BHN Performance Improvement Appraisal CY 2022 and Goals and Objectives for CY 2023

Broward Health North 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 North 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 Broward Health North 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, AHCA, AHRQ and those that are problem prone, high risk, or high-volume processes. This information is reported to the Quality Council then to the Board of Commissioners through the Quality Assessment and Oversight Committee (QAOC) and the Board of Commissioners.

Initiatives for 2021 include continuous patient tracers, unit shift huddles, and our total harm reduction program as a part of our journey to becoming a High Reliability Organization (HRO). Broward Health North participated in the Health Innovation and Improvement Network (HIIN) project to decrease mortality and morbidity, in the AHRQ Pressure Ulcer Prevention Collaborative, and the STRIVE project with the FHA.

Listed below is a summary of the PI activities of Broward Health North that reflects the hospital endeavors to reduce mortality and morbidity and to assure patient safety. Broward Health North will continue to work towards these goals during 2023.

<table>
<tr><th>PI Indicators</th><th>Goals</th><th>Findings</th><th>Actions</th><th>Objectives for CY 2023</th></tr>
<tr><td colspan="5">IMPROVE CORE MEASURES</td></tr>
<tr>
<td>CMS / TJC Core Measures</td>
<td>Achieve Top Decile for indicators that are at or above national average rate. Achieve national average or above rates for indicators that are below the national average rate.</td>
<td>Data collected:
<u>eCQM – Stroke Measures:</u>
• 4 of 4 indications above 95% and top decile, all above National average. Compared to 2021.
<table>
<tr><th>Year</th><th>Fallouts</th><th>Measure</th><th>%</th><th>%</th><th>Measure</th><th>Fallouts</th><th>Year</th></tr>
<tr><td rowspan="8">2021</td><td>17</td><td>STK – 1</td><td>96%</td><td colspan="3">No longer reported in eCQM</td><td rowspan="8">2022</td></tr>
<tr><td>4</td><td>STK – 2</td><td>99%</td><td>99%</td><td>STK – 2</td><td>5</td></tr>
<tr><td>1</td><td>STK – 3</td><td>97%</td><td>100%</td><td>STK – 3</td><td>0</td></tr>
<tr><td>0</td><td>STK – 4</td><td>100%</td><td colspan="3">No longer reported in eCQM</td></tr>
<tr><td>17</td><td>STK – 5</td><td>94%</td><td>95%</td><td>STK – 5</td><td>12</td></tr>
<tr><td>1</td><td>STK – 6</td><td>97%</td><td>97%</td><td>STK – 6</td><td>1</td></tr>
<tr><td>0</td><td>STK – 8</td><td>100%</td><td colspan="3">No longer reported in eCQM</td></tr>
<tr><td>28</td><td>STK – 10</td><td>91%</td><td colspan="3">No longer reported in eCQM</td></tr>
</table>
<u>Sepsis:</u>
• SEP –2022 was 75% improved compared to 2021, it was 78% volume increased from 441 cases (2021) to 585 in (2022).

<u>Out-Patient:</u>
• OP 18: 2022 CY was 201 minutes compared to 157 minutes in 2021.</td>
<td>• Concurrent screening of all new admissions with real time intervention to assure compliance.
• Continue to collect the data and drill down on fallout to identify improvement opportunities.
• Continue to educate new employees to core measure standards and expectations.
• Continue to coach and remediate all employees and physicians as necessary.

• Interdisciplinary Patient Flow Team at BHN to improve patient flow and reduce ED boarding times.

• Multidisciplinary sepsis committee</td>
<td>Achieve top decile for 100% of all indicators.

