Performance Improvement Appraisal/Evaluation CY 2020

Broward Health Medical Center continuously strives to provide comprehensive, individualized, and competent care to the patients it serves, regardless of race, gender, sexual orientation, religion, national origin, physical handicap or financial status. We follow the Broward Health Mission and Vision Statements. Broward Health respects and follows the Broward Health Five Star Values, Strategic Priorities and Success Pillars: Service, People, Quality/Safety, Finance and Growth. The PI Plan is presented to the regional Quality Council for approval then to the Medical Staff and Board of Commissioners.

The Department Leaders at BHMC work with their Administrators to prioritize their decisions regarding indicators for review. While indicators are chosen for review each year, new indicators may be chosen during the year based on patient safety concerns, information from Root Cause Analysis, trends identified in adverse incidents, etc. Indicators were chosen either by requirements by external agencies such as The Joint Commission, Centers for Medicare and Medicaid Services, AHRQ and those that are problem prone, high risk, or high volume processes. This information is reported to Quality Council then to the Board of Commissioners through the Quality Assessment and Oversight Committee (QAOC) and the Board of Commissioners Finance Committee.

Initiatives for 2020 included 8:00am daily safety huddle, monthly patient tracers, infection control surveillance rounds and selected quarterly point prevalence studies, weekly HAI huddles, unit shift huddles, monthly leadership meetings, Administrator on Call (AOC) rounds. BHMC participates in the Health Improvement Innovation Network (HIIN) project to reduce patient harm events. Core measures performance above national benchmarks. Completed the Joint Commission Triennial Survey May 2018 maintained accreditation status. Received The Joint Commission Re-accreditation certification Disease Specific Re-certifications in Re-certification in Total Hip and Knee in July 2018 and Primary Stroke in August 2018. Regulatory goals for 2021 include successful completion on disease specific TJC surveys and Triennial Survey: Comprehensive Stroke, Total Joint, Palliative Care, and Triennial Survey.

Listed below is a summary of the PI activities that reflect the hospital endeavors to reduce the mortality and morbidity and to assure patient safety.

PI Indicators	Goals 2020	Outcomes	Actions 2020	Goals 2021
CMS Core Measures	Achieve Top Decile for indicators that are at or above national rate and achieve national or above rates for indicators that are below the national rate. Achieve Letter B	There has been continued compliance with the core measures for 2020 YTD… **Metric Benchmark Result** **OP-18 172 166** **OP-23 100% 57.14%** **OP-29 81% 91%** **STK – 1 100% 100%** **STK-2 100% 100%** **STK- 3 100% 100%** **STK-4 100% 100%** **Metric Benchmark Result**	• Patient through put committee initiated in ED, additionally metrics reviewed at daily safety huddle. • Concurrent abstractions for HBIPS and Stroke. Drill down of case variances to identify process opportunities • Continued multidisciplinary Program specific committee meetings • Continued multidisciplinary	Achieve Top Decile for indicators that are at or above national rate and achieve national or above rates for indicators that are below the national rate. Achieve Letter B grade in Leapfrog Achieve CMS 3 Star Rating

PI Indicators	Goals 2020	Outcomes	Actions 2020	Goals 2021
	grade in Leapfrog Achieve CMS 3 Star Rating	**STK – 5 95% 97.9%** **STK -6 95% 98.7%** **STK – 8 95% 98.32%** **STK – 10 95% 99%** **HBIPS - 1a 100% 100%** **HBIPS - 2a 0.68 0.03** **HBIPS - 3a 0.49 0.015** **HBIPS - 5a 57% 100%** **PC-01 0% 0.0%** **Seps-1 44% 74.2%**	education (Updates, Standard & Expectations) • Hired Sepsis coordinator – to have concurrent review of practice	Achieve TJC Comprehensive Stroke Certification
HCAHPS	75th percentile	Metric Benchmark Score %Rank **Rating 75th % 68.6 35** **Recommend 75th % 69.3 40** **Comm Nurses 75th % 74.8 18** **Response 75th% 57.3 19**	• Continuation of FY19 initiatives: ○ Partnered with PG for Boot camps on NL and hourly rounding ○ Structured validation by NM ○ Standardized Shift Huddle ○ Discharge phone calls ○ Patient Family Advisory Committee created ○ Patient Experience Steering Committee, with separate action groups ○ Operations Leader Rounding on Nursing Units ○ Care Calls initiated during pandemic ○ Discharge lounge • New Customer Service Manager hired in 2019 • Implementation of 4 non-negotiable processes ○ Purposeful Rounding	**Reach and maintain 75th percentile ranking**

PI Indicators	Goals 2020	Outcomes	Actions 2020	Goals 2021
			○ Bedside shift report ○ Commit to sit ○ Discharge phone calls	
CLABSI	10% reduction in 2019 rate - goal 0.72 CMS benchmark = 0	**19/17523 – 1.08** **11 of the 19 Covid positive** **Without Covid rate would be 0.51**	• Daily multidisciplinary rounding and indication review • Presented 0800 daily huddle • Dialysis rounds • Vascular access team exchanging lines for midlines and extended dwell peripheral IVs • Resident and medical student education and Epi shadowing • Nursing and PCA competencies • Removal of catheters for elective joints • New hire orientation with CLABSI and CAUTI prevention interactive boards	10 % reduction in 2020 rate CMS benchmark = 0
CAUTI	10% reduction in 2018 rate - goal 1.31 CMS benchmark = 0	**14/10001 - 1.40** We improved over last year but did not reach goal or CMS benchmark	• Reviewed daily in 0800 huddle • HOUDINI physician uncheck disabled in IT • Daily multidisciplinary rounding and indication review • IT documentation of Foley • Resident and medical student education and Epi shadowing • Nursing and PCA competencies • Standardized products for foley care • HOUDINI physician re-education including Trauma quality • UA to UC reflex update • Removal of catheters for elective joints • New hire orientation with	10% reduction in 2020 rate 1.26 CMS benchmark = 0

