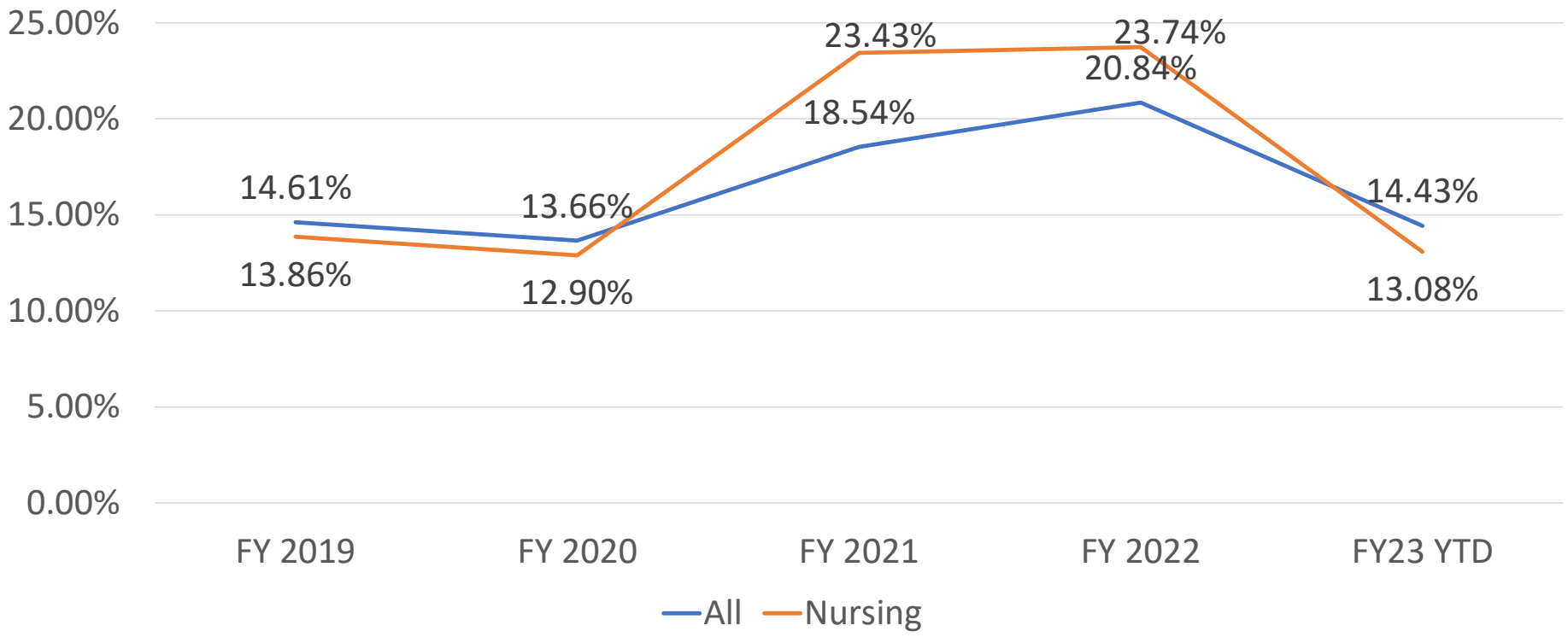
RN Workforce Update

South Broward Hospital District
Board of Commissioners Meeting
July 26, 2023

GREAT NEWS!
Turnover FY 19 – FY 23



FY23 PEOPLE Results

- 20% reduction in open requisitions
- 3,758 New Caregivers
- 662 Rehires; 17.61% of total new hires
- **1,249 New RNs including Nurse Residency & Nurse Fellowship Programs**
- Lowest turnover in five years!
  - **RN Turnover 13.08%**
  - ALL Turnover 14.43%


Recruitment
RN Workforce Strategy
Academic Partnerships
RN Career Paths

Nursing Workforce Strategy

STRATEGY

- Enhance Academic Partnerships
- Improve Student Experience
- Professional Development
- Increase Retention
- Staffing Resources Office
- Establish Gig Workforce
- Automate

SUCCESSES

- Increased Student Rotations
- Optimize Student Comm.
- Nurse Extern Program
- Increased Educators
- System Float Pool – 180 RNs
- 525 Residents & 260 Fellows

FUTURE

- MHS Nursing Website
- Professional Development
- Preceptor Development
- Fellowship for Leadership
- Simulation Center Expansion
- Florida First – GNE Program

NURSING CAREER LADDER

Nursing Student

Academic partner clinical rotations

Nurse Extern

Pre-Graduation

Nurse Resident

Post-Graduation

Nurse Fellowship

Specialty

Limitless Sky

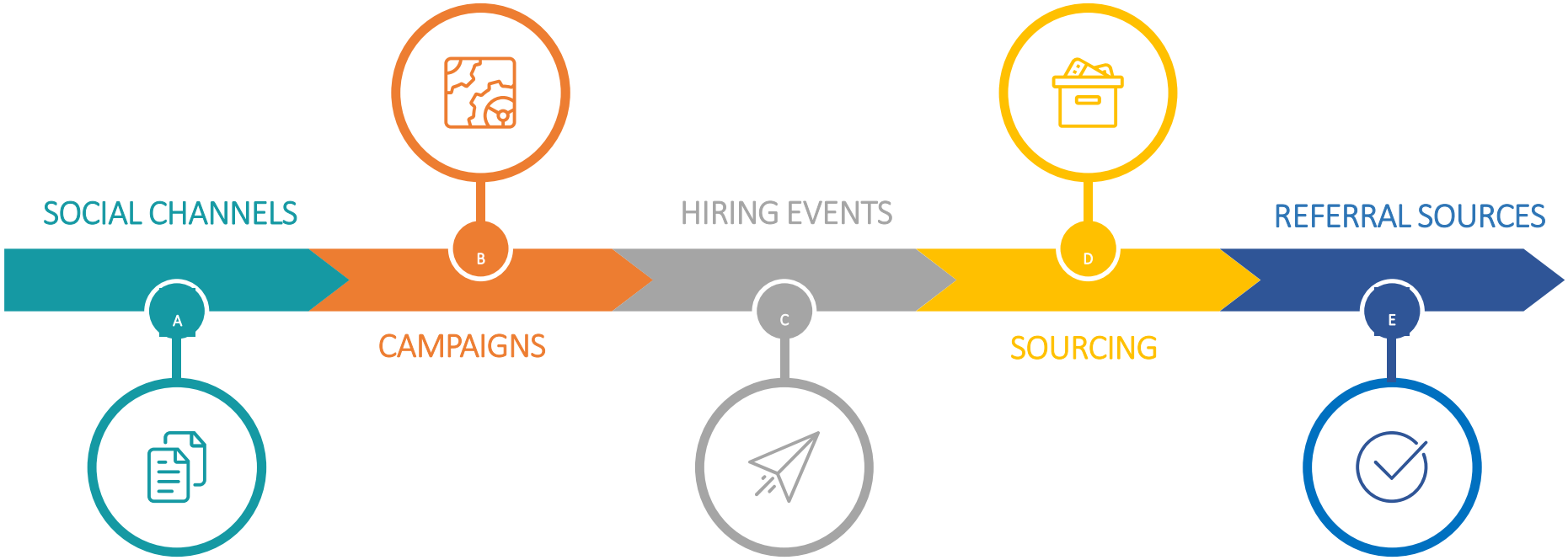
Clinical Ladder, Leadership, Education, etc.

Academic Partnerships

Academic Partners	Student Rotations
Barry University	148
Broward College	446
Chamberlain University	401
Florida Atlantic University	148
Florida International University	127
Jersey College	126
Nova Southeastern University	170
Utica University	55
West Coast University	131
	1752

Period: July 2022 – June 2023

RN Recruitment Strategies



Retention Strategy/Employee Value Proposition: Loan Forgiveness

Employees with linked student loans: **1,326**

Total linked student loan debt - **$68,738,987**

Median student loan debt per user - **$40,171**

Top 15 by Job Family:

Job Family	Count
Nursing	507
Pharmacy	95
Physician Support	84
Physicians	74
Patient Financial Services	70
Clinical Support	57
Imaging	53
Rehabilitation	45
Advanced Practice Providers	44
Information Technology	30
Laboratory	24
Respiratory	23
Community Services	22
Human Resources	18
Social Work	18

Thank you

SOUTH BROWARD HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF COMMISSIONERS OF THE SOUTH BROWARD HOSPITAL DISTRICT

INCLUDING REPRESENTATIVES OF THE MEDICAL STAFF OF EACH OF ITS HOSPITALS

June 28, 2023

A Regular Meeting of the Board of Commissioners of the South Broward Hospital District (S.B.H.D.) was held in person, and by video and telephone conference, on Wednesday, June 28, 2023, at 5:30 p.m.

The following members were present:

Mr. Brad Friedman	Chairman	In person
Ms. Elizabeth Justen	Vice Chairman	In person
Mr. Steven Harvey	Secretary Treasurer	In person
Mr. Jose Basulto		By video
Mr. Douglas Harrison		In person
Dr. Luis Orta		In person
Ms. Laura Raybin Miller		By video

A registration sheet listing attendees in person is on file in the Executive Office.

---

1. CALL TO ORDER / PUBLIC MEETING CERTIFICATION

There being a physical quorum present, the meeting was called to order by Mr. Friedman, who noted that public participation is welcome.

Mr. Frank Rainer, Senior Vice President and General Counsel, confirmed and provided his certification as General Counsel that all public notice and open meeting (Sunshine) legal requirements had been complied with for this meeting.

Mr. Friedman asked everyone to join him in a moment's silence to remember Mr. Kevin Corcoran, Chief Financial Officer of Memorial Hospital West, who had recently passed away.

2. PRESENTATIONS

a. Request Board Approval of Resolution No. 487 Honoring Blane Shatkin, M.D., Former Chief of the Medical Staff at Memorial Hospital Pembroke

Mr. Friedman read Resolution No. 487 honoring Blane Shatkin, M.D.

Dr. Orta ***moved, seconded*** by Mr. Harvey, that:

> ***THE BOARD OF COMMISSIONERS APPROVES RESOLUTION NO. 487 HONORING BLANE SHATKIN, M.D., FORMER CHIEF OF THE MEDICAL STAFF AT MEMORIAL HOSPITAL PEMBROKE***

The Motion ***carried*** unanimously.

Dr. Shatkin thanked the Board, Administrative staff and fellow physicians for their support during his four-year tenure as Chief of Staff, and stated that it was truly an honor for him to serve in this capacity. He also thanked his wife for her support.

The Board presented Dr. Shatkin with an award, and Mrs. Shatkin with flowers, and photographs were taken.

Mr. Friedman then took the opportunity to recognize Ms. Nina Beauchesne, outgoing Executive Vice President and Chief Transformation Officer, who was attending her last Board meeting before her retirement. Board members thanked Ms. Beauchesne for her contribution during her 32 years at Memorial. In response, Ms. Beauchesne thanked the Board for their support. She stated that Memorial was a special place and a great organization, with so many wonderful staff who do so much for the community.

Ms. Beauchesne was presented with flowers, and photographs were taken.

b. Hollywood Beach Shooting Response; Mr. Peter Powers, Chief Executive Officer, Memorial Regional Hospital

Mr. Powers introduced Randy Katz, D.O., Medical Director of Emergency Services; Andrew Rosenthal, M.D., Medical Director of Trauma Services; and Ms. Candace Pineda, Administrative Director of Trauma and Acute Care, all of whom are based at Memorial Regional Hospital.

Ms. Pineda led the presentation on the shooting, which took place on May 9, 2023, and gave details of the Trauma Center response. She recognized the first responders, and the positive collaboration Memorial had with them, to ensure the safe and swift treatment of the victims. She noted that the incident made the national news, which gave Memorial the opportunity to educate the country.

Dr. Katz is also the Medical Director for the City of Hollywood Fire Rescue. He reported that the nine victims were able to walk out of the hospital because of Memorial's training, and stressed the importance of regular training. He also thanked the emergency services for their involvement in responding to the incident.

Dr. Rosenthal then gave a report on trauma volume trends, which showed that volumes are increasing nationally. He gave details on trauma and acute care surgery, and injury data, and the injury prevention training which Memorial carries out in the community. He thanked the Board and staff for their support, which has allowed the Trauma Center to deal with this incident seamlessly.

Mr. Friedman congratulated the team and thanked them for their service. Mr. Harrison asked that staff ensure that ballistics are sent to the Police for their investigations.

3. APPROVAL OF MINUTES

a. Request Board Approval of the Minutes of the Regular Meeting Held on May 24, 2023

A copy of the Minutes is on file in the Executive Office.

Mr. Harvey ***moved, seconded*** by Mr. Harrison, that:

THE BOARD OF COMMISSIONERS APPROVES THE MINUTES OF THE REGULAR MEETING HELD ON MAY 24, 2023

The Motion ***carried*** unanimously.

b. Request Board Approval of the Minutes of the Special Meeting Held on June 14, 2023

A copy of the Minutes is on file in the Executive Office.

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

THE BOARD OF COMMISSIONERS APPROVES THE MINUTES OF THE SPECIAL MEETING HELD ON JUNE 14, 2023

The Motion ***carried*** unanimously.

4. *BOARD REGULAR BUSINESS*

a. Report from the President of the Medical Staff, Memorial Regional Hospital and Joe DiMaggio Children's Hospital; N. Spier, M.D.

1) Request Board Approval of the Executive Committee Report Regarding Recommendations for Appointments, Advancements, etc.

In the absence of Nigel Spier, M.D., Juan Martinez, M.D., presented the Executive Committee Report regarding recommendations for appointments, advancements, etc., convened on June 21, 2023, submitted for consideration, a copy of which is on file in the Executive Office.

Dr. Orta ***moved, seconded*** by Mr. Harvey, that:

THE BOARD OF COMMISSIONERS APPROVES RECOMMENDATIONS OF THE EXECUTIVE COMMITTEE OF THE MEDICAL STAFF AT MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL

The Motion ***carried*** unanimously.

b. Report from the Chief of Staff, Memorial Hospital West; F. De La Cruz, M.D.

1) Request Board Approval of the Executive Committee Report Regarding Recommendations for Appointments, Advancements, etc.

Fausto De La Cruz, M.D., presented the Executive Committee Report regarding recommendations for appointments, advancements, etc., convened on June 12, 2023, submitted for consideration, a copy of which is on file in the Executive Office.

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

THE BOARD OF COMMISSIONERS APPROVES RECOMMENDATIONS OF THE EXECUTIVE COMMITTEE OF THE MEDICAL STAFF AT MEMORIAL HOSPITAL WEST

The Motion ***carried*** unanimously.

c. Report from the Chief of Staff, Memorial Hospital Miramar; J. Villegas, M.D.

1) Request Board Approval of the Executive Committee Report Regarding Recommendations for Appointments, Advancements, etc.

Juan Villegas, M.D., presented the Executive Committee Report regarding recommendations for appointments, advancements, etc., convened on June 14, 2023, submitted for consideration, a copy of which is on file in the Executive Office.

Mr. Harrison ***moved, seconded*** by Dr. Orta, that:

THE BOARD OF COMMISSIONERS APPROVES RECOMMENDATIONS OF THE EXECUTIVE COMMITTEE OF THE MEDICAL STAFF AT MEMORIAL HOSPITAL MIRAMAR

The Motion ***carried*** unanimously.

d. Report from the Chief of Staff, Memorial Hospital Pembroke; N. Upadhyaya, M.D.

1) Request Board Approval of the Executive Committee Report Regarding Recommendations for Appointments, Advancements, etc.

Narendra Upadhyaya, M.D., presented the Executive Committee Report regarding recommendations for appointments, advancements, etc., convened on June 8, 2023, submitted for consideration, a copy of which is on file in the Executive Office.

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

THE BOARD OF COMMISSIONERS APPROVES RECOMMENDATIONS OF THE EXECUTIVE COMMITTEE OF THE MEDICAL STAFF AT MEMORIAL HOSPITAL PEMBROKE

The Motion ***carried*** unanimously.

e. Financial Reports; Mr. D. Smith, Executive Vice President and Chief Financial Officer

1) Request Board Approval of the Financial Reports for the Months of April and May 2023

Mr. Smith first presented the financial report for the month of April 2023, noting that Mr. Carlos Hernandez of RSM US LLP was in attendance.

Mr. Harrison ***moved, seconded*** by Dr. Orta, that:

THE BOARD OF COMMISSIONERS APPROVES THE FINANCIAL REPORT FOR THE MONTH OF APRIL 2023

The Motion ***carried*** unanimously.

Mr. Smith then presented the financial report for the month of May 2023.

Mr. Harvey ***moved, seconded*** by Mr. Harrison, that:

THE BOARD OF COMMISSIONERS APPROVES THE FINANCIAL REPORT FOR THE MONTH OF MAY 2023

The Motion ***carried*** unanimously.

2) Request Board Approval of Resolution No. 488, Amending Fiscal Year 2022-2023 Budgeted Operating Expenditures of the South Broward Hospital District

Mr. Smith presented the amended budget details. Mr. Harrison made a Motion, seconded by Mr. Harvey, to waive the reading of Resolution No. 488, which was agreed unanimously by the Board.

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

THE BOARD OF COMMISSIONERS APPROVES RESOLUTION NO. 488, AMENDING FISCAL YEAR 2022-2023 BUDGETED OPERATING EXPENDITURES OF THE SOUTH BROWARD HOSPITAL DISTRICT

The Motion ***carried*** unanimously.

f. Legal Counsel; Mr. F. Rainer, Senior Vice President and General Counsel

Mr. Rainer confirmed that he had nothing to report this month.

5. REPORTS TO THE BOARD; REPORTS FROM BOARD OFFICERS AND STANDING COMMITTEES

a. Contracts Committee Meeting Held on June 5, 2023; Dr. L. Orta, Chair

Dr. Orta presented the Minutes of the Contracts Committee Meeting held on June 5, 2023, a copy of which is on file in the Executive Office. Mr. Harrison made a Motion, seconded by Mr. Harvey, to waive the reading of the individual contract details; however, this was withdrawn after consulting with Mr. Rainer. Ms. Nina Beauchesne then gave further details of the individual contracts and took questions.

1) Request Board Approval of the New Physician Employment Agreement between South Broward Hospital District and Buse Sengul, M.D., for Adult Neurology Services, and Program Director, Neurology Residency

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

THE BOARD OF COMMISSIONERS APPROVES THE NEW PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN SOUTH BROWARD HOSPITAL DISTRICT AND BUSE SENGUL, M.D., FOR ADULT NEUROLOGY SERVICES, AND PROGRAM DIRECTOR, NEUROLOGY RESIDENCY

The Motion ***carried*** unanimously.

2) Request Board Approval of the New Physician Employment Agreement between South Broward Hospital District and Ignacio Castellon, M.D., for Chief, MCI Radiation Oncology

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

> ***THE BOARD OF COMMISSIONERS APPROVES THE NEW PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN SOUTH BROWARD HOSPITAL DISTRICT AND IGNACIO CASTELLON, M.D., FOR CHIEF, MCI RADIATION ONCOLOGY***

The Motion ***carried*** unanimously.

3) Request Board Approval of the New Physician Employment Agreement between South Broward Hospital District and Christine Feng, M.D., for Medical Director, MCI Pediatric Radiation Oncology

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

> ***THE BOARD OF COMMISSIONERS APPROVES THE NEW PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN SOUTH BROWARD HOSPITAL DISTRICT AND CHRISTINE FENG, M.D., FOR MEDICAL DIRECTOR, MCI PEDIATRIC RADIATION ONCOLOGY***

The Motion ***carried*** unanimously.

4) Request Board Approval of the New Physician Employment Agreement between South Broward Hospital District and Aaron Falchook, M.D., for Medical Director, MCI Radiation Oncology at Memorial Regional Hospital

Mr. Harrison ***moved, seconded*** by Mr. Friedman, that:

> ***THE BOARD OF COMMISSIONERS APPROVES THE NEW PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN SOUTH BROWARD HOSPITAL DISTRICT AND AARON FALCHOOK, M.D., FOR MEDICAL DIRECTOR, MCI RADIATION ONCOLOGY AT MEMORIAL REGIONAL HOSPITAL***

The Motion ***carried*** unanimously.

5) Request Board Approval of the New Physician Employment Agreement between South Broward Hospital District and Michael Burdick, M.D., for Medical Director, MCI Brachytherapy

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

> ***THE BOARD OF COMMISSIONERS APPROVES THE NEW PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN SOUTH***

BROWARD HOSPITAL DISTRICT AND MICHAEL BURDICK, M.D., FOR MEDICAL DIRECTOR, MCI BRACHYTHERAPY

The Motion ***carried*** unanimously.

6) Request Board Approval of the New Physician Employment Agreement between South Broward Hospital District and Tamara Smith, M.D., for Radiation Oncology - MCI

Mr. Harvey ***moved, seconded*** by Mr. Friedman, that:

THE BOARD OF COMMISSIONERS APPROVES THE NEW PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN SOUTH BROWARD HOSPITAL DISTRICT AND TAMARA SMITH, M.D., FOR RADIATION ONCOLOGY - MCI

The Motion ***carried*** unanimously.

7) Request Board Approval of the New Physician Employment Agreement between South Broward Hospital District and Maria Ciccia, M.D., for Radiation Oncology - MCI

Mr. Harvey ***moved, seconded*** by Mr. Harrison, that:

THE BOARD OF COMMISSIONERS APPROVES THE NEW PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN SOUTH BROWARD HOSPITAL DISTRICT AND MARIA CICCIA, M.D., FOR RADIATION ONCOLOGY - MCI

The Motion ***carried*** unanimously.

8) Request Board Approval of the Renewal Physician Employment Agreement between South Broward Hospital District and Brett Cohen, M.D., for Chief, General and Bariatric Surgery Programs

Mr. Friedman ***moved, seconded*** by Mr. Harvey, that:

THE BOARD OF COMMISSIONERS APPROVES THE RENEWAL PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN SOUTH BROWARD HOSPITAL DISTRICT AND BRETT COHEN, M.D., FOR CHIEF, GENERAL AND BARIATRIC SURGERY PROGRAMS

The Motion ***carried*** unanimously.

9) Request Board Approval of the Renewal Physician Employment Agreement between South Broward Hospital District and Jeremy Gallego Eckstein, M.D., for Medical Director, Bariatric Surgery

Mr. Harvey ***moved, seconded*** by Mr. Harrison, that:

THE BOARD OF COMMISSIONERS APPROVES THE RENEWAL PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN SOUTH BROWARD HOSPITAL DISTRICT AND JEREMY GALLEGO ECKSTEIN, M.D., FOR MEDICAL DIRECTOR, BARIATRIC SURGERY

The Motion ***carried*** unanimously.

10) Request Board Approval of the Renewal Physician Employment Agreement between South Broward Hospital District and Dennis A. Hart, M.D., for Chief, Pediatric Physical Medicine and Rehabilitation

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

THE BOARD OF COMMISSIONERS APPROVES THE RENEWAL PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN SOUTH BROWARD HOSPITAL DISTRICT AND DENNIS A. HART, M.D., FOR CHIEF, PEDIATRIC PHYSICAL MEDICINE AND REHABILITATION

The Motion ***carried*** unanimously.

11) Request Board Approval of the Renewal Physician Employment Agreement between South Broward Hospital District and Daren David Grosman, M.D., for Adult Hematology Oncology

Mr. Harvey ***moved, seconded*** by Mr. Harrison, that:

THE BOARD OF COMMISSIONERS APPROVES THE RENEWAL PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN SOUTH BROWARD HOSPITAL DISTRICT AND DAREN DAVID GROSMAN, M.D., FOR ADULT HEMATOLOGY ONCOLOGY

The Motion ***carried*** unanimously.

12) Request Board Approval of the Renewal Physician Employment Agreement between South Broward Hospital District and Matthew L. Fazekas, M.D., for Medical Director, Pediatric Sports Medicine

Mr. Friedman ***moved, seconded*** by Mr. Harrison, that:

THE BOARD OF COMMISSIONERS APPROVES THE RENEWAL PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN SOUTH BROWARD HOSPITAL DISTRICT AND MATTHEW L. FAZEKAS, M.D., FOR MEDICAL DIRECTOR, PEDIATRIC SPORTS MEDICINE

The Motion ***carried*** unanimously.

13) Request Board Approval of the Renewal Physician Employment Agreement between South Broward Hospital District and Patrick Reynolds, M.D., for Medical Director, Palliative Care and Pain Management

Mr. Harvey ***moved, seconded*** by Mr. Harrison, that:

> ***THE BOARD OF COMMISSIONERS APPROVES THE RENEWAL PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN SOUTH BROWARD HOSPITAL DISTRICT AND PATRICK REYNOLDS, M.D., FOR MEDICAL DIRECTOR, PALLIATIVE CARE AND PAIN MANAGEMENT***

The Motion ***carried*** unanimously.

14) Request Board Approval of the Renewal Physician Employment Agreement between South Broward Hospital District and Sima A. Parikh, M.D., for Pediatric Neurology – Associate Medical Director of the Epilepsy Monitoring Unit

Mr. Harrison ***moved, seconded*** by Mr. Friedman, that:

> ***THE BOARD OF COMMISSIONERS APPROVES THE RENEWAL PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN SOUTH BROWARD HOSPITAL DISTRICT AND SIMA A. PARIKH, M.D., FOR PEDIATRIC NEUROLOGY – ASSOCIATE MEDICAL DIRECTOR OF THE EPILEPSY MONITORING UNIT***

The Motion ***carried*** unanimously.

15) Request Board Approval of the Renewal Physician Employment Agreement between South Broward Hospital District and Andres Jimenez-Gomez, M.D., for Medical Director, Neuro Developmental Program

Mr. Harvey ***moved, seconded*** by Mr. Harrison, that:

> ***THE BOARD OF COMMISSIONERS APPROVES THE RENEWAL PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN SOUTH BROWARD HOSPITAL DISTRICT AND ANDRES JIMENEZ-GOMEZ, M.D., FOR MEDICAL DIRECTOR, NEURO DEVELOPMENTAL PROGRAM***

The Motion ***carried*** unanimously.

16) Request Board Approval of the Renewal Physician Employment Agreement between South Broward Hospital District and Frank Scholl, M.D., for Chief, Joe DiMaggio Children's Hospital Heart Institute; Chief, Pediatric and Congenital Cardiac Surgery; and Surgical Director, Heart Transplantation and Mechanical Circulatory Assistance, Joe DiMaggio Children's Hospital

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

THE BOARD OF COMMISSIONERS APPROVES THE RENEWAL PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN SOUTH BROWARD HOSPITAL DISTRICT AND FRANK SCHOLL, M.D., FOR CHIEF, JOE DIMAGGIO CHILDREN'S HOSPITAL HEART INSTITUTE; CHIEF, PEDIATRIC AND CONGENITAL CARDIAC SURGERY; AND SURGICAL DIRECTOR, HEART TRANSPLANTATION AND MECHANICAL CIRCULATORY ASSISTANCE, JOE DIMAGGIO CHILDREN'S HOSPITAL

The Motion ***carried*** unanimously.

Ms. Beauchesne reported on additional contracts, presented for information only, and an RFP for Disaster Debris Removal and Disposal.

17) Request Board Approval of the Minutes of the Contracts Committee Meeting Held on June 5, 2023

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

THE BOARD OF COMMISSIONERS APPROVES THE MINUTES OF THE CONTRACTS COMMITTEE MEETING HELD ON JUNE 5, 2023

The Motion ***carried*** unanimously.

b. <u>Finance Committee Meeting Held on June 22, 2023; Ms. E. Justen, Chair</u>

Ms. Justen presented the Minutes of the Finance Committee Meeting held on June 22, 2023, a copy of which is on file in the Executive Office. Mr. Veda Rampat, Treasurer, gave details of the items discussed at the meeting, and introduced Mr. Gary Wyniemko, Ms. Deirdre Robert, and Mr. David Moore from NEPC.

1) Request Board Approval of the Minutes of the Finance Committee Meeting Held on June 22, 2023

Mr. Harvey ***moved, seconded*** by Mr. Harrison, that:

THE BOARD OF COMMISSIONERS APPROVES THE MINUTES OF THE FINANCE COMMITTEE MEETING HELD ON JUNE 22, 2023

The Motion ***carried*** unanimously.

6. <u>REPORT OF SPECIAL COMMITTEES</u>

None.

7. <u>ANNOUNCEMENTS</u>

None.

8. UNFINISHED BUSINESS

None.

9. NEW BUSINESS

Mr. Friedman confirmed that the next Joint Meeting of the South Broward and North Broward Hospital Districts will be held on Wednesday, August 2, 2023, at Memorial Regional Hospital's Conference Center.

10. PRESIDENT'S COMMENTS

Mr. Wester began by recognizing Ms. Beauchesne, and Mr. Douglas Zaren, Chief Executive Officer of Memorial Regional Hospital South, who are both retiring, and thanked them for their contribution and achievements at Memorial.

Mr. Wester congratulated Ms. Melida Akiti, who has been promoted to Chief Community Officer. Ms. Akiti confirmed her commitment to the role, and reported that the next "One City at a Time" event will take place in Hallandale in August.

Governor Ron DeSantis has signed the framework for the Freedom Budget for the fiscal year 2023-2024. Included in the signed budget are all of Memorial's legislative budget priorities presented at the Board Regular Meeting last month by Ms. Lubby Navarro, Vice President, Government Affairs.

Joe DiMaggio Children's Hospital has been named a US News and World Report Best Children's Hospital for Orthopedics for the ninth year in a row.

Mr. Wester gave an update on the Monthly Operating Report (MOR) Meeting which took place earlier in the week.

Envision Healthcare has filed for bankruptcy, due to fiscal pressures, as has the Radiation Oncology company GenesisCare.

A discussion has taken place with Broward Health regarding where they see their IT infrastructure going forward, and if they wish to use Memorial's platform or their own. Broward Health will report back to Memorial in the next week or two to confirm their decision.

The Broward Health/Memorial Free Standing Emergency Department facility was tabled at the Meeting of the Sunrise City Commission the previous day, to approve the site plan.

Mr. Matthew Muhart, Executive Vice President and Chief Strategy Officer, attended a Price Transparency Meeting in Washington DC.

11. CHAIR'S COMMENTS

Mr. Friedman congratulated Ms. Beauchesne on her retirement, and Ms. Akiti on her promotion, on behalf of all the Board members.

12. COMMISSIONERS' COMMENTS

The following Board members made comments:

Ms. Miller noted the strong financial month in May. She thanked everyone for doing a great job.

Mr. Basulto thanked everyone for everything they do, including assisting him when he has helped members of the community.

13. ADJOURNMENT

There being no further business to come before the Board, Mr. Friedman declared the meeting adjourned at 6:40 p.m.

