Broward Health Imperial Point Performance Improvement Appraisal CY 2020 and Goals and Objectives for CY 2021

Broward Health Imperial Point 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 BHIP 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 2021 include continuous patient tracers and continuation / enhancement of weekly administrative huddles, unit shift huddles, and our total harm reduction program. BHIP participated in the Health Improvement Innovation Network (HIIN) project to decrease mortality and morbidity. BHIP received Joint Commission Disease Specific re-certification in Primary Stroke in December 2019 and is scheduled for review of Heart Failure program due in Q22020 and their triennial accreditation survey window opens in November 2020.

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. BHIP will continue to work towards these goals during 2020.

PI Indicators	Goals	Findings	Actions	Objectives for CY 2021
IMPROVE CORE MEASURES				
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.	There has been continued compliance with the core measures for 2020 in the following areas: • Stroke – within or above targets with all reported to The Joint Commission. 2020 data is as follows: o STK-1 DVT Prophylaxis 100% o STK-2 DC on Antithrombotics) 100% o STK-3 Anticoagulant TX for Afib = 100% o STK-4 - Thrombolytic Therapy o STK-5 Antithrombotic (by end of day 2) =94%. 2 fallouts o STK- 6 DC on Statin = 100% o STK- 8 Stroke Education = 100% o STK- 10 Assess for Rehab= 100%	• Continue to collect the data and drill down on fallouts. • Continue to educate new physicians, APP's and employees to core measure standards and expectations. • Continue to coach and remediate all employees and physicians as necessary. • Continue Sepsis PI Team with physician champions and optimize IT integration with EHR	Achieve top decile for 90% of all indicators. Perform within the top 10% decile

		• SEPSIS – CY 2020 ended at 76% compliance rate. This is below CMS benchmark of 81% and above National benchmark's rate of 55% • HBIPS- 2020 with significant improvement dur to IT modifications to Cerner and ongoing education to BHU physicians, APP's and staff..	• Continue collaboration with BHU Working with IT to improve physician's Sepsis subphase by: Allowing ONLY physicians and APP's to initiate Sepsis subphase. Adjusting sepsis labs to be drawn after antibiotics are administered Education for physicians, APP's and staff related to CMS HBIPS changes will remain ongoing in order to maintain positive patient outcomes	
IMPROVE OUTCOMES				
Mortalities	Below Crimson National Average for Mid-Sized Non-Teaching Facilities	• The overall risk-adjusted mortality rate was 0.79% (60/7572 Crimson Cohort of 1.24%. • The risk-adjusted AMI mortality rate was 0% (0/11) for 2019 which is below the Crimson Cohort of 7.42%. • The risk-adjusted heart failure mortality rate was 1.75% (1/57) for 2019 which is slightly above the Crimson Cohort Rate of 1.66%. • The risk-adjusted pneumonia mortality rate was 2.13% (1/9) for 2019 which is below the Crimson Cohort rate of 3.00%. • The risk-adjusted COPD mortality rate was 1.72% (1/58) for 2019 which is slightly above the Crimson Cohort rate of 1.71%.	• Continue to review all mortalities, identify trends, perform peer review when necessary, and look for opportunities to continue to decrease mortality rates. • Rates above benchmarks due to low volumes.	Maintain risk-adjusted overall, AMI, heart failure, COPD and pneumonia mortality rates below the Crimson Cohort average.
Readmissions	Below Crimson National Average for All Hospitals	• The overall risk-adjusted all cause 30 day readmission rate for 2020 was 12.2% (461/3791) which was above the Crimson Cohort rate of 11.4%. • The risk-adjusted AMI readmission rate for 2020 was 6.8% (3/44) which was above the Crimson Cohort of 2.9%. Very low volume. • The risk-adjusted heart failure readmission rate for 2020 was 16.2% (21/130) which was below the Crimson Cohort of 21.4% • The risk-adjusted pneumonia readmission rate for 2020 was 10.2% (27/264) which was below the Crimson Cohort rate of 13.3%.	• Proactive risk assessment for readmissions • Rates above benchmarks due to low volumes. • Referral of patients to Disease State Management • Discharge folders with specific patient information have been rolled out to improve discharge communication around	Maintain risk-adjusted overall, AMI, pneumonia, heart failure and readmission rates below the Crimson Cohort average. Improve pneumonia risk-adjusted readmission rates to at or below Crimson Cohort average.

