/18-2/18. The project started in January 2019 and our baseline compliance rate was 40%. Sustained improvement was observed starting July 2019. We have been above our target of 70% or greater for 14 consecutive months.

PDSA Cycle

CHANGE 1
Marketing shared efforts to help increase sepsis awareness. Marketing campaigns added to meeting discussions.

CHANGE 2
In addition to sepsis physician champion, more physicians in attendance. Medical staff shared valuable feedback. Added to meeting discussions.

CHANGE 3
Pharmacy Clinical Coordinator shared Antibiotic stewardship activities specific to sepsis patients. Added to meeting agenda.

CHANGE 4
Case Mgt. Clinical Coordinator shared findings from review of Sepsis readmission. Added to meeting agenda.

CHANGE 5
Registered Dietitian shared interventions specific to sepsis patients. Added to meeting agenda.

CHANGE 6
Quality Specialist shared review of PS 13 Postoperative sepsis rate. Added to meeting agenda.

Lessons Learned
1. Treating sepsis is a team sport, each discipline plays an integral role in the care of the sepsis patient.
2. Adding one discipline at a time, allowed the Sepsis committee to review each change independently.

Next Steps
1. Include representatives from the outpatient clinics to the sepsis committee meetings.
2. Designate a Critical Care RN sepsis champion.
3. Provide sepsis presentations to Broward County’s First Responders.
4. Systemwide sepsis committee focusing on enhancing the Electronic Health Record (EHR).
5. Emergency Department (ED) RN sepsis champion will attend sepsis committee meetings.

Sepsis Driver Diagram

Primary Drivers
- Sepsis Awareness
- Patient Safety
- Sepsis Drivers

Secondary Drivers
- ED RN sepsis champions to ensure compliance
- Multidisciplinary team approach

IT changes:
- Auto repeat for 3rd lactate acid if the 2nd lactate acid is > the 1st
- Template in place to use Ideal Body Weight in patients with BMI > 30
- SIRS Sepsis Alert for the pharmacist

Other existing processes prior to this project:
- ED sepsis alert flagged overhead & sepsis icon visible on the ED tracking board
- EHR: sepsis power plan and sepsis physician re-evaluation template
- Sepsis code activated in the ED and handed off to the next level of care
- Sepsis education class for embarking nurses
- SIRS sepsis alert in EHR
Facility #11366 SEP-1: Sepsis

Facility Rate
95th Percentile
90th Percentile
75th Percentile
50th Percentile
25th Percentile
# BROWARD HEALTH Q3 2020 INTERVENTIONS

<table>
<thead>
<tr>
<th>Intervention Type</th>
<th>All Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>De-escalation</td>
<td>381</td>
</tr>
<tr>
<td>Renal dosing adjustment*</td>
<td>3409</td>
</tr>
<tr>
<td>Bug-Drug mismatch</td>
<td>139</td>
</tr>
<tr>
<td>IV to PO conversion</td>
<td>1125</td>
</tr>
<tr>
<td>Therapeutic duplication#</td>
<td>223</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>3929</strong></td>
</tr>
</tbody>
</table>

*Includes ALL Renal Dose Adjustment  
# All medications
# BROWARD HEALTH PHARMACY
## ANTIMICROBIAL STEWARDSHIP

<table>
<thead>
<tr>
<th>Intervention Type</th>
<th>YTD Total</th>
<th>3&lt;sup&gt;rd&lt;/sup&gt; Quarter</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; Quarter</th>
<th>1&lt;sup&gt;st&lt;/sup&gt; Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>De-escalation</td>
<td>913</td>
<td>381</td>
<td>157</td>
<td>375</td>
</tr>
<tr>
<td>Renal dosing adjustment*</td>
<td>7178</td>
<td>3409</td>
<td>2265</td>
<td>1504</td>
</tr>
<tr>
<td>Bug-Drug mismatch</td>
<td>389</td>
<td>139</td>
<td>59</td>
<td>191</td>
</tr>
<tr>
<td>IV to PO conversion*</td>
<td>2168</td>
<td>1125</td>
<td>296</td>
<td>747</td>
</tr>
<tr>
<td>Therapeutic duplication#</td>
<td>726</td>
<td>223</td>
<td>102</td>
<td>401</td>
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<tr>
<td>Totals</td>
<td>10026</td>
<td>3929</td>
<td>2879</td>
<td>3218</td>
</tr>
</tbody>
</table>

*Includes all adjustments
*All IV to Enteral interventions
<table>
<thead>
<tr>
<th>3rd Quarter Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cefazolin desensitization Power Plan</td>
</tr>
<tr>
<td>COVID-19 Power plan implementation</td>
</tr>
<tr>
<td>Penicillin desensitization Power Plan</td>
</tr>
<tr>
<td>Minimum Inhibitory Concentration (MIC) Pocket Cards</td>
</tr>
<tr>
<td>Impact of a pharmacy-driven procalcitonin protocol on duration of antimicrobial therapy study</td>
</tr>
<tr>
<td>Antibiotics Renal Adjustment Pocket Cards</td>
</tr>
<tr>
<td>Formulary streamline: Removal of nitazoxanide</td>
</tr>
</tbody>
</table>
7.9 INFECTION PREVENTION
CLABSI ~ ALL REPORTING UNITS

BHMC NHSN - CLABSI
SIR ~ All Reporting Units
CY 2020
Threshold 0.687
Benchmark 0

BHN NHSN - CLABSI
SIR ~ All Reporting Units
CY 2020
Threshold 0.687
Benchmark 0

BHIP NHSN - CLABSI
SIR ~ All Reporting Units
CY 2020
Threshold 0.687
Benchmark 0

BHCS NHSN - CLABSI
SIR ~ All Reporting Units
CY 2020
Threshold 0.687
Benchmark 0
CLABSI ~ PEDIATRIC

BHMC NHSN - CLABSI
SIR ~ Pediatric (incl. NICU, PICU, Peds)
CY 2020

BHCS NHSN - CLABSI
SIR ~ Pediatric (incl. NICU, PICU, Peds)
CY 2020
CAUTI ~ ALL REPORTING UNITS

BHMC NHSN - CAUTI
SIR ~ All Reporting Units
CY 2020

Threshold 0.774
Benchmark 0

Infections  SIR  Threshold

Jan  Feb  Mar  Apr  May  Jun  Jul  Aug  Sep  Oct  Nov  Dec  Total YTD

BHIP NHSN - CAUTI
SIR ~ All Reporting Units
CY 2020

Threshold 0.774
Benchmark 0

Infections  SIR  Threshold

Jan  Feb  Mar  Apr  May  Jun  Jul  Aug  Sep  Oct  Nov  Dec  Total YTD

BHN NHSN - CAUTI
SIR ~ All Reporting Units
CY 2020

Threshold 0.774
Benchmark 0

Infections  SIR  Threshold

Jan  Feb  Mar  Apr  May  Jun  Jul  Aug  Sep  Oct  Nov  Dec  Total YTD

BHCS NHSN - CAUTI
SIR ~ All Reporting Units
CY 2020

Threshold 0.774
Benchmark 0

Infections  SIR  Threshold

Jan  Feb  Mar  Apr  May  Jun  Jul  Aug  Sep  Oct  Nov  Dec  Total YTD
HOSPITAL-ONSET MRSA BACTEREMIA
HYSTERECTOMY SSI

BHMC NHSN - Hysterectomy SSI
SIR ~ CY 2020
Threshold 0.722
Benchmark 0

BHN NHSN - Hysterectomy SSI
SIR ~ CY 2020
Threshold 0.722
Benchmark 0

BHCS NHSN - Hysterectomy SSI
SIR ~ CY 2020
Threshold 0.722
Benchmark 0

BHIP NHSN - Hysterectomy SSI
SIR ~ CY 2020
Threshold 0.722
Benchmark 0
7.10 HOSPITAL ACQUIRED PRESSURE INJURY
7.11 GRIEVANCES
COMPLAINTS & GRIEVANCES

• All Grievances follow policy GA 001-010 Complaint/Grievance Management

• Monthly Grievance Committee meetings represented by Customer Service Manager, Administration and Quality
Q3 2020 BHCS CAPTURED COMPLAINTS & GRIEVANCES