THE BOARD OF COMMISSIONERS OF THE SOUTH BROWARD HOSPITAL DISTRICT

BY: _____ **ATTEST:** _____

Brad Friedman, Chairman **Steven Harvey, Secretary Treasurer**

Memorial Healthcare System

July 20, 2023

Mr. Brad Friedman
Chairman
Board of Commissioners
South Broward Hospital District

Dear Mr. Friedman:

The Executive Committees of the Medical Staff met on these dates:

- Memorial Regional Hospital (MRH) and Joe DiMaggio Children's Hospital (JDCH) on July 19, 2023
- Memorial Hospital West (MHW) on July 10, 2023
- Memorial Hospital Pembroke (MHP) on July 13, 2023
- Memorial Hospital Miramar (MHM) on July 18, 2023

All committees made a recommendation to accept the report of the Credentials Committee as follows:

That the following applicants be approved for membership as indicated:

New Applicant Name	Specialty (Sponsor)	Status	Adult & Pediatrics	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Aguilar, Manuela Magaly, PA	Emergency Medicine (Dr. Louis Jane)	Allied	Adult			X			2 years	
Bashkatov, Volha, APRN, CRNA	Nurse Anesthetist (Dr. Kiesha Raphael)	Allied	Adult & Pediatrics	X	X	X	X	X	2 years	
Berbel Caban, Ana Beatriz, MD	Critical Care Medicine	Active	Adult	X	X	X	X		2 years	
Bharadwa, Daphnie Vanessa, APRN	Employee Health (Dr. Barbara Coplowitz)	Allied	Adult	On staff	X	X	X		2 years	
Bivins, Megan MD	Pediatrics	Active	Pediatrics					X	2 years	
Blackman, Angela P, APRN	Neurosurgery (Dr. Christopher DeMassi)	Allied	Adult	X	X	X	X		2 years	
Boccio, Eric,	Emergency Medicine	Active	Adult	X	X				2	

New Applicant Name	Specialty (Sponsor)	Status	Adult & Pediatrics	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
MD									years	
Bonanno, Charles, MD	Nephrology	Active	Adult	X	X	X	X		2 years	
Brown, Blake Morgan, MD	Internal Medicine	Active	Adult	X	X	X	X		2 years	
Carmona, Osvaldo Antonio, MD	Internal Medicine	Active	Adult		X		X		2 years	
Cheema, Ayesha Sarfraz, MD	Internal Medicine	Active	Adult	X	X	X	X		2 years	
Chery, Stevenson Brisson, MD	Family Medicine	Active	Adult	X					2 years	
Chouake, Robert Joseph, MD	Otolaryngology/ Head and Neck Surgery	Active	Adult & Pediatrics				X		2 years	
Cohen, Danielle Rachael, MD	Emergency Medicine	Active	Adult	X					2 years	
Criado Carrero, Ricardo Javier, MD	Internal Medicine	Active	Adult	X	X	X	X		2 years	
Diaz, Nicolle, MD	Pediatric Critical Care	Active	Pediatrics					X	2 years	
Duran, Alper, MD	Diagnostic Radiology	Active	Adult & Pediatrics	X	X	X	X	X	2 years	
Egued, Manuel, MD	Internal Medicine	Active	Adult	X	X	X	X		2 years	
El Zaeedi, Mohamad Saleh L, MD	Thoracic Surgery	Active	Adult	X	X	X	X		2 years	Two year initial appointment and proctoring of procedures as follows: 1) Video Assisted Thoracic Surgery

New Applicant Name	Specialty (Sponsor)	Status	Adult & Pediatrics	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										(VATS)/Thoracoscopy-First 3 cases must be proctored; 2) Electromagnetic navigational bronchoscopy (ENB)-First 5 cases must be proctored; 3) Endobronchial Ultrasound with Transbronchial Needle Aspiration (EBUS)-First 10 cases must be proctored to include thorough demonstration of knowledge of mediastinal anatomy and lymph node stations; and 4) Robotic Assisted Surgery-First 3 cases to be proctored.
Enaiett, Lindsay Renee, APRN, CRNA	Nurse Anesthetist (Dr. Kiesha Raphael)	Allied	Adult & Pediatrics	X	X	X	X	X	2 years	
Encaoua, Caroline Allison Melanie Ache, MD	Diagnostic Radiology	Active	Adult & Pediatrics	X	X	X	X	X	2 years	
Farnsworth, Brigitte Elizabeth, APRN	Neurology (Dr. Mhd Zakaria)	Allied	Adult	X	X				2 years	
Forman, Nathaniel, MD	Pediatric Emergency Medicine	Active	Pediatrics		X		X	X	2 years	Two year initial appointment. Pending

New Applicant Name	Specialty (Sponsor)	Status	Adult & Pediatrics	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										training documentation for privileges to perform and interpret emergent, focused or investigational ultrasound.
Fridman, Mark Aaron, PA	Pediatric Otolaryngology/ Head and Neck Surgery (Drs. Samantha Britni Allen; Aiysha Balbosa & Samuel Ostrower)	Allied	Pediatrics		X			X	2 years	
Fuller, Lanisha Denise, MD	Anatomic and Clinical Pathology	Active	Adult & Pediatrics	X	X	X	X	X	2 years	
Giraldo, Viviana, APRN	Transplant Nephrology and Transplant Surgery (Drs. Basit Javaid; Linda Chen; Joseph Africa; Edson Franco; Heather LaGuardia & Seyed Ghasemian)	Allied	Adult	X					2 years	
Goldstein, Lara Nicole, MD	Emergency Medicine	Active	Adult	X	X				2 years	
Gonzalez, Denise Marie, APRN, CNM	Nurse Midwife (Drs. Timothy De Santis; Nicholas Jeffrey; Michael Yuzefovich; Hilary Eggers; Erin Myers; Hany Moustafa & Julie Kang)	Allied	Adult	X					2 years	
Goodrich, Andrew Swee, DO	Emergency Medicine	Active	Adult	On staff	X				2 years	
Grandez, Cesar, MD	Internal Medicine	Active	Adult	X	X	X	X		2 years	

New Applicant Name	Specialty (Sponsor)	Status	Adult & Pediatrics	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Gregoire-Bottex, Marie Myrtha, MD	Pediatric Pulmonary Disease	Active	Pediatrics				X	X	2 years	
Hans, Bharat Bhushan, MD	Internal Medicine	Active	Adult	X	X	X	X		2 years	
Hernandez Zuniga, Mauricio Javier, MD	Internal Medicine	Active	Adult	X	X	X	X		2 years	
Hibbs, Matthew Joseph, MD	Pediatric Hospice and Palliative Medicine	Active	Pediatrics	X			X	X	2 years	
Jones, Christine, APRN, CRNA	Nurse Anesthetist (Dr. Walter Diaz)	Allied	Adult & Pediatrics	X	X	X	X	X	2 years	
Jorge-Rodriguez, Natalie, MD	Family Medicine	Active	Adult		X				2 years	
Lenis, Jamie Ursula, APRN	Maternal Fetal Medicine (Drs. Jaime Rodriguez & Jeanine Carbone-Lazarus)	Allied	Adult	On staff	X		On staff		2 years	
Lopez-Pena, Maricarmen, MD	Pediatric Rheumatology	Active	Pediatrics	X	X		X	X	2 years	
Marrero, Cassidy Taylor, PA	Pediatric Otolaryngology/ Head and Neck Surgery (Drs. Samantha Britni Allen; Aiysha Balbosa & Samuel Ostrower)	Allied	Pediatrics	X			X	X	1 year	One year initial appointment pending FPPE results
McCormack, Jessica, APRN	Transplant Nephrology (Drs. Basit Javaid; Seyed Ghasemian; Heather LaGuardia; Edson Franco; Joseph Africa & Linda Chen)	Allied	Adult	X					2 years	
McCusker, Ryan P., CCP	Perfusionist (Dr. Frank Scholl)	Allied	Adult & Pediatrics	X				X	2 years	

New Applicant Name	Specialty (Sponsor)	Status	Adult & Pediatrics	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
McGuire, Jonathan Estevan, MD	Internal Medicine	Active	Adult	X	X	X	X		2 years	
Merilien, Esther, APRN	Hematology (Dr. Foluso Ogunsile)	Allied	Adult	X	X	X	X		2 years	
Molokie, Jessica, MD	Pediatrics	Active	Pediatrics					X	2 years	
Mora Tejeda, Iris, APRN	Internal Medicine (Dr. Fausto De La Cruz)	Allied	Adult		X				2 years	
Moreno, Frank	Surgical Assistant	Allied	Adult & Pediatrics				X		1 year	One year initial appointment pending FPPE results
Mufleh, Amani Marwan, APRN	Transplant Nephrology and Transplant Surgery (Drs. Basit Javaid; Heather LaGuardia; Edson Franco; Seyed Ghasemian; Joseph Africa & Linda Chen)	Allied	Adult	X					2 years	
Nasser, Mohamed, MD	Neurology	Active	Adult	X	X	X	X		2 years	
O'Connor, Jacquelyn Christine, APRN, CRNA	Nurse Anesthetist (Dr. Kiesha Raphael)	Allied	Adult & Pediatrics	X	X	X	X	X	2 years	
Purohit, Luv, MD	Internal Medicine	Active	Adult	X	X	X	X		2 years	
Qureshi, Tazeen, MBBS	Pediatrics	Active	Pediatrics					X	2 years	Two year initial appointment. Suprapubic tap privileges not approved due to lack of training.
Rodulfo, Alejandro	Psychiatry	Active	Adult	X					2 years	

New Applicant Name	Specialty (Sponsor)	Status	Adult & Pediatrics	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Enrique, MD										
Rojas, Janina Elizabeth, MD	Pediatrics	Active	Pediatrics				X		2 years	
Runyon, Jonathan Neal, MD	Pediatric Critical Care Medicine	Active	Pediatrics					X	2 years	
Saini, Vishal, DO	Neurocritical Care	Active	Adult	X	X	X	X		2 years	
Saunders, Jessica MD	Pediatric Pulmonology	Active	Pediatrics	X			X	X	2 years	
Shaikh, Zuber A., MD	Internal Medicine	Active	Adult	X	X	X	X		2 years	
Shanmugham, Prashanth, MD	Pediatric Critical Care	Active	Pediatrics					X	2 years	Two year initial appointment. Bronchoscopy privileges not approved due to lack of training.
Sherman, Evan Scott, MD	Pediatric Emergency Medicine	Active	Pediatrics		X		X	X	2 years	
Silverman, Daniel, MD	Psychiatry	Active	Adult & Pediatrics	X	X			X	2 years	
Sinyor, Benjamin, MD	Family Medicine	Active	Adult	X	X	X	X		2 years	
Smolar, David Evan, MD	Neurological Surgery	Active	Adult & Pediatrics	X	X	X	X	X	2 years	
Sole, Keila, DO	Pediatrics	Active	Pediatrics	X	X		X		2 years	
Tine, Stephanie, DPM	Podiatry	Active	Adult & Pediatrics	X					2 years	
Vargas Pelaez, Alvaro Felipe, MD	Cardiovascular Disease	Active	Adult	X					2 years	
Velez Martinez, Mariella, MD	Cardiovascular Disease	Active	Adult	X	X	X	X		2 years	
Vigandt, Erika,	Internal Medicine	Active	Adult	X	X	X	X		2	

New Applicant Name	Specialty (Sponsor)	Status	Adult & Pediatrics	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
MD									years	
Vila Torres, Sebastian Gabriel, MD	Internal Medicine	Active	Adult	X	X	X	X		2 years	
Yorukoglu, Neslihan, APRN	Hematology and Medical Oncology (Drs. Hugo Fernandez; Yehuda Deutsch; Jennifer Logue; Nina Nguyen; Claudia Paba-Prada; Jose Sandoval-Sus; Carlos Silva Rondon & Fernando Vargas Madueno)	Allied	Adult	X	X				2 years	
Yousuf, Fawad, MD	Neurology	Active	Adult	X	X	X	X		2 years	

That the following applicants for reappointment be approved as indicated:

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Allen DPM, Amanda J	Podiatry	8/1/2023	Adult	Active	Active	Active	Active		2 years	Two year reappointment and additional privileges for the Use of Fluoroscopy.
Alphonse APRN, Sandra	Emergency Medicine (Dr. Gustavo Gonzalez, Jr.)	8/1/2023	Adult			Allied			2 years	
Alvarez MD, Joan Adolfo	Obstetrics and Gynecology	8/1/2023	Adult	Active					2 years	
Antoine MD, Louis Bernard	Psychiatry	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Arango MD, Dillonelijah	Orthopedic Surgery	8/1/2023	Adult		Active		Active		2 years	
Arce MD, Orlando Xavier	Pediatric Cardiology	8/1/2023	Pediatrics		Active		Active	Active	2 years	
Askari MD, Karen Racedo	Endocrinology, Diabetes and Metabolism	8/1/2023	Adult	Active			Active		2 years	
Avery MD, Matthew	Orthopedic Surgery	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active		2 years	
Bartos DO, Simona	Dermatology	8/1/2023	Adult	Active					2 years	
Bassan MD, Eric Michael	Emergency Medicine	8/1/2023	Adult	Active					2 years	
Bataskov MD, Karrie L	Obstetrics and Gynecology	8/1/2023	Adult		Active		Active		2 years	
Baylis MD, Robert Wells	Orthopedic Surgery	8/1/2023	Adult	Active					2 years	
Bengoa MD, Federico G	Vascular and Interventional Radiology	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Benjamin MD, Dwight Evon	Obstetrics and Gynecology	8/1/2023	Adult				Active		2 years	Two year reappointment. The following privileges were not approved for failure to meet reappointment criteria: 1) Repair of Vesico-Vaginal, Vesico-Uterine; and 2) Urethro-Vaginal.
Bergeron Carter APRN, Stacy Lea Clark	Advanced Heart Failure and Transplant Cardiology (Drs. Priyanka	8/1/2023	Adult	Allied	Allied				2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
	Gosain; Namita Joseph & Iani Patsias)									
Bilasano MD, Vivian Blanquisco	Internal Medicine	8/1/2023	Adult	Active	Active		Active		2 years	
Boyd APRN, Jeremy Taylor	Emergency Medicine (Dr. Juan Villegas)	8/1/2023	Adult				Allied		2 years	
Bratter DO, Jonathan David	Obstetrics and Gynecology	8/1/2023	Adult		Active		Active		2 years	Two year reappointment. First three Acessa procedures must be proctored.
Bridgewater MD, Richard L	Obstetrics and Gynecology	8/1/2023	Adult		Active		Active		2 years	Two year reappointment. First three robotic assisted surgery cases must be proctored.
Brown MD, Gary Orian	Family Medicine	8/1/2023	Adult	Active	Active	Active			2 years	
Bula DMD, Aurelio Antonio	Pediatric Dentist	8/1/2023	Pediatrics					Active	2 years	
Bullock MD, James Montgomery	Orthopedic Surgery	8/1/2023	Adult		Active		Active		2 years	
Bustamante Rivas, Carlos I, MD	Infectious Disease	8/1/2023	Adult	Active	Active				2 years	Two year reappointment and a change to Community Affiliate status.
Bustamante MD, Edgar Lizandro	Internal Medicine	8/1/2023	Adult	Active	Active	Active	Active		2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Cabrera MD, Denise	Family Medicine	8/1/2023	Adult	Active					2 years	
Cabrerizo DMD, Ania	Pediatric Dentist	8/1/2023	Pediatrics					Active	2 years	
Cano Cevallos MD, Edison Jose	Infectious Disease	8/1/2023	Adult	Active	Active		Active		2 years	
Cano MD, Roberto Antonio	Oncology and Hematology	8/1/2023	Adult	Active					2 years	
Cantero, Victor H., MD	Obstetrics and Gynecology	8/1/2023	Adult	Active	Active		Active		2 years	Two year reappointment of Dr. Cantero at MRH and MHW. MHM approved Dr. Cantero for a two year reappointment, with continuation of the Focused Professional Practice Evaluation (FPPE) as previously approved and noticed by correspondence on December 18, 2019.
Cantor Varela MD, Manuel Enrrique	Internal Medicine	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Cavitt MD, Layla	Family Medicine	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Chaize DO, Robin Lynn	Pediatric Hospitalist	8/1/2023	Pediatrics					Active	2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Cogan MD, John	Electrophysiology	8/1/2023	Adult & Pediatrics	Active	Active	Active		Active	2 years	Two year reappointment. Alcohol septal ablation privileges were not approved for failing to meet reappointment criteria, reporting 0 out of 4 cases during the past 2 years.
Cordero APRN, CRNA, David	Nurse Anesthetist (Dr. Richard Elf)	8/1/2023	Adult & Pediatrics	Allied	Allied	Allied	Allied	Allied	2 years	
Correa MD, Eloisa Margarita	Family Medicine	8/1/2023	Adult	Active					2 years	
Cristea MD, Emilian Alexandru	Nephrology	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Dalal DO, Azhar Iqbal	Internal Medicine	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Davis, Lowell Scott, DO	Interventional Pain Medicine	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Davis MD, Richard Edmund	Otolaryngology/ Head and Neck Surgery and Plastic Surgery	8/1/2023	Adult & Pediatrics				Active		2 years	Two year reappointment and approval of additional privileges as follows: 1) Partial maxillectomy and Neck - Incision 2) Drainage neck abscess.
De Los Santos MD, Pablo	Vascular Surgery	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Del Pino-White DO, Perla	Family Medicine	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Deutsch MD, Yehuda Ethan	Oncology and Hematology	8/1/2023	Adult	Active	Active		Active		2 years	
Diaz MD, Diego Mauricio	Pediatric Gastroenterology	8/1/2023	Pediatrics	Active	Active		Active	Active	2 years	
Dolberg MD, Michael Eric	Colon and Rectal Surgery	8/1/2023	Adult	Active	Active	Active	Active		2 years	Two year reappointment and approval of additional privileges as follows: 1) Low Anterior Resection 2) Anterior Perineal Resection 3) Ventral Hernia 4) Transanal rectal resection 5) Repair of rectal prolapse 6) Surgical repair of anal fistula 7) Low anterior resection/abdominal perineal resection 8) Oophorectomy as part of an en bloc procedure 9) Placement of colonic stent.
Drmanovic MD, Zoran	Anesthesiology	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Dubrovsky MD, Tatyana	Pediatric Neurology	8/1/2023	Pediatrics	Active	Active		Active	Active	2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Easterling MD, Kenneth Jay	Orthopedic Surgery	8/1/2023	Adult				Active		2 years	
Eichinger PA, Theresa Anne	Surgical Assistant (Dr. Farid Assouad)	8/1/2023	Adult & Pediatrics	Allied	Allied	Allied			2 years	
Espinosa APRN, Michael	Radiation Oncology (Drs. Michael Burdick; Ignacio Castellon; Maria Ciccia; Aaron Falchook; Christine Feng & Tamara Smith)	8/1/2023	Adult & Pediatrics	Allied	Allied	Allied	Allied	Allied	2 years	
Estreicher MD, Michael Benjamin	Emergency Medicine	8/1/2023	Adult	Active		Active			2 years	
Fazekas MD, Matthew Laub	Pediatric Sports Medicine	8/1/2023	Pediatrics	Active			Active	Active	2 years	
Fortu MD, Jesusa Milalaine Terrado	Pediatric Emergency Medicine	8/1/2023	Pediatrics		Active		Active	Active	2 years	
Fraser MD, Marika A	Otolaryngology/ Head and Neck Surgery	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Funes PSYD, Catherine Fernanda	Psychology	8/1/2023	Adult	Active					2 years	
Garazi MD, Esther Danielle	Anesthesiology	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Garcia APRN, Ana Beatriz	Palliative Medicine (Dr. Patrick Reynolds)	8/1/2023	Adult		Allied				2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Garcia APRN, CNM, Jennifer Lynn	Nurse Midwife (Dr. Laviniu Anghel)	8/1/2023	Adult				Allied		2 years	
Garcia APRN, CRNA, Melanie Eleanor	Nurse Anesthetist (Dr. Kiesha Raphael)	8/1/2023	Adult & Pediatrics	Allied	Allied	Allied	Allied	Allied	2 years	
Georges, Woody, APRN, DNP	Infectious Disease (Dr. Roger Spitzer)	8/1/2023	Adult	Allied		Allied			2 years	
Gerenstein MD, Gustavo Marcelo	Anesthesiology	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Giardino APRN, CNM, Monica Frances	Nurse Midwife (Dr. Susan Davila)	8/1/2023	Adult	Allied	Allied				2 years	
Golding MD, Allan Colville	Endocrinology, Diabetes and Metabolism	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Gonzalez APRN, Jenessy	Thoracic Surgery (Dr. Mark Block)	8/1/2023	Adult	Allied	Allied	Allied	Allied		2 years	
Gonzalez APRN, Pamela Amanda	Neonatal Perinatal Medicine (Drs. Mesfin Afework; Yasser Al-Jebawi; Richard Auerbach; Sharell Bindom; Gianina Davila; Cristian Esquer; Cherie Foster; Vicki Johnston; Doron Kahn; Angela Leon Hernandez; Lester McIntyre; Estela Pina-Rodrigues;	8/1/2023	Pediatrics					Allied	2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
	Mariela Sanchez Rosado; Bruce Schulman; Mona Shehab; Max Shenberger; Flavio Soliz & Pablo Valencia.)									
Gosain MD, Priyanka	Advanced Heart Failure and Transplant Cardiology	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Gresseau APRN, Shama R	Physical Medicine and Rehabilitation (Drs. James Salerno; Raul Rolon Torres; Ian Miller; Robert Klecz; Joanne Delgado-Lebron; Jackson G Cohen; Ivor Nugent; Janice Cohen; Jeremy Jacobs; Theophila Semanoff & Sarah Pastoriza)	8/1/2023	Adult	Allied					2 years	
Grosman MD, Daren David	Oncology and Hematology	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Hajje MD, Daher Roberto	Anatomic and Clinical Pathology	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Hart-Unger MD, Sarah Rachel	Pediatric Endocrinology	8/1/2023	Pediatrics		Active		Active	Active	2 years	
Henner MD, Benjamin Joseph	Anesthesiology	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	Two year reappointment. Use of Fluoroscopy privileges not

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										granted; outside of Dr. Henner's scope of practice.
Hernandez MD, Pedro	Nephrology	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Hesse MD, Sabine Vera	Otolaryngology/Head and Neck Surgery	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Hoffman MD, Seth Asher-Kraines	Critical Care Medicine	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Hunter MD, Robert Lawrence	Obstetrics and Gynecology	8/1/2023	Adult		Active		Active		2 years	Two year reappointment, with additional privilege cluster- Obstetrical Hospitalist and the relinquishment of Obstetrical and Gynecology core privileges.
Ialenti MD, Marc Nicholas	Orthopedic Surgery	8/1/2023	Adult	Active	Active		Active		2 years	
Imran MD, Muhammad	Internal Medicine	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Janney PA, Gabrielle	Pediatric Emergency Medicine (Dr. Heidi Cohen)	8/1/2023	Pediatrics		Allied		Allied	Allied	2 years	
Jaramillo APRN, Ingry Alexandra	Pediatric Surgery (Dr. Jill Whitehouse)	8/1/2023	Pediatrics	Allied				Allied	2 years	
Joorabchi DO, Sina A	Otolaryngology/Head and Neck Surgery	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Kachappilly APRN, Preetha Liju	Internal Medicine and Nephrology (Drs. Sukvinder Gulati & Manjit Gulati)	8/1/2023	Adult	Allied	Allied	Allied			2 years	
Kaliki MD, Giri Venkata	Pediatric Critical Care Medicine and Pediatric Cardiology	8/1/2023	Pediatrics					Active	2 years	
Kaner MD, Jeffrey Bruce	Gastroenterology	8/1/2023	Adult	Active	Active				2 years	Two year reappointment with additional privileges as follows: 1) Dilation of the esophagus or pylorus 2) Percutaneous endoscopic gastrostomy (PEG) 3) Use of fluoroscopy. Approved relinquishment of Moderate Sedation privileges.
Klein MD, Robert	Obstetrics and Gynecology	8/1/2023	Adult		Active		Active		2 years	
Koerner APRN, CRNA, Theodore III	Nurse Anesthetist (Drs. Howard Leibowitz & Kiesha Raphael)	8/1/2023	Adult & Pediatrics	Allied	Allied	Allied	Allied	Allied	2 years	
Kowalski DO, Ian Joseph	Palliative Medicine	8/1/2023	Adult	Active					2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Kubal MD, Aarup Anant	Ophthalmology	8/1/2023	Adult & Pediatrics	Active	Active				2 years	
Kubiliun-Kotzen DO, Rosa	Pediatric Emergency Medicine	8/1/2023	Pediatrics		Active		Active	Active	2 years	
Kurup, Shreeja Satheesh, APRN	Anesthesiology (Dr. Kiesha Raphael)	8/1/2023	Adult & Pediatrics	Allied	Allied	Allied	Allied	Allied	2 years	
Kurzer MD, Eliecer	Urology	8/1/2023	Adult		Active		Active		2 years	
Lane MD, Alan S	Ophthalmology	8/1/2023	Adult	Active					2 years	
Lanoue MD, Alix	Gastroenterology	8/1/2023	Adult	Active	Active				2 years	
Lao MD, Oliver Bennett	Pediatric Surgery	8/1/2023	Pediatrics	Active	Active		Active	Active	2 years	
Laratro PSYD, Marnie Dena	Psychology	8/1/2023	Adult & Pediatrics	Active				Active	2 years	
Lazar, Jared, DO	Family Medicine	8/1/2023	Adult	Active					2 years	
Levine MD, Sherry Leigh	Otolaryngology/Head and Neck Surgery	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Lewy-Alterbaum MD, Ana Lorena	Endocrinology, Diabetes and Metabolism	8/1/2023	Adult	Active					2 years	
Llaguna MD, Omar Hidalgo	Surgical Oncology	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Maggs CCP, Georgina H	Perfusionist (Drs. Michael Cortelli & Frank Scholl)	8/1/2023	Adult & Pediatrics	Allied				Allied	2 years	
Markovich MD, Alexander	Nephrology	8/1/2023	Adult	Active	Active	Active	Active		2 years	Two year reappointment and additional

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										privileges as follows: 1) Percutaneous biopsy of autologous and transplanted kidneys 2) Insertion of temporary vascular access for hemodialysis and related procedures.
Marshall MD, David S	Anatomic and Clinical Pathology	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Martinez MD, Dario	Internal Medicine	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Matei DO, Emil M	Surgery	8/1/2023	Adult	Active	Active	Active	Active		2 years	Two year reappointment and additional privileges as follows: 1) Duodenal Switch 2) Abdominoplasty 3) Adrenalectomy open; Low Anterior Resection 4) Anterior Perineal Resection 5) Use of Fluoroscopy 6) Parathyroid Surgery 7) Paraesophageal or Hiatal Hernia Repair

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										8) Splenectomy open 9) Gastrectomy. Pancreatic resection privileges were not approved for failure to meet criteria, reporting 0 out of 5 cases during the past 2 years.
McCarthy MD, Kevin J	Orthopedic Surgery	8/1/2023	Adult			Active			2 years	
McClure MD, Shawn Andrew	Oral Maxillofacial Surgery	8/1/2023	Adult & Pediatrics	Active	Active			Active	2 years	
Merunko MD, Alexey	Internal Medicine	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Merunko MD, Olga	Internal Medicine	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Messa III, Charles Angelo, MD	Plastic Surgery	8/1/2023	Adult		Active	Active	Active		2 years	Two year reappointment and approval of Pediatric Encounter Exempt privilege cluster.
Minor PA, Gerard Jerome	Pediatric Gastroenterology (Drs. Aymin Delgado and Mario Tano)	8/1/2023	Pediatrics	Allied	Allied		Allied	Allied	2 years	
Miranda MD, Lilliam Maria	Rheumatology	8/1/2023	Adult		Active				2 years	
Mishiev MD, Baaz	Gastroenterology	8/1/2023	Adult	Active	Active				2 years	Two year reappointment and relinquishment of privileges as

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										follows: 1) Moderate Sedation 2) Dilation of the esophagus or pylorus 3) Percutaneous endoscopic gastrostomy (PEG) 4) Use of the fluoroscopy in a procedure where the physician is a concurrent privilege holder.
Mitchell MD, Vanessa Monique	Internal Medicine	8/1/2023	Adult	Active	Active	Active	Active		2 years	Two year reappointment and additional privileges for the Care of a patient with acute stroke (MHW).
Molina MD, Enrique G	Gastroenterology	8/1/2023	Adult	Active	Active				2 years	Two year reappointment and relinquishment of Moderate Sedation privileges.
Montero Hurtado MD, Alfredo	Internal Medicine	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Montes-Berrios MD, Veronica	Anesthesiology and Critical Care Medicine	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	Two year reappointment with additional privileges for the Care of a patient

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										with acute stroke (MHW).
Motley MD, Rohana	Obstetrics and Gynecology	8/1/2023	Adult & Pediatrics	Active				Active (GYN only)	2 years	
Muttal MD, Saraswati A	Neurointraoperative Monitorist	8/1/2023	Adult & Pediatrics	Active	Active	Active		Active	2 years	
Neuwirth MD, Zev Joey	Internal Medicine	8/1/2023	Adult	Active					2 years	
Nguyen MD, Van Hoang	Anesthesiology	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Oramas DDS, Victor R	Pediatric Dentist	8/1/2023	Pediatrics		Active		Active	Active	2 years	Two year reappointment. Moderate Sedation privileges were not approved for failure to meet reappointment criteria, reporting 0 out of 5 cases for the past 2 years.
Otero MD, Eduardo Alejandro	Neonatal Perinatal Medicine	8/1/2023	Pediatrics					Active	2 years	Two year reappointment and the relinquishment of Moderate Sedation privileges.
Papastavros MD, Vassiliki Anna	Dermatology	8/1/2023	Adult		Active				2 years	
Pascuzzo MD, Tara Lee	Internal Medicine	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Patzke MD, Anamaria Duvnjak	Pediatrics	8/1/2023	Pediatrics				Active		2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Pavuluri MD, Vamsi Mohan	Cardiovascular Disease	8/1/2023	Adult	Active	Active	Active			2 years	Two year reappointment. Moderate Sedation privileges were not approved for failure to meet reappointment criteria, reporting 1 out of 5 cases during the past 2 years.
Payenson MD, Alon	Emergency Medicine	8/1/2023	Adult	Active	Active				2 years	Two year reappointment and additional privileges for Moderate Sedation.
Paz Cruz APRN, CRNA, Monica	Nurse Anesthetist (Dr. Karim Abouelenin)	8/1/2023	Adult & Pediatrics	Allied	Allied	Allied	Allied	Allied	2 years	
Perez, Olga Teresa, MD	Family Medicine	8/1/2023	Adult				Active		Denied	Denied continued reappointment for failure to meet Board certification requirement.
Peshimam MD, Samir Ahmad	Critical Care Medicine	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Petrovani MD, Nicola Karen	Pediatric Emergency Medicine	8/1/2023	Pediatrics		Active		Active	Active	2 years	
Popp MD, Tarah Joy	Pediatric Cardiology	8/1/2023	Pediatrics	Active	Active		Active	Active	2 years	Two year reappointment and additional privileges for Interpretation of Fetal Echocardiogram.