Improve sepsis compliance to < 75% of the national average.</td>
</tr>
</table>

		• OP 29: 2022 was at 91%.		
IMPROVE OUTCOMES				
Mortalities	Below National Average for all hospitals Below National Average for All Hospitals for Medicare Patients Aged 65 and older	• The overall risk-adjusted mortality rate in 2022 was 2.6% (284 / 11,041) compared to 1.61% (216/13434) in 2021. • The risk-adjusted AMI mortality rate in 2022 was 3.1% (5 /159) compared to 3.9% (7 / 179) in 2021. • The risk-adjusted Heart Failure mortality rate in 2022 was 2.6% (11 / 423) compared to 1.2% (5 / 414) in 2021. • The risk-adjusted pneumonia mortality rate in 2022 was 4.0% (19 / 479) compared to 5.5% (25 / 458) in 2021. • The risk-adjusted COPD mortality rate in 2022 was 1.0% (2 / 191) compared to 1.5% (3 / 199) in 2021. • The risk-adjusted Sepsis mortality rate in 2022 was 11.6% (140 / 1,206) compared to 22.1% (230 / 1,039) in 2021.	• Continue to review all mortalities, identify trends, perform peer review when necessary, and look for opportunities to continue to decrease mortality rates. • Clinical Care Teams initiated COPD and HF to work on standardizing care for this population.	Maintain risk-adjusted overall, AMI, heart failure, pneumonia, and sepsis mortality rates below the national average.
Readmissions	Below National Average for All Hospitals	**<u>Readmission Rates on All Payor All Cause</u>** • The risk-adjusted AMI readmission rate in 2022 was 7.8% (24 / 138) compared to 2021 = 7.5% (15 / 185). • The risk-adjusted heart failure readmission rate in 2022 was 21% (92/455) compared to 2021 = 22% (74 / 342). • The risk-adjusted pneumonia readmission rate in 2022 was 19% (84 / 473) Compared to 2020 = 19.1% (85 / 448). • The risk-adjusted COPD readmission rate in 2022 was 21.4% (44 / 206) compared to 2021 = 16% (34 / 219). • **<u>Readmission Rates on Medicare 65+</u>** o The risk-adjusted AMI 65+ readmission rate in 2022 was 7.8% (24 / 138) compared to 2021 = 7.5% (15 / 185). o The risk-adjusted Heart Failure 65+ readmission rate in 2022 was 21% (92/455) compared to 2021 = 22% (74 / 342). o The risk-adjusted Pneumonia 65+ readmission rate in 2022 was 19% (84 / 473) Compared to 2020 = 19.1% (85 / 448). o The risk-adjusted COPD 65+ readmission rate in 2022 was 21.4%	• Referral to Population Health • Advocating with physicians for home monitoring. • Agreement w/ Margate Health Clinic for 2 appt's. daily for patient follow-up. • CM to schedule follow-up appointments. • System wide Multidisciplinary PI team working to reduce readmissions. • Follow up calls from nursing. • COPD care team to look at in house care for standardization.	Improve all payor all cause readmission rates below national average.

		(44 / 206) compared to 2021 = 16% (34 / 219).		
IMPROVE PATIENT SAFETY				
Falls	< 2.0% per 1000 patient days	• 130 falls out of 78372 patient days for a rate of 1.66% falls per 1000 patient days **compared to** 2021 = 132 falls out of 69369 patient days for a rate of 1.90% falls per 1,000 patient days. This represents a decrease in falls and in rate. • 1 fall with serious injuries out of 78372 patient days for a rate of 0.013% **compared to** 2021 - 5 falls with serious injuries out of 69369 patient days for a rate of 0.072%.	• 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 • Proactive hourly rounds • Educate staff and patients regarding fall prevention. • Analyze data for trends.	Decrease the hospital's fall rate and reduce falls with injuries by 2.0%
Hospital-acquired Pressure Injury	Below National Average	There were 14 HAPIs out of 78,372 patient days for a rate of 0.18% per 1000 patient days compared to 2021 of 17 HAPIs out of 69,369 patient days for a rate of 0.25% per 1,000 patient days. Of those in 2022 there was 1 Stage III for a rate of 0.01, 0 Stage IV for a rate 0.00, and 13 unstageable for a rate of 0.17. Compared to 2021 - there was 0 Stage III for a rate of 0.00, 0 Stage IV for a rate 0.00, and 5 unstageable for a rate of 0.07%. This represents an increase in overall HAPIs Stage III and unstageable wounds.	• All nursing staff required to attend SWAT Boot Camp • SWAT nurse to documents in IVIEW for consistency. • PCA Bootcamp was completed for all floor PCAs to help educate at the bedside for all levels. • Perform drill down on all hospital-acquired pressure ulcers. • Annual patient safety fair for 100% of staff	Decrease the hospital's HAPI rate by 3.5%
Mislabeled Specimens	Less than 7	There were 4 mislabeled specimens out of 142,260 in 2021 compared to 6 mislabeled specimens out of 239,66 in 2022. This represents a decrease in the difference between 2021/2022.		
DECREASE HOSPTIAL-ACQUIRED INFECTIONS				