- Attitude/Respect, 24, 23%
- Delay/process/financial issues, 22, 21%
- Appropriateness of Care/Instructions, 14, 14%
- Communication, 29, 28%
- Safety Issues/Concerns, 8, 8%
- Skill of Staff, 5, 5%
- Environment/Nutrition al, 8, 8%
- Safety Issues/Concerns, 5, 5%
Q3 2020 BHN CAPTURED COMPLAINTS & GRIEVANCES

- Attitude/Respect, 5, 13%
- Delay/process/financial issues, 9, 23%
- Appropriateness of Care/Instructions, 7, 18%
- Communication, 8, 20%
- Environment/Nutrition al, 2, 5%
- Safety Issues/Concerns, 6, 15%
- Responsiveness, 1, 3%
- Skill of Staff, 1, 3%

98
Q3 2020 BHMC CAPTURED COMPLAINTS & GRIEVANCES

- Safety Issues/Concerns, 16
- Appropriateness of Care/Instructions, 12
- Attitude/Respect, 11
- Communication, 7
- Environment/Nutritional, 4
- Responsiveness, 1
- Delay/process/financial issues, 2
- Skill of Staff, 4
Q3 2020 BHIP CAPTURED COMPLAINTS & GRIEVANCES

- Communication: 22%
- Safety Issues/Concerns: 19%
- Appropriateness of Care/Instructions: 18%
- Attitude/Respect: 19%
- Delay/process/financial issues: 11%
- Skill of Staff: 4%
- Environment/Nutritional: 7%
7.12 RISK MANAGEMENT REGIONAL REPORTS

A1. BHMC       Q2 2020
B1. BHN        Q2 2020
C1. BHIP       Q2 2020
D1. BHCS       Q2 2020
E1. BH AMB     Q2 2020
### Occurrence Category CY20

<table>
<thead>
<tr>
<th>Category</th>
<th>Q3</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADR</td>
<td>2</td>
<td>0.16%</td>
</tr>
<tr>
<td>Delay</td>
<td>40</td>
<td>3.10%</td>
</tr>
<tr>
<td>Falls</td>
<td>90</td>
<td>6.98%</td>
</tr>
<tr>
<td>HIPAA PHI</td>
<td>8</td>
<td>0.62%</td>
</tr>
<tr>
<td>Infection Control</td>
<td>15</td>
<td>1.16%</td>
</tr>
<tr>
<td>Lab</td>
<td>33</td>
<td>2.56%</td>
</tr>
<tr>
<td>Medication Variance</td>
<td>49</td>
<td>3.80%</td>
</tr>
<tr>
<td>OB/Delivery</td>
<td>71</td>
<td>5.74%</td>
</tr>
<tr>
<td>Patient Care Issues</td>
<td>410</td>
<td>31.63%</td>
</tr>
<tr>
<td>Patient Rights</td>
<td>3</td>
<td>0.23%</td>
</tr>
<tr>
<td>PPID</td>
<td>5</td>
<td>0.39%</td>
</tr>
<tr>
<td>Safety</td>
<td>45</td>
<td>3.49%</td>
</tr>
<tr>
<td>Security</td>
<td>463</td>
<td>35.89%</td>
</tr>
<tr>
<td>Skin and Wound</td>
<td>21</td>
<td>1.55%</td>
</tr>
<tr>
<td>Surgery Issues</td>
<td>35</td>
<td>2.71%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1290</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

### Inpatient Falls by Category CY20

<table>
<thead>
<tr>
<th>Category</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eased to floor by employee</td>
<td>5</td>
</tr>
<tr>
<td>Found on floor</td>
<td>25</td>
</tr>
<tr>
<td>From bed</td>
<td>8</td>
</tr>
<tr>
<td>From chair</td>
<td>1</td>
</tr>
<tr>
<td>From equipment, i.e stretcher, table, etc.</td>
<td>1</td>
</tr>
<tr>
<td>From Toilet</td>
<td>3</td>
</tr>
<tr>
<td>Patient States</td>
<td>3</td>
</tr>
<tr>
<td>Slip</td>
<td>4</td>
</tr>
<tr>
<td>Trip</td>
<td>1</td>
</tr>
<tr>
<td>While ambulating</td>
<td>3</td>
</tr>
<tr>
<td>FALLS Total</td>
<td>54</td>
</tr>
</tbody>
</table>

### OB DELIVERY CY20

<table>
<thead>
<tr>
<th>Category</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fetal Distress</td>
<td>1</td>
</tr>
<tr>
<td>Fetal/Maternal Demise</td>
<td>2</td>
</tr>
<tr>
<td>Maternal complications</td>
<td>2</td>
</tr>
<tr>
<td>Maternal Transfer To Higher Level Of Care</td>
<td>3</td>
</tr>
<tr>
<td>Neonatal complications - Admit NICU</td>
<td>34</td>
</tr>
<tr>
<td>Neonatal complications - IV Infiltrate</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
</tr>
<tr>
<td>Postpartum Hemorrhage</td>
<td>8</td>
</tr>
<tr>
<td>Return To Ldr (Labor Delivery Room)</td>
<td>2</td>
</tr>
<tr>
<td>RN Attended Delivery</td>
<td>4</td>
</tr>
<tr>
<td>Shoulder Dystocia</td>
<td>7</td>
</tr>
<tr>
<td>Unplanned Procedure</td>
<td>1</td>
</tr>
<tr>
<td>OB DELIVERY Total</td>
<td>71</td>
</tr>
</tbody>
</table>

### HAPIs CY20

<table>
<thead>
<tr>
<th>Category</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Injury - Acquired</td>
<td>4</td>
</tr>
</tbody>
</table>
MEDICATION VARIANCES CY20: Q3

<table>
<thead>
<tr>
<th>Issue</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraindication</td>
<td>3</td>
</tr>
<tr>
<td>Control Drug Discrepancy Investigation</td>
<td>1</td>
</tr>
<tr>
<td>Control Drug Discrepancy-count</td>
<td>4</td>
</tr>
<tr>
<td>Control Drug Diversion/Suspicion</td>
<td>2</td>
</tr>
<tr>
<td>Delayed dose</td>
<td>3</td>
</tr>
<tr>
<td>Labeling Error</td>
<td>1</td>
</tr>
<tr>
<td>Missing/Lost Medication</td>
<td>1</td>
</tr>
<tr>
<td>Omitted dose</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
<tr>
<td>Prescriber Error</td>
<td>2</td>
</tr>
<tr>
<td>Reconciliation</td>
<td>1</td>
</tr>
<tr>
<td>Unsecured Medication</td>
<td>1</td>
</tr>
<tr>
<td>Wrong Concentration</td>
<td>1</td>
</tr>
<tr>
<td>Wrong dosage form</td>
<td>3</td>
</tr>
<tr>
<td>Wrong dose</td>
<td>5</td>
</tr>
<tr>
<td>Wrong Drug or IV Fluid</td>
<td>3</td>
</tr>
<tr>
<td>Wrong frequency or rate</td>
<td>5</td>
</tr>
<tr>
<td>Wrong patient</td>
<td>1</td>
</tr>
<tr>
<td>Wrong time</td>
<td>1</td>
</tr>
<tr>
<td>MEDICATION Total</td>
<td>49</td>
</tr>
</tbody>
</table>

ADR CY20: Q3

<table>
<thead>
<tr>
<th>Issue</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>2</td>
</tr>
</tbody>
</table>

ADR CY20:

No adverse event. No trends identified.

SURGERY RELATED ISSUES CY20: Q3

<table>
<thead>
<tr>
<th>Issue</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent Issues</td>
<td>4</td>
</tr>
<tr>
<td>Extubation/Intubation</td>
<td>1</td>
</tr>
<tr>
<td>Puncture or Laceration</td>
<td>3</td>
</tr>
<tr>
<td>Sponge/Needle/Instrument Issues</td>
<td>3</td>
</tr>
<tr>
<td>Sterile field contaminated</td>
<td>5</td>
</tr>
<tr>
<td>Surgical Count</td>
<td>10</td>
</tr>
<tr>
<td>Surgery Delay</td>
<td>1</td>
</tr>
<tr>
<td>Surgery/Procedure-Cancelled</td>
<td>1</td>
</tr>
<tr>
<td>Surgical Complication</td>
<td>5</td>
</tr>
<tr>
<td>Unplanned Surgery</td>
<td>2</td>
</tr>
</tbody>
</table>

SURGERY RELATED ISSUES CY20:

All surgical count related issues came back with negative x-ray results. All consent issues were addressed real time - of those 1 received verbal consent from the patients and 2 were emergent procedures.