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Rejtman DO, Marcos	Palliative Medicine	8/1/2023	Adult	Active	Active				2 years	
Rivera APRN, CRNA, Eva F	Nurse Anesthetist (Dr. Karim Abouelenin)	8/1/2023	Adult & Pediatrics	Allied	Allied	Allied	Allied	Allied	2 years	
Rivero-Barba PSYD, Amina	Psychology	8/1/2023	Adult	Active					2 years	
Rivers MD, Aeisha Kekhia Stimage	Surgical Oncology	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Romano MD, John Charles	Internal Medicine	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Roth DO, Esther Malka	Family Medicine	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Salas DPM, Yanira E	Podiatry	8/1/2023	Adult & Pediatrics		Active				2 years	
Sanchez Landazabal MD, Martha S	Pediatrics	8/1/2023	Pediatrics		Active		Active	Active	2 years	
Saporta MD, Inbar	Cardiovascular Disease	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Schneider PHD, Barry Alan	Psychology	8/1/2023	Adult	Active					2 years	
Segovia APRN, Carlos	Surgical Assistant	8/1/2023	Adult & Pediatrics		Allied				2 years	
Semanoff MD, Theophila C	Physical Medicine and Rehabilitation	8/1/2023	Adult	Active	Active	Active	Active		2 years	
Sered MD, Samuel M	Diagnostic Radiology	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Shah MD, Trisha	Reproductive Endocrinology	8/1/2023	Adult				Active		2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Shatkin MD, Blane Taylor	Plastic Surgery	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Simon MD, Michael Ari	Urology	8/1/2023	Adult		Active		Active		2 years	
Singh APRN, Neeta L	Neonatal Perinatal Medicine (Drs. Cherie D Foster; Mesfin Afework; Yasser Al-Jebawi; Richard Auerbach; Sharell Bindom; Gianina Davila; Cristian Esquer; Vicki Johnston; Doron Kahn; Lester McIntyre; Estela Pina-Rodrigues; Bruce Schulman; Mona Shehab; Flavio Soliz; Pablo Valencia; Angela Leon Hernandez; Mariela Sanchez Rosado & Max Shenberger.)	8/1/2023	Pediatrics		Allied		Allied	Allied	2 years	
Smart APRN, CNM, Claire	Nurse Midwife (Dr. Laviniu Anghel)	8/1/2023	Adult				Allied		2 years	
Snow APRN, CRNA, Laurie Caryn Siegel	Nurse Anesthetist (Dr. Walter Diaz)	8/1/2023	Adult & Pediatrics	Allied	Allied			Allied	2 years	
Stengel MD, Joel Zachry	Gastroenterology	8/1/2023	Adult & Pediatrics	Active	Active			Active	2 years	Two year reappointment and additional privileges as

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										follows: 1) Dilation of the esophagus or pylorus 2) Percutaneous endoscopic gastrostomy (PEG) 3) Use of the Fluoroscopy. Approved relinquishment of Moderate Sedation privileges.
Sutton APRN, Tracy Lee	Internal Medicine and Nephrology (Drs. Emilian Cristea & Barbara Coplowitz)	8/1/2023	Adult	Allied	Allied	Allied	Allied		2 years	
Swift MD, Deborah Lynn	Obstetrics and Gynecology	8/1/2023	Adult		Active		Active		2 years	
Sykes APRN, Andrea Mead	Critical Care Medicine (Dr. Alvaro Visbal-Ventura)	8/1/2023	Adult	Allied	Allied	Allied	Allied		2 years	
Taylor MD, Kenneth Warren	Orthopedic Surgery	8/1/2023	Adult	Active	Active	Active			2 years	
Torres MD, Miguel Angel	Obstetrics and Gynecology	8/1/2023	Adult & Pediatrics				Active		2 years	Two year reappointment and additional privileges as follows: 1) Use of Morcellator (First 3 cases to be

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										proctored) 2) Acessa Procedure (First 3 cases to be proctored). Repair of vesico-vaginal vesico uterine, and urethro vaginal fistula privileges were not approved for failure to meet reappointment criteria, reporting 0 out of 2 cases, during the past 2 years.
Umlas Odzer MD, Shari-Lynn	Diagnostic Radiology	8/1/2023	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Urban-Galvez DO, Stephanie Nhora	Pediatrics	8/1/2023	Pediatrics				Active		2 years	
Van-Horne MD, Simone Soyini	Internal Medicine	8/1/2023	Adult	Active			Active		2 years	
Vara MD, Alexander	Orthopedic Surgery	8/1/2023	Adult		Active		Active		2 years	Two year reappointment and relinquishment of privileges as follows: 1) Simple hand surgery procedures including repair of lacerations

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										2) superficial/deep infection 3) digital tip injuries 4) skin grafts 5) amputations 6) trigger finger (DeQuervain's disease) 7) carpal tunnel decompression 8) fractured metacarpals, phalange and wrist 9) ganglion (palm or wrist, flexor sheath).
Wang DO, Annie	Pediatrics	8/12023	Pediatrics		Active		Active	Active	2 years	
Weiss MD, Lindsay	Pediatric Hospitalist	8/1/2023	Pediatrics					Active	2 years	

That the following changes in privileges for lack of Crew Resource Management Training Course be approved:

Practitioners Name	Specialty (Sponsor)	Appointment Date	Expirable Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
Arno, Lee Howard, APRN	Emergency Medicine (Dr. Boaz Rosenblat)	12/19/2022	7/1/2023	Adult			X	X		Discontinue invasive privileges pending completion of CRM training.
Crosno, Jesse, PA	Physician Assistant-Surgery	12/19/2022	7/1/2023	Adult				X		Discontinue invasive privileges

Practitioners Name	Specialty (Sponsor)	Appointment Date	Expirable Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
	(Dr. David Shenassa)									pending completion of CRM training.
Grabler, Jennifer Marie, PA	Physician Assistant-Surgery (Drs. Eric Stelnicki and George Kamel)	12/19/2022	7/1/2023	Adult & Pediatrics	X			X	X	Discontinue invasive privileges pending completion of CRM training.
Peters, Anthony John, DO	Emergency Medicine	12/19/2022	7/1/2023	Adult	X					Discontinue invasive privileges pending completion of CRM training.

That the following requests for changes, additions or relinquishment of privileges be approved:

Name	Specialty (Sponsor)	Request	Privilege	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
Bharadwa, Daphnie Vanessa, APRN	Internal Medicine (Dr. Barbara Coplowitz)	Change	From -Medical and Surgical To -Core Privileges: Employee Health.	Adult	X					Approved.
Byfield, Mitzie, APRN, CNM	Nurse Midwife (Drs. Nicholas Jeffrey, Erin Myers, Julie Kang & Hany Moustafa)	Additional	Vaginal birth after Cesarean section/trial of labor after Cesarean birth (VBAC/TOLAC).	Adult	X					Approved.

Name	Specialty (Sponsor)	Request	Privilege	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
Goodrich, Andrew Swee, DO	Critical Care Medicine & Emergency Medicine	Additional	1) Core Privileges in Emergency Medicine; 2) Use of Ultrasound 3) Deep Sedation (First 5 cases must be proctored).	Adult	X					Approved. First five Deep Sedation procedures must be proctored.
Morales, Marylin, APRN	Transplant Nephrology and Transplant Surgery (Drs. Basit Javaid; Heather LaGuardia; Joseph Africa; Edson Franco; Seyed Ghasemian & Linda Chen)	Additional	Prescribe/order controlled substances (DEA required).	Adult	X					Approved.
Murillo, Adiene Caridad, APRN	Oncology and Hematology (Drs. Aurelio Castrellon; Adriana Milillo Naraine & Alejandra Ergle)	Additional	Prescribe/order controlled substances (DEA required).	Adult	X	X				Approved.

Name	Specialty (Sponsor)	Request	Privilege	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
Perez-Mitchell, Carlos Esteban, MD	Otolaryngology /Head and Neck Surgery	Additional	Robotic Assisted Surgery (First 3 cases must be proctored) Robotics re-training course not required.	Adult & Pediatrics	X	X				Approved. First three robotic procedures must be proctored.
Pietri Mattei, Keysha Ivelisse, MD	Obstetrics and Gynecology	Additional	Endometrial Ablation -- NovaSure Procedure-First 3 cases must be proctored.	Adult		X				Approved. First three Endometrial Ablation – NovaSure procedures must be proctored.
Riordan, Krysten Ann, PA	Orthopedic Surgery (Dr. Daniel Chan)	Additional	1) Management of traction apparatus; 2) Function as surgical first assistant to the supervising physician in credentialed procedure; 3) Management and removal of surgical drains; 4) Superficial debridement.	Adult	X					Approved.
Rivera, Michael A, DPM	Podiatry	Relinquish	Privilege Cluster: NON-SURGICAL CONSULTS in Podiatry - Adult.	Adult & Pediatrics		X				Approved.

Please be advised that these applicants for appointment and reappointment were processed through the Board approved Credentialing Procedure that meets and exceeds the requirements of Florida Statute 395.011, and the standards of The Joint Commission.

The Executive Committees also accepted the following recommendations for changes in staff status as indicated:

Name	Specialty (Sponsor)	Topic	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
Aleyas, Sajive, MD	Pulmonary Disease	Request resignation effective 12/1/2022.	Adult	Active	Active	Active	Active		Accepted resignation effective 12/1/2022.
Bahadue, Felicia Lynn, MD	Obstetrics and Gynecology	Request resignation effective 7/21/2023.	Adult				Active		Accepted resignation effective 7/21/2023.
Bataskov, Karrie L., MD	Obstetrics and Gynecology	Request resignation at MRH & JDCH only, effective 8/1/2023.	Adult	Active	On staff		On staff	Active	Accepted resignation at MRH & JDCH only, effective 8/1/2023.
Borges Garnica, Alfredo Jose, SA	Surgical Assistant	Request resignation effective 6/19/2023.	Adult & Pediatrics	Allied	Allied	Allied			Accepted resignation effective 6/19/2023.
Bushkin, Frederic L, MD	Surgery	Request resignation at MHW & MHM only, effective 6/12/2023.	Adult	On staff	Active		Active		Accepted resignation at MHW & MHM only, effective 6/12/2023.
Cabrera, Edward, MD	Family Medicine	Request resignation at MHP only, effective 5/30/2023.	Adult	On staff	On staff	Active	On staff		Accepted resignation at MHP only, effective 5/30/2023.
De Los Santos Florian, Roosevelt Antonio, MD	Pediatrics	Request resignation effective 5/29/2023.	Pediatrics		Active		Active	Active	Accepted resignation effective 5/29/2023.
Duerkes, James A., DO	Obstetrics and Gynecology	Request resignation effective 6/16/2023.	Adult		Active				Accepted resignation effective 6/16/2023.

Name	Specialty (Sponsor)	Topic	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
El Kommos, Adam M., MD	Anesthesiology	Request resignation effective 6/20/2023.	Adult & Pediatrics	Active	Active	Active	Active	Active	Accepted resignation effective 6/20/2023.
Faraci, Andrea Victoria, MD	Obstetrics and Gynecology	Request resignation effective 6/13/2023.	Adult				Active		Accepted resignation effective 6/13/2023.
Ferland, Louise Diane, MD	Plastic Surgery	Request resignation effective 7/1/2023.	Adult & Pediatrics	Active	Active	Active	Active	Active	Accepted resignation effective 7/1/2023.
Fine, Jay B, MD	Plastic Surgery	Request resignation at MHP only, effective 5/31/2023.	Adult & Pediatrics		On staff	Active	On staff		Accepted resignation at MHP only, effective 5/31/2023.
Furia, Allen F, MD	Pediatrics	Request resignation effective 6/9/2023.	Pediatrics					Active	Accepted resignation effective 6/9/2023.
Gabe, Daniel B., DPM	Podiatry	Request resignation effective 6/20/2023.	Adult	Active					Accepted resignation effective 6/20/2023.
Garcia-Ocasio, Rafael E., MD	Obstetrics and Gynecology	Request resignation effective 6/8/2023.	Adult				Active		Accepted resignation effective 6/8/2023.
Gotthelf, Cheryl Ann, PHD	Psychology	Request resignation effective 6/5/2023.	Adult	Active					Accepted resignation effective 6/5/2023.
Greenstein, Yakov, MD	Psychiatry	Request resignation effective 6/21/2023.	Adult & Pediatrics	Active				Active	Accepted resignation effective 6/21/2023.
Guevara, Jade Gieseke, MD	Ophthalmology	Request resignation effective 6/21/2023.	Adult		Active				Accepted resignation effective 6/21/2023.
Hamdeh, Samir H., AA	Anesthesiologist Assistant (Dr. Amy Pulido)	Request resignation effective 6/19/2023.	Adult & Pediatrics	Allied	Allied	Allied	Allied	Allied	Accepted resignation effective 6/19/2023.

Name	Specialty (Sponsor)	Topic	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
Lobb, David Christopher, MD	Pediatric Plastic Surgery	Request resignation effective 6/30/2023.					Active	Active	Accepted resignation effective 6/30/2023.
Mack, Kenneth Aaron, MD	Internal Medicine	Request resignation effective 9/8/2022.	Adult	Active	Active	Active	Active		Accepted resignation effective 9/8/2022.
Maggs, Georgina H., CCP	Perfusionist (Drs. Michael Cortelli & Frank Scholl)	Request resignation at MHW, MHP & MHM only, effective 8/1/2023.	Adult & Pediatrics	On staff	Allied	Allied	Allied	On staff	Accepted resignation at MHW, MHP & MHM only, effective 8/1/2023.
McCarthy, Kevin J., MD	Orthopedic Surgery	Request resignation at MRH & MHW only, effective 5/19/2023.	Adult	Active	Active	On staff			Accepted resignation at MRH & MHW only, effective 5/19/2023.
Mejia, Alexander, MD	Obstetrics and Gynecology	Request resignation effective 8/1/2023.	Adult				Active		Accepted resignation effective 8/1/2023.
Miranda Torres, Carolina MD	Pediatric Pulmonology	Request resignation effective 7/31/2023.	Pediatrics	Active	Active		Active	Active	Accepted resignation effective 7/31/2023.
Perez, Paloma Irizarry, MD	Otolaryngology/ Head and Neck Surgery	Request resignation effective 6/30/2023.	Adult & Pediatrics				Active		Accepted resignation effective 6/30/2023.
Perlman, Varisa Boriboon, MD	Pediatrics	Request resignation effective 4/29/2023.	Pediatrics					Active	Accepted resignation effective 4/29/2023.
Rivero-Barba, Amina, PSYD	Psychology	Request resignation at JDCH only, effective 4/14/2023.	Adult	On staff				Active	Accepted resignation at JDCH only, effective 4/14/2023.
Scanlon, Jesse Lee, PA	Pediatric Critical Care Medicine (Dr. Allan	Request resignation effective 4/14/2023.	Pediatrics					Allied	Accepted resignation effective 4/14/2023.

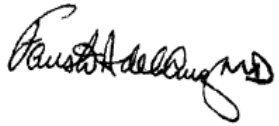
Name	Specialty (Sponsor)	Topic	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
	Greissman)								
Strauss, Neil Howard, DPM	Podiatry	Request resignation effective 6/6/2023.	Adult & Pediatrics	Active	Active	Active	Active		Accepted resignation effective 6/6/2023.
Subei, Adnan, DO	Neurology	Request resignation effective 6/6/2023.	Adult	Active	Active				Accepted resignation effective 6/6/2023.
Vargas, Erika V., APRN	Employee Health	Automatic termination of membership and privileges due to no sponsor, effective 3/1/2023.	Adult			Allied			Automatic termination of membership and privileges due to no sponsor, effective 3/1/2023.
Victorio APRN, Isabelo Ian Domingo	Electrophysiology (Dr. Awais Humayun)	Request resignation at MRH only due to no sponsor, effective 6/12/2023.	Adult	Allied	On staff	On staff	On staff		Accepted resignation at MRH only, effective 6/12/2023.
Vijil, Julio Cesar Jr, MD	Nephrology	Automatic termination for failure to request reappointment effective 8/1/2023.	Adult	Active					Automatic termination for failure to request reappointment effective 8/1/2023.
Visbal, Jhan Patrick, PA	Electrophysiology (Dr. Awais Humayun)	Request resignation at MRH only due to no sponsor, effective 6/13/2023.	Adult	Allied	On staff	On staff	On staff		Accepted resignation at MRH only, effective 6/13/2023.
Wrotslavsky, Michal, PA	Family Medicine (Dr. Scott English)	Request resignation effective 5/4/2023.	Adult	Allied					Accepted resignation effective 5/4/2023.
Young, Ming-Lon, MD	Pediatric Cardiology	Request resignation effective 6/30/2023.	Pediatrics	Active				Active	Accepted resignation effective 6/30/2023.

July 2023	MHS
New Physician Appointments	49
New AHP Appointments	18
Physician Reappointments	130
AHP Reappointments	29
Physician Resignations/Terminations	24
AHP Resignations/Terminations	5

Your approval of these recommendations is requested.

Sincerely,

Nigel Spier, M.D.
President
Memorial Regional Hospital
Joe DiMaggio Children's Hospital



Fausto A. De La Cruz, M.D.
Chief of Staff
Memorial Hospital West

Juan Villegas, M.D.
Chief of Staff
Memorial Hospital Miramar

Narendra R Upadhyaya, MD
Chief of Staff
Memorial Hospital Pembroke

Memorial Healthcare System

MEMORIAL REGIONAL HOSPITAL ▪ MEMORIAL REGIONAL HOSPITAL SOUTH ▪ JOE DIMAGGIO CHILDREN'S HOSPITAL
MEMORIAL HOSPITAL WEST ▪ MEMORIAL HOSPITAL MIRAMAR ▪ MEMORIAL HOSPITAL PEMBROKE

MHS Bylaws Committee Executive Summary

of Proposals for Revision – July 2023

1. Revision to Allied Health/ Advanced Practice Nomenclature :
    a. Reclassification of select current members of the Allied Health Professional (AHP) staff to be called Advanced Practice Providers (APPs) to reflect industry standard and legal reference documents. **There is no change to current Bylaws that govern practice or processes; this is strictly a name change.**
    b. Document changes: All references to Allied Health Professionals will now be listed as Allied Health Professionals/Advanced Practice Professionals, except items that specify a single classification.
    c. Specific Delineations are as follows:
        i. Allied Health Professionals (AHP)
            1. Certified Clinical Perfusionist
            2. Certified Neuro Intraoperative Monitorist (technician)
            3. Registered Nurse First Assistant
            4. Surgical Assistant
        ii. Advanced Practice Providers (APP)
            1. Anesthesia Assistant
            2. Advanced Practice Registered Nurse
            3. Certified Nurse Midwife
            4. Certified Registered Nurse Anesthetist
            5. Physician Assistant

Revisions to Allied Health/ Advanced Practice Nomenclature:

1. Document changes include:

   a. In Bylaws, Rules and Regulations, Policies and Procedures, all references of "Allied Health" will be replaced with "Allied Health/Advanced Practice".
   b. Bylaws section 6.8 – "Allied Health" to be replaced with "Advanced Practice" – regarding ability to perform an H & P:

> Sect. 6.8 History and Physical Requirements
>
> The attending physician shall ensure that a complete medical history and physical examination for each patient is performed and documented no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. This may be delegated to an ~~Allied Health~~ Advanced Practice Provider ~~Professional~~ who is privileged to conduct and document a patient history and physical. In the event the medical history and physical examination are completed within thirty (30) days before admission or registration, an updated examination of the patient, including any change in the patient's condition, must be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. All patient history and physicals shall be performed by the attending physician and/or another treating practitioner in accordance with the Medical Staff Bylaws and Rules and Regulations.

   c. In Policies and Procedures – separation of nomenclature defined; all other requirements remain:

> ALLIED HEALTH PROFESSIONALS /ADVANCED PRACTICE PROVIDERS
>
> The Board has determined the categories of individuals eligible for clinical privileges as an Allied Health Professional ("AHP") or as an Advanced Practice Provider (APP) as defined as in these Bylaws and as determined appropriate by the Medical Staff. These categories include:
>
> Allied Health Professionals (AHP)
> - Certified Clinical Perfusionist
> - Certified Neuro Intraoperative Monitorist
> - Registered Nurse First Assist
> - Surgical Assistant
>
> Advanced Practice Providers (APP)
> - Anesthesia Assistant
> - Advanced Practice Registered Nurse
> - Certified Nurse Midwife
> - Certified Registered Nurse Anesthetist
> - Physician Assistant

MHS Performance Improvement Plan 2023

Executive Summary of Revisions

1. **Cover Page**: Date changed to 2023
2. **Page 3: Performance Improvement Scope**
    a. Added Memorial Cancer Institute
3. **Page 8: Process – Project sources**
    a. Added item #33: National Database of Nursing Quality Indicators (NDNQI)
    b. Added item #34: Solutions for Patient Safety (JDCH)
4. **Page 15: Communication of Findings, Conclusions, Actions, and Recommendations**
    a. Deleted the reference to “Reporting Flow Diagrams” as those are no longer utilized

PERFORMANCE IMPROVEMENT PLAN
2023

MEMORIAL REGIONAL HOSPITAL
HOLLYWOOD, FLORIDA

JOE DIMAGGIO CHILDREN'S HOSPITAL
HOLLYWOOD, FLORIDA

MEMORIAL REGIONAL HOSPITAL SOUTH
HOLLYWOOD, FLORIDA

MEMORIAL HOSPITAL WEST
PEMBROKE PINES, FLORIDA

MEMORIAL HOSPITAL PEMBROKE
PEMBROKE PINES, FLORIDA

MEMORIAL HOSPITAL MIRAMAR
MIRAMAR, FLORIDA

MEMORIAL PHYSICIAN GROUP
HOLLYWOOD, FLORIDA

MEMORIAL PRIMARY CARE
DANIA BEACH, HOLLYWOOD, HALLANDALE BEACH, PEMBROKE PINES, and MIRAMAR, FLORIDA

PERFORMANCE IMPROVEMENT PLAN

TABLE OF CONTENTS

I. MISSION STATEMENT

Heal the body, mind and spirit of those we touch.

II. VISION STATEMENT

To be a premier clinically integrated delivery system providing access to exceptional patient-and family-centered care, medical education, research, and innovation for the benefit of the community we serve.

III. PILLARS OF EXCELLENCE

1. Safety

- Memorial will be a nationally recognized organization for positive clinical and non-clinical outcomes.

2. Quality

- Memorial will continue to deliver quality services and be able to measure that quality against the nation's top performers.

3. **Service**
   - A strong and positive image of Memorial service excellence will exist with our customers: patients, families, community, physicians, and hospital staff.

4. **People**
   - Our patient, staff and physician satisfaction will be very high and will be a result of a strong commitment to teamwork. Memorial Healthcare System will be the hospital of choice for employment in our community.

5. **Finance**
   - Memorial will maintain financial success.

6. **Growth**
   - Memorial will become a regional provider in healthcare.

7. **Community**
   - Physicians, patients, and other organizations will actively seek our services. We will be the hospital of choice and will continue to meet the growing needs of our community. We will improve the health status of the community.

IV. PERFORMANCE IMPROVEMENT PROGRAM

A. SCOPE

The Memorial Healthcare System is a leader in providing high quality health care services to South Broward residents. Memorial Regional Hospital, Memorial Regional Hospital South, Joe DiMaggio Children's Hospital, Memorial Hospital West, Memorial Hospital Pembroke, and Memorial Hospital Miramar together provide comprehensive acute care and rehabilitation services. Additional facilities and services provided are Memorial Manor (Skilled Nursing Facility), Memorial Physician Group (MPG), Inpatient and Outpatient Behavioral Health, Urgent Care Centers, 24/7 Care Center, Memorial Primary Care, Memorial Specialty Pharmacy, Memorial Home Infusion, and Memorial Cancer Institute.

Transplant and Heart Failure Programs are a part of the system-wide Performance Improvement Program through bi-directional communication and integration. Transplant and Heart Failure programs have additional Quality Assessment/Performance Improvement (QAPI) Committees and membership is reflective of multidisciplinary caregivers and hospital/system support. Transplant and Heart Failure Programs have a QAPI Plan which is separate from this plan.

The populations served are culturally diverse and range from birth to end of life. The primary languages are English, Spanish, French, and Creole. A variety of special needs services are provided to enhance safety and quality of services provided to patients and families.

Clinical vendors are evaluated and monitored to ensure safe quality care is provided by contracted vendors. Expectations are made in writing and data produced by the vendor is evaluated by appropriate clinical subject matter experts and leaders who monitor the contracted services.

B. OVERSIGHT AND INTENT OF PERFORMANCE IMPROVEMENT INITIATIVES

The Board of Commissioners of the South Broward Hospital District (d/b/a Memorial Healthcare System)

a) Set priorities for performance improvement activities and patient health outcomes.
b) Give priority to high-volume, high-risk, or problem prone processes for performance improvement activities.
c) Identify the frequency data collection for performance improvement activities.
d) Reprioritize performance improvement activities in response to changes in the internal or external environment.

The Performance Improvement Program (PIP) is a System-wide planned, comprehensive, and ongoing effort to achieve safety and excellence in our structures, processes, and outcomes. The purpose is to fulfill the intent of our Mission, Vision, and The Seven Pillars of Excellence. This is accomplished by:

a) Systematically collecting, aggregating, and using statistical tools and techniques to analyze and display data.
b) Analyzing and comparing internal data over time to identify levels of performance, patterns, trends, and variations.
c) Uses the results of data analysis to identify improvement opportunities.
d) Monitor the effectiveness and safety of services and quality of care.
e) Acts on improvement priorities and acts when it does not achieve or sustain planned improvements.

The intent of this program is to design and select measures for which data collection and analysis will yield meaningful information that allows for the evaluation of existing or planned structures, outcomes, and processes.
The objective is to-

a) Implement a well-planned and designed process that sustains improvement over time.
b) Monitor for undesirable patterns or trends.
c) Sustain excellent performance.
d) Enhance performance improvement, safety, and customer satisfaction over time.

The performance improvement plan is structured in a manner that accounts for each member hospital's unique circumstances and any significant differences in patient populations and services offered at each entity.

C. DELEGATION OF AUTHORITY

The Board of Commissioners delegates the authority to manage the details of the performance improvement activities to the President and Chief Executive Officer of the Memorial Healthcare System. The President/CEO of MHS therefore extends this authority to the CEO/Administrator and the Medical Staff Executive Committee of the respective MHS healthcare facilities, and governance committee of MPG who in turn, delegate the hospital performance improvement functions to the Quality Care and Patient Safety Council. The Board of Commissioners, through the Board Peer Review Committee and its designated representative on the Quality Care and Patient Safety Council, will exercise its oversight responsibility by receiving and reviewing summaries of all Medical Staff and organizational performance improvement, risk management, safety, and customer satisfaction activities quarterly, and where applicable, recommending additional Performance Improvement (PI) and safety initiatives.

D. MEDICAL STAFF

The Board of Commissioners delegates the authority for performing appropriate performance improvement review of professional care to the Medical Staffs of the individual hospitals. The preamble to the individual Medical Staff Bylaws indicates acceptance of responsibility for the quality and safety of medical care.

The Medical Staff has delegated, through the Department Chief (or his/her designees), the responsibility to perform Professional Practice Evaluation, both ongoing and focused and to participate in the assessment and evaluation of other important patient care processes and organizational functions. The peer review process is outlined in the *Medical Staff Rules & Regulations* and the *Medical Staff Peer Review Policy*. Aggregate performance and safety data will be used by

the Medical Staff departments for the privileging and credentialing process and will be shared among all the facilities for purposes of reappointment. The Executive Committee of the Medical Staff will be responsible for the needs of the PIP.

E. ANCILLARY SERVICES AND NURSING DEPARTMENTS

Each department's leadership is accountable and responsible for assessing, planning, improving, and evaluating their department's performance and the prioritization of their department's performance improvement activities. Additional indicators and projects, specific to the department's scope and service, can be selected. Priority should be given to processes that a) enhance patient safety; b) place the patients at risk if not performed well; c) performed when not indicated or not performed when indicated d) have been or are likely to be problem prone; e) affect a large percentage of patients, and f) improve customer satisfaction. Department leadership is responsible for ensuring that new processes and services are well designed, and that performance improvement activities are planned, systematic, implemented and evaluated.

The Department Leader of the service (or his/her designee) is responsible for participating in intra-, interdepartmental, or organizational PI activities as appropriate.

The Department Leaders are responsible for a) meeting quality control and quality assurance activities as prescribed by regulating agencies, and b) assessing and improving those important functions applicable to their patient populations and processes. Additionally, they are responsible for the ongoing evaluation of current professional publications, models, evidence based best practices, standards of practice and care, etc. and applying them to the existing processes/program as appropriate to facilitate ongoing performance improvement and safety in their area of responsibility.

Each department's employees are responsible for participating in performance improvement activities as assigned, communicating to immediate supervisors any performance or safety improvement opportunities as they are identified. This allows incorporation of continuous quality improvement and safety principles into all work processes.

All Department Leaders (or their designees) should report the progress of pertinent performance improvement endeavors to their committees at their respective hospitals.

Findings will be shared, when appropriate, with other hospital departments, hospital staff, Medical Staff, hospital committees, Quality Care and Patient Safety Council and the MHS Quality and Patient Safety Steering Committee. When indicated, district-wide teams or task forces are formed.

A critical component of PI is the staff level knowledge of ongoing performance improvement processes in their departments, as well as the hospital and system wide. PI data, projects, team efforts, outcomes and safety opportunities are shared and staff is educated through PI boards, discussion at staff meetings, huddles, competency verification sessions, etc.

F. PROCESS

The organization's appropriate individuals, departments and disciplines work collaboratively to reduce and prevent errors and enhance quality, safety, and performance. Patient and Family Centered Care groups at each hospital assist in this effort as well.

Performance Improvement may be accomplished using any standard PI tool, such as PDSA (Plan, Do, Study, Act), PDCA (Plan, Do, Check, Act), Six Sigma, Lean, as well as MAGIC (Measure, Assess, Generate Ideas, Implement, and Check). Failure Mode Effects Analysis (FMEA) and Root Cause Analysis (RCA) as prescribed by The Joint Commission are additional methodologies utilized to enhance safety and performance.

In an effort to become a high reliability organization, Memorial Healthcare System is committed to a Just Culture. Just Culture recognizes that humans are destined to make mistakes, and to drift from processes or procedures that are in place. Through the concept of Just Culture, leadership and staff are educated to view human mistakes and errors as the outcomes of imperfect processes that might benefit from evaluation and redesign. Through the Just Culture principles and algorithm, there is a shift of focus from errors and outcomes to system design and behavioral choices.

MHS District-wide Quality and Patient Safety Committee (QPSC)

The district-wide Quality and Patient Safety Committee (QPSC) meets regularly to address, coordinate, and communicate quality and safety initiatives system-wide. The QPSC is co-chaired by the Chief Quality Officer (MHS) and the Chief Nurse Executive (MHS). Additional functions performed by the QPSC are a) assigning teams to projects that focus on meeting the assessed needs of patients, families, employees, the community, and regulatory compliance; b)

ensuring adequate resources for team activities; c) monitoring the teams' progress d) redirecting the teams' focus when corrective actions do not yield the desired results.