PI Indicators	Goals 2020	Outcomes	Actions 2020	Goals 2021
			CLABSI and CAUTI prevention interactive boards • Cases presented at weekly HAC meeting	
Surgical Site Infections	10% reduction in 2019 rate 5.67 CMS benchmark = 0 10% reduction in 2019 rate 1.98 CMS benchmark = 0	**Colon Surgery 9/134 6.72** We remained flat and did not reach the CMS goal. **Hysterectomy 2/78 2.56** We remained flat and did not reach the CMS goal.	• Intense Analysis/Drill down of SSI's conducted with Epidemiology, nurse manager and staff involved to determine any lessons learned and opportunities for improvement • Cases referred to applicable Peer Review Committee • Multi-disciplinary Weekly HAC Meeting • Pre-procedure education about bathing • Keep track of bathing issues in pre-op for inpatient side for immediate follow up • Physician office manager outreach • Glucose control process • Limiting traffic in OR • Normothermia • Attire • Post op dressing changes • EVS • Patient hand hygiene wipes • Out of bed post-op • Joined CUSP program ACS • Presentation of CLASS 1 and CLASS 2 at Department of surgery	10% reduction in 2020 rate 6.05 CMS benchmark = 0 10% reduction in 2019 rate 2.3 CMS benchmark = 0
C-diff	10% reduction in 2019 rate 2.115 CMS benchmark = 0	36/1068760 0.336 We reached the facility goal and the CMS achievement Goal but not the CMS goal of zero.	• EHR hard stop for reordering C-diff antigen within 7-days • ED Triage screen in place • Continue Antibiotic monitoring - pharmacist interventions and RMO • C-diff decision tree tool re-educated in all nursing huddles	10% reduction in 2020 rate 0.304 CMS benchmark = 0

PI Indicators	Goals 2020	Outcomes	Actions 2020	Goals 2021
			• EVS staff room cleaning re-education validation of rooms cleaning • HH Observations (unit level and mock teams) • Staff, physician and resident education • Multi-disciplinary Weekly HAI Safety Huddle • IT updates: order expiring after 24 hr, laxative reminder, diarrhea on admission question • Isolation log and rounds	

Readmissions	Below Crimson National Average for All Safety Net Hospitals for Medicare Patients Age 65 and older	• The Medicare AMI readmission rate for 2020 was **9.26%** which is below the National (9.62%) and decreased from last year.
		• The Medicare risk heart failure readmission rate for 2020 was **13.01%** which is above National (16.07%) and decreased from last year.
		• The Medicare pneumonia readmission for 2020 was **14.18%** which is below the National (14.7%) but above last year's rate.
		• The Medicare risk-adjusted COPD readmission rate for 2020 was **11.36%** which is above National (17.46%) and decreased from last year.
		• All payers 30 day readmission rate **10.63** national comparison was 11.50
			• Corporate Re-admissions PI Team
			  ○ Checklist for d/c process and handoff created
			  ○ Education to CM d/c process
			  ○ F/U appt for by CM on COPD and CHF readmitted patients
			  ○ Electronic process for Population Health, Coordination of Care
			  ○ Developed new assessment for TOC follow-up call on high risk patients
			
			Continued actions outlined below:
			• CM partner with Population Health
			• CM partner with HSAG
			• CM partner with identified SNFs and Rehabs
			• Advocating with physicians to have home care ordered whenever possible for home monitoring
			• COPD/CHF committees
			• Respiratory therapy developed
				Below Crimson National Average for All Hospitals for Medicare Patients Age 65 and older

PI Indicators	Goals 2020	Outcomes	Actions 2020	Goals 2021
			COPD d/c plan with ambulation and DOE assessment.	
Antimicrobial Stewardship	Continue processes to maintain TJC Standards 10% reduction in MDROs On the Adult side we saw a > than 10 % decrease in MDRO	• Maintained focus on ASP standards • Facility Medical Director of Infection Prevention in place	• Regional and Corporate Multidisciplinary committee • Decentralized pharmacists to units • Antimicrobial prospective audit and feedback (MedMined, Mpage, PK) • ASP policies automatic IV to PO renal dosing, PK • ASP initiatives (required antibiotic duration, indication, PPI indication) • Ongoing Medication Utilization Evaluations (MUEs) • Antimicrobial research projects in place	Continue processes to maintain TJC Standards 10% reduction in MDROs
Hand Hygiene	Hospital-wide Achieve >90%	• CY 2020 achieved 135960/ 97.11% hospital-wide compliance.	• Hand Hygiene Ninja's secret shoppers • Ongoing unit level observations and mock team observations. • HH data shared at various hospital and medical staff committees • Unit level HH data pushed out monthly by Quality • 200 observations per unit started in June • IC rounds • TJC tracers	5% improvement in hand hygiene rates.