SECURITY CY20: Q3

<table>
<thead>
<tr>
<th>Issue</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access control</td>
<td>1</td>
</tr>
<tr>
<td>Aggressive behavior</td>
<td>21</td>
</tr>
<tr>
<td>Arrest</td>
<td>1</td>
</tr>
<tr>
<td>Assault/Battery</td>
<td>33</td>
</tr>
<tr>
<td>Code Assist</td>
<td>137</td>
</tr>
<tr>
<td>Code Elopedent</td>
<td>12</td>
</tr>
<tr>
<td>Contraband</td>
<td>26</td>
</tr>
<tr>
<td>Criminal Event</td>
<td>1</td>
</tr>
<tr>
<td>Property Damaged/Missing</td>
<td>26</td>
</tr>
<tr>
<td>Rapid Response Team - Visitor</td>
<td>2</td>
</tr>
<tr>
<td>Security Presence Requested</td>
<td>200</td>
</tr>
<tr>
<td>Vehicle Accident</td>
<td>1</td>
</tr>
<tr>
<td>Verbal Abuse</td>
<td>2</td>
</tr>
</tbody>
</table>

SECURITY CY20:

11.03% increase in security reporting from 417– Q2 CY20 to 463– Q3 CY20. 41.46% of all security incidents are related to our Behavior Health Population.

On going efforts to address property related issues. New policies and procedures have been established and education will be completed and implemented in December.

Actually number of assaults is 25 as 9 incidents are duplicates. IST team continues to follow up with staff who have been injured by
SAFETY CY20

<table>
<thead>
<tr>
<th>Safety Event</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biohazard Exposure</td>
<td>2</td>
</tr>
<tr>
<td>Code Red</td>
<td>13</td>
</tr>
<tr>
<td>Elevator entrapment</td>
<td>1</td>
</tr>
<tr>
<td>Safety Hazard</td>
<td>20</td>
</tr>
<tr>
<td>Sharps Exposure</td>
<td>9</td>
</tr>
<tr>
<td>SAFETY Total</td>
<td>45</td>
</tr>
</tbody>
</table>

SAFETY CY20:

10% decrease in Safety reporting from 50–Q2 CY20 to 45–Q3 CY20. Only 2 Code red events were actual events, all other incidents were either moisture or construction related.

One incident was related to an employee heating up food in a plastic tupperware causing it to smoke and the other was related to a fire coming from construction waste bin.

REGIONAL RISK MANAGEMENT SECTION: (MAY INCLUDE PERFORMANCE IMPROVEMENT INITIATIVES, SERIOUS INCIDENTS, AHCA ANNUAL REPORTABLE EVENTS, CODE 15 REPORTS, AND/OR INTENSE ANALYSIS/RCAs COMPLETED, ETC.)

PATIENT FALL FROM OR TABLE:

Patient FIN# 106116369 who is a 67 y/o female presented on 10/12/2020 for a left total hip replacement, anterior approach by Dr. Chenard. She had a history of a L knee arthroplasty followed by a surgical site infection in that leg in 2018. After IV antibiotic treatment, she developed possible Redman Syndrome and was admitted to BHN. Other hx includes asthma, anxiety, increased BMI, depression, arthritis, previous R. hip surgery, and tonsil and adenoid surgery.

The patient, after completion of the surgery, fell off the table while being prepared to be taken off the CT table. C-spine control was obtained, the patient remained intubated with adequate airway protection, and Dr. Otmezguine took control of the situation and log rolled her. He obtained x-rays and pan CT scan. The patient did suffer a hip dislocation that Dr. Chenard reduced. After CT results were obtained and all were negative, the patient was awakened from anesthesia and transferred to S4trium. The patient was discharged 10/14/2020.
OCCURRENCE CATEGORY CY20:
Increase in occurrence variance reports from 699 in Q2 to 961 in Q3, reflecting a 37% increase.

During the second quarter, the Covid-19 pandemic continued and elective surgeries were canceled, resulting in a decreased census. In Q3, elective surgeries resumed and census increased.
The overall Near Miss Occurrences during the 3rd Quarter CY 20 were 28, or 3% of overall occurrences.
The goal continues to be increased reporting to discern trends in order to implement risk reduction measures.

INPATIENT FALLS BY CATEGORY CY20:
(Does not include Fall near misses).
48 falls in CY20Q3 compared to 28 in CY20Q2, a 71% increase. Rate of 2.4 with a benchmark of 2.61 (YTD 1.9).
Two patient injuries - one femoral fracture and one nasal bone fracture.
BHN has transitioned from discussing falls during the monthly Nurse Leadership Harm meeting to a stand-alone committee consisting of a multidisciplinary team to investigate and implement risk reduction measures.

HAPIS CY20: Increase from 5 HAPIS in Q2 to 7 in Q3.
Rate 0.39. Four out of seven occurred in ICU settings and two in the trauma unit. Increase in medical device-related pressure injuries due to number of patients on vents and in prone position.
Education provided to SWAT team and management on prevention techniques.

MEDICATION VARIANCES CY20:
Near miss 2 vs Actual 34 (total 36).
1 of 3

<table>
<thead>
<tr>
<th>Occurrence Category CY20</th>
<th>Q3</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADR</td>
<td>5</td>
<td>0.52%</td>
</tr>
<tr>
<td>DELAY</td>
<td>33</td>
<td>3.43%</td>
</tr>
<tr>
<td>FALL</td>
<td>66</td>
<td>6.87%</td>
</tr>
<tr>
<td>HIPAA/PHI</td>
<td>8</td>
<td>0.83%</td>
</tr>
<tr>
<td>INFECTION</td>
<td>5</td>
<td>0.52%</td>
</tr>
<tr>
<td>LAB</td>
<td>10</td>
<td>1.04%</td>
</tr>
<tr>
<td>MEDICATION</td>
<td>36</td>
<td>3.75%</td>
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<tr>
<td>PATCARE</td>
<td>333</td>
<td>34.65%</td>
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<tr>
<td>PATRIGHT</td>
<td>1</td>
<td>0.10%</td>
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<tr>
<td>PPI</td>
<td>6</td>
<td>0.62%</td>
</tr>
<tr>
<td>SAFETY</td>
<td>10</td>
<td>1.04%</td>
</tr>
<tr>
<td>SECURITY</td>
<td>327</td>
<td>34.03%</td>
</tr>
<tr>
<td>SKINWOUND</td>
<td>104</td>
<td>10.82%</td>
</tr>
<tr>
<td>SURGERY</td>
<td>17</td>
<td>1.77%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>961</td>
<td>100.00%</td>
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<table>
<thead>
<tr>
<th>Inpatient Falls by Category CY20</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eased to Floor by Employee</td>
<td>6</td>
</tr>
<tr>
<td>Found on Floor</td>
<td>33</td>
</tr>
<tr>
<td>From Bed</td>
<td>5</td>
</tr>
<tr>
<td>From Chair</td>
<td>1</td>
</tr>
<tr>
<td>While Ambulating</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
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<table>
<thead>
<tr>
<th>HAPIs CY20</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 2</td>
<td>1</td>
</tr>
<tr>
<td>DTI</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICATION VARIANCES CY20</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

105
RISK MANAGEMENT QUARTERLY REPORT QUARTER 3

**Contraindication** 2
**Control Drug Discrepancy-count** 1
**Delayed dose** 7
**Extra Dose** 3
**Missing/Lost Medication** 1
**Omitted dose** 8
**Other** 4
**Prescriber Error** 1
**Unsecured Medication** 1
**Wrong dose** 1
**Wrong Drug or IV Fluid** 3
**Wrong frequency or rate** 2
**Wrong time** 2
**Total** 36

**ADR CY20**

<table>
<thead>
<tr>
<th>Category</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>2</td>
</tr>
<tr>
<td>Cardiopulmonary</td>
<td>1</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5</td>
</tr>
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</table>