Employees are involved in performance improvement. They participate in teams, task forces, hospital wide and departmental based councils. Projects for teams, FMEAs, task forces, or RCAs may come from many sources, including, but not limited to:

1. Patient safety initiatives
2. Patient or other customer complaints/suggestions/surveys (Press Ganey** or HCAHPS, CGCAHPS, OASCAHPS)
3. Medical Staff department meetings
4. Risk Management findings (adverse occurrences, sentinel events, "near misses" or trends of occurrences)
5. Department leadership or other committee meetings
6. Employee surveys/suggestions
7. AHRQ Culture of Safety Survey
8. Community surveys/suggestions
9. Findings reported in Clinical Effectiveness Meetings, Quality Care and Patient Safety Council, Performance Improvement/Risk management/Safety committees, Environment of Care committees, Infection Prevention and Control or any other ad hoc committee.
10. CMS Core Measures **
11. Joint Commission Sentinel Event Alerts
12. Joint Commission ORYX and Accelerate PI Reports
13. National Patient Safety Goals (NPSG), Joint Commission
14. Agency for Healthcare Research and Quality (AHRQ)**
15. Institute for Healthcare Improvement**
16. Agency for Health Care Administration (AHCA)**

17. American College of Surgeons (ACS)**
18. Health Research and Educational Trust (HRET), an affiliate of the American Hospital Association**
19. Centers for Disease Control
20. Health Effectiveness Data and Information Sets (HEDIS)
21. Quality Payment Program (QPP)
22. Meaningful Use/Promoting Interoperability Program
23. The Joint Commission standards, and other regulatory agencies
24. Antibiotic Stewardship Program
25. Leapfrog survey results**
26. Quality Care and Patient Safety Council
27. MHS Safety and Quality Committee
28. National Surgical Quality Improvement Program (NSQIP)**
29. Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)**
30. Exchange of Data for Rehabilitation Facilities (EQUADR)
31. American College of Surgeons-Improving Surgical Care and recovery (ISCR)**
32. National Perinatal Information Center (NPIC)**
33. National Database of Nursing Quality Indicators (NDNQI)**
34. Solutions for Patient Safety**

** Benchmarking availability

Measuring the Success of Performance Improvement

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

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

Data Collection encompasses the following Elements of Performance (Frequency of aggregation/reporting):

1. EVALUATIONS OF CONDITIONS IN THE ENVIRONMENT (monthly/quarterly)
    a) The Environment of Care Committee meets regularly to measure compliance with issues including but not limited to: Utilities, Security, Fire Protection, Hazardous Materials and Waste Management, Storage, Clinical Engineering, Life Safety Code, Employee Health (Workplace Violence), Water Management and Emergency Preparedness.

2. STAFF OPINIONS AND PERCEPTIONS (biennially)
    a) Surveys are conducted at regular intervals to measure staff opinion and perception. Topics that are measured include, but are not limited to: customer focus, teamwork, workload, quality of care, resiliency, senior management, non-punitive response to error, staffing, frequency of events reported and organizational learning.

3. PATIENTS' PERCEPTIONS OF CARE, TREATMENT AND SERVICE (monthly)
    a) HCAHPS, CGCAHPS and OASCAHPS (The Hospital, Clinical Groups and Outpatient & Ambulatory Surgery Consumer Assessment of Health Provider Surveys), which is reported by the Centers for Medicare and Medicaid, are the tool the Healthcare System utilizes to assess patients' perception of their care.
    b) Press Ganey Surveys are conducted to assess patients' or clients' perception of their care or their family's care.
    c) A patient grievance system is maintained, and appropriate persons address all complaints and grievances. Grievances can be aggregated and trended by type, unit, and/or individual over time.

4. HIGH RISK PROCESSES

a) Medication Management (monthly/quarterly)

(1) Pharmacy and Therapeutics Committees and the District Formulary Committee meet regularly to address standardization of the formulary use of medications, and to discuss interventions for safety, quality, and infection control concern. Quality performance on outside vendors is reviewed and include medication compounding.

(2) Safe Medication Teams meet regularly at the facility level to discuss adverse occurrences, trends of undesirable variations over time, levels of performance, patterns and variations and address opportunities for reducing the risk points in the medication management system such as:

(a) Adverse drug reactions

(b) Medication administration errors

(c) Medication incompatibilities

(d) Adverse occurrences resulting from medication errors “Near Misses”

(3) Processes are in place to monitor and eliminate the use of unapproved and dangerous abbreviations.

(4) Pain assessment and management with use of opioids, including tracking of adverse events related to opioid use.

b) Blood and Blood Product Use (monthly/quarterly)

(1) District-wide Transfusion Committee, and hospital specific utilization review committees meet regularly to address and discuss adverse occurrences and address opportunities for reducing risks in the blood product administration process such as:

(a) Blood transfusion reactions and analysis of confirmed blood transfusion reactions.

(b) Wastage of blood products.

(c) Availability of blood products and action plans to avoid critical shortages of blood products.

(2) Patterns of inappropriate usage are addressed when identified.

c) Restraint Use and Seclusion (monthly/quarterly)
   (1) Restraint and seclusion usage is monitored by nursing, with a goal of achieving zero use by monitoring the appropriateness of alternatives and diversional activities employed prior to initiating restraint use or seclusion.

d) Operative and Other Invasive Procedures (monthly/quarterly)
   (1) In concert with Medical Staff By-laws and Rules and Regulations, the Medical Staff monitors and measures at least the following indicators:
      (a) Adverse events or patterns of adverse events during moderate or deep sedation and anesthesia use.
      (b) Deaths or injuries potentially related to the administration of anesthetics or procedures.
      (c) Major discrepancies between preoperative and postoperative diagnosis (including pathologic) diagnosis.
      (d) Operative and other invasive or noninvasive procedures that place patients at risk, with a focus on high risk, high volume or low-volume and therefore high-risk procedures or new services.
      (e) Any unexpected occurrence or outcome (complication).
      (f) Unexpected return to the Operating Room.
      (g) Anesthesia Awareness.
      (h) “Time Out” (Universal Protocol) for patient procedure and side-site identification.
      (i) Safe medication administration practices.
      (j) Fire safety in the surgical services areas.
      (k) Results of Crew Resource Management safety initiative implementation.

e) Quality indicator data, including patient care data and other relevant data such as that submitted to or received from Medicare quality reporting and quality performance programs data related to hospital readmissions and hospital acquired conditions. The hospitals select and use ORYX® measures that are relevant to their patient population and identify, prioritize, and monitor performance improvement.

(2) Members with medical staff privileges do not initially review their own cases for quality improvement program purposes.

f) Resuscitation and Its Outcomes (monthly/quarterly)

(1) All mortalities

(2) Blue Alerts

(a) The number and location of cardiac arrests

(b) The outcome of resuscitation

(c) Transfer to a higher level of care

*An interdisciplinary committee reviews cases and data to identify and suggest practice and system improvements in resuscitation performance

(3) Rapid Response Teams and Help Alerts

5. RISK MANAGEMENT (monthly/quarterly)
MHS has an organization-wide Risk Management Program with a designated Risk Manager for the system. The Risk Management Program, Quality Management Program, Infection Control Program and Safety Program have a mutual relationship on the organizational and institutional levels. Any deviation from the routine operation of the hospital, including without limitation, injury, hazard, unexpected complication or adverse result, near-miss, allegations of sexual misconduct, or death while in or related to seclusion or restraints are reported to Risk Management. Incidents are tracked and trended and reviewed for opportunities for process improvements to enhance safety. Additionally, Root Cause Analyses are conducted for significant events, including the following:
- Sentinel Events
- Code 15's
- Never Events

6. UTILIZATION MANAGEMENT (monthly/quarterly)
The Utilization Review Committee evaluates aggregate data that may include:

(1) Prescription and ordering practices.

(2) Avoidable days.

(3) Length of stay.

(4) Timeliness and appropriateness of tests and procedures throughout the continuum of care.

(5) Appropriateness of discharge planning.

Please refer to the Annual Utilization Review Plan

7. QUALITY CONTROL (as mandated)
   (1) Department leaders are accountable and responsible to assure that all quality control functions in their areas of responsibility are monitored consistent with manufacturer's recommendations, policy and procedures, accreditation, certification, and licensure requirements.

   (2) Quality control findings that are found to be outside acceptable parameters (out of control), are addressed, the problem identified and corrected, and documented.

8. INFECTION CONTROL SURVEILLANCE, PREVENTION AND REPORTING (monthly/quarterly)
   (1) MHS has a comprehensive Infection Control Prevention Program with a focus on safety, quality control, risk assessment and risk reduction and performance improvement.

   (2) Healthcare associated infections are monitored and evaluated for clusters or changes in patterns, with a focus on containment and prevention of the spread of infectious organisms; current projects of special concern are the acquisition and transmission of multi-drug resistant organisms (MDRO) and subsequent prevention strategies.

   (3) Antibiograms are created annually, and resistance patterns compared to prior findings to evaluate emergent resistance to antibiotic therapy.

   Please refer to the Annual Infection Control Appraisal and Plans
   Please refer to the Antibiotic Stewardship Plan

9. RESEARCH (as available)

MHS participates in research activities as pertinent and in compliance with the Internal Review Board's approval. Research publications are utilized to establish evidence-based practice guidelines, identify "gold standards" and benchmarks for comparison data.

10. ORGAN PROCUREMENT (quarterly, as available)

11. TISSUE BANK (STORAGE ONLY) (quarterly)
    Tissue freezer temperature monitoring, tissue recalls.

12. QAPI for Transplant and Services and Heart Failure Program

13. Designated Imaging performance measures as defined by The Joint Commission

14. Adequacy of staffing is included when undesirable patterns, trends, or variations in its performance related to safety and quality of care are identified and analyzed as a possible cause.

G. FAILURE MODE AND EFFECTS ANALYSIS

As needed, a failure mode and effects analysis will be conducted for the healthcare system to identify opportunities for improving the systems for patient care delivery and enhance customer safety. A "High Risk Process" which is a process that is not planned or implemented correctly, has a significant potential for impacting the safety of the patient will be the focus.

H. COMMUNICATION OF FINDINGS, CONCLUSIONS, ACTIONS, AND RECOMMENDATIONS

Depending on the scope of service and size of each facility, the flow of communication and the composition of councils and committees may be tailored to meet the facility's unique needs. Please refer to the facility's specific Reporting Calendars. Pertinent Performance Improvement information is reported to the Board of Commissioners.

Existing in each hospital are the following forums for communication of pertinent findings:

- The Performance Improvement Risk Management Committee

- The Quality Care and Patient Safety Committee
- The Medical Executive Committee

I. CONFIDENTIALITY

Reports, drafts, minutes, proceedings, screening information or data, recommendations, correspondence, any work product or communication of hospital or Medical Staff committees established pursuant to the Bylaws, generated by others at the directions of the committee or by the committee itself are considered privileged and confidential information.

V. ONGOING APPRAISAL

The Board of Commissioners evaluates the Memorial Healthcare System Performance Improvement Plan, and the resultant performance improvement activities, quarterly as part of the Memorial Healthcare System's Board Peer Review. Ongoing effectiveness of the program is evaluated based on the comprehensive involvement of all departments or services, on studies which demonstrate improvement in patient care, in the enhancement of patients, employee and environmental safety, in clinical performance, in championship service as measured by customer satisfaction, and the cost-effectiveness of the program.

The Performance Improvement Plan is approved as below. Please refer to meeting minutes for attendees and details.

Name of Hospital	Quality Care and Patient Safety Council Meeting Date	Medical Executive Committee Meeting Date	South Broward Hospital Board of Commissioners Meeting Date
Memorial Regional Hospital/Memorial Regional Hospital South/			
Joe DiMaggio Children's Hospital			
Memorial Hospital Pembroke			
Memorial Hospital West			
Memorial Hospital Miramar			

2023 UTILIZATION REVIEW PLAN CHANGES

- PG 1, PARA 3, line 6, date changed from 2022 TO 2023
- PG 7, PARA 8, 2.12.2, line 4, added the word manager
- PG 8, PARA 3, 2.12.7, line 4, added Condition 44, <2 Midnights/Part B reviews, managed care denials
- PG 9, PARA 4, 2.13.9, line five, changed American College of Utilization Review Physicians to American Board of Quality Assurance and Utilization Review Physicians (ABQAURP)
- PG 14, 3.6.5, changed date from 2022 to 2023 regarding CMS Final Rule
- PG 22, date changed 2022 to 2023 on Physician Attestation Statement Form

MEMORIAL HEALTHCARE SYSTEM
MEMORIAL REGIONAL HOSPITAL MEDICAID PROVIDER # 010020000
MEMORIAL HOSPITAL WEST MEDICAID PROVIDER # 010252100
MEMORIAL HOSPITAL PEMBROKE MEDICAID PROVIDER # 010222900
MEMORIAL HOSPITAL MIRAMAR MEDICAID PROVIDER # 010345400

UTILIZATION REVIEW PLAN

PREAMBLE

Memorial Healthcare System consists of four short-term general acute care hospitals operated and governed by the Board of Commissioners of the South Broward Hospital District (Memorial Healthcare System). The four hospitals are: Memorial Regional Hospital, Memorial Hospital West, Memorial Hospital Pembroke, and Memorial Hospital Miramar. As one means of achieving the goals of the Memorial Healthcare System, the Board of Commissioners has adopted an organized utilization review program. The purpose of this program is to assure the appropriate allocation of each hospital's resources, and to provide quality patient care in a cost efficient manner. To describe the utilization review program and to govern the operation of the program, Memorial Healthcare System has implemented this Utilization Review Plan. The Joe DiMaggio Children's Hospital and Memorial Regional Hospital South, as part of Memorial Regional Hospital, are included in this plan.

The utilization review program has been organized and the plan written so as to assure that each hospital in the Memorial Healthcare System is in compliance with the Social Security Amendments of 1983, Public Law 98-21, as they are implemented by 42 CFR Part 482, Subpart G, Section 482.30 headed "Condition of Participation: Utilization Review". "Section 482.30 provides, among other things, for applicability of utilization review plan requirements under Title XVIII (Medicare) and under Title XIX (Medicaid). The plan includes the additional requirements found in 42 CFR 456.100-456.725, Subpart C and 42 CFR 412.1 to 412.64 which addresses special utilization review requirements for hospitals paid under the prospective payment system

The program and plan also have been organized and written to satisfy the standards of the Joint commission on Accreditation of Health Care Organizations (Joint Commission) for the establishment of an effective utilization review program. In addition to Memorial's Medicare and Medicaid patients, all other patients of the hospital are subject to admission and continued stay review policies. Studies conducted within the utilization review program may be patient population specific, e.g., required review, and/or entire population, etc. This plan, reviewed and revised in 2023, supersedes all previous Utilization Review Plans of any hospital in the Memorial Healthcare System.

Note: Throughout the body of this Utilization Review Plan, the "Hospital" will refer to each hospital in the Memorial Healthcare System: Memorial Regional Hospital, Joe DiMaggio Children's Hospital, Memorial Regional Hospital South, Memorial Hospital West, Memorial Hospital Pembroke, and Memorial Hospital Miramar.

ARTICLE I - AUTHORITY AND RESPONSIBILITY

1.1 The Board of Commissioners of the Memorial Healthcare System delegates the authority for the conduct of the Hospital's utilization program to the Hospital's Administrator and to the Medical Staff through its Executive Committee. In order to facilitate a more comprehensive assessment and implementation of utilization review, the Administrator and in turn, the Executive Committee delegate the authority and functions of utilization review to be incorporated into the Utilization Review Committee. The Utilization Review Committee delegates to the hospital-employed Physician Advisors, coordinators, medical and administrative support personnel and to the Committee's Chairman the authority to take definitive action on a case-specific basis regarding utilization issues.

1.2 The commitment of the Board of Commissioners and of the Executive Committee of the Medical Staff to a utilization review program and their delegation of the authority and duties for the program are demonstrated by the approval of this Utilization Review Plan and its annual review by the Board and the Executive Committee.

1.3 The Hospital, it's governing Board and Medical Staff, in conforming to the requirements of, and in conforming to the various regulatory entities, do hereby define and describe the plan for review of the utilization of the hospital facilities and services and the quality of care. All admission certification, continued stay review, and medical care evaluation studies will be performed in accordance with the Code of Federal Regulations (CFR).

1.4 The utilization review activities have been established as an integrated function of the Utilization Review Committee, which is a standing committee of the Hospital's Medical Staff. An administrative staff member, Chief Medical Officer (CMO), members of the Clinical Effectiveness Department, and the Director of Medical Staff Services support the committee in its daily activities.

1.5 As certain preferred provider organizations (PPO), health maintenance organizations (HMO), and the like enter into agreements with the Hospital, the sponsoring insurance carriers or plan administrators apply their proprietary utilization review policies and procedures to their subscribers of the hospital services and engage their own personnel to conduct their utilization review program. Moreover, the Hospital's daily utilization review activities will also be applied to this patient population. A liaison will be maintained with these outside utilization review programs and their patient populations will be included in the assessment of the utilization practices at the Hospital.

ARTICLE II – ORGANIZATION

2.1 Utilization Review Committee shall be composed of two or more physicians and other professional personnel. According to the Medical Staff By Laws, the membership shall consist of the following members with voting privileges:

1) Chief Medical Officer for each Hospital (Physician) Acts as Physician Advisor as needed
2) Medical Director/UM, MHS (Physician)
3) Medical Director-Clinical Effectiveness (Primary Physician Advisor if available)
4) Additional Physician Advisors for each hospital (when applicable)
5) Director/Manager of Clinical Effectiveness (RN) for each Hospital
6) Chief Financial Officer for each Hospital
7) Director/Manager of Utilization Management, (RN) MHS

Non-voting members of the Utilization Review Committee may include other staff members of the respective facility.

2.2 Responsibilities and Functions

2.2.1 The Utilization Review Committee will carry out the responsibilities and functions as defined in the Utilization Review Plan.

2.2.2 Establish, conduct, coordinate and control an in process utilization review program in compliance with all applicable Federal and State regulations, Joint Commission standards and special utilization review agreements executed by the Hospital, for all patients regardless of payment source.

2.2.3 Determine the type of review and studies to be performed as well as the norms, standards and criteria to be used.

2.2.4 Conduct concurrent review with respect to the medical necessity of the admission, duration of stay, professional services furnished, including drugs and biological, appropriateness of the level of care, as well as the quality of care.

2.2.5 Identify and monitor practitioners who furnish or order services that are not medically necessary, do not meet professionally recognized standards of care, or are not properly documented in the medical record.

2.2.6 Identify utilization problems, implement recommendations for corrective action, and document the impact of corrective action by the concurrent monitoring of the utilization of hospital resources.

2.2.7 The analysis of review activities and the evaluation of data compiled by the utilization review program, and by other hospital wide information systems, are utilized to formulate recommendations for changes in hospital policies and Medical Staff practices.

2.2.8 The Medical Staff Executive Committee receives reports on utilization review findings and other utilization activities from the Utilization Review Committee. The Executive Committee has the exclusive privilege to make recommendations that will result in changes in utilization practices for both the Medical Staff and the Hospital.

2.2.9 Maintain close liaison with other Medical Staff and hospital committees to assure that identified utilization concerns are referred to the appropriate committee for resolution.

2.2.10 Identify and institute review activities and techniques found to be effective at other hospitals or reported in the literature, and compare the results of these review activities with those of other hospitals.

2.2.11 Monitor the effectiveness of the discharge planning process and assure that those patients, as well as the Medical Staff needing discharge planning assistance, receive it.

2.2.12 Supervise the review activities of the Utilization Management Specialist, Clinical Effectiveness Specialists, RN Case Managers and of the Physician Advisors.

2.2.13 Institute and monitor review activities to coincide with the types of surveillance reviews conducted by or Quality Improvement Organization (QIO) designated for Florida.

2.3 Review Activities

2.3.1 Review activities should include but need not be limited to:

1) Provide for pre-admission review for each category of admissions as designated by the UR Committee

2) Admission review to determine whether the services are medically necessary and are delivered in the most appropriate setting.

3) Continued stay review to promote efficiency of hospital services, decrease length of stay, and assure that discharge needs are met.

4) Approved pre-certified inpatient admissions.

5) Transfers to the Hospital of high-risk populations from any other facility.

6) Invasive procedures where patterns of under or over-utilization have been identified.

7) Cases included in focused review.

8) Potential outliers.

2.4 Ad Hoc Members and Special Representatives

2.4.1 On his sole authority, the Chairman of the Utilization Review Committee may appoint members of the Medical Staff and of the Hospital's Leadership staff as ad hoc members of the Committee. Ad hoc members serve at the pleasure of the Chairman, are appointed because of a specialized

knowledge or training they offer the Committee, may participate in all discussions of the Committee but may not vote on motions before the Committee. An ad hoc member, making continuing contributions to the Committee, may be recommended to the President of the Medical Staff or to the Hospital's Administrator for appointment as a regular member of the Committee.

2.4.2 Special representatives from the Medical Staff, the hospital's management or external agencies may be invited to attend Committee meetings by the Chairman. Such special representatives typically will be restricted in their participation to specific subjects with whom they have been invited to assist the Committee, and they shall not vote. Special representatives usually will not be invited to attend Committee meetings on a continuing basis.

2.5 Subcommittees

2.5.1 The Chairman of the Utilization Review Committee at his/her discretion may appoint subcommittees from the membership of the Committee to study and to make recommendations on subjects requiring more time for deliberation and consideration of data than is possible during regular Committee meetings.

2.6 Voting Rights and Obligations

2.6.1 Each member of the Committee shall have the right and obligation to register a vote on motions accepted by the chairman and seconded for voting purposes, except that only physician members of the Committee shall vote on subjects who require the exercise of medical judgment based on medical training and experience.

2.6.2 A member of the Committee shall abstain from voting only on those motions, which represent a conflict of interest as defined in section 2.8. The person must declare the nature of the conflict of interest for the minutes of the meeting.

2.7 Meeting and Minutes

2.7.1 Regular meetings of the Utilization Review Committee shall be held at least quarterly. The time and place of the quarterly meeting shall be decided at the first regularly scheduled meeting of the fiscal year, but shall be subject to change during the course of the year with the concurrence of the membership. An agenda will be issued to members prior to each regular meeting.

2.7.2 Special meetings of the Committee may be called by the Chairman to permit action to be taken on subjects that are deemed, by the Chairman, to require resolution prior to the next regularly scheduled meeting. At least two of the Physician members of the Committee must be in attendance. The minutes shall be prepared in the format adopted by the Medical Staff Executive Committee and may be adapted by the Utilization Review Committee for the purpose of reporting its utilization review deliberations.

2.7.3 A quorum shall consist of voting Medical Staff membership of the committee in attendance at the meeting.

2.7.4 Official minutes of every meeting, regular and special, shall be kept and an official copy shall be retained in the Medical Staff Office with other Medical Staff Committee minutes. Committee minutes shall be submitted to the Chief of the Medical Staff for distribution to and action by the

Medical Staff Executive Committee. Copies of the minutes also shall be issued to each member of the Committee. The minutes shall be prepared in a format adopted by the Executive Committee, which may be adapted by the Utilization Committee for the purposes of reporting its deliberations.

2.8 Conflict of Interest

2.8.1 To maintain objectivity in the deliberations and review activities, committee members and staff shall be expected to refrain from decision making or voting participation in any patient specific case review in which the member or staff person is the attending or consulting physician; is a legal relative or guardian; is a professional associate of the attending physician or is a professional associate of the patient. If an individual is uncertain whether a conflict of interest exists in a given case, he/she shall seek a ruling from the Utilization Review Committee or from the Chairman if between meetings. The existence of a conflict of interest is not intended to prevent the member or staff person with the conflict from participation in the discussion of a patient specific case. However, such a person should declare the existence of the conflict, and should refrain from voting on or personally deciding the case in which the conflict of interest exists.

2.8.2 As a statement of principle and to satisfy federal rules and regulations according to CFR456.106, participation in reviews conducted or supervised by the UR Committee is prohibited for any individual who has a direct financial interest in any hospital. An EQ Health Solutions Physician Attestation Statement (Code of Federal Regulation Section 456.106(d) is signed attesting that there is no financial interest in any hospital and therefore no conflict of interest is signed by the voting members of the Utilization Review Committee annually.

2.9 Confidentiality

2.9.1 In the conduct of the work of the Committee, members and staff personnel will be exposed to clinical and social information which relate to specifically identified patients. In keeping with Florida State law and with the Hospital's policy that no disclosure of patient specific clinical or social information is made, except with the written consent of the patient or guardian, Utilization Review Committee members and staff are required to maintain Utilization Review Program patient information in the strictest confidence. Access to utilization data, which is controlled, or in the possession of the Committee is limited to Committee members and staff and to other personnel or members of the Medical Staff who must have access for purposed study, assessment and response. PPO's, HMO's insurance program administrators, the Joint Commission, Department of Health and Human Services and the federally designated Utilization and Quality Improvement Organization (QIO) program for the State of Florida may have access to Committee controlled utilization data under varying agreements and understandings with the Hospital**.** Memorial Healthcare System has developed policies and procedures to address the privacy standards of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 which was effective April 14, 2003.

2.10 Fraud and Abuse

2.10.1 Sections 1128 and 1156 of the Social Security Act, sets forth the obligations for all providers and practitioners who furnish, order, or arrange for health care services for which payment is made under Medicare, Medicaid or Maternal and Child Health Programs (Title XVIII, XIX and V of the Social Security Act).

2.10.2 In the process of ordering or furnishing medical care, the provider will assure that the care meets professionally recognized standards of quality, that the evidence of medical necessity and quality of care will be provided, and, there is reasonable assurance that the care will be provided in the appropriate level.

2.11 Review and Appeal Process

2.11.1 Through its admission, continued stay review activities and through its assessment of case mix management system data on physician specific practice profiles, the Utilization Review Committee may identify physicians and non-physician professionals who appear to be furnishing or ordering services which are not medically necessary, do not meet professionally recognized standards of care or are not properly documented in the medical record.

2.11.2 Whether as a result of individual case finding or an involving practice pattern, the Physician Advisors (PA), the Chief Medical Officers, or the Chairman or the Chief of the Department will personally discuss the findings with the practitioner. The findings will be described and a formal explanation will be requested.

2.11.3 If after a practitioner has had an opportunity to respond to a finding by one of the above representatives of the Utilization Review Committee, and there is a lack of agreement about the finding, the case will be placed on the agenda of the Committee for resolution by peers. The decision is final unless the practitioner exercised his/her due process rights to a hearing as provided for in the Medical Staff Bylaws. In the event that the practitioner accepts the finding by the representative of the Committee, that acceptance will be noted in the correspondence regarding the case.

2.11.4 During the re-appointment process, documented utilization review deficiencies will be reviewed and recommendations made to improve the utilization practices of the Medical Staff.

2.12 Clinical Effectiveness Specialists, RN Case Managers and Utilization Management Specialist (UR Nurses)

2.12.1 Clinical Effectiveness Specialists, RN Case Managers and Utilization Management Specialist are registered nurses with substantial inpatient experience who are capable of making competent clinical judgments about the clinical status and needs of the patient based on the contents of the patient's medical record, and discussion with the healthcare providers.

2.12.2 Clinical Effectiveness Specialists, RN Case Managers and Utilization Management Specialist are employees of the Hospital. The Clinical Effectiveness Specialist and RN Case Managers report to the Director/Manager of Clinical Effectiveness. The Utilization Management Specialist report to the Director/Manager/Supervisor of Utilization Management. For all guidance in the application of review criteria, the Clinical Effectiveness Specialists, RN Case Managers and Utilization Management Specialist are under the direction of the Physician Advisors and the Chief Medical Officers, or his/her designee, and the Chairman of the Utilization Review Committee.

2.12.3 Routine utilization review activities are performed by the Utilization Management Specialist in the Centralized Utilization Review Department and are expected to utilize the approved review criteria as described in section 3.6 Screening Criteria of this UR Plan.

2.12.4 The Clinical Effectiveness Specialist, RN Case Managers and Utilization Management Specialist will apply the appropriate screening criteria to high risk populations as identified by the Utilization Review Committee, for admission, readmission, continued stay review, as well as discharge screens.

2.12.5 Whenever the Clinical Effectiveness Specialist, RN Case Managers and Utilization Management Specialist is unable to if determine medical necessity for admission is met; or, if the services are being rendered in the appropriate setting; or, if the patient may be safely discharged; or, if services are medically necessary or appropriate by utilizing the criteria, the case must be referred to a Physician Advisor for a decision.

2.12.6 The Clinical Effectiveness Specialists, RN Case Managers and/or Utilization Management Specialist are responsible for the preparation, completion, and maintenance of prescribed documentation (paper or electronic version) for each patient admission as directed in 42 CFR 456.111. The documentation serves as a chronological record of the review decisions being made during the course of the patient's hospitalization and the basis for those decisions.

2.12.7 The Director/Manager of Clinical Effectiveness and Director of Utilization Management is responsible for maintenance of statistics and data of review activities. Routine statistical reports including the number of Physician Advisor reviews, hospital issued notices of non-coverage, Condition 44, < 2 Midnight/Part B Reviews, managed care denials, and other such correspondence will be reported as well as retained.

2.12.8 The Clinical Effectiveness Specialists, RN Case Managers and Utilization Management Specialist suggest subjects for utilization review studies based on their observations of problems and the outcomes of monitors which contribute to inappropriate utilization and they participate in the conduct of such studies.

2.12.9 To prevent unnecessary hospital days, the Clinical Effectiveness Specialist, RN Case Managers, Utilization Management Specialist, and Social Workers maintain a close liaison in their efforts to perform discharge planning activities. To prevent a delay in the discharge planning process, the Clinical Effectiveness Specialist may initiate referrals to the Social Workers.

2.13 Physician Advisors

2.13.1 Physician Advisors are licensed physicians who have substantial experience in clinical practice of medicine in a hospital setting.

2.13.2 Physician Advisors are under contract with the Hospital and are to assume the responsibilities to perform the duties described in the Utilization Review Plan. For guidance in their review of cases referred by the Clinical Effectiveness Specialist, RN Case Managers, and Utilization Management Specialist, the physician advisors work under the direction of the Utilization Review Committee and work cooperatively with the Chief Medical Officers and/or Memorial Healthcare System Chief Medical Officer. A Physician Advisor cannot have any financial interest in any hospital.

2.13.3 A principal duty of the physician advisor is to review any cases referred by the Clinical Effectiveness Specialist, RN Case Managers, and Utilization Management Specialist when screening criteria is not met for one or more reasons.

2.13.4 Frequently, it will be necessary for the physician advisor to speak by telephone with the attending physician to obtain information which may not be documented in the patient's chart, before making a decision regarding medical necessity, appropriateness of setting, quality of care and the like.

2.13.5 The PA must demonstrate complete objectivity in reaching an adverse decision. There must be a personal communication with the attending physician and the Clinical Effectiveness Specialist, RN Case Manager or Utilization Management Specialist regarding the adverse decision. An attempt should be made to use the experience as a means of improving the attending physician's utilization practices during the encounter.

2.13.6 When an attending physician does not agree with an adverse determination made by the PA, the case must be referred for resolution to the Chairman of the Utilization Review Committee, or his/her designee in the absence of the Chairman. The Chairman may involve the Chairman of the appropriate Department or Section in the decision. In this situation, the PA must inform the Chairman or designee of the circumstances of the case, the basis for his adverse determination, and must seek a decision on that same day as adverse determination.

2.13.7 The Chief Medical Officer and/or Physician Advisor, as a hospital-based physician and as a member of the Utilization Review Committee serves as a ready source of another opinion for those cases in which the PA is undecided regarding a finding. It remains the responsibility of the PA to communicate a review decision to the attending even though the CMO may contribute to that determination. The PA may also refer cases involving questionable quality of care, inappropriate setting, and medically unnecessary services to the Chief Medical Officer.

2.13.8 The physician advisor serves in a consultative role assisting in the review setting and modification of review criteria, in the review of specific cases brought to the Utilization Review Committee and in the identification of utilization problems which may be the subjects of studies undertaken by the Utilization Review Committee.

2.13.9 The physician advisor, as a result of his/her working experiences with the Hospital's utilization program and as a result of their interest in the field, is an educational resource for the Medical Staff on utilization practices. They are expected to participate in educational programs on utilization issues. The PAs are encouraged to enhance their knowledge of utilization review matters by active membership in the American Board of Quality Assurance and Utilization Review Physicians (ABQAURP).