		• The risk-adjusted COPD readmission rate for 2020 was 24.3% (35/144) which as below the Crimson Cohort rate of 15.2%.	symptoms and disease processes • Advocating with physicians to have home care ordered whenever possible for home monitoring • Interdisciplinary rounds to be inclusive of Hospitalist groups • Case Management rounding • Referral for follow-up appointments	
IMPROVE PATIENT SAFETY				
Falls	<3.15 per 1000 patient days (NDNQI)	Total Falls 2020 all units except Behavioral Health Unit (BHU) 87/39306 rate of 2.21 which is greater than the target rate of 1.99. The overall 2020 fall rate was greater than 2019 in which there were 59/27884 falls with a fall rate of 2.12 Of the 87 falls in 2020, 22 (25%) sustained injury of various severity injury levels ranging from 1-4. .	• Continue to perform post fall huddles and include patient/family whenever possible. • Perform an intense analysis on all falls. • Continue use of bed and chair alarms • Educate staff and patients regarding fall prevention. • Analyze data for trends.	Maintain the hospital's low fall rate and reduce falls and falls with injuries by 10%
Hospital-acquired Pressure Injuries	Below National Average (NDNQI)	There were 19 HAPIs out of 39299 patient days for a rate of 0.05. This was a slight increase from 2019 in which there were 18 HAPI out of 45185 patient days for a rate of 0.04. Of those, in 2020 there were 6 Stage II 0 Stage III 0 Stage IV 6 were DTI 2 were MDRPI 5 were Unstageable	• All nursing staff re-educated on skin incontinence and products to use. • Weekly skin care rounds on all units • Daily rounding by NM/ANM • Education on hand-off communication to staff • Perform IA on all hospital-acquired pressure ulcers	Maintain hospital's low HAPU rate and maintain 0 stage 3 and 0 stage 4 wounds
Mislabeled	< 0.3%	There were 4 mislabeled specimens out of 200947 accessions in 2020. This was up from 2 in 2019 out of 205593 accessions.	• Continue to coach and remediate employees as necessary. • Perform intense analysis on all mislabeled specimens. • Analyze data for trends. • Continue the use of bedside specimen scanning.	Decrease number of mislabeled/unlabeled specimens by 10%. Goal to be at zero.

DECREASE HOSPTIAL-ACQUIRED INFECTIONS				
CLABSI (ICU)	<0.9 per 1000 device days	The number of CLABSI for 2020 was 3 with 4448 device days at a rate of 0.67 which is a slight decrease from 2019~ 4 with 4,199 device days for a rate of 0.95.	• Increase surveillance to all nursing units. • Aggressive rounding to get the central line out. • Continue the Centurion Guardian Program. • Continue Chlorhexidine bath. • Participate in HSAG HAI program. • Continue to follow central line bundle	Prevalence rounding by Epidemiologist for dressing change observations, just-in-time learning, and further supporting staff
CAUTI (ICU)	<1.4 per 1000 catheter days	The number of CAUTI for 2020 was 5 with 3880 catheter days for a rate of 1.29 This is decrease from 2019 which was 5 CAUTIs, 3310 catheter days for a rate of 1.51	• Increase surveillance to all nursing units. • Continue nurse catheter withdrawal protocol. • ED engagement in preventing insertion. • Continue Chlorhexidine bath. • Continue HOUDINI protocol for all patients with foley catheter. • Participate in HSAG HAI program. • Continue to follow catheter bundle	Physician partnering …
VAP	Zero	There were 7 VAC, zero IVAC and PVAP in 2020 in ICU. This was a significant decrease from 2019 in which there were 6 VAC, 2 IVAC, and 1 PVAP.	• Support Respiratory therapy in data collection • Continue with infection control rounds. • Educate staff regarding infection control practices. • Continue to follow bundle.	Maintain VAP rate for ICU at zero.
Surgical Site Infections	Below National Average	For 2020: There was 1 infection out of 116 colon surgeries performed for a rate of 0.88. There was 1 infection out of 236 hysterectomy surgeries performed for a rate of 0.43. This was a decrease from 2019 in which there was 1 infection out of 260 hysterectomy procedures in 2019 for a rate of 0.38. 2 were superficial infections one was organ space – NHSN will be 1/244 infections. There was 1 infection out of 112 colon surgeries for a rate of 0.89 in 2019.	• Intense analysis of all SSI with epidemiologist and OR Director. Cases shared at OR committee for physician guidance and recommendations • Continue to monitor recommended prophylactic antibiotic use.	Decrease surgical site infections to below the VBP threshold as measured by SIR

		There were 2 superficial infections and 5 PATOS infections and 1 organ space infection. This represents a decrease in rate and a decrease in actual infections.	• Address SSI reduction strategies with medical staff surgeons • Monitor for trends. • Refer for peer review as necessary. • Drill down on the infection related to colorectal surgery to identify trends. • Review all surgical classifications to verify correct classification • Work with surgeons to document infection pre-op. • Verify weight based dosages of antibiotics being used	
IMPROVE EFFICIENCY				
ED Throughput	At or Below National Average	ED-1b median time ED arrival to ED departure in 2020 was 126 minutes with significant improvement from 2019 and less than target goal of 180 minutes ED-2b median admit decision time to ED departure for 2020 was 220 minutes which is less than the target goal of 240 minutes.	• Daily flow meeting to discuss ED, Lab, Rad volume and TATs. Discuss outliers • Monthly patient flow meetings led by ED Medical Director • Display ED and patient flow metrics daily . • Hospitalist bed rounds to expedite discharges • Six Sigma team was established to decrease throughput times	Improve median ED throughput time to at or below national average.