**SURGERY RELATED ISSUES CY20**

<table>
<thead>
<tr>
<th>Category</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia Complication</td>
<td>1</td>
</tr>
<tr>
<td>Consent Issues</td>
<td>3</td>
</tr>
<tr>
<td>Extubation/Intubation</td>
<td>2</td>
</tr>
<tr>
<td>Puncture or Laceration</td>
<td>1</td>
</tr>
<tr>
<td>Sponge/Needle/Instrument Issues</td>
<td>1</td>
</tr>
<tr>
<td>Sterile field contaminated</td>
<td>1</td>
</tr>
<tr>
<td>Surgical Count</td>
<td>1</td>
</tr>
<tr>
<td>Surgery Delay</td>
<td>2</td>
</tr>
<tr>
<td>Surgery/Procedure Cancelled</td>
<td>1</td>
</tr>
<tr>
<td>Surgical Complication</td>
<td>2</td>
</tr>
<tr>
<td>Unplanned Return to OR</td>
<td>2</td>
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<tr>
<td><strong>Total</strong></td>
<td>17</td>
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**SECURITY CY20**

<table>
<thead>
<tr>
<th>Category</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access control</td>
<td>2</td>
</tr>
<tr>
<td>Aggressive behavior</td>
<td>9</td>
</tr>
<tr>
<td>Assault/Battery</td>
<td>8</td>
</tr>
<tr>
<td>Code Assist</td>
<td>138</td>
</tr>
<tr>
<td>Code Elopement</td>
<td>19</td>
</tr>
<tr>
<td>Contraband</td>
<td>25</td>
</tr>
<tr>
<td>Criminal Event</td>
<td>1</td>
</tr>
<tr>
<td>Property Damaged/Missing</td>
<td>36</td>
</tr>
<tr>
<td>Security Presence Requested</td>
<td>80</td>
</tr>
<tr>
<td>Smoking Issues</td>
<td>3</td>
</tr>
<tr>
<td>Threat of violence</td>
<td>4</td>
</tr>
<tr>
<td>Trespass</td>
<td>1</td>
</tr>
<tr>
<td>Verbal Abuse</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>327</td>
</tr>
</tbody>
</table>

**MEDICATION VARIANCES CY20:**
Near miss 2 vs Actual 34 (total 36).
Rate of 0.01%. No Adverse Outcomes/Trends.
Increase in medication variances by 100% from 17 to 34.
Increase in HAS amount consistent with trend of increased reports overall. Risk, nursing, and administration collaborate monthly to discuss medication variances, trends, and lessons learned from medication variances. Lessons learned now created into videos produced and starred in by pharmacy staff and sent out to all BHN in CEO newsletter as well as played on tv outside of main hospital elevators.

**SURGERY RELATED ISSUES CY20:**
17 Surgical-related issues (15 actual vs 2 near miss). Increase by 42% since quarter 2, likely related to increase in elective procedures since Covid surgical restriction lifted. No trends identified. One surgical complication due to burn from drill, which was removed and checked by rep. Second complication related to hematoma formation post thyroid/parathyroidectomy; informed consent complete including bleeding and related procedures. One unplanned return to OR related to puncture enteroctomy from VP shunt placement; informed consent complete. Second unplanned return to OR related to migration of surgical screw, a known risk of procedure. Informed consent complete.

**SECURITY CY20:**
Increase in security occurrences from 210 in Q2 to 327 in Q3, reflecting a 56% increase. Code Assists increased from 87 to 138 (59% increase). Security presence requested increased from 42 to 80, a 90% increase. Majority of the Code Assists were caused by aggressive/disruptive patients, patient confusion, and agitated/noncompliant patients. No other trends identified.

**ADR CY20:** 5 ADRs with a rate of 0.02.
### RISK MANAGEMENT QUARTERLY REPORT QUARTER 3

<table>
<thead>
<tr>
<th>Electrical Hazard</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Hazard</td>
<td>8</td>
</tr>
<tr>
<td>Sharps Exposure</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

- **Safety Hazard CY20:** Increase in safety occurrences from 5 in Q2 to 10 in Q3. Two near misses vs 8 actual. One electrical hazard involving a damaged light switch resulting in the breaker tripping. Light switch was replaced, proper operation verified and no damage. No trends noted in the safety hazards.

### REGIONAL RISK MANAGEMENT SECTION:

**Per AHCA Annual Reportable Events, Code 15 Reports, and/OR Intense Analysis/RCA’s Completed, etc.**

1. 82 y/o male transferred to BHN from another BH hospital several hours after confirmation of Brain Attack and a acceptance by BHN.
   - **Opportunity:** Timeliness of obtaining a medical attending.
   - **Actions:** Admit a transferred Brain Attack patient to Neuro Interventionalist in order to expedite procedure until confirming admitting physician for Priority One Transfers.

2. 76 y/o female presented to BHN with upper extremity weakness CT Brain confirmed Brain Attack on-call Neuro Interventionalist currently in procedure at BHN. Neuro Interventionalist at BHMC directed patient be transferred to BHMC.
   - **Opportunity:** Non-compliance with Comprehensive Stroke Center requirements caring for concurrent Brain Attacks.
   - **Actions:** Policy/Algorithm developed Corporate-wide on triaging and managing simultaneous Brain Attacks.

3. 28 y/o female with Hx Diabetes, Gastroparesis, Depression, Anxiety and prior Suicide Attempt sustained a self-inflicted injury neck and wrist laceration (non-life threatening) while in care of BHN.
   - **Opportunity:** Patient entered hospital with weapons in her possession (switchblades)
   - **Actions:** Consideration for wanding patient’s belongings in ED and questioning whether they are in possession of any weapons.

4. 57 y/o male presented to ED with open ankle fracture S/P fall at home while intoxicated. Patient underwent repair of ankle fracture/dislocation Morphine ordered for pain control initially effective subsequently ineffective and a 1x order for breakthrough pain provided Dilauidid 2mg and a Pain Consult. 18 minutes following administration pt resting comfortably in bed denies pain. Approximately 45 minutes later pt found unresponsive Code Blue ROSC achieved Anoxic Brain Injury subsequently Dx.
   - **Opportunity:** To take into consideration opiate naïve patients potential reaction to narcotics specifically respiratory suppression also consideration for obstructive sleep apnea based on patient’s body habitus.
   - **Actions:** Pharmacy replaced Dilauidid 2mg doses with 1 mg (2mg no longer orderable, system-wide initiative) Incorporate STOP-Bang assessment to assess for underlying OSA for all patients system-wide with alerts/orders/etc.

In an abundance of caution case reported to AHCA as a Code 15 as other potential contributory factors such as a potential pulmonary embolus per chart review.
### Occurrence Category CY20

<table>
<thead>
<tr>
<th>Category</th>
<th>Q3</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care Issues</td>
<td>356</td>
<td>45%</td>
</tr>
<tr>
<td>Security</td>
<td>268</td>
<td>34%</td>
</tr>
<tr>
<td>Delay</td>
<td>39</td>
<td>5%</td>
</tr>
<tr>
<td>Falls</td>
<td>30</td>
<td>4%</td>
</tr>
<tr>
<td>Safety</td>
<td>22</td>
<td>3%</td>
</tr>
<tr>
<td>Surgery Issues</td>
<td>16</td>
<td>2%</td>
</tr>
<tr>
<td>Adverse Drug Reaction</td>
<td>12</td>
<td>2%</td>
</tr>
<tr>
<td>Lab</td>
<td>11</td>
<td>1%</td>
</tr>
<tr>
<td>Medication Variance</td>
<td>10</td>
<td>1%</td>
</tr>
<tr>
<td>Skin &amp; Wound</td>
<td>9</td>
<td>1%</td>
</tr>
<tr>
<td>Infection Control</td>
<td>8</td>
<td>1%</td>
</tr>
<tr>
<td>Patient ID</td>
<td>4</td>
<td>1%</td>
</tr>
<tr>
<td>HIPAA PHI</td>
<td>3</td>
<td>0%</td>
</tr>
<tr>
<td>Patient Rights</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>789</td>
<td>100%</td>
</tr>
</tbody>
</table>

The total number of reported incidents increased by 30% compared to last quarter. Categorized by risk severity we had a total of 701 level 1, 68 level 2, and 19 level 3 and 1 level 4 incidents reported and investigated. The increase in incident reporting signifies a proactive risk management program.