2.14 Administrative Support of Committee

2.14.1 The Administration of the Hospital has been and continues to be committed to providing the personnel, equipment, supplies, data and other resources needed by the Committee to meet its responsibilities and perform its functions.

2.15 The Clinical Effectiveness and Centralized Utilization Review Departments

2.15.1 The daily utilization review activities of the Committee are delegated to the Centralized Utilization Review Department and are conducted by the Utilization Management Specialists and the Physician Advisors who are assigned to the Centralized UR and Clinical Effectiveness Departments.

2.15.2 The Clinical Effectiveness Department and Centralized Utilization Review Department maintains files of QIO denials and inquiries, establishes communication with the attending physician regarding requests of additional information on denied cases and referrals for quality of care concerns, and assists the attending physician in all appeal issues.

2.15.3 The Departments have responsibility for:

1) Liaison with other departments including Medical Staff, Health Information Management, Admitting and Finance.
2) Coordinating Physician Advisor functions.
3) Maintaining specified records.

2.15.4 The Clinical Effectiveness Department and Centralized Utilization Review Department maintains records of its activities including:

1) Utilization Review worksheets. (paper or electronic version)
2) Hospital Issued Notices of Non-Coverage (HINN).
3) Letters of adverse findings for services being rendered in an inappropriate setting; for unnecessary admissions; and questionable quality of care.
4) IMM (Important Message from Medicare) appeals
5) MOON (Medicare Outpatient Observation Notice)

2.16 Integrated Information System Support

The Hospital's computer sub-systems collect clinical, financial, utilization review and demographic data elements in an integrated information system. There are no real limits as to the computer programs, which may be written to produce data, and statistical reports, which can assist the Committee and its staff in analyzing utilization patterns and in detecting inappropriate utilization practices. The analysis of and comparison of physicians' clinical practice patterns, in terms of length of stay and use of ancillary services, for the same diagnoses or diagnosis related groups (DRGs), is a method of detecting questionable utilization practices. The Utilization Review Committee members, with the assistance of the Administrative Staff member, will decide jointly the type and format of computer generated reports it wishes to use in analyzing utilization practices.

2.17 Other Departments Supporting Committee

2.17.1 Medical Staff Services

The Director of Medical Staff Services and his/her associates maintain the minutes and files with all related attachments and correspondence; send meeting notices well in advance of the meeting dates.

2.17.1 Health Information Management

2.17.2.1 The Health Information Management Department (Medical Records) is the source of clinical data abstracting and participates with the attending physician in the assignment of each discharge to a diagnosis-related group (DRG).

2.18 Quality of Care Review

2.18.1 Although a functional component of the Hospital's Administration and the Quality Management Department/Clinical Effectiveness Department, the Director/Manager of Clinical Effectiveness assists the Clinical Effectiveness Specialists, RN Case Managers, Utilization Management Specialist and the physician advisor to view such traditional utilization issues as appropriateness of services and medical necessity in terms of improving the quality of care.

2.19 Social Work, RN Case Manager Clinical Effectiveness Specialist Functions

2.19.1 To meet the objectives of the hospital to provide efficient discharge planning, the following will be utilized:

1) An effective identification of patients requiring discharge planning.
2) Early initiation for Social Worker/RN Case Manager/Clinical Effectiveness Specialist's evaluation of the patient's need for discharge planning assistance.
3) Multi-disciplinary team planning when needed to meet the needs of the patient, his family, or legal representative.
4) Ensure that the appropriate level of care can be provided upon discharge.
5) Continuing assessment throughout the patient's stay to determine that the discharge plan is still appropriate.
6) A written plan and summary, including recommendations for follow-up, will be maintained by the Social Worker/RN Case Manager/Clinical Effectiveness Specialist in the patient's current medical record.

2.19.2 To assist in the identification of patients who are most likely to require assistance with discharge planning, the following screening will be used: Clinical Effectiveness Specialists and RN Case Manager will assess patients with critical discharge planning needs during their chart reviews. Clinical Effectiveness Specialists and RN Case Manager will identify "high risk" patients during their reviews. These are patients who may require further assessment for discharge planning, counseling, and community service or crisis intervention. The Clinical Effectiveness Specialist and RN Case Manager will work closely with the Social Worker in such cases.

2.20 Nursing Service

2.20.1 Staff nurses attending to the daily needs of hospitalized patients may be the first to identify utilization problems associated with their patients. The considerable knowledge which nurses have about the circumstances of their patients' care and about the practice patterns of attending physicians, makes them important sources of information and thus important daily contacts for Clinical Effectiveness Specialists, RN Case Managers and Utilization Management Specialist and Physician Advisors in the course of conducting concurrent reviews.

ARTICLE III - UTILIZATION PROBLEMS - IDENTIFICATION AND RESOLUTION

3.1 The purpose of the Utilization Review Program, as previously stated in this Plan, are ultimately achieved, only through a process of identifying and resolving problems, concerns and issues both about the appropriate utilization of the Hospital and its services by the Medical Staff and about the efficiency and effectiveness with which the Hospital, makes its services available to the Medical Staff and its patients.

3.2 The Utilization Review Committee will identify apparent utilization problems through the observations and findings of its Clinical Effectiveness Specialists, RN Case Manager Utilization Management Specialist and physician advisors while conducting routine review activities and through the assessment of data, statistics, and reports that are periodically submitted.

3.3 The Utilization Review Committee also will promote the monitoring of the appropriateness of care and services and the identification/resolution of utilization problems in all of the Hospital's major clinical departments and ancillary departments. Emphasizing the need for each department to collect and analyze data, statistics and activities indicators, which uniquely describe its work, practices and activities, will do this. The findings of and actions taken by individual departments in monitoring appropriateness will be reviewed for hospital wide applications.

3.4 Ongoing review processes, which are used to varying degrees in the Hospital's Utilization Review Program, are defined as follows:

3.4.1 All review worksheets (paper or electronic) will include at a minimum the following information:

1) Identification of the recipient.
2) Name of recipient's physician.
3) Date of the admission and dates of application for and authorization if medical benefits if application is made after admission.
4) Individual written plan of care required under 42 CFR 456.80
5) Date of Initial and subsequent continued review dates as described under 42 CFR 456.128 and 456.133.
6) Date of operating room reservation if applicable.
7) Justification of emergency admission if applicable.
8) Reasons and plan for continued stay, if the attending believes continued stay is necessary.
9) Additional supportive information.

3.4.2 Review Types

3.4.2.1 Preadmission (Prospective Review):

The assessment of care before it is rendered to determine that the care is medically necessary and is to be provided in the appropriate health care setting. It is usually performed in anticipation of or at the time of a planned inpatient admission.

3.4.2.2 Admission Review:

The assessment of a patient's need for an acute care hospitalization and to determine the stay is medically necessary. The review of the physician's plan of care and an admission note will assist the Clinical Effectiveness Specialists, RN Case Manager and Utilization Management Specialist in the identification of acute care needs. This review normally is completed within one working day of the admission.

3.4.2.3 Continued Stay Review:

The assessment of a patient's need for continued hospitalization. The initial continued stay review should take place on either the next working day identified by the 50th percentile of the DRG geometric mean length of stay or the -4th working day following the admission review. All further continued stay reviews will be done within four (4) working days of the last review date with rehab and NICU cases being reviewed at seven-day intervals through the hospital stay

3.4.2.4 Focused Review:

Focused review occurs in those areas where care is rendered to patients where the greatest potential for utilization problems may exist. Outlier cases are considered to be patients in the hospital greater than 30 days. These cases are reviewed monthly and reported at the Utilization Review Committee. Concurrent focused review permits intervention in a case where necessary to prevent financial loss to the hospital. Retrospective focused review is useful for identification of utilization problems, but is not of value where immediate intervention may be needed.

3.5 Profile Analysis:

The regular review of data reports such as profiles of care for selected patient groups, practitioners or payers of service to identify patterns of care which might not be evident from the review of a single case.

3.6 Screening Criteria

3.6.1 Screening criteria are predetermined elements or values developed by physicians and other health care professionals using objective clinical findings, professional literature available and their medical expertise.

3.6.2 These criteria form an objective base against which specific performance can be measured, to evaluate the quality and appropriateness of the care being rendered, and the medical necessity for further care. The use of such criteria also enables non-physician personnel to screen cases and direct only those requiring peer reviews to a Physician Reviewer.

3.6.3 Screening criteria describe the need for hospitalization in terms of how ill the patient is, what kind of treatment the patient is receiving and whether there are indications that the patient can be safely discharged. Because they are descriptive of the type of treatment the patient should be receiving, screening criteria also are useful in identifying deficiencies in the quality of the care being rendered. The utilization review criteria used by Memorial are adopted by the Utilization Review Committee and approved for use by the Executive Committee of the Medical Staff

3.6.4 The screening criteria used predominately in the Hospital's utilization review processes for the commercial lines of business and the uninsured population is the latest publication of Interqual Intensity of Service, Severity of Illness and Discharge Screening Criteria (ISD Screening Criteria).

3.6.5 Memorial will follow CMS' final rule 2023

3.6.6 Two Midnight Rule as the guideline for determining admission status for the Medicare

3.6.7 FFS and Medicare Advantage plan and will augment with Physician Advisor review and case discussion with attending physicians as necessary.

3.6.8 For Medicaid FFS and Medicaid Managed Care populations, Memorial will follow Florida Medicaid's definition of Inpatient Care and augment the 2 midnight rule review criteria with the latest publication of Interqual Intensity of Service, Severity of Illness and Discharge Screening Criteria (ISD Screening Criteria).

3.6.9 Criteria are periodically reviewed and evaluated to assure that they continue to meet the needs of the utilization review program. New criteria may be developed or the Committee may revise criteria at any time.

3.7 Concurrent Review Process:

3.7.1 Concurrent review will be performed utilizing Interqual's Level of Care Criteria.

3.7.2 The criteria will be the resource for determining the necessity for the continued admission, as well as the readiness for discharge.

3.7.3 Admission Review

3.7.3.1 The Utilization Management Specialist initiate the admission review process within the first working day following the patient's admission to an acute care setting.

3.7.3.2 During the admission review process, the Utilization Management Specialist will utilize the specific screening criteria per line of business as outlined under section 3.6 of this UR Plan. The criteria utilized is documented in the case notes in the utilization review system. If no criteria are met, the case is referred to a Physician Advisor for a medical determination pertaining to necessity of acute hospitalization.

3.7.3.3 All Medicaid and Medicare recipients admitted to the Hospital will be certified at the time of the admission by the attending physician. The Utilization Management Specialist or hospital designee will highlight the electronic medical record for the attending physician's signature. Recertification of the Plan of Care will be made at least every sixty days. In the case of Behavioral Health, recertification of the plan of care for Medicare will be made at 12 days and every 30 days and for Medicaid at admission and every 30 days. For patients who apply for assistance during the hospital stay, the certification must be in place prior to payment authorization per CFR 456.121

If after a consultation with the attending physician (if appropriate), the Utilization Management Specialist is still unable to certify the admission the Physician Advisor will be contacted. It is the

responsibility of the Utilization Management Specialist to contact the Physician Advisor to review an admission that failed admission criteria using the approved screening criteria. The Utilization Management Specialist may not make decisions to deny admission as medically unnecessary or inappropriate.

3.7.3.4 A physician, physician assistant or nurse practitioner acting within the scope of practice, as defined by State Law and under the supervision of a physician, must re-certify for each applicant or recipient the inpatient medical services in a mental hospital are needed. In the case of mental health services, the physician, or the physician assistant or nurse practitioner acting within the scope to practice as defined by State Law, may re-certify the applicant or recipient for inpatient psychiatric services under the supervision of the physician.

At the time Utilization Management Specialist, or Physician Advisor certifies the admission; all pertinent data must be recorded on the review worksheet. This information indicates when the next review should be conducted. The initial continued stay review should take place on either the next working day identified by the 50th percentile of the DRG geometric mean length of stay or the 4th working day following the admission review. All further continued stay reviews will be done within four (4) working days of the last review date unless otherwise indicated. Review of rehabilitation cases and NICU may be conducted at a minimum of seven days intervals.

3.7.3.5 Referral to the Physician Advisor will occur on the same day that the Utilization Management Specialist initiate the admission certification process.

3.7.3.6 If the Physician Advisor has reason to believe the admission is not necessary, he/she must confer with the Attending Physician giving an opportunity for the presentation of clarifying information before a decision is made.

3.7.3.7 If the additional information is sufficient to convince the Physician Advisor that the admission is necessary, the Physician Advisor will instruct the Utilization Management Specialist to certify the admission. This must be documented on the Specialist worksheet. (paper or electronic)

3.7.3.8 If the Attending Physician does not present clarifying information and concurs with the Physician Advisor that acute hospitalization is not indicated, an adverse determination will be rendered.

3.8 Continued Stay Reviews

3.8.1 At the time of the review, the Utilization Management Specialist refer to specific criteria to determine if criteria are still met. If the criteria are met, the Utilization Management Specialist documents the criteria that are satisfied and continues the review process.

3.8.2 The Health Information Management Department (Medical Records) establishes, directs and monitors the procedures that guarantee the Hospital's compliance with Medicare Certification requirements for Day and Cost outliers as stipulated in Section 412.80 of 42 CFR Medicare regulations, Social Security Amendments of 1983 (PL 98-21). All Medicaid and Medicare recipients admitted to the Hospital will be certified at the time of admission by the attending physician. Recertification of the Plan of Care will be made at least every sixty days. Recertification for Medicare Behavioral Health will be made at 12 days and every 30 days and for Medicaid recipients every 30 days.

3.8.3 Non PPS certification of all Medicare Beneficiaries will be established on the 12th day of hospitalization with subsequent re-certification on the 18th day and every 30th day thereafter. Extended stay review for medical necessity is accomplished by the Utilization Management Specialist in a timely manner, most often every fourth working day and not longer than every seventh day in selected cases. Continued stay review for medical necessity is completed by the Utilization Management Specialist in a manner that promotes appropriate utilization of hospital services. This review would be no longer than the fourth working day, except in selected cases where the review would occur not longer than every seventh day.

3.8.4 If no criteria are met, the Clinical Effectiveness Specialist, RN Case Manager, and Utilization Management Specialist refer to the discharge screening criteria. If the discharge screens are met, the Clinical Effectiveness Specialist/RN Case Manager /Utilization Management Specialist checks to see if discharge or transfer is planned for the next working day. If discharge or transfer is not planned, the case is referred to a Physician Advisor. If discharge or transfer is planned, the Clinical Effectiveness Specialist/RN Case Manager/ Utilization Management Specialist review the case the following day to assure that the plan has been carried out. If this plan has been carried out, review is complete.

3.8.5 If a discharge screen has not been met, or if the plan for discharge or transfer is not carried out, the Clinical Effectiveness Specialist/RN Case Manager/Utilization Management Specialist reviews the record to determine if a new medical problem has occurred. If no new medical problem occurs, the discharge screens are met and there is no intensity of services, the case is referred to the Physician Advisor.

3.8.6 If the Utilization Management Specialist is unable to certify the continued stay based on information contained in the medical record, the Utilization Management Specialist must seek consultation with the Attending Physician. If the Utilization Management Specialist is still uncertain of the medical necessity for the continued stay, she/he must refer the case to a Physician Advisor that same day. If the Physician Advisor determines hospital stay is necessary, he/she will direct the Utilization Management Specialist to certify the continued stay. His/her medical determination must appear on the utilization review system.

3.8.7 Upon review of the medical record, if the Physician Advisor believes further stay is not medically necessary, he/she must confer with the Attending Physician to afford him/her an opportunity to present clarifying information.

3.8.8 If the Attending Physician presents additional information sufficient to satisfy the Physician Advisor of the medical necessity for continued hospital stay, the Physician Advisor will direct the Utilization Management Specialist to certify the continued stay.

3.8.9 If the Attending Physician agrees with the Physician Advisor that continued stay is no longer medically necessary and discharges the patient, this does not constitute an adverse determination. In the case of a disagreement between the Attending Physician and the Physician Advisor, the Physician Advisor will call in a Physician Advisor Consultant. If the physician advisor consultant agrees that continued stay is not medically necessary, an adverse determination is made and notification of those parties concerned will take place.

3.8.10 In order to avoid an arbitrary decision in the termination of benefits procedure, two (2) physicians must concur. The two (2) physicians may be the Physician Advisor and the Attending Physician, the Physician Advisor and a second Physician or the Attending Physician and the Chief Medical Officer**.**

3.9 Denial/Termination of Benefits

3.9.1 When medical appropriateness can no longer be certified, the Clinical Effectiveness Specialist/RN Case Manager, Utilization Management Specialist will discuss the case to give written notification of non-certification with the Chief Medical Officer, or his/her designee. The notice will be given in accordance with the Federal or State guidelines.

3.9.2 An admission letter of adverse determination is required to be given to the patient or the patient's representative when it has been determined the admission lacks medical necessity. The patient or the patient's representative may be notified by telephone, followed by the letter of adverse determination sent certified mail with return receipt requested when the patient is incapacitated and cannot acknowledge the receipt of the letter. With regard to the Medicaid recipient, the adverse determination will be effective at midnight on the day that medical necessity ceases to exist.

3.9.3 In case of disagreement between the attending physician and the Physician Advisor, the physician advisor must seek a second opinion from a Physician Advisor Consultant who is simply a second physician advisor. If the second opinion agrees that the admission was not medically necessary, the adverse determination is made and notification of concerned parties will take place. All such discussion and communication shall be conducted within two (2) working days following the patient's admission.

3.9.4 When a determination has been made that the patient no longer meets criteria for an inpatient stay, and an adverse determination has been deemed appropriate, the notice will be given in accordance with the Federal or State guidelines.

3.9.5 If the committee makes an adverse final decision on a recipient's need for continued stay before the assigned review date, the committee gives notice within two (2) working days after the date of the final decision.

3.9.6 Notification of the adverse determination will be forwarded to the following:

1) Attending Physician
2) Hospital Administration/Finance
3) Patient (sponsor or next of kin)
4) Fiscal Intermediary (AHCA – First Coast Service Options)
5) QIO (eQHealth for Medicaid or KEPRO for Medicare)

3.9.7 This written Notification of Adverse Initial Determination may be preceded by oral communication.

3.9.8 The written Notice of Adverse Determination will contain the following information:

1) The reason for the determination
2) The date after which the patient's stay in the hospital will not be approved as medically necessary or appropriate in an in-patient hospital level of care.

ARTICLE IV - DISCHARGE PLANNING

4.1 The Director/Manager of Clinical Effectiveness of the Hospital shall be responsible for coordinating the discharge planning function of the hospital. Discharge planning shall have as its objectives:

1) Facilitating a safe discharge as soon as an acute level of care is no longer required;
2) Encouraging active participation of the patient/family in decisions about discharge planning;
3) Assisting the attending physician, the patient and the patient's family to plan for discharge to a setting appropriate to the medical, physical and social needs of the patient;
4) Providing current information and expert advice to the attending physician, the patient and the patient's family about alternative facilities for patient placement when the patient cannot be managed in his home environment;
5) Providing current information and expert advice to the attending physician, the patient and the patient's family about resources available to assist in the care of the patient in the home environment;
6) Assuring that patient's medical information to meet the patient's ongoing care needs is provided to the facility in a timely manner, prior to or at the time of the patient's transfer.
7) Developing criteria for initiating discharge planning and applying the criteria to identify patients whose diagnoses, problems, or psychosocial circumstances usually require discharge planning. (Case finding)

4.2 The need for discharge planning for a given patient may be identified by any member of the healthcare team assigned to the patient, or by a Clinical Effectiveness Specialist, RN Case Manager in the course of their review activities. In each case, the need for discharge planning shall be referred directly to the Social Worker or Clinical Effectiveness Specialist.

4.3 The Clinical Effectiveness Specialists and RN Case Managers will identify those patients that represent a high risk for utilization concerns and make the appropriate social service referral as soon as a need is identified, but no later than the second concurrent review.

4.4 The hospital's Social Worker, RN Case Manager and/or Clinical Effectiveness Specialist, in conjunction with the Discharge Coordinators, shall conduct discharge planning preparations.

4.5 The Director/Manager of Clinical Effectiveness, Nursing Service, and the receiving facility, shall develop recommendations regarding the type and nature of the patient's medical information provided to those facilities receiving patients.

ARTICLE V - REVIEW AND EVALUATION OF UTILIZATION REVIEW PLAN

5.1 The Utilization Review Plan in its entirety, including its standards, criteria and norms for conducting concurrent review, shall be reviewed and evaluated at least annually and revised as necessary.

5.2 Structure: The Plan's contents shall be compared with actual utilization organization at Memorial, with current Joint Commission standards and with applicable Federal and State regulations governing utilization activities in acute care hospitals.

5.3 Process: The Plan's contents shall be assessed to determine if it has functional and effective review processes, discharge planning, education programs, data abstracting, a management information system, data retrieval and management information reporting.

5.4 Outcome: The effectiveness of a utilization review program can be measured by such key indicators as:

1.) Lengths of stay which are low or declining.
2.) Declining or stabilized numbers of referrals to physician advisors.
3) Denials of benefits prevented by interventions of physician advisors or other staff.
4) Declining denial rate, number of days and cases denied.
5) Cases being appropriately referred for Physician Review.
6) Lengths of stay in keeping with state and local norms.
7) Limited variations in lengths of stay and charges from physician to physician for the same diagnostic category.
8) Few differences in mortality rate or severity level between physicians.
9) The number of utilization problems identified and resolved in the process described above.

5.5 After deliberating on the recommendations for Plan revisions, the full Committee shall vote to approve or disapprove the proposed revisions in whole or part and the action of the Committee will be reported to the Medical Staff Executive Committee and to the Board of Commissioners for their approval.

5.6 The Director of Medical Staff with the minutes and records of other committee meetings and deliberations shall maintain records and minutes of this review and evaluation process.

ARTICLE VI - QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

6.1 The objectives of the department include the gathering of meaningful and representative information on a concurrent basis. This information then needs to be disseminated to the various committees for evaluation.

6.2 The Scope of Service is as follows:

1) Provide a program of Utilization Review that is in compliance with all State and Federal regulations, as well as the special utilization review requirements executed by third party payers.
2) Conduct concurrent reviews to assure the medical necessity of admission and that the professional services rendered meet the standards of appropriateness and quality.
3) Identify and monitor those practitioners that do not furnish professionally recognized standards of care.
4) Identify utilization problems and implement recommendations for corrective action.
5) Analyze the results of external review agencies and formulate policies that will prevent sanction.
6) Monitor the effectiveness of the discharge planning process to prevent unnecessary hospital days.
7) Provide a mechanism for Peer Review of utilization issues referred by the Clinical Effectiveness Specialists, RN Case Manager and/or Utilization Management Specialist.
8) When appropriate, provide an informal education tool for the Medical Staff

6.3 The effectiveness of Utilization Management can be identified by the following issues:

1) The recommendation by the Utilization Review Committee for focus studies in those MSDRG's identified for over-utilization.
2) The recommendation of the committee to focus on those practitioners that has been identified to have over-utilization habits.
3) The identification of hospital services that need refinement to provide more efficient health care.
4) The continued limited exposure to external review.
5) The cooperation of the managed care programs to provide concurrent reviews and peer to peer process for denied cases to assist with improved cash flow.

ATTACHMENT A

PLAN OF CARE

Definition: At the time of admission to a hospital, a physician involved in the care of a Medicaid recipient must establish a written plan of care. The Code of Federal Regulations 42 CFR 456.80 Subpart C provides:

"Before admission to a hospital or before authorization for payment, a physician and other personnel involved in the care of an individual must establish a written plan of care for each applicant or recipient." The plan of care must include:

1.) Diagnosis, symptoms, complaints and complications indicating the need for admission,
2.) A description of the functional level of the individual,
3.) Any orders for medications, treatments, restorative and rehabilitative services, activities, social service, and diet,
4.) Plan for continuing care, as appropriate and plans for discharge as appropriate.

Periodic Review: Orders and activities must be developed in accordance with the instructions of the physician. This plan of care must be reviewed and revised as appropriate by all personnel involved in the care of the patient. The physician must review each plan of care at least every 60 days.

Documentation: The information required for the plan of care may be entered in the physician's order sheet, progress notes, and/or history and physical. There is no regulation governing the placement of this information, but it is imperative that it be included in the medical record.

Monitoring by the QIO: The QIO monitors physician compliance to this regulation during the retrospective medical record review. If the QIO identifies any areas of non-compliance, the hospital will be notified.

Department Responsibility: Compliance with the physician's plan of care requirement may be subject to Federal and State review. Those records without a plan of care are subject to Federal disallowance and may result in recoupment of Medicaid payments.

Physicians Attestation Statement

Code of Federal Regulation –

Section 456.106(d) Organization ad composition of UR committee; disqualification from UR committee membership.

Committee reviews will not be conducted by any person who holds a financial interest in any hospital or by a person who was/is professionally involved in the case being reviewed.

The following individuals are members of the Utilization Review Committee for the Medical staff year beginning _____ and herby state:

- No financial interest exist between the undersigned members and _____ or any other hospital.

- No review will be conducted by a member who was professionally involved in the case being reviewed.

Name	Signature	Date signed

MHS Infection Prevention and Control (IPC) Plan CY 2023

Executive Summary of Revisions

The MHS Infection Prevention and Control (IPC) Plans for CY 2023 were reviewed and updated by the System Infection Prevention Working Committee using Joint Commission and Centers for Medicare and Medicaid Services required elements for Infection Prevention programs. All six hospitals have their own Plan.

The **Plan** includes *Authority Statement*, *Scope of Service* that is specific based on hospital location, populations served, and services provided for CY 2022 year including top diagnoses and top procedures by volume, and standard plan elements including a more thorough required section describing "Investigation of Outbreaks."

The **Risk Assessment** uses a *Hazard Vulnerability* template in use by other MHS departments and was scored in 2023 Q1 based on CY 2022 actual risks and reviewed by the hospital's multidisciplinary Infection Control committee or working team. Using the actual risks from the previous year, the CY 2023 *priorities, goals, and objectives* are identified using a Pareto graph to visually represent the top 20% of risks in four main areas: hospital acquired infections, community risks, healthcare worker risks, and environmental risks.

The **Evaluation/Appraisal and Goals and Objectives** reviews and evaluates the previous year's CY 2022 hospital-specific goals and objectives by comparing the previous year's CY 2022 data for infections, hand hygiene, staff vaccination, and more. The goals and resultant data are clearly stated to compare performance in both 2021 and 2022, with a summary of action items undertaken in the past year, and a specific, achievable goal metric for 2023.

The oversight and support of this essential program at each facility should now include at least one highly trained Manager, the system Director of Infection Prevention and Epidemiology for MHS, and the Chief Physician, Division of Infectious Diseases and Medical Director of Infection Control and Antimicrobial Stewardship for MHS.

MHS Infection Prevention and Control (IPC) Plan CY 2023

Approval Dates

Name of Hospital	Quality Care and Patient Safety Council *Meeting Date*	Medical Executive Committee *Meeting Date*	South Broward Hospital Board of Commissioners *Meeting Date*
Memorial Regional Hospital & Memorial Regional Hospital South			
Joe DiMaggio Children's Hospital			
Memorial Hospital Pembroke	3/7/23		
Memorial Hospital West			
Memorial Hospital Miramar			

Infection Prevention and Infection Control Plan 2023

Our Mission: Heal the body, mind, and spirit of those we touch.

Our Vision: To be a premier clinically integrated delivery system providing access to exceptional patient- and family-centered care, medical education, research, and innovation for the benefit of the community we serve.

Our Commitment: Family Centered and Patient Focused Care

Purpose: The purpose of the Memorial Regional Hospital Infection Prevention and Control Plan is to define the scope of activities and to provide a framework for the systematic organization wide approach to create an effective infection control program. The Infection Prevention and Infection Control Plan integrates all departments, patient care sites and practices with the intent:

To create and implement a comprehensive infection control, prevention and epidemiology program aimed at protecting patients, healthcare providers, employees, volunteers and visitors from contracting/and or transmitting infections and diseases.

To collaborate with the Emergency Preparedness Committee by engendering advance planning and preparedness critical to help mitigate the impact of an epidemic or pandemic event.

To collaborate with the local and state Health Departments to monitor incidence of infections, identify potential outbreaks, and implement actions to mitigate and control the spread of infection.

To collaborate as a multidisciplinary team with all departments and services to minimize the morbidity, mortality and economic burdens associated with infection through prevention and control efforts throughout the facilities and in the well and ill populations.

Authority Statement

Pursuant to the approval by the Medical Executive Committee:

1. The Infection Preventionist (IP) or designee has the authority to obtain cultures as needed to ascertain if someone has a hospital acquired infection (HAI).

2. The IP or designee has the authority to enact measures deemed appropriate to prevent the transmission of communicable diseases.

3. Depending on the severity of the measures required for the containment of the causative pathogen, collaboration with the Medical Director and/or MHS's Infectious Disease consultants will be initiated.

Scope of Service 2023

Memorial Regional Hospital (MRH) is located on the northwest corner of Johnson Street and North 35 Avenue, west of Interstate 95 (I-95) and east of the Florida Turnpike and is the flagship hospital of South Broward Hospital System, DBA: Memorial Healthcare System.

3501 Johnson Street, Hollywood.

(Receiving facility for patients with high acuity – and requiring specialty services, a Safety- Net Hospital)

MRH is a 647 Bed Adult Acute Care Tertiary Care and Behavioral Health facility and houses the following institutes:

- Level I Trauma Care
- Memorial Cardiac and Vascular Institute
- Memorial Cancer Institute
- Memorial Neuroscience Institute

MRH offers the following services:

- Emergency Care
- Cancer Care
- Cardiac and Vascular Care
- Neurology
- Neurosurgery
- Bariatrics
- Family Birthplace
- Behavioral Health (inpatient and emergency)
- Nutrition
- Stroke Treatment
- Surgery
- Women's Services
- Transplant Services
- Inpatient Dialysis

Acuity:

- 73 Critical Care beds
- 421 Medical/Surgical/Stepdown/Telemetry/Oncology beds
- 99 Obstetrics/Gynecology beds (including high risk antepartum)
- 54 Behavioral Health beds
- 84 Emergency Department beds
- 21 Surgical Suites

Population served - Ages: 18 – End of Life

Top 4 Surgical Procedures:

- C-Section
- Gynecologic Oncology
- Colon/Gastrointestinal
- Joint Replacement

Top 6 Medical Diagnosis:

- COVID-19
- Sepsis
- Hypertension

- Chronic Kidney Disease
- Non-ST-Segment Myocardial Infarction
- Maternal Care

Top 3 Out-Patient Procedures:

- Cardiac Catheterization
- Transfusion Services
- Mastectomy

Memorial Transplant Institute: Memorial Regional Hospital, 3501 Johnson Street, Hollywood.

Services:

- Heart
- Kidney
    - Living donor
- Ventricular Assist Device (VAD)

Population Served:

Pediatric and Adult

Memorial Pathology Services: 9571 Premier Parkway, Miramar.