CLABSI	<0.80 per 1000 device days	The number of CLABSI: 4 out of 5,689 device days with a rate of 0.70% in 2022. compared to 15 out of 8,679 device days with a rate of 1.73% in 2021 The Standardized Infection Ratio (SIR) as reported by NHSN was, 2022: 0.536 2021: 1.376	• Increase surveillance to all nursing units. • Aggressive leadership/unit rounding to evaluate appropriate central line use. • Continue Chlorhexidine bath. • Continue to follow the central line bundle.	Decrease infection rates to below VBP achievement thresholds with a goal of zero.
CAUTI	<0.89 per 1000 catheter days	The number of CAUTI: 4 out of 5,701 catheter days for a rate 0.70% for 2022. compared to 2 out of 7,250 catheter days for a rate of 0.28% in 2021. This represents an increase in rate and device utilization. The SIR as reported by NHSN was, 2022: 0.328 2021: 0.134	• Aggressive leadership/unit rounding to evaluate appropriate foley use. • Increase surveillance to all nursing units. • Continue nurse catheter withdrawal protocol. • ED engagement in preventing insertion. • Continue Chlorhexidine bath. • Coordinate with surgeons to prevent unnecessary perioperative insertion. • Continue HOUDINI protocol for all patients with foley catheter. • Continue to follow catheter bundle.	Decrease infection rates to below VBP achievement thresholds with a goal of zero.
Surgical Site Infections	Below National Average	The number of Surgical Site Infection (SSI): Total Abdominal Hysterectomy (TAH): 0 out of 13 TAH procedures with a rate of 0% in 2022. compared to 0 out of 7 TAH procedures with a rate of 0% in 2021. The SIR as reported by NHSN was, 2022: 0.00 2021: 0.00 The number of SSI (Colon): 2 out of 102 Colon procedures with a rate of 1.96% in 2022.	• SSI Six Sigma PI team to concentrate on class II colon. • Continue tracking all colon infections even the ones that do not meet reportable definition. • Continue to monitor recommended prophylactic antibiotic use. • Address SSI reduction strategies with medical staff • Monitor for trends / Refer to peer.	Decrease surgical site infections to below the VBP threshold as measured by SIR.

		compared to 11 out of 127 Colon procedures with a rate of 14.75% in 2021. The SIR as reported by NHSN was, 2022: 0.007 2021: 2.75	• Drill down on the infection related to colorectal surgery. • Continue Chlorhexidine bath. • IP Medical Director to meet with Surgeons with SSI cases. Multidisciplinary team drill down on all SSIs	
MRSA Lab ID	Above CMS VBP Achievement Threshold	The number of MRSA bacteremia: 1 out of 72,744 patient days with a rate of 0.01% in 2022. compared to 5 out of 81,937 patient days with a rate of 0.06% in 2021. The SIR as reported by NHSN was, 2022: 2.809 2021: 0.897	• Hand hygiene • Blood culture performance competency • Antibiotic duration, indication and PPI indication documentation. • IV to PO policy • Physician documented indication, duration a required field in orders. • Debrief w/ staff involved after HAI identified.	Decrease infections to below the VBP threshold as measured by SIR
CDI Lab ID	Below CMS VBP Achievement Threshold	The number of C-Diff Infection: 3 out of 72,744 patient days with a rate of 0.41% in 2022. compared to 12 out of 81,937 patient days with a rate of 1.46% in 2021. The SIR as reported by NHSN was, 2022: 0.260 2021: 0.227	• Staff education regarding collection process. Ticket-to-test requirements. • Hand hygiene program • Analysis of causative risk factors in all positive cases such as age, SNF resident, recent antibiotics, • Isolation precaution	Decrease infections to below the VBP threshold as measured by SIR