### Inpatient Falls by Category CY20

<table>
<thead>
<tr>
<th>Category</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Found on floor</td>
<td>7</td>
</tr>
<tr>
<td>From Bed</td>
<td>5</td>
</tr>
<tr>
<td>Patient States</td>
<td>4</td>
</tr>
<tr>
<td>While ambulating</td>
<td>3</td>
</tr>
<tr>
<td>Slip</td>
<td>1</td>
</tr>
<tr>
<td>From Toilet</td>
<td>1</td>
</tr>
<tr>
<td>Eased to floor by employee</td>
<td>1</td>
</tr>
<tr>
<td>From Bedside Commode</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>23</td>
</tr>
</tbody>
</table>

We had an increase of 27% in inpatient falls. There were 3 falls with injury out of a total of 23 falls for the quarter. Out of those 3 falls, 1 of them were level 4 or greater.

### HAPIS CY20

<table>
<thead>
<tr>
<th>Category</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decubitus – Stage II</td>
<td>3</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>3</td>
</tr>
</tbody>
</table>

There were no changes in the number of HAPI events compared to Q2.

### Medication Variances CY20

<table>
<thead>
<tr>
<th>Variance</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Drug Discrepancy-count</td>
<td>1</td>
</tr>
<tr>
<td>Control Drug Diversion/Suspicion</td>
<td>1</td>
</tr>
<tr>
<td>CPOE issue</td>
<td>1</td>
</tr>
<tr>
<td>Hoarding Medications For Later Use</td>
<td>1</td>
</tr>
<tr>
<td>Omitted dose</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>Prescriber Error</td>
<td>1</td>
</tr>
<tr>
<td>Scan Failed</td>
<td>1</td>
</tr>
<tr>
<td>Unordered Drug</td>
<td>1</td>
</tr>
<tr>
<td>Wrong Drug or IV Fluid</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>10</td>
</tr>
</tbody>
</table>
ADR CY20

<table>
<thead>
<tr>
<th>Category</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>9</td>
</tr>
<tr>
<td>Cardiopulmonary</td>
<td>1</td>
</tr>
<tr>
<td>Dermatological</td>
<td>1</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
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SURGERY RELATED ISSUES CY20

<table>
<thead>
<tr>
<th>Issue</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Complication</td>
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</tr>
<tr>
<td>Unplanned Return to OR</td>
<td>4</td>
</tr>
<tr>
<td>Surgery/Procedure Cancelled</td>
<td>2</td>
</tr>
<tr>
<td>Surgical Count</td>
<td>2</td>
</tr>
<tr>
<td>Surgery Delay</td>
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</tr>
<tr>
<td>Consent Issues</td>
<td>1</td>
</tr>
<tr>
<td>Anesthesia Complication</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
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</table>

SECURITY CY20

<table>
<thead>
<tr>
<th>Issue</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security Presence Requested</td>
<td>133</td>
</tr>
<tr>
<td>Code Assist</td>
<td>78</td>
</tr>
<tr>
<td>Aggressive behavior</td>
<td>19</td>
</tr>
<tr>
<td>Contraband</td>
<td>12</td>
</tr>
<tr>
<td>Property Damaged/Missing</td>
<td>8</td>
</tr>
<tr>
<td>Assault/Battery</td>
<td>4</td>
</tr>
<tr>
<td>Code Strong</td>
<td>3</td>
</tr>
<tr>
<td>Threat of violence</td>
<td>3</td>
</tr>
<tr>
<td>Code Elopement</td>
<td>3</td>
</tr>
<tr>
<td>Verbal Abuse</td>
<td>2</td>
</tr>
<tr>
<td>Vehicle Accident</td>
<td>1</td>
</tr>
<tr>
<td>Trespass</td>
<td>1</td>
</tr>
<tr>
<td>Criminal Event</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>268</strong></td>
</tr>
</tbody>
</table>

SAFETY CY20

<table>
<thead>
<tr>
<th>Issue</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Hazard</td>
<td>15</td>
</tr>
<tr>
<td>Sharps Exposure</td>
<td>2</td>
</tr>
<tr>
<td>False Alarm</td>
<td>2</td>
</tr>
<tr>
<td>Code Red</td>
<td>1</td>
</tr>
<tr>
<td>Biohazard Exposure</td>
<td>1</td>
</tr>
<tr>
<td>Elevator entrapment</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

ADR CY20: No significant trends identified.

SURGERY RELATED ISSUES CY20: Cancelled Surgeries and Unplanned Return to ORs are tracked and trend by Quality.

SECURITY CY20: For Q3, security presence required is a new HAS sub category introduced. Security Presence Required events preceed calling code assist events.

SAFETY CY20: There has been a 15% decrease in safety events compared to last quarter.
No AHCA Reportable Annual events for Q 3 2020.

No Code 15 Reportable events for Q3 2020.
OCCURRENCE CATEGORY CY20:

During the 3rd Quarter, there were a total of 333 Occurrence Variance Reports compared for 287 for 2nd Quarter 2020. This reflects an increase by 46 or 7.42% for Q3 CY2020.

P.S: Due to updated Late OVRs, the updated Occurrence Variance Reports for 2nd Quarter 2020 was increased from 287 to 292 (OB increased by 1, PPID increased by 3 and Security increased by 1). This reflects an updated increase by 6.56% for Q3 CY2020.

INPATIENT FALLS BY CATEGORY CY20:

The total Inpatient falls for 3rd Quarter CY 2020 were 37. This reflects an increase by 14 resulting in 23.33% from 23 reported in Q2 CY 2020. There were 8 MINOR injuries, 2 MAJOR injuries and 2 NO injuries. Of the 2 MAJOR injures, 1 patient sustained hematoma of the right psoas muscle and the other patient sustained a fracture of the right shoulder. An Intense Analysis was conducted on the shoulder fracture incident and it was determined that the fall was unavoidable.

OB DELIVERY CY20:

During this Quarter there were 14 reported occurrences, which reflects no change from Q2 2020.

For delays greater than 30 minutes, a referral is sent to Quality.

Maternal complications are referred and reviewed by Quality Management/Peer Review for Quality of Care Concerns.

HAPIS CY20:

There were no changes in the number of HAPIs reported in Q3 and Q2 of CY 2020.

During Q3, 1 HAPI occurred on 4N and 1 on 3ST.
**MEDICATION VARIANCES CY20**

<table>
<thead>
<tr>
<th>Category</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Drug Charting</td>
<td>3</td>
</tr>
<tr>
<td>Control Drug Diversion/Suspicion</td>
<td>2</td>
</tr>
<tr>
<td>Delayed Dose</td>
<td>2</td>
</tr>
<tr>
<td>Extra Dose</td>
<td>1</td>
</tr>
<tr>
<td>Labeling Error</td>
<td>1</td>
</tr>
<tr>
<td>Missing/Lost Medication</td>
<td>1</td>
</tr>
<tr>
<td>Omitted Dose</td>
<td>2</td>
</tr>
<tr>
<td>Prescriber Error</td>
<td>2</td>
</tr>
<tr>
<td>Pyxis Count Discrepancy</td>
<td>1</td>
</tr>
<tr>
<td>Pyxis False Stackout</td>
<td>1</td>
</tr>
<tr>
<td>Return Bin Process Error</td>
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</tr>
<tr>
<td>Unordered Drug</td>
<td>1</td>
</tr>
<tr>
<td>Unsecured Medication</td>
<td>1</td>
</tr>
<tr>
<td>Wrong Concentration</td>
<td>3</td>
</tr>
<tr>
<td>Wrong Dose</td>
<td>2</td>
</tr>
<tr>
<td>Wrong Drug or IV Fluid</td>
<td>2</td>
</tr>
<tr>
<td>Wrong Frequency or Rate</td>
<td>1</td>
</tr>
<tr>
<td>Wrong Route</td>
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</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>30</td>
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</table>

**ADR CY20**

<table>
<thead>
<tr>
<th>Category</th>
<th>Q3</th>
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**SURGERY RELATED ISSUES CY20**

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**SECURITY CY20**

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**MEDICATION VARIANCES CY20:**

During 3rd Quarter, there were 30 Medication Occurrences, which reflect an increase by 8, resulting in 15.38% from 22 reported in Q2 CY 2020. There were 9 Near Misses that were medication-related. Medication Variances are reviewed at the Medication Safety and P&T Committees. The Committees review for quality improvement opportunities, and recommendations are addressed collectively by all Regions.