Services:

- Anatomic Pathology
- Clinical Pathology

Memorial Cancer Institute (MCI), Medical Office Centre

- Breast Cancer Center, 1150 N. 35th Ave., Suite 170, Hollywood
- Infusion Suite, 1150 N. 35th Ave., Suite 270, Hollywood
- Medical Offices, 1150 N. 35th Ave., Suites 330 and 385

Memorial Cardiac and Vascular Institute: 20803 Biscayne Boulevard, Aventura, Suite 204

- Comprehensive evaluation and medical management of heart health, including disease prevention
- Non-invasive cardiac diagnostic procedures

Memorial Cancer Institute: 20801 Biscayne Boulevard, Aventura, Suite 200

- Comprehensive Cancer Care

Plan of Care and Practice for Infection Prevention and Control

The following activities are within the scope of care and practice of the infection prevention, infection control and epidemiology professionals:

Planning for management of infection control and prevention (IC & P) program (IC.01.01.01)

- The goal of the Infection Prevention, Infection Control and Epidemiology program is to prevent healthcare associated infections in patients, healthcare providers, and visitors.
- A multidisciplinary team collaborates to develop a comprehensive written plan

Performance of risk assessments at least annually and whenever significant changes occur, at a minimum inclusion of IP's, medical staff, leadership and nursing

- Identification, prioritization, and documentation of risk assessment based in order of probability and level of harm based on (IC.01.03.01)
    - Geographic location, community, and population served
    - Care, treatment and services provided
    - Analysis of surveillance activities and aggregate IC data
        - Pareto Analysis

Goal setting to reduce risk of infection to patients and community (IC.01.04.01)

- Written goals, based on identified risks, include
    - Addressing prioritized risks
    - Limiting unprotected exposure to pathogens
    - Limiting the transmission of infections associated with procedures
    - Limiting the transmission of infections associated with the use of medical equipment, devices and supplies

Development of an IC & P Plan (IC.01.05.01)

- Utilization of evidence based guidelines such as APIC, SHEA, CDC, HICPAC, OSHA etc. or, in absence of such guidelines, expert consensus
- Written description of activities, including surveillance, to minimize, reduce or eliminate risk of infection

Performance of activities based on relevant professional guidelines and scientific practices.

Development, implementation and documentation of infection surveillance, prevention, and control

P & Ps that adhere to nationally recognized guidelines

Communication and collaboration with quality assessment and performance improvement program (QAPI) and Risk Management on IC & P issues

Training and education of employees and medical staff on practical application of IC & P guidelines and P & Ps

Prevention and control of healthcare associated infections, including audit of adherence to IC & P & P by hospital employees and medical staff (IC.02.01.01)

- Implementation of IC & P activities involving departments, employees, and medical staff
- Provision of important IC & P information to patients, employees, medical staff, and visitors
    - Respiratory Hygiene Practices
    - Hand Hygiene

- Implementation of standard and transmission based precautions
- Utilization of personal protective equipment (PPE)
    - Donning
    - Doffing
    - Disposal
    - Storage
    - Reprocessing (in rare circumstances of necessity due to lack of supplies in epidemic emergencies)
- Implementation of surveillance
- Storage and disposal of infectious waste
- Investigation of outbreaks (IC.01.05.01)
    - APIC Text of Infection Control and Epidemiology; April 7, 2020. Chapter 12.*Outbreak Investigations/ Epidemiology, Surveillance, Performance, and Patient Safety Measures* for framework and guidelines conducting an outbreak investigation
- Reporting of surveillance, prevention and control information to appropriate staff within facility
- Reporting of surveillance, prevention and control information to local, state and federal public health authorities
- Informing receiving organizations of patients of patient requiring monitoring, treatment, and/or isolation
    - Upon transfer arrangement
    - After transfer, upon discovery
    - Upon receiving such patient and not having been notified by transferring facility

Preparation of response to an influx of potentially infectious patients (IC.01.06.01)

The results of the hospital's infection risk assessment is prioritized in order of level of probability and potential for harm by a multidisciplinary team of stakeholders. Goals for reducing the risks of the infections that pose the greatest threat to patients and the community are defined. These goals lead to focused activities, based on relevant professional guidelines and sound scientific practices.

Reduction of risk of infections associated with medical equipment, devices, and supplies (IC.01.02.01)

- Implementation of IC &P activities
- Adherence to Spaulding Classification (CDC)
- Cleaning and performing low level disinfection of medical equipment, devices and supplies consistent with Manufacturer's Instruction for Use (IFUs)
- Performing intermediate and high-level disinfection and sterilization of medical equipment, devices and supplies
- Disposal of medical equipment, devices and supplies
- Storage of medical equipment, devices and supplies
- Reprocessing single use devices
- Availability of Manufacturer's Instructions for Use

Prevention of transmission of infectious disease among patients, licensed independent practitioners and staff (IC.02.03.01)

In collaboration with Medical Staff and Employee Health Services:

- Screening for exposure and/or immunity to infectious diseases available to LIPs and employees who may come in contact with infections in the workplace
- Management of LIPs and employees who are suspected of or were occupationally exposed
- Management of patients who have been exposed to an infectious disease
- Assessing compliance with and confirming proper use of optimal personal protective equipment (PPE)
- Assessing compliance with and confirming proper implementation of isolation guidelines and Hand Hygiene

Vaccination against influenza to licensed independent practitioners and staff. (IC.02.04.01)

- Annual influenza vaccination program that is offered to licensed independent practitioners and staff.
- Education of licensed independent practitioners and staff about, at a minimum, the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza.
- Provision of influenza vaccination at sites and times accessible to licensed independent practitioners and staff.
- Improvement of influenza vaccination rates
- Written description of the methodology used to determine influenza vaccination rates
- Evaluation of the reasons given by staff and licensed independent practitioners for declining the influenza vaccination. This evaluation occurs at least annually
- Improvement of vaccination rates according to established goals at least annually
- Provision of influenza vaccination rate data to key stakeholders which may include leaders, licensed independent practitioners, nursing staff, and other staff at least annual
- Collaboration with Employee Health Department, utilizing above process, to provide additional vaccination against:
    - Hepatitis B
    - Covid-19
    - Tetanus, Diphtheria and Pertussis
    - Varicella

Implementation of evidence-based practices to prevent health-care associated infections due to the following: (IC.02.05.01)

- Multidrug Resistant organisms (MDRO)
    - *Candida auris*
    - *MDR Acinetobacter baumannii*
    - *MDR Carbapenem-resistant enterobateriaceae*
    - *MRSA*
    - *Pseudomonas aeruginosa*
- Central Line-associated bloodstream infections (CLABSI)
    - Participation in CDC's National Healthcare Safety Network
- Catheter-associated urinary tract infections (CAUTI)
    - Participation in CDC's National Healthcare Safety Network

- Ventilator Associated Event (VAE)
    - Participation in CDC's National Healthcare Safety Network
- Emerging Infectious Diseases
    - Covid-19 and evolving variants
- *Clostridioides difficile*
    - Participation in CDC's National Healthcare Safety Network
- Surgical Site Infections (SSI)
    - For these:
    - Development and implementation of P & P based on evidence-based practice, aimed at reduction
    - Periodic risk assessments and surveillance, aimed at reduction
    - Measurement and monitoring of infection prevention processes, outcomes, and compliance using evidence-based guidelines or best practices
    - Participation The American College of Surgeons National Surgical Quality Improvement Program (NSQIP)

Evaluation of effectiveness of infection prevention and control plan and program (IC.03.01.01)

- Plan's prioritized risks
- Plan's goals
- Program's efficacy
- Communication of findings to patient safety program
- Inclusion of results of evaluation when revising the plan

Communication and collaboration with Antimicrobial Stewardship Program (ASP) (MM.09.01.01)

Ratification of competency of Infection Control and Prevention team members

Preparation of response to an influx of potentially infectious patients, emergency preparedness (IC.01.06.01)

- Monitoring and evaluation of current clinical and epidemiological information from its resources regarding new infections that could cause an influx of potentially infectious patients
- Communication of critical information to licensed independent practitioners and staff about emerging infections that could cause an influx of potentially infectious patients
- Written plan delineating management of influx of infectious patients

Management of Environment during demolition, renovation, or new construction to reduce risk of infection (EC.02.06.05)

- Infection Control Risk Assessment (ICRA)

National Patient Safety Goal (NPSG.07.0101)

Compliance with either the current CDC hand hygiene guidelines Transplant Safety (TS.03.03.01)

Investigation of adverse events related to tissue use or donor infections

- Compliance with P&P for identifying, tracking, storing, and handling tissues, medical devices and other implantable.
- Investigation of infections suspected of being directly related to the use of tissue
- Reporting of infection to tissue supplies
- Sequestering tissue suspected of causing infection
- Notification of recipient of infectious agents that may have been transmitted through tissue

Water Management Program (EC.02.05.02)

Participation in interdisciplinary water management program that addresses Legionella and other waterborne pathogens.

Emergency Management Operations Program (EM.01.01.01)

Participation in interdisciplinary emergency management operations program: engagement in planning activities include identifying risks, prioritizing likely emergencies, attempting to mitigate them when possible, and considering its potential emergencies in developing strategies for preparedness, with a focus on infection control and prevention. This includes, where possible, collaboration with relevant parties in the community.

Staffing:

Memorial Regional Hospital

- Director, Quality & Patient Safety
- Assistant Director, Quality and Patient Safety
- 4 Infection Preventionists
- 1 (0.1) per diem FTE IP open position

Job descriptions delineate the scope and responsibility for each Infection Prevention professional

Memorial Healthcare System (Oversight and Support)

- Chief Physician, Division of Infectious Diseases and Medical Director of Infection Control and Antimicrobial Stewardship, MHS
- Physicians, Infectious Disease (MRH, MRHS)
- Director, Infection Prevention and Epidemiology, MHS

Hours of Operation:

Monday – Friday 8:00 am – 5:00 pm; other times immediate availability by cell phone.

References:

https://e-dition.jcrinc.com/Frame.aspx January 1, 2022

APIC Text of Infection Control and Epidemiology; April 7, 2020

Joe DiMaggio Children's Hospital

Infection Prevention and Infection Control Plan

Our Mission: Heal the body, mind, and spirit of those we touch.

Our Vision: To be a premier clinically integrated delivery system providing access to exceptional patient- and family-centered care, medical education, research, and innovation for the benefit of the community we serve.

Our Commitment: Family Centered and Patient Focused Care

Purpose: To create and implement a comprehensive infection control, prevention and epidemiology program aimed at protecting patients, healthcare providers, employees, volunteers, and visitors from contracting/and or transmitting infections and diseases

To collaborate with the Emergency Preparedness Committee by engendering advance planning and preparedness critical to help mitigate the impact of an epidemic or pandemic event

To collaborate with the local and state Health Departments to monitor incidence of infections, identify potential outbreaks, and implement actions to mitigate and control the spread of infection

To collaborate with all departments and services to minimize the morbidity, mortality and economic burdens associated with infection through prevention and control efforts throughout the facilities and in the well and ill populations

Authority Statement

Pursuant to the approval by the Medical Executive Committee:

1. The Infection Preventionist (IP) or designee has the authority to obtain cultures as needed to ascertain if someone has a hospital acquired infection (HAI).

2. The IP or designee has the authority to enact measures deemed appropriate to prevent the transmission of communicable diseases.

3. Depending on the severity of the measures required for the containment of the causative pathogen, collaboration with the Medical Director and/or MHS's Infectious Disease consultants will be initiated.

Scope of Service 2022 – 23

Joe DiMaggio Children's **Hospital (JDCH)** is located at 1005 Joe DiMaggio Drive Hollywood, is a 216-bed full-service pediatric hospital that offers the following services:

(Receiving facility for patients with high acuity – and requiring specialty services)

JDCH offers the following services:

- Level I Trauma Care
- Emergency Services
- Cardiac and Vascular Services
- Neurology
    - Epilepsy Monitoring Unit
- Cancer Care
- Neonatal Intensive Care (Level IV)
- Endocrinology
- General Surgical Services
- Sports and Dance Medicine
- Orthopedics
- Behavioral Health (inpatient, outpatient and emergency)
- Dialysis, Inpatient and Outpatient
- Inpatient Rehabilitation Services
- Neurosurgery
- Palliative Care/Hospice
- Ophthalmology
- Immunology/Genetics
- Hematology
- Ear, Nose and Throat (ENT)
- Cystic Fibrosis
- Gastrointestinal Services
- Transplant Services

Acuity:

- 46 Critical Care beds
- 84 Neonatal ICU (Level II/III) beds
- 68 Medical/Surgical/Telemetry/Stepdown/Oncology beds
- 12 Behavioral Health beds
- 6 Rehabilitation beds
- 37 Emergency beds
- 9 Surgical Suites
- 4 Cardiac Surgical Procedure/Hybrid Suites

Population served: Ages 0 – 21 years

Top Surgical Procedures:

- Dental Procedures (i.e., multiple caries)
- Myringotomy w/Tube insertions
- Ear, Nose and Throat (ENT) (Tonsillectomy and Adenoidectomy)
- General Surgery (i.e., laparoscopic appendectomy)
- Orchiopexy, circumcision

Top 4 Medical Diagnosis:

- Abdominal pain (Nausea, Vomiting, Diarrhea)
- Viral Respiratory Illness
- Asthma and Bronchiolitis
- Neurology (Epilepsy and Seizure Monitoring)

Top 4 Outpatient Procedures:

- Procedural Sedation (Lumbar Punctures, Chemotherapy, Imaging Studies)
- Renal Biopsies
- Incision and Drainage
- Minor Outpatient Procedures (Circumcision, Botox, Auditory Brainstem Response)

Outpatient Rehabilitation Centers

- Joe DiMaggio Children's Rehabilitation Center - 5830 Coral Ridge Drive, Coral Springs
    - Pediatric MRI Services
    - Feeding Therapy
    - Occupational and Physical Therapy
    - Speech Therapy
    - Pediatric ENT
    - Pediatric Pulmonology
    - Concussion Clinic
    - U-18 Sports Medicine
- Joe DiMaggio Children's Health Specialty Center – 3377 S. State Road 7, Wellington
    - Imaging Services
    - Outpatient Surgery
        - ENT
        - Orthopedics
        - Plastic/reconstruction
        - Urology
    - Rehabilitative Services
        - Physical and Occupational Therapy
        - Speech Therapy
        - Feeding Therapy
        - U-18 Sports Medicine Rehabilitation

Plan of Care and Practice for Infection Prevention and Control

The following activities are within the scope of care and practice of the infection prevention, infection control and epidemiology professionals:

Planning for management of infection control and prevention (IC & P) program (IC.01.01.01)

- The goal of the Infection Prevention, Infection Control and Epidemiology program is to prevent healthcare associated infections in patients, healthcare providers, and visitors.
- A multidisciplinary team collaborates to develop a comprehensive written plan that identifies

Performance of risk assessments at least annually and whenever significant changes occur, at a minimum inclusion of IP's, medical staff, leadership and nursing

- Identification, prioritization and documentation of risk assessment based in order of probability and level of harm based on (IC.01.03.01)
    - Geographic location, community, and population served
    - Care, treatment and services provided
    - Analysis of surveillance activities and aggregate IC data

Goal setting to reduce risk of infection to patients and community (IC.01.04.01)

- Written goals, based on identified risks, include
    - Addressing prioritized risks
    - Limiting unprotected exposure to pathogens
    - Limiting the transmission of infections associated with procedures
    - Limiting the transmission of infections associated with the use of medical equipment, devices and supplies

Development of an IC & P Plan (IC.01.05.01)

- Utilization of evidence-based guidelines such as APIC, SHEA, CDC, HICPAC, etc. or, in absence of such guidelines, expert consensus
- Written description of activities, including surveillance, to minimize, reduce or eliminate risk of infection

Performance of activities based on relevant professional guidelines and scientific practices

Development, implementation and documentation of infection surveillance, prevention, and control P & P's that adhere to nationally recognized guidelines

Communication and collaboration with quality assessment and performance improvement program (QAPI) and Risk Management on IC & P issues

Training and education of employees and medical staff on practical application of IC & P guidelines and P & P

Prevention and control of healthcare associated infections, including audit of adherence to IC & P & P by hospital employees and medical staff (IC.02.01.01)

- Implementation of IC & P activities involving departments, employees and medical staff
- Provision of important IC & P information to patients, employees, medical staff and visitors
    - Respiratory Hygiene Practices
    - Hand Hygiene
- Implementation of standard and transmission-based precautions
- Utilization of personal protective equipment (PPE)
- Implementation of surveillance
- Storage and disposal of infectious waste
- Investigation of outbreaks (IC.01.05.01)

- MHS utilizes a standard process for investigating outbreaks of infectious disease based on resources from local and state health department, CDC, APIC and SHEA. The series of steps outlined are performed simultaneously while being extremely time-sensitive due to nature of containing an outbreak, stopping spread, and preventing further infection. Activities like literature review and research cannot be overlooked and are important to review historical investigations and outbreaks. Healthcare outbreaks also must be sensitive to alerting key stakeholders, administrators, as well as contacting local health department to assist in investigation. The following written process is the basic guideline for investigating outbreaks of infectious disease at MHS:
    1. Recognizing outbreak or cluster based on surveillance activity or notification of event
    2. Confirming presence of an outbreak by comparing historical surveillance data
    3. Verify diagnosis and establish case definition
    4. Case finding and abstracting health records into a line list
    5. Analyzing commonalities for descriptive epidemiology (person, place, time) and creating an epi curve
    6. Field research in rounding and observing practices that may identify cause of outbreak and hypothesizing causes
    7. Implementing interventions to prevent and control infections
    8. Communicating findings, after-action reports, and health promotion and education materials

    Campbell, E. A., Eichhorn, C. L., Outbreak Investigations. In Boston K.M., et al, eds. APIC Text. 2020. Available at https://text.apic.org/toc/epidemiology-surveillance-performance-and-patient-safety-measures/outbreak-investigations. Links to an external site. Accessed January 17, 2023.
    Centers for Disease Control and Prevention. Outbreak investigations in healthcare settings. Healthcare-Associated Infections (HAIs). Available at https://www.cdc.gov/hai/outbreaks/index.html Links to an external site.. Reviewed June 14, 2021. Accessed January 17, 2023.
- Reporting of surveillance, prevention, and control information to appropriate staff within facility
- Reporting of surveillance, prevention and control information to local, state and federal public health authorities
- Informing receiving organizations of patients of patient requiring monitoring, treatment, and/or isolation
    - Upon transfer arrangement
    - After transfer, upon discovery
    - Upon receiving such patient and not having been notified by transferring facility

Reduction of risk of infections associated with medical equipment, devices, and supplies (IC.01.02.01)

- Implementation of IC &P activities
- Cleaning and performing low level disinfection of medical equipment, devices and supplies
- Performing intermediate and high-level disinfection and sterilization of medical equipment, devices and supplies
- Disposal of medical equipment, devices and supplies

- Storage of medical equipment, devices and supplies
- Reprocessing single use devices
- Availability of manufacturer's Instructions for use (IFUs)

Prevention of transmission of infectious disease among patients, licensed independent practitioners and staff (IC.02.03.01)

- Screening for exposure and/or immunity to infectious diseases available to LIPs and employees who may come in contact with infections in the workplace
- Management of LIPs and employees who are suspected of or were occupationally exposed
- Management of patients who have been exposed to an infectious disease
- Assessing compliance with and confirming proper use of optimal personal protective equipment (PPE)
- Assessing compliance with and confirming proper implementation of isolation guidelines and Hand Hygiene

Implementation of evidence-based practices to prevent healthcare associated infections due to the following: (IC.02.05.01)

- Multidrug Resistant organisms (MDRO)
- Central Line-associated bloodstream infections (CLABSI)
- Catheter-associated urinary tract infections (CAUTI)
- Ventilator Associated Event (VAE)
- Emerging Infectious Diseases
- *Clostridioides difficile*
- Surgical Site Infections (SSI)
    - For these:
    - Development and implementation of P & P based on evidence based practice, aimed at reduction
    - Periodic risk assessments and surveillance, aimed at reduction
    - Measurement and monitoring of infection prevention processes, outcomes, and compliance using evidence-based guidelines or best practices

Evaluation of effectiveness of infection prevention and control plan (IC.03.01.01)

    - Plan's prioritized risks
    - Plan's goals
- Communication of findings to patient safety program
- Include findings of evaluation when revising the plan

Communication and collaboration with Antimicrobial Stewardship Program (ASP) (MM.09.01.01)

Ratification of competency of Infection Control and Prevention team members

Preparation of response to an influx of potentially infectious patients, emergency preparedness (IC.01.06.01)

- Monitoring and evaluation of current clinical and epidemiological information from its resources regarding new infections that could cause an influx of potentially infectious patients
- Communication of critical information to licensed independent practitioners and staff about emerging infections that could cause an influx of potentially infectious patients
- Written plan delineating management of influx of infectious patients

Management of Environment during demolition, renovation, or new construction to reduce risk of infection (EC.02.06.05)

- Infection Control Risk Assessment (ICRA)

National Patient Safety Goal (NPSG.07.0101)

Improving compliance with the current CDC Hand Hygiene guidelines and the Transplant Safety guidelines (TS.03.03.01)

- iRound electronic audit tool for manual monitoring used in 2020 and 2021
- Implementation of Electronic Monitoring in 2022
- Discontinuation of the Electronic Monitoring System implemented March 2023 due to reliability and validity concerns with hand hygiene data
- Continuation of the use of iRound electronic audit tool to monitor hand hygiene

Transplant Safety (TS.03.03.01)

Investigation of adverse events related to tissue use or donor infections

- Compliance with policy and procedure for identifying, tracking, storing, and handling tissues, medical devices and other implantables.
- Investigation of infections suspected of being directly related to the use of tissue
- Reporting of infection to tissue supplies
- Sequestering tissue suspected of causing infection
- Notification of recipient of infectious agents that may have been transmitted through tissue

Water Management Program (EC.02.05.02)

Participation in interdisciplinary water management program that addresses Legionella and other waterborne pathogens.

Emergency Management Operations Program (EM.01.01.01)

Participation in interdisciplinary emergency management operations program: engagement in planning activities include identifying risks, prioritizing likely emergencies, attempting to mitigate them when possible, and considering its potential emergencies in developing strategies for preparedness, with a focus on infection control and prevention. This includes, where possible, collaboration with relevant parties in the community.

Staffing:

Joe DiMaggio Children's Hospital

- 1 Manager, Infection Prevention and Control

- 1 Infection Preventionist
- 2 Physician Co-Directors of Pediatric Infectious Disease

Memorial Healthcare System (Oversight and Support)

- Chief Physician, Division of Infectious Diseases and Medical Director of Infection Control and Antimicrobial Stewardship, MHS
- Physicians, Infectious Disease (MRH, MRHS)
- Director, Infection Prevention and Epidemiology, MHS

Hours of Operation:

Monday – Friday 8:00 am – 5:00 pm; other times immediate availability by cell phone.

Infection Prevention and Infection Control Plan

Our Mission: Heal the body, mind, and spirit of those we touch.

Our Vision: To be a premier clinically integrated delivery system providing access to exceptional patient- and family-centered care, medical education, research, and innovation for the benefit of the community we serve.

Our Commitment: Family Centered and Patient Focused Care

Purpose: To create and implement a comprehensive infection control, prevention and epidemiology program aimed at protecting patients, healthcare providers, employees, volunteers, and visitors from contracting/and or transmitting infections and diseases

To collaborate with the Emergency Preparedness Committee by engendering advance planning and preparedness critical to help mitigate the impact of an epidemic or pandemic event.

To collaborate with the local and state Health Departments in addition to other community entities such as nursing homes and other hospital systems to monitor the incidence of infections, identify potential outbreaks, and implement actions to mitigate and control the spread of infection.

To collaborate with all departments and services to minimize the morbidity, mortality and economic burdens associated with infection through prevention and control efforts throughout the facilities and in the well and ill populations.

Authority Statement

Pursuant to the approval by the Medical Executive Committee:

1. The Infection Preventionist (IP) or designee has the authority to obtain cultures as needed to ascertain if someone has a hospital acquired infection (HAI).

2. The IP or designee has the authority to enact measures deemed appropriate to prevent the transmission of communicable diseases.

3. Depending on the severity of the measures required for the containment of the causative pathogen, collaboration with the Medical Director and/or MHS's Infectious Disease consultants will be initiated.

Scope of Service 2022– 23

Memorial Regional Hospital South (MRHS)

MRHS is located at 3600 Washington Street in Hollywood, Florida. It is a 216-bed secondary acute care facility, and it houses the following institute:

- Memorial Rehabilitation Institute

MRHS offers the following services:

- 24 hrs. Emergency Care
- Adult Inpatient Rehabilitation

IP-IC Scope of Service

- Adult Inpatient Acute Medical, Surgical and Telemetry Services
- Radiology Services
- Women's Imaging Services
- General Surgery
- Endoscopy
- Interventional Radiology

Acuity:

- 44 Medical Surgical/Telemetry/ Intermediate Critical Care beds
- 89 Inpatient Rehabilitation beds
- 12 Emergency Department beds
- 9 Surgical Suites

Population served:

- Emergency Care – 0 – End of Life
- Inpatient Services – 18 – End of Life
- Rehabilitation – 16 – End of Life

Top 3 Surgical Diagnosis:

- Plastic Surgery
- Orthopedic Surgery
- Breast Procedures

Top 3 Medical Diagnosis:

- Unspecified abnormalities of gait and mobility
- Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side
- Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side

Top 6 Rehabilitation Diagnosis:

- Stroke
- Traumatic Brain Injury
- Amputee
- Cancer
- Spinal Cord Injury
- Orthopedic/Trauma and Complex Medical

Top 3 Outpatient Procedures:

1. Injections, anesthetic agent, or steroid, transforaminal epidural with imaging guidance
2. Injections, diagnostic or therapeutic agent, paravertebral facet joint
3. Arthroplasty, knee, condyle and plateau, medial and lateral compartments (total knee arthroplasty)

IP-IC Scope of Service

Top 3 Inpatient Procedures:

1. Excision of toenail
2. Insertion of infusion device into superior vena cava
3. Excision of esophagus

Plan of Care and Practice for Infection Prevention and Control

The following activities are within the scope of care and practice of the infection prevention, infection control and epidemiology professionals:

Planning for management of infection control and prevention (IC & P) program (IC.01.01.01)

- The goal of the Infection Prevention, Infection Control and Epidemiology program is to prevent healthcare associated infections in patients, healthcare providers, and visitors.
- A multidisciplinary team collaborates to develop a comprehensive written plan.

Performance of risk assessments at least annually and whenever significant changes occur, at a minimum inclusion of IP's, medical staff, leadership, and nursing.

- Identification, prioritization, and documentation of risk assessment based in order of probability and level of harm based on (IC.01.03.01)
    - Geographic location, community, and population served.
    - Care, treatment, and services provided.
    - Analysis of surveillance activities and aggregate IC data
        - Pareto Analysis

Goal setting to reduce risk of infection to patients and community (IC.01.04.01)

- Written goals, based on identified risks, include.
    - Addressing prioritized risks
    - Limiting unprotected exposure to pathogens
    - Limiting the transmission of infections associated with procedures.
    - Limiting the transmission of infections associated with the use of medical equipment, devices, and supplies.

Development of an IC & P Plan (IC.01.05.01)

- Utilization of evidence-based guidelines such as APIC, SHEA, CDC, HICPAC, OSHA etc. or, in absence of such guidelines, expert consensus
- Written description of activities, including surveillance, to minimize, reduce or eliminate risk of infection.

Performance of activities based on relevant professional guidelines and scientific practices.

Development, implementation and documentation of infection surveillance, prevention, and control

P & Ps that adhere to nationally recognized guidelines

Communication and collaboration with quality assessment and performance improvement program (QAPI) and Risk Management on IC & P issues

Training and education of employees and medical staff on practical application of IC & P guidelines and P & Ps

Prevention and control of healthcare associated infections, including audit of adherence to IC & P & P by hospital employees and medical staff (IC.02.01.01)

- Implementation of IC & P activities involving departments, employees, and medical staff
- Provision of important IC & P information to patients, employees, medical staff, and visitors
    - Respiratory Hygiene Practices
    - Hand Hygiene
- Implementation of standard and transmission-based precautions
- Utilization of personal protective equipment (PPE)
    - Donning
    - Doffing
    - Disposal
    - Storage
- Implementation of surveillance
- Storage and disposal of infectious waste
- Investigation of outbreaks (IC.01.05.01)
    - APIC Text of Infection Control and Epidemiology; April 7, 2020. Chapter 12.*Outbreak Investigations/ Epidemiology, Surveillance, Performance, and Patient Safety Measures* for framework and guidelines conducting an outbreak investigation
    - Initiates outbreak investigation when an outbreak or cluster is suspected consistent with CDC Guidelines.
    - Institutes early control measures, prepares a preliminary case definition, and compares current incidence with usual or baseline data.
    - Develops case definition based on time, place, person.
    - Evaluates efficacy of the control measures.
    - Reports finding to Medical Director of Infectious Diseases, System Director of Infection Prevention, Quality Care and Patient Safety Committee, appropriate Medical Staff Departments and Florida Department of Health, if warranted.
- Reporting of surveillance, prevention, and control information to appropriate staff within facility
    - The Infection Control Practitioner reports to the Director of Quality who reports to the Chief Nursing Officer.
    - The Infection Control Practitioner will report to the Medical Staff any trends within their departments.
    - The Infection Control Practitioner will report relevant findings to PIRM Committee, and Environment of Care Committee quarterly and a report will be submitted quarterly to the Quality Care and Patient Safety Council. The report is then submitted to the Medical Executive Committee, and to the Board of Commissioners.

- Reporting of surveillance, prevention, and control information to local, state, and federal public health authorities in accordance with laws and regulations.
- Informing receiving organizations of patients requiring monitoring, treatment, and/or isolation
    - Upon transfer arrangement
    - After transfer, upon discovery
    - Upon receiving a patient and if notification had not occurred by the transferring facility

Preparation of response to an influx of potentially infectious patients (IC.01.06.01)

The results of the hospital's infection risk assessment are prioritized in order of level of probability and potential for harm by a multidisciplinary team of stakeholders. Goals for reducing the risks of infections that pose the greatest threat to patients and the community are defined. These goals lead to focused activities, based on relevant professional guidelines and sound scientific practices.

- MHS Highly Communicable Disease Preparedness and Response guidelines
- COVID-19 guidelines continuously updated on intranet.