**ADR CY20:**

There were 2 ADRs reported for Q3 CY 2020 which remained unchanged from Q2 CY 2020.

**SURGERY RELATED ISSUES CY20:**

During Q3 CY 2020, there were 14 Surgery related issues, which reflect an increase by 27.27% from Q2 CY 2020 which was 8. Surgery/Procedure Cancelled are tracked and trended.

**SECURITY CY20:**

Q3 2020 reported 71 occurrences, which reflects an increase by 13 or 10.08% from 58 reported in Q2 CY 2020. Property Damaged/Missing was 16 in Q3 2020. This reflects a 3.23% increase from Q2 2020, which was a total of 15.
SAFETY CY20 | Q3
--- | ---
CODE RED | 2
SAFETY HAZARD | 4
SHARPS EXPOSURE | 4
GRAND TOTAL | 10

SAFETY CY20:
During Q3 CY 2020, 10 events were reported and 13 in Q2 CY 2020. This reflects a 13.04% decrease. Occurrences related to staff and LIPs are referred to Employee Health for management and confidentiality.

REGIONAL RISK MANAGEMENT SECTION:
(MAY INCLUDE PERFORMANCE IMPROVEMENT INITIATIVES, SERIOUS INCIDENTS, AHCA ANNUAL REPORTABLE EVENTS, CODE 15 REPORTS, AND/OR INTENSE ANALYSIS/RCA COMPLETED, ETC.)

ACHA ANNUAL REPORTABLE EVENTS:
There were (3) AHCA Annual Reportable Events, which were all Falls related

CODE 15 REPORTS:
There was (0) Code 15 reported, for the 3rd Quarter CY 2020.

INTENSE ANALYSIS ON INPATIENT FALL WITH RIGHT SHOULDER FRACTURE

Scenario:
91 YO male admitted with compression fracture of L4 due to fall at ALF. On admission, patient was assessed as a high risk for fall and appropriate fall preventative measures were implemented. Primary RN reported during the IA, that due to the patient being a high risk for falls, she rounded on the patient more frequently than hourly and although the patient was pleasantly confused, a sitter was not warranted as patient was sleeping and not getting out of bed. Less than an hour prior to the fall, patient was assisted with standing up at the bedside to use the urinal, but was unable to void. Patient was assisted back to bed and bed alarm reactivated. Within an hour, patient’s bed alarm was sounding, the patient was found lying on his right side on the floor by his bed. Patient reported that he was going to the bathroom. Patient complained of pain to right shoulder and arm. X-Ray of right shoulder revealed a **Comminuted Fracture of the Right Humerus**. Patient was assigned a sitter post-fall.

OPPORTUNITY IDENTIFIED:

(1) Pharmacy’s review noted that Flomax was being administered on the night shift. After the patient returned from surgery, the time had already elapsed for administration of the medication. During the IA, it was recommended to notify the patient’s physician and possibly skipping that evening dose since it was already delayed.

(2) Based on the patient’s history (recent fall), medication being used, pleasantly “confused” and just returning from surgery, a sitter should have been utilized.

CONCLUSION:
Based on the circumstances with the fall measures in place, and the staff rounding more frequently to meet the patient’s needs, it was determined that this fall was unavoidable.

PROCESS IMPROVEMENT INITIATIVE

New Falls Audit Tool Roll-out Plan for October 2020

*Incorporation of daily Safety huddles on every shift, to discuss fall risk patients and other safety concerns.

*Daily audits of 5 charts (3 fall risks and 2 random patients).

*Incorporation of falls prevention in pre-op teaching for surgical patients.

*Ensure patients are appropriately assessed upon admission.

*Fall preventative measures implemented should be based on the MFRS.

*Clinical Education to collaborate with Physical Therapy in providing Gait Belt training to staff.
staff.

*Obtain order for Physical Therapy for patients identified as fall risks.

*Educate and explain to patients and family, using the teach back method the “WHY” they are a “fall risk” and the need for fall preventative measures.

*Medication reviewed on admission for high risk patients and recommendations communicated to physicians and staff.

* Patient roundings should be individualized; rounding should also include ensuring fall
BROWARD HEALTH AMBULATORY SERVICES - RISK MANAGEMENT QUARTERLY REPORT QUARTER 3

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Seven of the 9 falls were from Gold Coast, 5 Home Health, 2 Home Hospice. Three falls resulted in minor injury. All patients receiving PT services and fall prevention education. One CHS visitor fall and one patient near miss fall. Visitor related to syncope episode. Patient near miss while stepping out of scale.

Two patient care from Home Health. One infection Control related to patient who tested positive for COVID.

Two HIPAA PHI reports. Wrong discharge papers discovered at pharmacy, PPID reinforced with nurse. Patient presented to US with papers for another patient. PPID completed with employee followed by monitoring.

Six medication variances. Two patients received PPD instead of Tdap. Patients contacted to return for vaccine ordered. MA asked assistance from senior MA who misunderstood her accent and administered PPD. MA repeated the error on another patient. Nurse coordinator met with both MAs and implemented two person checks against order before any medication administration. One patient called pharmacy to question oyster shell calcium + D that she received as she has shellfish allergy which was previously documented on chart. The pharmacists were reminded to pay close attention to allergies prior to verifying a script and drug utilization reviews in pharmacy’s software which flags patient allergies in comparison to drugs prescribed when a contraindication is determined. In the event that a pharmacist is interrupted while verifying a script as in this scenario, upon return, the pharmacist should restart the verification process in order to decrease the chances of an occurrence like this happening again. One related to prescription sent to Walgreens for patient’s mother instead of patient. Same first and last names on system, both DOB in January. Nextgen added daughter’s middle name Lazo. Employee coached on use of 2 identifiers to initiate order.

Lab event related to LabCorp not locating specimen, patient contacted to return (CEB UC patient).

Three infection event reported patient who presented to clinic positive for Tb. Patient presented to ED and employee health not notified.

Safety event reported dentist finger cut when using matrix band. Consider using different band and double gloving.

Other reported wrong x-ray report. Investigated by radiology, physician was viewing one patient’s images but documented under another. Addendum completed and APRN followed up with patient, no harm. Forward to regional radiology manager.
**WESTON & IMAGING**

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**WESTON & IMAGING**

ADR due to patient with hives after Optiray 320 at Weston Imaging, resolved.

Medication event related to documentation and did not affect patient.

Patient care related to abnormal CT brain result at imaging center and patient transfer to ED. Other AMA.

One Lab occurrence related to UCC not realizing that patient needed swab test instead of antibody test ordered by surgeon for surgery pre-op. Patient returned without additional charge. Other due to Quest not locating specimen. Patient called to redo it without charges.

Safety event reported employee who cut finger while removing cast, employee health notified.

Security related to patient’s inappropriate behavior.
PHYSICIAN OFFICES

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One employee fall without injuries. One patient fall due to feeling weak at building lobby, no injuries. Other patient appeared to have a syncopal event, suffered small abrasion and refused transfer to ED.

Four patient care events. One report that patient expired at BHIP on same day of office visit. Care reviewed by medical director as appropriate. Suggestions for these patients with higher level of acuity to be seen by physician or for APRN to bring in physician at end to see patient and review recommendations. APRN can then document consultation. Two unstable patients transferred to hospital. One disruptive patient.

Two safety events related to needle stick. BHPG nurse managers to ensure that the offices have safety needles and if possible dispose needles/syringes without proper safety device. Other near miss when MA almost got stuck with new Saf-T wing butterfly, stated this had happened before. Education department arranged for re-entry with service.

Three of the four security occurrences related to patient aggressive behavior. Other related to missing supplies so supplies moved to other locked area.

Lab related to physician mishandling of specimen. PCPs should be sending patients to testing sites instead of testing them for COVID-19 at the office. VP Clinical Services will address issue with compliance.

PPID related to encounter billed under wrong patient. Same name. Bills corrected and employee re instructed on using two patient identifiers.
# BROWARD HEALTH AMBULATORY SERVICES - RISK MANAGEMENT QUARTERLY REPORT QUARTER 3

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Three of the four HIPAA/PHI events reported Early Steps form sent to wrong provider. One report sent to wrong fax number. Compliance held educational session with staff.
<table>
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<th>Mar</th>
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<th>June</th>
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<td>1</td>
<td>4</td>
<td>0</td>
<td>5</td>
<td>14</td>
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</table>

HIPAA/PHI occurrence related to bill sent to wrong insurance by managed care.

One employee clinical event.

Security events managed by security.
8.1 COMMUNITY HEALTH SERVICES: HEALTHCARE FOR THE HOMELESS
HEALTHCARE FOR THE HOMELESS

• Funded by Health Resources & Services Administration (HRSA)
• Offers a wide array of healthcare and related services to the homeless population
• 2019 HRSA operational site visit resulted in Diabetes Action Plan
• Quality Assurance Specialist hired to ensure quality assurance and improvement
DIABETES & HOMELESSNESS

• Diabetes and prediabetes affect millions of Floridians
• 7th leading cause of death in Florida
• Increasing rates of diabetes among individuals experiencing homelessness
• Homelessness complicates management of diabetes
• Homeless patients with diabetes are at high risk of developing comorbidities
DIABETES ACTION PLAN

• Approved by HRSA and implemented in July 2019
• Includes activities to strengthen HCH performance on the diabetes measure
• Focuses on three goals:
  1. Decrease no show rate for AADE certified self management classes by 10%
  2. Reduce participating patients with Hemoglobin A1C 10% or higher by 2%
  3. Promote diabetes control and prevention through education to more patients as evidenced by increase in average number of participants in group DSM classes from 3 to at least 5 patients per class
### Performance Measure for HCH Patients with Diabetes, 2019-2020

| Goal 1: Decrease No-Show rate for AADE certified diabetes self-management (DSM) classes by at least ten percent (10%) by July 2020. Goal 58% |
|---|---|---|---|---|---|
| Measurement of monthly attendance in diabetes classes | 49% | 79% | 75% | 100% | 76% |
| # of patients who attended class | 5 | 12 | 3 | 6 | 26 |
| # of patients who were scheduled for class | 18 | 15 | 5 | 6 | 44 |
| NO SHOW RATE | less than 58% | 51% | 21% | 25% | 0% | 24% |

| Goal 2: Reduce participating HCH patients with HbA1c of 10% or higher by 2% |
|---|---|---|---|---|
| Complete outreach to all patients with HbA1c 8% or greater and schedule at least 80% of identified patients for group DSM classes. | 80% | 19% | 27% | 43% | 24% | 29% |
| # of patients with HbA1c 8% or greater and scheduled for DSM class | 18 | 15 | 5 | 6 | 44 |
| # of patients identified as having HbA1c 8% or greater | 67 | 47 | 11 | 37 | 162 |
| Average HbA1C | equal to or less than 8% | 8 | 8 | 6 | 7 | 7 |
| Proportion of patients with HbA1c higher than 8% past 3 months. | less than 16.2% | 10% | 12% | 12% | 9% | 11% |
| # of patients with HbA1c greater than 8% who were seen by PCP this month | 67 | 47 | 11 | 37 | 162 |
| # of patients with HbA1c greater than 8% past 3 months | 46 | 39 | 80 | 105 | 269 |

| Goal 3: Promote diabetes control and prevention through education to more patients by August 1, 2020 as evidenced by increase in the average number of participants in group DSM classes |
|---|---|---|---|
| Increase average # of participants in group DSM classes from 3 patients to at least 5 patients per class | more than 5 | 3 | 4 | 0 | 0 | 1 |
| # of established patients with diagnosis of pre-DM and DM who attend group classes | 5 | 12 | 3 | 6 | 26 |
| # of established patients with diagnosis of pre-DM and DM | 446 | 335 | 348 | 334 | 366 |
CONTINUOUS QUALITY ASSURANCE/IMPROVEMENT ACTIVITIES

• Continue to monitor the Diabetes Action Plan and related HCH funded indicators
• Outreach and provide education to patients
• Conduct monthly chart review to track diabetes and other clinical quality measures
• Complete progress report for submission to HRSA
• Ensure patient safety and satisfaction
LEAPFROG
FALL 2020

• **BHIP**  
  A  
  Process/Structural  
  • All Regions maximized points
  • Safety Survey- Regions 100 compliant

• **BHCS**  
  B  
  • HCAHPS- steady improvements

**Outcome Measures**

• **BHN**  
  C  
  • Hospital Acquired Infections  
    – Steady improvements
    – Reduce SIR < 1

• **BHMC**  
  C  
  • Patient Safety Indicators  
    – Quality & Coding review all potential HACs & PSI  
    – Reduction in Hospital Acquired Pressure Injuries

Next Public Reporting Period Spring 2021
LEAPFROG
FALL 2020

- BHIP 3.1784
- BHCS 2.9983 (0.16 from A)
- BHN 2.9309  (0.041 from B, 0.2475 from A)
- BHMC 2.8969 (0.0751 from B, 0.2621 from A)

<table>
<thead>
<tr>
<th>Grade</th>
<th>Safety Grade Criteria (at or above cut point)</th>
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</thead>
<tbody>
<tr>
<td>A</td>
<td>≥ 3.159</td>
</tr>
<tr>
<td>B</td>
<td>≥ 2.972</td>
</tr>
<tr>
<td>C</td>
<td>≥ 2.506</td>
</tr>
<tr>
<td>D</td>
<td>≥ 2.040</td>
</tr>
<tr>
<td>F</td>
<td>&lt; 2.040</td>
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</table>
8.3 PATIENT ENGAGEMENT
JOURNEY TO HIGH RELIABLE ORGANIZATION

• Transformational Change
  Intersection of
  Quality Outcomes & Experience of Care & Employee Engagement

• Align Culture
  – Patient Centric
  – Robust Data Strategy
  – Patient Loyalty
  – Staff Engagement
  – System of Accountability
The Impact of COVID-19 on Patient Trust

Patient Trust Pre–COVID-19

Baseline trust in the medical system

Culture
Safety, Teamwork...

Clinical
Skill, Prep for Discharge...

Caring Behaviors
Courtesy, Inform, Empathy, Privacy...

Operational
Access, Timeliness, Environment, Amenities

Likelihood to Recommend/Loyalty confirming patient TRUST
How COVID-19 Impacts Patient Trust

VULNERABILITY TO DISEASE

The disease is still incompletely understood, and the efficacy of treatments remains uncertain.

1. COVID-19 is highly contagious.
2. Neither patients nor caregivers are sure that health care organizations can keep them safe.
3. These fears have been exacerbated by concerns that supplies of PPE, ventilators, and ICU beds might not be adequate.