Reduction of risk of infections associated with medical equipment, devices, and supplies (IC.01.02.01)

- Surveillance methodology utilizing CDC NHSN with sources for identification including:
    - Microbiologic records
    - Reports from Information Systems including patient census/diagnosis.
    - EPIC and outside labs
    - Chart reviews and patient interviews
    - Post-discharge surveillance
    - Reporting of suspect/known infections or infection control issues from staff and units' multidisciplinary rounds
    - Device day usage for urinary catheters, central line catheters, and ventilators
    - Public health reporting of state mandated reportable infections.
    - Microbiologic monitoring of water and dialysate
- Implementation of IC &P activities
- Adherence to Spaulding Classification (CDC)
- Cleaning and performing low level disinfection of medical equipment, devices and supplies consistent with Manufacturer's Instruction for Use (IFUs)
- Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies
- Disposal of medical equipment, devices, and supplies
- Storage of medical equipment, devices, and supplies
- Reprocessing single use devices consistent with regulatory and professional standards.
- Availability of Manufacturer's Instructions for Use

Prevention of transmission of infectious disease among patients, licensed independent practitioners and staff (IC.02.03.01)

In collaboration with Medical Staff and Employee Health Services:

- Screening for exposure and/or immunity to infectious diseases available to LIPs and employees who may be exposed to infections within the workplace
- Management of LIPs and employees who are suspected of or were occupationally exposed
- Management of patients who have been exposed to an infectious disease
- Assessing compliance with and confirming proper use of optimal personal protective equipment (PPE)
- Assessing compliance with and confirming proper implementation of isolation guidelines and Hand Hygiene

Vaccination against influenza of licensed independent practitioners and staff. (IC.02.04.01)

- Annual influenza vaccination program that is offered to all licensed independent practitioners and staff.
- Education of licensed independent practitioners and staff about, at a minimum, the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza.
- Provision of influenza vaccination at sites and times accessible to licensed independent practitioners and staff.
- Improvement of influenza vaccination rates
- Written description of the methodology used to determine influenza vaccination rates
- Evaluation of the reasons given by staff and licensed independent practitioners for declining the influenza vaccination. This evaluation occurs at least annually, and it's reported in PIRM
- Improvement of vaccination rates according to established goals at least annually
- Provision of influenza vaccination rate data to key stakeholders which may include leaders, licensed independent practitioners, nursing staff, and other staff at least annual
- Collaboration with Employee Health Department, utilizing above process, to provide additional vaccination against:
    - Hepatitis B
    - Covid-19
    - Tetanus, Diphtheria and Pertussis
    - Varicella

Implementation of evidence-based practices to prevent healthcare associated infections due to the following: (IC.02.05.01)

- Multidrug Resistant organisms (MDRO)
    - *Candida auris*
    - *MDR Acinetobacter baumannii*
    - *MDR Carbapenem-resistant enterobateriaceae*
    - *MRSA*
    - *Pseudomonas aeruginosa*
- Central Line-associated bloodstream infections (CLABSI)
    - Participation in CDC's National Healthcare Safety Network
- Catheter-associated urinary tract infections (CAUTI)
    - Participation in CDC's National Healthcare Safety Network

IP-IC Scope of Service

- Ventilator Associated Event (VAE)
  - Participation in CDC's National Healthcare Safety Network
- Emerging Infectious Diseases
- *Clostridioides difficile*
  - Participation in CDC's National Healthcare Safety Network
- Surgical Site Infections (SSI)
  - Development and implementation of P & P based on evidence-based practice, aimed at reduction
  - Periodic risk assessments and surveillance, aimed at reduction
  - Measurement and monitoring of infection prevention processes, outcomes, and compliance using evidence-based guidelines or best practices
  - Participation in The American College of Surgeons National Surgical Quality Improvement Program (NSQIP)

Evaluation of effectiveness of infection prevention and control plan and program (IC.03.01.01)

- Plan's prioritized risks
- Plan's goals
- Program's efficacy
- Communication of findings to patient safety program
- Include findings of evaluation when revising the plan

Communication and collaboration with Antimicrobial Stewardship Program (ASP) (MM.09.01.01)

Ratification of competency of Infection Control and Prevention team members

- Maintains membership in Association for Professionals in Infection Control and Florida Professionals in Infection Control.
- Attends one (1) educational seminar related to infection prevention and control per year.

Preparation for response to an influx of potentially infectious patients, emergency preparedness (IC.01.06.01)

- Monitoring and evaluation of current clinical and epidemiological information from its resources regarding new infections that could cause an influx of potentially infectious patients
- Communication of critical information to licensed independent practitioners and staff about emerging infections that could cause an influx of potentially infectious patients
- Written plan delineating management of influx of infectious patients

Management of Environment during demolition, renovation, or new construction to reduce risk of infection (EC.02.06.05)

- Infection Control Risk Assessment (ICRA)

National Patient Safety Goal (NPSG.07.0101)

Improving compliance with the current CDC Hand Hygiene guidelines and the Transplant Safety guidelines (TS.03.03.01)

- iRound electronic audit tool for manual monitoring used in 2020 and 2021
- Implementation of Electronic Monitoring in July of 2022
- Discontinuation of the Electronic Monitoring System in March of 2023 due reliability and validity concerns to properly collect HH observations.
- Continuation of the use of iRound electronic Audit tool to monitor HH

Investigation of adverse events related to tissue use or donor infections

- Compliance with P&P for identifying, tracking, storing, and handling tissues, medical devices and other implantable items.
- Investigation of infections suspected of being directly related to the use of tissue
- Reporting of infection to tissue suppliers
- Sequestering remaining tissue suspected of causing infection
- Notification of recipient of infectious agents that may have been transmitted through tissue

Water Management Program (EC.02.05.02)

- Participation in an interdisciplinary water management program that addresses Legionella and other waterborne pathogens.

Emergency Management Operations Program (EM.01.01.01)

- Participation in interdisciplinary emergency management operations program: engagement in planning activities which includes identifying risks, prioritizing likely emergencies, attempting to mitigate them when possible, and considering potential emergencies in developing strategies for preparedness, with a focus on infection control and prevention. This includes, where possible, collaboration with relevant parties in the community.

Staffing:

Memorial Regional Hospital South

- Director, Quality & Patient Safety
- Manager of Infection Prevention & Control/Rehab Quality

Job descriptions delineate the scope and responsibility for each Infection Prevention professional

Memorial Healthcare System (Oversight and Support)

- Chief Physician, Division of Infectious Diseases and Medical Director of Infection Control and Antimicrobial Stewardship, MHS
- Physicians, Infectious Disease (MRH, MRHS)
- Director, Infection Prevention and Epidemiology, MHS

Hours of Operation:

- Monday – Friday 8:00 am – 5:00 pm; other times immediate availability by cell phone.

References:

https://e-dition.jcrinc.com/Frame.aspx January 1, 2022

APIC Text of Infection Control and Epidemiology; April 7, 2020

Infection Prevention and Infection Control Plan 2023

Our Mission: Heal the body, mind, and spirit of those we touch.

Our Vision: To be a premier clinically integrated delivery system providing access to exceptional patient- and family-centered care, medical education, research, and innovation for the benefit of the community we serve.

Our Commitment: Family Centered and Patient Focused Care

Purpose: The purpose of the Memorial Hospital West Infection Prevention and Control Plan is to define the scope of activities and to provide a framework for the systematic organization wide approach to create an effective infection control program. The Infection Prevention and Infection Control Plan integrates all departments, patient care sites and practices with the intent:

1. To create and implement a comprehensive infection control, prevention and epidemiology program aimed at protecting patients, healthcare providers, employees, volunteers, and visitors from contracting/and or transmitting infections and diseases
2. To collaborate with the Emergency Preparedness Committee by engendering advance planning and preparedness critical to help mitigate the impact of an epidemic or pandemic event
3. To collaborate with the local and state Health Departments to monitor incidence of infections, identify potential outbreaks, and implement actions to mitigate and control the spread of infection
4. To collaborate with all departments and services to minimize the morbidity, mortality and economic burdens associated with infection through prevention and control efforts throughout the facilities and in the well and ill populations

Authority Statement

Pursuant to the approval by the Medical Executive Committee:

1. The Infection Preventionist (IP) or designee has the authority to obtain cultures as needed to ascertain if someone has a hospital acquired infection (HAI).

2. The IP or designee has the authority to enact measures deemed appropriate to prevent the transmission of communicable diseases.

3. Depending on the severity of the measures required for the containment of the causative pathogen, collaboration with the Medical Director and/or MHS's Infectious Disease consultants will be initiated.

Scope of Service 2022– 2023

Memorial Hospital West (MHW) is located at 703 N. Flamingo Road, Pembroke Pines, Florida 33028, and serves the population of Southwest Broward County and Northwest Broward County. MHW is the second largest member hospital of the South Broward Hospital System, DBA: Memorial Healthcare System. MHW is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a teaching facility.

(Receiving facility for patients with high acuity – and requiring specialty services)

MHW is a 486 Bed Adult Acute Care Tertiary Care facility and offers the following services:

Population served - Ages: 18 – End of Life, unless pediatric services are designated:

1. Emergency Care for Adults
2. Emergency Care for Children, birth – 17 years (Joe DiMaggio Children's Hospital)
3. Cancer Care
    a. Bone Marrow Transplant Unit
4. Cardiac and Vascular Care
5. Joint Replacement
6. Neurology
7. Neurosurgery
8. Bariatrics
9. Family Birthplace
    a. Level III Neonatal Intensive Care Unit (NICU)
10. Nutrition
11. Stroke Treatment
12. Surgery
13. Women's Services
14. Inpatient Dialysis
15. Outpatient Rehabilitation Services
16. Outpatient Rehabilitation Services for Children, birth – 17 years (Joe DiMaggio Children's Hospital)

Acuity:

- 32 Critical Care beds
- 412 Medical/Surgical/Stepdown/Telemetry/Oncology beds (69 Oncology inpatient beds and 7 Oncology Outpatient BMT beds)
- 44 Obstetrics/Gynecology beds
- 20 Level III NICU beds
- 50 Adult ED and 16 Peds ED
- 16 Surgical Suites

Top 10 Inpatient Medical Diagnosis:

1. Single live born infant, delivered vaginally
2. Single live born infant, delivered by cesarean
3. COVID-19
4. Sepsis
5. Maternal care for low transverse scar from previous cesarean delivery
6. Hypertensive heart and chronic kidney disease with heart failure, stage 1-4 or unspecified chronic kidney disease
7. Hypertensive heart disease with heart failure
8. Non-ST elevation (NSTEMI) myocardial infarction

9. Post-term pregnancy
10. Pneumonia

Top 5 Inpatient Primary Procedures:

1. Introduction of Remdesivir into Peripheral Vein
2. Measurement of Cardiac sampling and Pressure; Bilateral
3. Measurement of Cardiac sampling and Pressure; Left Heart
4. Dilation of Coronary Artery, Percutaneous Approach
5. Excision of Stomach, Percutaneous Approach

Top 5 Out-Patient Procedures:

1. Total Knee Arthroplasty
2. Hysteroscopy, surgical; with biopsy
3. Laparoscopic Repair of Initial Inguinal Hernia
4. Laparoscopic Total Hysterectomy
5. Laparoscopic Cholecystectomy

Additional Sites of Service:

Breast Cancer Center at Memorial Hospital West
603 North Flamingo Road, Suite 157, Pembroke Pines FL, 33028

Cardiac & Pulmonary Rehabilitation, Memorial Fitness & Rehab
701 North Flamingo Road, Pembroke Pines FL, 33028

Memorial Cancer Institute at Memorial Hospital West
603 North Flamingo Road, Suite 151, Pembroke Pines FL, 33028

Memorial Cancer Institute at Memorial Hospital West
603 North Flamingo Road, Suite 159, Pembroke Pines FL, 33028

Memorial Hospital West
703 North Flamingo Road, Pembroke Pines FL, 33028

Memorial Hospital West Cancer Institute
801 North Flamingo Road, Suite 11, Pembroke Pines FL, 33028

Memorial Hospital West – Outpatient Imaging
603 North Flamingo Road, Suite 306, Pembroke Pines FL, 33028

Memorial Primary Care – Silver Lakes
17786 SW 2nd Street, Pembroke Pines FL, 33029

Memorial Primary Care – West Miramar
10910 Pembroke Road, Miramar FL, 32305

Memorial Primary Care – Monarch Lakes
12781 Miramar Parkway, Suite 1-202, Miramar FL, 33027

Plan of Care and Practice for Infection Prevention and Control

The following activities are within the scope of care and practice of the infection prevention, infection control and epidemiology professionals:

Planning for management of infection control and prevention (IC & P) program (IC.01.01.01)

1. The goal of the Infection Prevention, Infection Control and Epidemiology program is to prevent healthcare associated infections in patients, healthcare providers, and visitors.
2. A multidisciplinary team collaborates to develop a comprehensive written plan

Performance of risk assessments at least annually and whenever significant changes occur, at a minimum inclusion of IP's, medical staff, leadership, and nursing

1. Identification, prioritization, and documentation of risk assessment based in order of probabilityand level of harm based on (IC.01.03.01)
    a. Geographic location, community, and population served
    b. Care, treatment, and services provided
    c. Analysis of surveillance activities and aggregate IC data
        i. Pareto Analysis

Goal setting to reduce risk of infection to patients and community (IC.01.04.01)

1. Written goals, based on identified risks, include
    a. Addressing prioritized risks
    b. Limiting unprotected exposure to pathogens
    c. Limiting the transmission of infections associated with procedures
    d. Limiting the transmission of infections associated with the use of medical equipment, devices, and supplies

Development of an IC & P Plan (IC.01.05.01)

1. Utilization of evidence-based guidelines such as APIC, SHEA, CDC, HICPAC, OSHA etc. or, inabsence of such guidelines, expert consensus
2. Written description of activities, including surveillance, to reduce or eliminate risk ofinfection

Performance of activities based on relevant professional guidelines and scientific practices

Development, implementation and documentation of infection surveillance, prevention, and control P & Ps that adhere to nationally recognized guidelines

Communication and collaboration with quality assessment and performance improvement program (QAPI) and Risk Management on IC & P issues

Training and education of employees and medical staff on practical application of IC & P guidelines and P&Ps

Prevention and control of healthcare associated infections, including audit of adherence to IC & P P&Ps by hospital employees and medical staff (IC.02.01.01)

1. Implementation of IC & P activities involving departments, employees, and medical staff
2. Provision of important IC & P information to patients, employees, medical staff, and visitors
    a. Respiratory Hygiene Practices
    b. Hand Hygiene
3. Implementation of standard and transmission-based precautions
4. Utilization of personal protective equipment (PPE)
    a. Donning
    b. Doffing
    c. Disposal
    d. Storage
    e. Reprocessing (in rare circumstances of necessity due to lack of supplies in epidemic emergencies)
5. Implementation of surveillance
6. Storage and disposal of infectious waste
7. Investigation of outbreaks (IC.01.05.01)
8. Reporting of surveillance, prevention, and control information to appropriate staff within facility
9. Reporting of surveillance, prevention, and control information to local, state, and federal publichealth authorities
10. Informing receiving organizations of patients of patient requiring monitoring, treatment, and/or isolation
    a. Upon transfer arrangement
    b. After transfer, upon discovery
    c. Upon receiving such patient and not having been notified by transferring facility

Investigation of outbreaks (IC.01.05.01)

MHS utilizes a standard process for investigating outbreaks of infectious disease based on resources from local and state health department, CDC, APIC and SHEA. The series of steps outlined are performed simultaneously while being extremely time-sensitive due to nature of containing an outbreak, stopping spread, and preventing further infection. Activities like literature review and research cannot be overlooked and are important to review historical investigations and outbreaks. Healthcare outbreaks also must be sensitive to alerting key stakeholders, administrators, as well as contacting local health department to assist in investigation. The following written process is the basic guideline for investigating outbreaks of infectious disease at MHS:

1. Recognizing outbreak or cluster based on surveillance activity or notification of event
2. Confirming presence of an outbreak by comparing historical surveillance data
3. Verify diagnosis and establish case definition
4. Case finding and abstracting health records into a line list
5. Analyzing commonalities for descriptive epidemiology (person, place, time) and creating an epi curve

6. Field research in rounding and observing practices that may identify cause of outbreak and hypothesizing causes
7. Implementing interventions to prevent and control infections
8. Communicating findings, after-action reports, and health promotion and education materials

Preparation of response to an influx of potentially infectious patients (IC.01.06.01)

The results of the hospital's infection risk assessment are prioritized in order of level of probability and potential for harm by a multidisciplinary team of stakeholders. Goals for reducing the risks of the infections that pose the greatest threat to patients and the community are defined. These goals lead to focused activities, based on relevant professional guidelines and sound scientific practices.

Reduction of risk of infections associated with medical equipment, devices, and supplies (IC.01.02.01)

1. Implementation of IC &P activities
2. Adherence to Spaulding Classification (CDC)
3. Cleaning and performing low level disinfection of medical equipment, devices and supplies consistent with Manufacturer's Instruction for Use (IFUs)
4. Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies
5. Disposal of medical equipment, devices, and supplies
6. Storage of medical equipment, devices, and supplies
7. Reprocessing single use devices
8. Availability of Manufacturer's Instructions for Use

Prevention of transmission of infectious disease among patients, licensed independent practitioners and staff (IC.02.03.01)

In collaboration with Medical Staff and Employee Health Services:

1. Screening for exposure and/or immunity to infectious diseases available to LIPs and employees who may encounter infections in the workplace
2. Management of LIPs and employees who are suspected of or were occupationally exposed
3. Management of patients who have been exposed to an infectious disease
4. Assessing compliance with and confirming proper use of optimal personal protective equipment (PPE)
5. Assessing compliance with and confirming proper implementation of isolation guidelines and Hand Hygiene

Vaccination against influenza to licensed independent practitioners and staff. (IC.02.04.01)

1. Annual influenza vaccination program that is offered to licensed independent practitioners and staff.
2. Education of licensed independent practitioners and staff about, at a minimum, the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza.

3. Provision of influenza vaccination at sites and times accessible to licensed independent practitioners and staff.
4. Improvement of influenza vaccination rates
5. Written description of the methodology used to determine influenza vaccination rates
6. Evaluation of the reasons given by staff and licensed independent practitioners for declining the influenza vaccination. This evaluation occurs at least annually
7. Improvement of vaccination rates according to established goals at least annually
8. Provision of influenza vaccination rate data to key stakeholders which may include leaders, licensed independent practitioners, nursing staff, and other staff at least annual
9. Collaboration with Employee Health Department, utilizing above process, to provide additional vaccination against:
    a. Hepatitis B
    b. Covid-19
    c. Tetanus, Diphtheria and Pertussis
    d. Varicella

Implementation of evidence-based practices to prevent healthcare associated infections due to the following: (IC.02.05.01)

1. Multidrug Resistant organisms (MDRO)
    a. Candida auris
    b. MDR Acinetobacter baumannii
    c. MDR Carbapenem-resistant enterobacteriaceae
    d. MRSA
    e. MDR Pseudomonas aeruginosa
2. Central Line-associated bloodstream infections (CLABSI)
    a. Participation in CDC's National Healthcare Safety Network
3. Catheter-associated urinary tract infections (CAUTI)
    a. Participation in CDC's National Healthcare Safety Network
4. Ventilator Associated Event (VAE)
    a. Participation in CDC's National Healthcare Safety Network
5. Emerging Infectious Diseases
6. *Clostridioides difficile*
    a. Participation in CDC's National Healthcare Safety Network
7. Surgical Site Infections (SSI)
    a. For these:
    b. Development and implementation of P & P based on evidence-based practice,aimed at reduction
    c. Periodic risk assessments and surveillance, aimed at reduction
    d. Measurement and monitoring of infection prevention processes, outcomes, and compliance using evidence-based guidelines or best practices
    e. Participation The American College of Surgeons National Surgical Quality Improvement Program (NSQIP)

Evaluation of effectiveness of infection prevention and control plan and program (IC.03.01.01)

1. Plan's prioritized risks
2. Plan's goals
3. Program's efficacy
    - Communication of findings to patient safety program
    - Include findings of evaluation when revising the plan

Communication and collaboration with Antimicrobial Stewardship Program (ASP) (MM.09.01.01)

Ratification of competency of Infection Control and Prevention team members

Preparation of response to an influx of potentially infectious patients, emergency preparedness (IC.01.06.01)

1. Monitoring and evaluation of current clinical and epidemiological information from its resources regarding new infections that could cause an influx of potentially infectious patients
2. Communication of critical information to licensed independent practitioners and staff about emerging infections that could cause an influx of potentially infectious patients
3. Written plan delineating management of influx of infectious patients

Management of Environment during demolition, renovation, or new construction to reduce risk of infection (EC.02.06.05)

- Infection Control Risk Assessment (ICRA)

National Patient Safety Goal (NPSG.07.01.01)

Compliance with either WHO or the current CDC hand hygiene guidelines

Transplant Safety (TS.03.03.01)

Investigation of adverse events related to tissue use or donor infections

1. Compliance with P&P for identifying, tracking, storing, and handling tissues, medical devices and other implantables.
2. Investigation of infections suspected of being directly related to the use of tissue
3. Reporting of infection to tissue supplies
4. Sequestering tissue suspected of causing infection
5. Notification of recipient of infectious agents that may have been transmitted through tissue

Water Management Program (EC.02.05.02)

Participation in interdisciplinary water management program that addresses Legionella and other waterborne pathogens.

Emergency Management Operations Program (EM.09.09.01)

Participation in interdisciplinary emergency management operations program: engagement in planning activities include identifying risks, prioritizing likely emergencies, attempting to mitigate them when possible, and considering its potential emergencies in developing strategies for preparedness, with a focus on infection control and prevention. This includes, where possible, collaboration with relevant parties in the community.

Staffing:

Memorial Hospital West

- Director, Quality & Patient Safety
- Manager, Infection Control
- 4 Infection Preventionists
- 1 Board Certified Internal Medicine and Infectious Disease Physician/Medical director

Job descriptions delineate the scope and responsibility for each Infection Prevention Professional

Memorial Healthcare System (Oversight and Support)

- Chief Physician, Division of Infectious Diseases and Medical Director of Infection Control and Antimicrobial Stewardship, MHS
- Physicians, Infectious Disease (MHW)
- Director, Infection Prevention and Epidemiology, MHS

Hours of Operation:

Monday – Friday 7:30 am – 4:30 pm; other times immediate availability by cell phone.

References:

APIC Text of Infection Control and Epidemiology; April 7, 2020

APIC Text of Infection Control and Epidemiology; April 7, 2020. Chapter 12. *Outbreak Investigations/ Epidemiology, Surveillance, Performance, and Patient Safety Measures* for framework and guidelines conducting an outbreak investigation

Campbell, E. A., Eichhorn, C. L., Outbreak Investigations. In Boston K.M., et al, eds. APIC Text. 2020. Available at https://text.apic.org/toc/epidemiology-surveillance-performance-and-patient-safety-measures/outbreak-investigations. Links to an external site. Accessed January 17, 2023.

Centers for Disease Control and Prevention. Outbreak investigations in healthcare settings. Healthcare-Associated Infections (HAIs). Available at https://www.cdc.gov/hai/outbreaks/index.html Links to an external site.. Reviewed June 14, 2021. Accessed January 17, 2023.

https://e-dition.jcrinc.com/Frame.aspx January 1, 2022

Memorial Hospital Miramar

Infection Prevention and Infection Control Plan 2023

Our Mission: Heal the body, mind, and spirit of those we touch.

Our Vision: To be a premier clinically integrated delivery system providing access to exceptional patient- and family-centered care, medical education, research and innovation for the benefit of the community we serve.

Our Commitment: Family Centered and Patient Focused Care

Purpose: The purpose of the Memorial Hospital Miramar Infection Prevention and Control Plan is to define the scope of activities and to provide a framework for the systematic organization wide approach to create an effective infection control program. The Infection Prevention and Infection Control Plan integrates all departments, patient care sites and practices with the intent:

1. To create and implement a comprehensive infection control, prevention and epidemiology program aimed at protecting patients, healthcare providers, employees, volunteers and visitors from contracting/and or transmitting infections and diseases
2. To collaborate with the Emergency Preparedness Committee by engendering advance planning and preparedness critical to help mitigate the impact of an epidemic or pandemic event
3. To collaborate with the local and state Health Departments to monitor incidence of infections, identify potential outbreaks, and implement actions to mitigate and control the spread of infection
4. To collaborate with all departments and services to minimize the morbidity, mortality and economic burdens associated with infection through prevention and control efforts throughout the facilities and in the well and ill populations

Authority Statement

Pursuant to the approval by the Medical Executive Committee:

1. The Infection Preventionist (IP) or designee has the authority to obtain cultures as needed to ascertain if someone has a hospital acquired infection (HAI).

2. The IP or designee has the authority to enact measures deemed appropriate to prevent the transmission of communicable diseases.

3. Depending on the severity of the measures required for the containment of the causative pathogen, collaboration with the Medical Director and/or MHS's Infectious Disease consultants will be initiated.

Scope of Service 2022– 23

Memorial Hospital Miramar (MHM) is located at 1901 SW 172nd Avenue, Miramar, FL 33029 and serves the population of Southwest Broward County and Northwest Miami-Dade County. MHM is the newest hospital of the South Broward Hospital System, DBA: Memorial Healthcare System. MHM is an acute care setting with a broad range of diagnosis groups and serves newborn to end of life including labor and delivery.

MHM is a 178 Acute Care Tertiary Care facility and offers the following services:

Population served - Ages: 18 – End of Life, unless pediatric services are designated:

1. Emergency Care for Adults
2. Emergency Care for Children, birth – 17 years (Joe DiMaggio Children's Hospital)
3. Cancer Care
4. Vascular and Interventional Radiology Care
5. Neurology
6. Family Birthplace Labor and Delivery
7. Family Birthplace Mother Baby
8. Level II & III Neonatal Intensive Care Unit (NICU)
9. Well -Baby Nursery
10. Nutrition
11. Stroke Treatment
12. Surgery
13. Women's Services
14. Outpatient Laboratory Services
15. Inpatient Dialysis
16. Outpatient Rehabilitation Services
17. Outpatient Rehabilitation Services for Children, birth – 17 years (Joe Di Maggio children's Hospital)
18. Medical Office Building II

Acuity:

- 18 Critical Care beds
- 94 Medical/Surgical/Stepdown/Telemetry
- 50 Obstetrics/Gynecology beds
- 16 Level II and III NICU beds
- 26 Adult Emergency Department beds
- 11 Pediatric Emergency Department beds
- 9 Obstetric Emergency Department beds
- 8 Surgical Suites – Main OR
- 4 Surgical Suites in Memorial Surgical Center (MSC)
- 3 Surgical Suites in Obstetrics

Top 10 Inpatient Medical Diagnosis:

1. Single live born infant, delivered vaginally
2. Single live born infant, delivered by cesarean
3. Maternal care for low transverse scar from previous cesarean delivery
4. COVID-19
5. Post-term pregnancy
6. Strep B carrier state complicating childbirth

7. Full-term premature rupture of membranes, unspecified as to length of time between rupture and onset of labor
8. Sepsis
9. Gestational pregnancy-induced hypertension without significant proteinuria, complicating childbirth
10. Oligohydramnios, Third Trimester

Top 10 Inpatient Primary Procedures:

1. Delivery of Products of Conception, external Approach
2. Insertion of Infusion Device into SVC, Percutaneous Approach
3. Performance of Urinary Filtration, Intermittent
4. Excision of Stomach, via Natural or Artificial Opening Endoscopic
5. Drainage of Right Pleural Cavity, Percutaneous Approach
6. Resection of appendix, percutaneous endoscopic approach
7. Inspection of Upper Intestinal Tract, via Natural or Artificial Opening Endoscopic
8. Resection of sigmoid colon, percutaneous endoscopic approach
9. Replacement of Left Knee Joint with Synthetic Substitute, Cemented, Open Approach
10. Replacement of Right Knee Joint with Synthetic Substitute, Cemented, Open Approach

Top 10 Outpatient Procedures:

1. Hysteroscopy, surgical; with biopsy
2. Laparoscopic total hysterectomy
3. Laparoscopic partial or total oophorectomy and/or salpingectomy
4. Laparoscopic with total hysterectomy, uterus greater than 250g, with removal of tubes and/or ovary
5. Laparoscopic cholecystectomy
6. Laparoscopic fulguration or excision of lesions of ovary, pelvic viscera, or peritoneal surface
7. Treatment of missed abortion, completely surgical, first trimester
8. Laparoscopic, Myomectomy
9. Laparoscopic, repair of inguinal hernia
10. Laparoscopic, removal of leiomyomata

Additional Sites of Service:

1. **Medical Office Building**
   1951 SW 172nd Avenue
   Miramar, FL 33029
2. **Medical Office Building 2: Memorial Surgery Center and Women's Center**
   1971 SW 172nd Avenue
   Miramar, FL 33029

Plan of Care and Practice for Infection Prevention and Control

The following activities are within the scope of care and practice of the infection prevention, infection control and epidemiology professionals:

A. **Planning** for management of infection control and prevention (IC & P) program (IC.01.01.01)

1. The goal of the Infection Prevention, Infection Control and Epidemiology program is to prevent health-care associated infections in patients, healthcare providers, and visitors.
2. A multidisciplinary team collaborates to develop a comprehensive written plan

B. Performance of **risk assessments** at least annually and whenever significant changes occur, at a minimum inclusion of IP's, medical staff, leadership and nursing

1. Identification, prioritization and documentation of risk assessment based in order of probability and level of harm based on (IC.01.03.01)
    a. Geographic location, community, and population served
    b. Care, treatment and services provided
    c. Analysis of surveillance activities and aggregate IC data
        i. Pareto Analysis

C. **Goal setting** to reduce risk of infection to patients and community (IC.01.04.01)

1. Written goals, based on identified risks, include
    a. Addressing prioritized risks
    b. Limiting unprotected exposure to pathogens
    c. Limiting the transmission of infections associated with procedures
    d. Limiting the transmission of infections associated with the use of medical equipment, devices and supplies

D. Development of an **IC&P Plan** (IC.01.05.01)

1. Utilization of evidence based guidelines such as APIC, SHEA, CDC, HICPAC, OSHA etc. or, in absence of such guidelines, expert consensus
2. Written description of activities, including surveillance, to minimize, reduce or eliminate risk of infection

E. Performance of activities based on relevant **professional guidelines and scientific practices**

F. **Development, implementation and documentation** of infection surveillance, prevention, and control, P & Ps that adhere to nationally recognized guidelines

G. **Communication and collaboration** with quality assessment and performance improvement program (QAPI) and Risk Management on IC & P issues

H. **Training and education** of employees and medical staff on practical application of IC & P guidelines and P&Ps

I. **Prevention and control** of healthcare associated infections, including audit of adherence to IC & P P&Ps by hospital employees and medical staff (IC.02.01.01)

1. Implementation of IC & P activities involving departments, employees and medical staff
2. Provision of important IC & P information to patients, employees, medical staff and visitors
    a. Respiratory Hygiene Practices
    b. Hand Hygiene
3. Implementation of standard and transmission based precautions
4. Utilization of personal protective equipment (PPE)
    a. Donning
    b. Doffing
    c. Disposal
    d. Storage
5. Implementation of surveillance
6. Storage and disposal of infectious waste
7. Investigation of outbreaks (IC.01.05.01)
    a. APIC Text of Infection Control and Epidemiology; April 7, 2020. Chapter 12.*Outbreak Investigations/ Epidemiology, Surveillance, Performance, and Patient Safety Measures* for framework and guidelines conducting an outbreak investigation
    b. Initiates outbreak investigation when an outbreak or cluster is suspected consistent with CDC Guidelines.
    c. Institutes early control measures and prepares a preliminary case definition, compares current incidence with usual or baseline data.
    d. Develops case definition based on time, place, person.
    e. Evaluates efficacy of the control measures.
    f. Reports finding to Medical Director of Infectious Diseases, System Director of Infection Prevention, Quality Care and Patient Safety Committee, appropriate Medical Staff Departments and Florida Department of Health, if warranted.
8. Reporting of surveillance, prevention and control information to appropriate staff within facility
    a. The Infection Control Practitioner reports to the Director of Quality who reports to the Chief Nursing Officer.
    b. The Infection Control Practitioner will report to the Medical Staff Departments any trends within their Departments.
    c. The Infection Control Practitioner will report relevant findings to PI/RM Committee, and Environment of Care Committee quarterly and a report will be submitted quarterly to the Quality Care and Patient Safety Council. The report is then submitted to the Medical Executive Committee, and to the Board of Commissioners.
9. Reporting of surveillance, prevention and control information to local, state and federal public health authorities.
10. Informing receiving organizations of patients requiring monitoring, treatment, and/or isolation
    a. Upon transfer arrangement
    b. After transfer, upon discovery
    c. Upon receiving such patient and not having been notified by transferring facility

J. <u>Preparation of response to an influx of potentially infectious patients</u> (IC.01.06.01)

The results of the hospital's infection risk assessment is prioritized in order of level of probability and potential for harm by a multidisciplinary team of stakeholders. Goals for reducing the risks of the

infections that pose the greatest threat to patients and the community are defined. These goals lead to focused activities, based on relevant professional guidelines and sound scientific practices.