CONTINUED AMBIGUITY IN CARE DELIVERY

1. Loss of familiar cues that suggest to patients that they are in good hands.
2. Prohibition of family visits during hospitalization.
3. Patients can tell their caregivers are struggling to learn new ways of performing basic functions.
4. Patients have also been asked to put individual needs behind public needs.
<table>
<thead>
<tr>
<th>Critical Element/Strategic Alignment</th>
<th>Tactic or Task</th>
<th>Notes</th>
<th>Cross Domain Impact Expected?</th>
<th>Primary Progress Metric</th>
<th>Owner</th>
<th>Status</th>
<th>Target Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A cross functional team</td>
<td>Executive Steering Committee establishes strategic priority; Create or refine PEX Task Force who drives tactics. Cross-functional representation of PEX stakeholders can help represent all interests to set priority for the Health System. This design can help deliver tactics that complement strategy.</td>
<td>Work Force (WF); Patient Experience (PX); Clinical</td>
<td>Patient Experience - Overall Rating, Likelihood to Recommend, Nurse Communication</td>
<td>Executive Leadership-B Gallison; D Small</td>
<td>Complete</td>
<td>Q1 2020, meeting monthly</td>
</tr>
<tr>
<td>2</td>
<td>Definition</td>
<td>Develop compelling definition linking staff role to organization's mission, vision, &amp; values. Definition of Patient Experience is a critical hub of culture connecting staff to engaged, resilient, &amp; safe care delivery.</td>
<td>WF; PX; Clinical</td>
<td>Patient Experience - Overall Rating, Likelihood to Recommend, Nurse Communication, CDIFF, CLABSI, CAUTI</td>
<td>Senior Executives/Executive Steering Committee</td>
<td>In Progress</td>
<td>Q3 2020</td>
</tr>
<tr>
<td>3</td>
<td>The Narrative</td>
<td>Create a narrative or theme that connects to the definition in a way that leverages stories which embody the ideal culture of Broward Health. Definition of Patient Experience is a critical hub of culture connecting staff to engaged, resilient, &amp; safe care delivery. Beginning discussions with CHRO and PEX Task Force and marketing.</td>
<td>WF, PX</td>
<td>Patient Experience - Overall Rating, Likelihood to Recommend, Nurse Communication, CDIFF, CLABSI, CAUTI</td>
<td>Executive Steering Committee; Marketing &amp; HR</td>
<td>In Progress</td>
<td>Q3 2020</td>
</tr>
<tr>
<td>4</td>
<td>Defined behaviors</td>
<td>Identify &amp; review all current behavior standards within system; Evolve to 1 standard set of universal skills to align behaviors with the experience of interacting with patients, family, and colleagues. Standard Behaviors help set the expectation for interactions and should connect directly to your definition and how Broward Health is to be viewed in your community. Standard Behaviors should be evaluated, refined, or created for all staff members, all roles in the organization. Assess relationship of those behaviors with leader competency; Finalize Broward Health standard PX behaviors; Communication/socialization/train; Leader Rounding &amp; Accountability for adoption</td>
<td></td>
<td>WF; PX; Clinical</td>
<td>PX - “Courtesy” &amp; “Friendless”; WF - Analyze item Themes around respect, stress, well-being, etc.; Clinical - Falls &amp; Trauma, CDIFF, CLABSI, CAUTI</td>
<td>PEX Task Force, HR</td>
<td>In Progress</td>
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<tr>
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</tr>
<tr>
<td>5</td>
<td>Data strategy</td>
<td>New PGO 2.0 deployment &amp; user migration</td>
<td>Establish preferred views of data; frequency of reporting; access to results; clear connection to goals; alignment with balanced scorecard</td>
<td>PX</td>
<td>New PGO Migration Completion NES Integration through New PGO</td>
<td>Quality Analytics; Press Ganey</td>
<td>Complete</td>
</tr>
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</table>
**Focused Tactics and Best Practices**

**Bundled Best Practice Consistency** - Evaluate best practices in play to determine effectiveness and operational delivery. Recommended best practices would ideally reach across workforce engagement, patient experience, safety and quality.

- **Huddles** (share info and positive patient or employee encounters);
- **Evaluate & elevate concerns / complaints**;
- **Care transitions (IP BSSR, Unit to Unit Handoffs; Goals on Whiteboard)**

It is especially important that best practices are deeply connected to behavior standards to ensure that the work is conducted with high quality and delivered with true compassion.

**PX**

**Clinical**

**WF**

**In Progress**

**Ongoing** - Evaluate Bi-Annually

---

**Talent management lifecycle**

Create a plan to support talent by connecting desired behaviors, definition, and reward/recognition. This should be framed through employee life-cycle; new hire plan; sustaining resiliency plan; leveraging tenured staff; honoring end of career.

Incentive that rewards desired behavior standards is an effective way to create repeatable care that is compassionate and encompasses the best examples of Broward Health culture.

Leadership development should promote talent management.

**WF**

**In Progress**

**Medical Staff**

**In Progress**

**Q3 2020**

---

**Provider-centric strategy**

Improving the patient experience and engagement of employees requires strong physician understanding and support. Engaging faculty through a provider focused strategy is vital.

Effort led by well-known physician leader; establish physician task force to drive strategy:

Narrative (how physician leaders talk about PEX); education material to support strategy & message; define physician’s role in PEX

**Clinical**

**WF**

**PX**

**In Progress**

**Medical Staff**

**In Progress**

**Q3 2020**
BALANCE SCORE CARD COMPARISON: OVERALL

BHCS: Overall

BHN: Overall

BHIP: Overall

BHMC: Overall

CY19  CY20  FY21 Goal
BHMC PATIENT EXPERIENCE JOURNEY INITIATIVES FOR SUCCESS

Heather Havericak MSN, CPON, FACHE
Chief Executive Officer BHMC/ SFCH
RATE HOSPITAL 0-10

*CAHPS Top Box

Discharge Date
1/1/2020
3/31/2020
4/1/2020
6/30/2020
7/1/2020
9/30/2020

Benchmark Period
1/1/2020
3/31/2020
4/1/2020
6/30/2020
7/1/2020
9/30/2020

Sample size
n=433
n=302
n=308

Peer group size
N=2762
N=2617
N=2572
RECOMMEND THE HOSPITAL

*CAHPS Top Box

<table>
<thead>
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<th>Benchmark Period</th>
<th>Sample size</th>
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<tr>
<td>4/1/2020</td>
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<td>n=297</td>
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COMMUNICATION WITH NURSES

*CAHPS

Discharge Date

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Benchmark Period

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<tbody>
<tr>
<td>3/31/2020</td>
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<td>30</td>
<td>54</td>
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Sample size

<table>
<thead>
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<th>n=441</th>
<th>n=303</th>
<th>n=309</th>
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<tbody>
<tr>
<td>Peer group size</td>
<td>N=2771</td>
<td>N=2631</td>
<td>N=2587</td>
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</table>
COMMUNICATION WITH DOCTORS

- **Discharge Date**
  - 1/1/2020
  - 4/1/2020
  - 7/1/2020

- **Benchmark Period**
  - 1/1/2020
  - 4/1/2020
  - 7/1/2020

- **Sample size**
  - n=442
  - n=303
  - n=308

- **Peer group size**
  - N=2764
  - N=2628
  - N=2583
PATIENT EXPERIENCE ACTION PLAN

• “No Meeting Zone” 9-11am dedicate nurse manager rounds 100% of patients
• Daily Patient Experience Huddle 11:15 report compliance, items to be escalated, & significant recognitions
• Commitment to personal connections from staff and leaders 100% of patients
• Care Calls conducted on all inpatient units both shifts & documented in the EMR
• Discharge phone call attempted on 100% of patients discharged to home
• Access & enhancements made to rounding platform, BH Connect, including the development of a template for the Emergency Department
• All nursing leaders below targeted benchmarks for FY2021 KPIs meet monthly with CEO, CNO, Directors of Nursing, and Manager of Patient Experience with unit-specific action plans
• Patient Experience Domain Sub-Committees to report up to the Patient Experience Steering Committee with updated action plans and specific key performance indicators
DOCTOR COMMUNICATION INITIATIVES

- Doctor Communication Sub-Committee measured on individual performance.
  - 1\textsuperscript{st} competition - Kentucky Derby where each provider was provided a random “derby horse name”. Scores were presented each month.
    - Winner: Dr. Azhar Dalal (Universally Acclaimed) went from 63.9% top box score to 93.3%.
  - 2\textsuperscript{nd} competition - Mario Kart Specialty Series where departments are assigned a specific Mario Kart character and progress is measured by the entire department. Race track kept in Medical Staff Office.
  - Ongoing - Secret Shoppers assigned to observe individual providers on demonstrating 3 key behaviors of their choice.
  - Physician expert speakers at each committee meeting.
  - Physician representatives are standing agenda items on monthly department meetings.
THE BROWARD HEALTH DERBY - SEPT 2020

12 Physicians - Individual Scores will be Shared Here Each Month
1. Admiral
2. All About the Benjamin's
3. Backyard Wrestler
4. Con Queso
5. Fancypants
6. Jazz Hands
7. Mint Julep Juggler
8. Quantifiable Amounts of Awesome
9. Twinkle Toes
10. Universally Acclaimed
11. Yankee Doodle
12. Oodles of Noodles
UNIVERSALLY ACCLAIMED
BROWARD HEALTH
MARIO KART
SPECIALTY SERIES