1. MHS Highly Communicable Disease Preparedness and Response guidelines
2. COVID-19 guidelines continuously updated on intranet

K. Reduction of risk of infections associated with medical equipment, devices, and supplies (IC.01.02.01)

1. Surveillance methodology utilizing CDC NHSN with sources for identification including
    a. Microbiologic records
    b. Reports from Information Systems including patient census/diagnosis
    c. EPIC and outside labs
    d. Chart reviews and patient interview
    e. Post-discharge surveillance
    f. Reporting of suspect/known infections or infection control issues from staff and unit multidisciplinary rounds
    g. Device day usage for urinary catheters, central line catheters, and ventilators
    h. Public health reporting of state mandated reportable infections
    i. Microbiologic monitoring of water and dialysate
2. Implementation of IC&P activities
3. Adherence to Spaulding Classification (CDC)
4. Cleaning and performing low level disinfection of medical equipment, devices and supplies consistent with Manufacturer's Instruction for Use (IFUs)
5. Performing intermediate and high-level disinfection and sterilization of medical equipment, devices and supplies
6. Disposal of medical equipment, devices and supplies
7. Storage of medical equipment, devices and supplies
8. Reprocessing single use devices
9. Availability of Manufacturer's Instructions for Use

L. Prevention of transmission of infectious disease among patients, licensed independent practitioners and staff (IC.02.03.01)

In collaboration with Medical Staff and Employee Health Services:

1. Screening for exposure and/or immunity to infectious diseases available to LIPs and employees who may come in contact with infections in the workplace
2. Management of LIPs and employees who are suspected of or were occupationally exposed
3. Management of patients who have been exposed to an infectious disease
4. Assessing compliance with and confirming proper use of optimal personal protective equipment (PPE)
5. Assessing compliance with and confirming proper implementation of isolation guidelines and Hand Hygiene

M. Vaccination against influenza to licensed independent practitioners and staff. (IC.02.04.01)

1. Annual influenza vaccination program that is offered to licensed independent practitioners and staff.
2. Education of licensed independent practitioners and staff about, at a minimum, the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza.
3. Provision of influenza vaccination at sites and times accessible to licensed independent practitioners and staff.
4. Improvement of influenza vaccination rates
5. Written description of the methodology used to determine influenza vaccination rates
6. Evaluation of the reasons given by staff and licensed independent practitioners for declining the influenza vaccination. This evaluation occurs at least annually
7. Improvement of vaccination rates according to established goals at least annually
8. Provision of influenza vaccination rate data to key stakeholders which may include leaders, licensed independent practitioners, nursing staff, and other staff at least annual
9. Collaboration with Employee Health Department, utilizing above process, to provide additional vaccination against:
    a. Hepatitis B
    b. Covid-19
    c. Tetanus, Diphtheria and Pertussis
    d. Varicella

N. <u>Implementation of evidence-based practices</u> to prevent health-care associated infections due to the following: (IC.02.05.01)

1. Multidrug Resistant organisms (MDRO)
    a. Candida auris
    b. MDR Acinetobacter baumannii
    c. MDR Carbapenem-resistant enterobateriaceae
    d. MRSA
    e. MDR Pseudomonas aeruginosa
2. Central Line-associated bloodstream infections (CLABSI)
    a. Participation in CDC's National Healthcare Safety Network
3. Catheter-associated urinary tract infections (CAUTI)
    a. Participation in CDC's National Healthcare Safety Network
4. Ventilator Associated Event (VAE)
    a. Participation in CDC's National Healthcare Safety Network
5. Emerging Infectious Diseases
6. *Clostridioides difficile*
    a. Participation in CDC's National Healthcare Safety Network
7. Surgical Site Infections (SSI)
    a. <u>For these:</u>
    b. Development and implementation of P & P based on evidence based practice, aimed at reduction
    c. Periodic risk assessments and surveillance, aimed at reduction

d. Measurement and monitoring of infection prevention processes, outcomes, and compliance using evidence-based guidelines or best practices
e. Participation The American College of Surgeons National Surgical Quality Improvement Program (NSQIP)

O. **Evaluation** of effectiveness of infection prevention and control plan and program (IC.03.01.01)

1. Plan's prioritized risks
2. Plan's goals
3. Program's efficacy
    - Communication of findings to patient safety program
    - Include findings of evaluation when revising the plan

P. Communication and collaboration with **Antimicrobial Stewardship Program** (ASP) (MM.09.01.01)

Q. Ratification of **competency** of Infection Control and Prevention team members

1. Maintains membership in Association for Professionals in Infection Control and Florida Professionals in Infection Control.

2. Attends one (1) educational seminar related to infection prevention and control per year.

R. Preparation of response to an influx of potentially infectious patients, **emergency preparedness** (IC.01.06.01)

1. Monitoring and evaluation of current clinical and epidemiological information from its resources regarding new infections that could cause an influx of potentially infectious patients
2. Communication of critical information to licensed independent practitioners and staff about emerging infections that could cause an influx of potentially infectious patients
3. Written plan delineating management of influx of infectious patients

S. **Management of Environment during demolition, renovation, or new construction to reduce risk of infection** (EC.02.06.05)

- Infection Control Risk Assessment (ICRA)

T. **National Patient Safety Goal** (NPSG.07.0101): Compliance with either WHO or the current CDC hand hygiene guidelines

1. iRound electronic capture of manual monitoring used in 2020 and 2021
2. Implementation of Electronic Monitoring in July 2022 with a go-live date of October 2022
3. Discontinuation of Electronic Hand Hygiene Monitoring System March 2023 due to reliability and validity concerns
4. Continuation of iRounds for electronic hand hygiene audits to monitor hand hygiene.

U. **Transplant Safety** (TS.03.03.01)

Investigation of adverse events related to tissue use or donor infections

1. Compliance with P&P for identifying, tracking, storing, and handling tissues, medical devices and other implantables.
2. Investigation of infections suspected of being directly related to the use of tissue
3. Reporting of infection to tissue supplies
4. Sequestering tissue suspected of causing infection
5. Notification of recipient of infectious agents that may have been transmitted through tissue

V. Water Management Program (EC.02.05.02)

Participation in interdisciplinary water management program that addresses Legionella and other waterborne pathogens.

X. Emergency Management Operations Program (EM.01.01.01)

Participation in interdisciplinary emergency management operations program: engagement in planning activities include identifying risks, prioritizing likely emergencies, attempting to mitigate them when possible, and considering its potential emergencies in developing strategies for preparedness, with a focus on infection control and prevention. This includes, where possible, collaboration with relevant parties in the community.

Y. Staffing:

Memorial Hospital Miramar

- 1 Infection Preventionist with Masters of Science in Nursing (MSN), Bachelor of Science in Nursing (BSN), and Associates in Medical Laboratory Technology (MT).
- Director, Quality & Patient Safety

Memorial Healthcare System (Oversight and Support)

- Chief Physician, Division of Infectious Diseases and Medical Director of Infection Control and Antimicrobial Stewardship, MHS
- Physicians, Infectious Disease (MHM)
- Director, Infection Prevention and Epidemiology, MHS

Z. Hours of Operation:

Monday – Friday 7:30 am – 4:30 pm; other times immediate availability by cell phone.

References:

https://e-dition.jcrinc.com/Frame.aspx January 1, 2022

APIC Text of Infection Control and Epidemiology; April 7, 2020

Memorial Hospital Pembroke

New: 02/11 **Revision: 01/2023**

TITLE: **INFECTION CONTROL PLAN 2023**

PURPOSE

1. The Infection Control Program at Memorial Hospital Pembroke, including off-site 24/7 Care Center and Primary Care Clinics, is designed to identify infections and opportunities for disease transmission risk reduction strategies for patients (inpatient and outpatient), visitors, physicians, volunteers, vendors, students, contracted personnel, and staff.

2. The Infection Control Department recommends and implements risk reduction practices by integrating evidence-based principles and national guidelines on infection prevention and control into all direct and indirect standards of practice. Additional guidance is provided by the Memorial Hospital System Clinical Steering Committee.

3. The Infection Control Program supports Memorial Hospital Pembroke's mission to heal the body, mind and spirit of those we touch with a concern for the whole patient and a commitment to quality.

EPIDEMIOLOGY

1. **The Infection Control Program at Memorial Hospital Pembroke is established to address all aspects of infection prevention and control using sound epidemiologic principles for patients (inpatient and outpatient), visitors, physicians, volunteers, vendors, students, contracted personnel, and staff. and ancillary departments (including, but not limited to food and nutrition, facilities management, central supply, environmental, patient financial, rehabilitation, imaging, laboratory, surgical, and wound healing center services).**
   a) Memorial Hospital Pembroke Infection Control Program policies and procedures are developed based upon established Guidelines, Regulations, epidemiological principles, and research on hospital/healthcare acquired infections including the following:

CDC Guidelines	OSHA Regulations
WHO Guidelines	Joint Commission/CMS Regulations
APIC Guidelines	CMS Regulations/Conditions of Participation (CoPs)
Leapfrog®	DOT regulations
MHS Clinical Steering Committee	

   b) The specific program activities may vary from year to year based on at least annual:
      - Analysis of the patient demographics.
      - Assessment of services offered.
      - Number and type of procedures stratified for high/low volume, high/low risk, and problem prone areas.
      - Type of contract services utilized.

- Analysis of emerging MDRO pathogens.
- Analysis of emerging communicable or biological diseases or threats
- Assessment and implementation of strategies for reduction of HAIs

c) The Memorial Hospital Pembroke Infection Control Program component involves consistent collaboration with the Employee Health Department in implementing interventions for reducing the risk of infection transmission as well as to improve employee safety.

2. The Infection Control Program is designed to provide on-going monitoring and identification of factors, which place the patient at risk for infection and the implementation of processes to decrease hospital-associated infections.
   a) Prioritized Risks:

- Central Line Associated Bloodstream Infection (CLABSI)
- Catheter Associated Urinary Tract Infection (CAUTI)
- Clostridium difficile infection/colitis (CDI)
- Identification of Multi-drug resistant organisms (MDRO) and implementation of appropriate isolation precautions
  - MDR-*Carbapenem-Resistant Enterobacteriaceae*
  - MDR-*Acinetobacter Baumannii*
  - MDR-*Candida Auris*
- Surgical Site Infections (SSI)
- Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia
- Hand Hygiene (HH) Compliance
- Influenza and COVID-19 vaccination rates for hospital associated healthcare workers (HCW
- Ventilator Associated Pneumonia (VAP)
- Immediate Use Steam Sterilization (IUSS) usage
- Pandemic and emergency preparedness and response.
  - Development and implementation of COVID-19 and EBOLA Playbook: Routine updates based on current evidence-based guidelines
  - Highly Communicable Diseases: Preparedness and Response guidelines
  - Ongoing monitoring and evaluation of emerging communicable and biological threats in the community
- Bed Bug Mitigation
- Tuberculosis exposure control
- Pandemic and emergency preparedness and response.
  - Development and implementation of COVID-19 Playbook: Routine updates based on current evidence-based guidelines
  - Highly Communicable Diseases: Preparedness and Response guidelines
  - Ongoing monitoring and evaluation of emerging communicable and biological threats in the community
- Compliance with Infection Control policies and procedures

   b) Clinical and managerial skills, education, availability, and interdepartmental communication are key components of the program.

c) Infection Control principles are incorporated into the Nursing Standards of Care and the departmental Infection Control Guidelines.
d) These principles, and their conceptual framework, are the basis for the assessment, planning, implementation, and evaluation of the Infection Control Program.

SCOPE OF SERVICE

1. The scope of service of the Infection Control Program is to minimize the morbidity, mortality, and economic burdens associated with infection, through prevention and control efforts for inpatient and outpatient populations serviced by Memorial Hospital Pembroke. This is accomplished using epidemiologically relevant data to plan, implement and evaluate strategies in order to minimize, reduce or eliminate infection risk to patients (inpatient and outpatient), visitors, physicians, volunteers, vendors, students, contracted personnel and staff. The Infection Control Program is divided into routine activities that address the integrated facets of surveillance (observation, monitoring, and analysis); epidemiological investigation and evaluation; consultation; and education including:
   a) Identifying, managing, reporting, and ensuring follow-up with patients who have reportable and/or communicable diseases, whether present on admission or have healthcare facility onset.
   b) Managing risk (perceived or actual) and complying with mandates listed under the umbrella of infection control by licensing and accrediting agencies.
   c) Measuring, monitoring, evaluating, and reporting program effectiveness, and when indicated, expanding activities associated with health, safety, and quality improvement for both inpatient and outpatient services.

DEMOGRAPHICS

1. Population served: Community-Broward County and North Miami-Dade.
2. Types of diagnoses: Acute care setting with broad range of diagnosis groups.
3. Ages: Adults (18+) to end of life.

STAFFING PATTERNS

Description of staff: Manager of Infection Control consists of one FTE. The Manager of Infection Control reports to the Director of Quality and Patient Safety.

1. Credentials –The Manager of Infection Control is a licensed clinical laboratory personnel or registered nurse with at least 1 year of experience.
2. Hours of operation – 7:30 am – 4:00 pm. There is voice mail messaging for off-hour non-emergent calls, and there is availability via mobile phone 24 hours a day, 7 days a week.
3. There will be appropriate, clinically necessary and timely support services provided by the department during off hours through the Administrative Officer and/or designated personnel. The Department is on call to all areas of the facility to assist in rapid response.
4. One Infectious Disease Physician, Board Certified in both Internal Medicine, and Infectious Disease, used as consultants for any outbreaks or complex situations.

OVERALL PROGRAM GOALS

1. To identify baseline information about the frequency and type of hospital-associated infections.
2. To promote actions that are designed to limit the spread and/or prevent the occurrence of hospital-associated infections.
   a) The primary goal is to identify and reduce risks of acquiring and transmitting infections among patients (inpatient and outpatient), visitors, physicians, volunteers, vendors, students, contracted personnel, and staff. The secondary goal is to prevent the spread of infections from

patients to healthcare workers by enforcing sound infection prevention practices, providing immunization services for hepatitis B, tetanus, diphtheria, pertussis, measles, mumps, rubella, varicella, and influenza, and reducing potential exposures to blood and body fluids.

3. To minimize the morbidity, mortality, and economic burdens associated with infection through prevention and control efforts in the well and ill populations.

OBJECTIVES

1. To provide an effective, ongoing program that prevents or reduces the risk of infections for patients (inpatient and outpatient), visitors, physicians, volunteers, vendors, students, contracted personnel and staff. continuous improvement of the functions and processes involved in the prevention of infection that includes:
   a) Reducing infection risks through various interventions such as use of aseptic techniques, compliance with hand hygiene guidelines, environmental sanitation, use of antibiotics, use of standard precautions and isolation of patients with certain infectious diseases.
   b) Ongoing monitoring and evaluation of emerging communicable and biological threats in the community.
      1) Highly Communicable Diseases: Preparedness and Response guidelines
      2) Ongoing monitoring and evaluation of emerging communicable and biological threats in the community
   c) Adherence to appropriate infection control principles to patients (inpatient and outpatient), visitors, physicians, volunteers, vendors, students, contracted personnel, and staff.
   d) Maintaining a systematic program of surveillance and reporting of notifiable diseases internally and to public health agencies.
   e) Assisting in the evaluation of related products and equipment.
   f) Compliance with current standards, guidelines, applicable local, state, and federal regulations, and accrediting agency standards.
   g) Recommending and implementing corrective actions based on records, data, and reports of infection or infection potential among patients (inpatient and outpatient), visitors, physicians, volunteers, vendors, students, contracted personnel, and staff.
   h) Communicating identified problems and recommendations to the appropriate individuals, committees and/or departments as well as applicable sister healthcare facilities, Local, State and Federal agencies, and other community healthcare partners.
   i) Maintaining effective interaction with Employee Health department to prevent and manage exposure, to identify communicable diseases and promote vaccination rate of hospital healthcare workers including but limited to influenza, Hepatitis B, tetanus, and COVID-19.
   j) Minimizing exposure to infectious agents by use of OSHA, CDC, and WHO guidelines, establishing standard operating procedures, requirements for personal protective equipment, engineering controls (e.g., chemical fume hoods, air handlers, etc.) and waste disposal procedures.
   k) Considering epidemiologically significant issues endemic to the populations served by Memorial Hospital Pembroke and implementation of risk reduction strategies for high-risk patients.
   l) Partnering with Facilities Management team in ongoing assessment of Water Management Program for prevention of Legionella and/or other waterborne disease.
   m) Perform Infection Control Risk Assessments for renovation, construction, demolition, or general maintenance performed in the Hospital, 24/7 Care Center, or the clinics.
   n) Maintain surveillance/inspection of all Infection Control considerations during planning/construction of Free Standing Emergency Department (FSED)

FUNCTIONS OF INFECTION CONTROL AND EPIDEMIOLOGY

Managing Critical Data and Information

1. Surveillance is performed as part of the Clinical Quality and Risk Prevention Programs.
   a) Monitoring shall include, but not limited to, high volume/high risk; low volume/high-risk.
2. Rate calculations
   a) The rate calculations for the following identified epidemiologically important issues include, but are not limited to:

Infection	Rate Calculation
Catheter-associated urinary tract infection, central line blood stream infection, and ventilator-associated pneumonias	# device related hospital-acquired infections x 1000 # of device days
Surgical Site Infections	# of hospital-acquired surgical site infections # of patients with specific surgical procedure x 100
Clostridium difficile Infections	# related hospital-acquired infections x 1000 # of total patient days
MRSA Bacteremia	# related hospital-acquired infections x 1000 # of total patient days

Other Important Infection Prevention Measures	Rate Calculation
Immediate Use Steam Sterilization	# of instruments IUSS # of total surgeries
Healthcare Personnel Vaccination Rate Staff who worked at MHP for at least 30 days between October 1 & March 31 (includes those with documentation of vaccination outside MHP)	Employee HCP: # of staff who received influenza vaccination # of employed staff X 100 Non Employed HCP (LIPs): # of non-employed staff who received influenza vaccination # of non-employed staff X 100
Contract /Volunteer Vaccination Rate Staff who worked at MHP for at least 30 days between October 1 & March 31 (includes those with documentation of vaccination outside MHP)	Non Employed HCP (Students/volunteers) # of non-employed Staff who received influenza vaccination # of non-employed staff X 100 Non Employed HCP (Contract personnel) # of non-employed Staff who received influenza vaccination # of non-employed staff X 100

3. The occurrence and follow-up of infections/communicable diseases among patients, staff, physicians and visitors will be documented.
4. Surveillance methodology
   a) Sources for infection identification include:
      - Microbiology records
      - Reports from Information Systems including patient census/diagnosis
      - Medical Chart reviews
      - Post-discharge surveillance of high-volume procedures
      - Reporting of suspect/known infections or infection control issues from staff
      - Line day usage for urinary catheters, central line catheters and ventilator day use.
      - EPIC ICON and outside labs.
      - Community healthcare facilities, ALF, and outside agencies.
      - Notifications from local and state Health Departments
      - Collaborative relationships with sister facilities, other local Health Care Facilities.

   b) Hospital-associated infections are identified using the CDC/NHSN definitions for hospital-associated infections[1].
   c) Regular review of data collection
   d) Benchmarking will be based on internal and external data
   e) Monitoring of sterilization process
   f) Microbiologic monitoring of treated water and dialysate[2]
   g) Public Health reporting of State mandated reportable infections[3]
5. To verify compliance with the program, the Manager of Infection Control shall conduct periodic infection control surveillance rounds with follow-up required by the department manager/director.
   a) The Department Director or designee will conduct direct observation of appearances and practices in their specific clinical areas.

AUTHORITY AND RESPONSIBILITY

1. The Medical Staff provides direction and expertise from their individual respective areas and disciplines in conjunction with the Infectious Disease Physicians to manage the hospital infection surveillance, prevention, and control program.

MANAGER OF INFECTION CONTROL'S DUTIES

1. Responsible for the day-to-day management of the Infection Control Program with guidance and input from the Chief Medical Officer and the Director of Quality and Patient Safety. Collaborates and consults with the Healthcare System's Infectious Disease Physicians and Manager of Infection Control.
2. Maintains close communication with nursing departments, surgical services, clinical support services, laboratory, and all departments throughout the facility regarding patients with infections and those at greatest risk of health care associated infections and epidemiological issues within the community.
3. Develops a system for identifying, reporting, investigating, and controlling infections and communicable diseases.
4. Compiles and analyzes surveillance data and presents data with respect to baseline data to the appropriate Committee.

---

[1] (January 2019). CDC/ National Health Safety Network "*Identifying Healthcare-associated Infections (HAI) for NHSN Surveillance".*

[2] Association for Advancement of Medical Instrumentation: Dialysis. In AAMI Standards and Recommendations, Vol 3. Arlington, VA: American National Standard; 1993.

[3] Florida Statue Section 381.0031(1, 2) Reportable Diseases/Conditions in Florida, October 20, 2016.

   a) Identifies potential/actual infection control issues and makes recommendations to the appropriate level of management.
5. Investigates trends of infections, clusters, and unusual infections.
   a) Communicates hospital-associated infection occurrences with Risk Management as needed.
   b) Communicates hospital-associated infection occurrences with infection prevention colleagues within the Memorial System.
6. Monitors patient placement and appropriate use of precautions.
   a) Serves as a consultant with patient placement concerns.
   b) Reviews appropriateness of inter- and intra-facility transfer for all COVID-19 patients and patients with history of/active MDRO infections.
7. Conducts or facilitates infection control surveillance rounds or focus reviews.
8. Conducts an intense analysis in collaboration with appropriate personnel when a hospital-associated infection is identified.
9. Assists with staff education in strategies for Hospital Acquired Infection (HAI) reduction.
10. Serves as a consultant with physicians, staff, contract personnel, patients, volunteers, students and/or visitors regarding risks and risk reduction measures associated with disease transmission and benefits of control measures.
11. In conjunction with the laboratory personnel, reports state reportable diseases/condition to the county and state public health department.
12. Participates in Product Evaluation Sub-Committees to ensure infection related products and equipment support safe and sound practices and principles. (VATS)
13. Responds to notification of a recalled item(s) specific to infection related issues. (ECRI)
14. Participates in the new employee orientation and area specific in-services when requested.
   a) Provides informal education and serves as a consultant to the staff during routine patient/facility rounding.
15. The Manager of Infection Control will participate in the development of policies and procedures related to governing control of infection and communicable diseases, including, but not limited to, isolation issues, exposure to blood and body fluids, and the reporting of communicable diseases to the appropriate agencies. The Manager of Infection Control will work with the Employee Health Nurse regarding the reporting and tracking of communicable diseases affecting employees.
16. The Manager of Infection Control will be consulted in developing policies and procedures in individual departments such as those involving disposable items; sterilization and decontamination policies and procedures; linen and housekeeping policies and procedures; hazardous materials; and pharmacy related admixtures for intravenous fluids. The Manager of Infection Control will be available to assist and advise with all hospital departments' policies and procedures regarding Infection Control concerns and assist with implementation.
17. When the hospital becomes aware that it has transferred a patient to another facility that has an infection requiring monitoring, treatment and/or isolation, it will notify the receiving facility by phone of such.
18. Manages content and disseminates decisions made by the MHP Infection Prevention Team.
19. Manages content and disseminates decisions made by the MHS Clinical Steering Committee.
20. Provides recommendations and relevant data in support of Antibiotic Stewardship Committee.
21. Patients are treated preserving their confidentiality. Information obtained and actions taken as consequence of Infection Control Surveillance shall be confidential and protected.
22. Risk of hospital associated infections is monitored based upon patient diagnosis and health status. Rapid access via computer of laboratory and pathology test results is available to the Manager of Infection Control. Outside reference labs are used as necessary.

23. Care of patient at risk and with identified hospital associated infection will be monitored on an ongoing basis. Interventions for prevention of transmission will be implemented.
24. Patient will receive education on the prevention and control of infection by nursing staff and Manager of Infection Control as necessary.
25. Management of Human Resources -
    a) Provide orientation and continuing education of all personnel regarding Infection Control.
    b) Maintains Infection Control Policies.
    c) Monitors tuberculosis program, updates TB Control Plan, provides educational programs on TB, reviews and updates mandatory written guide and employee self-education packet annually.
    d) Acts as consultant to hospital and physicians.
26. Improving Organizational Performance
    a) Attends performance improvement meetings as needed.
    b) Provides statistics and reports to PI Committee and the Infection Control Committee.
    c) Assists and interacts with all departments on Performance Improvement projects by an interdisciplinary approach.
    d) Shares information hospital wide through dissemination of information with healthcare providers who directly affect patient outcomes.
27. Leadership
    a) Participate in the development of guidelines for surveillance, prevention and control of infections.
    b) Provide information and statistical reports regarding surveillance activity.
    c) Provide information on ongoing basis regarding new regulations and guidelines.
    d) Review all Infection Control Policies annually or as needed.
28. Management of Environment of Care
    a) Participate in surveillance rounds performed bi-annually and as needed on all departments to ensure compliance and facilitate any corrective actions
    b) Monitor and update Bio-medical waste policies and procedures.
    c) Monitor compliance with OSHA Blood borne Pathogen and Tuberculosis Standards.
    d) Review and evaluation of construction projects with completion of applicable Infection Control Risk Assessment.
29. Management of Information
    a) Act as hospital resource agents for data collection, interpretation and analysis.
    b) Reports of surveillance activities are shared with all departments involved in prevention of infection.
    c) Information from Infection Control activities is shared with all Patient Care Departments to improve the quality of patient care.

DEPARTMENT LEADERS' INFECTION PREVENTION DUTIES

1. Ensure current infection control policies and procedures are available in all patient care areas/departments.
    a) Review/Assess existing departmental policies and procedures in collaboration with the Manager of Infection Control to current practice standards/guidelines and submit policies to the Manager of Infection Control who will consult with the Infectious Disease Physicians when necessary for review and approval.
    b) Ensure appropriate patient care practices and product safety is maintained within the department along with adherence to infection control policies and compliance with hand hygiene guidelines.

c) Ensure appropriate line day collection for invasive devices (urinary catheters, central lines, and ventilators) and monitors use for medical necessity in Critical Care and the Medical-Surgical areas and medical necessity for insertion in Emergency Department/Surgical Services Department.
d) Coordinate with the Manager of Infection Control, educational programs on infection prevention and control.

EMPLOYEE/STAFF/PROVIDERS INFECTION PREVENTION DUTIES

1. All health care workers of the organization will adhere to the Infection Control Program for the control of infections.
   a) Complete the Annual Review self-study program including the above information during their annual evaluation period.
2. All health care workers must participate fully in the Employee Health program.
3. All employees will notify the Manager of Infection Control of infection related issues.

COMMUNICATIONS

1. An open-line of communication will be maintained between Infection Control, Infectious Disease Physicians, Risk Management, Quality Management and Performance Improvement Programs.
   a) Criteria for hospital-associated infection reporting will be adhered to according to published guidelines.

PERFORMANCE IMPROVEMENT

1. Performance improvement tools will be utilized to systematically monitor, evaluate and improve the Infection Control program.
2. Hospital performance related to hospital acquired infections, performance improvement initiatives, action plans and goals will be reported to applicable committees.

REPORTING MECHANISM

1. The Manager of Infection Control reports to the Director of Quality and Patient Safety who reports to the Chief Nursing Officer.
3. The Manager of Infection Control will report to the Medical Staff Departments any trends within their Departments.
3. The Manager of Infection Control will report quarterly to the Performance Improvement Risk Management Committee, Quality Care and Patient Safety Council and Department of Medicine and Surgery. The report is then submitted to the Medical Executive Committee and to the Board of Commissioners.

INTERVENING DIRECTLY TO INTERRUPT THE TRANSMISSION OF INFECTIOUS DISEASES

1. Initiate investigation when an outbreak or cluster is suspected consistent with CDC Guidelines[4].
2. Institute early control measures and prepares a preliminary case definition, compare current incidence with usual or baseline data.
3. Develop case definition based on time, place, and person.
4. Evaluate efficacy of the control measures.
5. Report findings to Quality Care and Patient Safety committee, appropriate Medical Staff departments and Department of Health if warranted.

[4] Center for Disease Control and Prevention – http://www.cdc.gov/outbreaks

EMPLOYEE HEALTH

1. The Employee Health Program functions in conjunction with the Infection Control Program.
2. Employee Health Policies and Procedures shall be reviewed as related to the transmission of infections in the Hospital.

PERFORMANCE IMPROVEMENT ACTIVITIES

1. Currently Manager of Infection Control is involved in the following Hospital-wide and System-wide Performance Improvement activities:

ACTIVITY	INTERDISCIPLINARY
Performance Improvement/Risk Management Committee (PIRM)	Infection Control, Quality, Department Leaders, Chief Nursing Officer
MHS Value Analysis Team (VATS)	MHS ICPs, MHS RNs, MHS Directors
MHS Infection Control Committee Meeting	MHS Infection Control Practitioners, Employee Health Nurses, Patient Safety Officer, Department Leaders
MHP Sepsis, Infection Prevention, & Antibiotic Stewardship Committee (SIPAS)	Infection Control, Quality, Unit/Department Leaders, Clinical Pharmacist, Director of Nursing, Infection Control MD
Environment of Care Committee (EOC)	Infection Control, Facilities Management, Department Leaders, Chief Nursing Officer, Chief Financial Officer
Emergency Management Committee (EM)	Infection Control, Department Leaders, Chief Nursing Officer, Chief Financial Officer
Pharmacy and Therapeutics Committee (P&T)	Infection Control, Pharmacy Leaders, Physician Leaders, DONs
Quality Care and Patient Safety Committee (QCPS)	Infection Control, CNO, CMO, CFO, Chief Physicians, Department Leaders, Quality
Critical Care Committee	Infection Control, Critical Care Leaders, Critical Care Physician, CNO, DONs, Quality, Pharmacy Leaders
Department of Medicine and Surgery	Infection Control, CNO, CMO, Chief Physicians, Department Leaders, Quality
Performance Improvement/Risk Management Committee (PIRM)	Infection Control, Quality, Department Leaders, Chief Medical Officer

EVALUATION OF THE PROGRAM

1. The effectiveness of the Program is evaluated annually by the Hospital and the Infectious Disease Physicians. See Annual Appraisal and Goals
   a) The evaluation of the plan's effectiveness will be conducted using a risk assessment and prioritization matrix with comparison of current year HAI metrics rates (CLABSI, VAP, CAUTI, etc) against prior year rates. Included in the matrix will be action plans outlining prevention steps initiated to meet established goals.

b) The report and evaluation will be forwarded to Quality Care and Patient Safety Committee.
c) The report and evaluation will be forwarded to the Medical Executive Committee and to the Governing Board.