Broward Health Imperial Point Performance Improvement Appraisal CY 2022 and Goals and Objectives for CY 2023

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 low-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 2023 include continuous patient tracers and continuation / enhancement of weekly administrative huddles, unit shift huddles, and our zero-harm reduction program. BHIP will continue to participate in the Hospital Quality Improvement Contract (HQIC) project to increase patient safety and improve quality of life. BHIP will continue to maintain survey readiness in anticipation of the Joint Commission Triennial accreditation and Disease Specific re-certification in Primary Stroke and Heart Failure programs.

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

PI Indicators	Goals	Findings	Actions	Objectives for CY 2023
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 2022 in the following areas: • Stroke – within or above targets with all reported to The Joint Commission. 2022 data is as follows: o STK-1: 2 fallouts 30/32= 93% o STK-2: 0 fallouts 33/33= 100% o STK-3: 1 fallout 4/5= 80% o STK-4: 0 fallouts= 100% o STK-5: 2 fallouts= 94% o STK-6: 0 fallouts= 100% o STK-8: 0 fallouts = 100% o STK-10: 3 fallouts= 97% Compared to 2021 o STK-1: 93% o STK-2: 100% o STK-3: 100% o STK-4: 100% o STK-5: 98% o STK-6: 100% o STK-8: 100% o STK-10: 98%	• Stroke Coordinator will continue concurrent and retrospective reviews of all patients. All data outliers will have an intense review to ensure compliance. All opportunities for improvement identified will be presented by the Stroke Coordinator at Stroke Committee meetings. • Coaching and remediation to physicians and staff as needed. • Stroke Coordinator will ensure all education provided to new physicians, APP's, and employees to AHA clinical practice guidelines for Stroke standards and expectations. • Continually review and share patient outcomes to ensure transparency and accountability when outliers and patient outcomes are compromised. Escalate patient safety issues to Stroke Medical Director and Chief Medical Officer for clarity, guidance, or peer review process as appropriate.	Achieve top decile for 90% of all indicators. Perform within the top 10% decile.

		SEPSIS – CY 2022 ended at 77.5% compliance rate. This is at CMS benchmark of 78% and above National benchmark's rate of 55% HBIPS- 2022 with significant improvement due to IT modifications to Cerner, ongoing education to BHU physicians, APP's, and staff, and sharing outcomes within the organization at: o Medical Executive Committee o Medical Monitoring Committee o Patient Care Key Group o Behavioral Health Staff meetings	Sepsis/ HBIPS: • Quality will continue to ensure the organization is informed of new clinical practices and guidelines related to the disease specific and core measure. • Continually review and share patient outcomes to ensure transparency and accountability when outliers and patient outcomes are compromised. Escalate patient safety issues to Stroke Medical Director and Chief Medical Officer for clarity, guidance, or peer review process as appropriate. • Continue to engage hospital leadership, physicians, patients, and families and multidisciplinary team members to maximize benefit to both the hospital and the patients they serve. • Optimize IT integration with EHR	
IMPROVE OUTCOMES				
Mortalities	Below National Average for Mid-Sized Non-Teaching Facilities	• The risk-adjusted AMI mortality rate in 2022 was 0% (0/10) ~ benchmark 13.6%. · • The risk-adjusted Heart Failure mortality rate in 2022 was 0% (0/42) ~ benchmark 12%. • The risk-adjusted pneumonia mortality rate in 2022 was 40% (0 /60) ~benchmark 16%. • · The risk-adjusted COPD mortality rate in 2022 was 1.0% (1 / 25) ~less than the benchmark of 8.1%	• 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 Vizient cohort average.
Readmissions	Below National Average for All Hospitals	• The overall risk-adjusted all cause 30-day readmission rate was 6.8% which decreased from 9.3% in 2022. • The risk-adjusted AMI and COPD readmission rate for 2022 was 0% • The risk-adjusted heart failure readmission rate for 2022 5.5% which	• 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 symptoms.	Maintain risk-adjusted overall, AMI, pneumonia, heart failure and readmission rates below the Vizient cohort average. Improve pneumonia risk-adjusted readmission rates to at or below Vizient Cohort average.

		was less than the national average of 21.10% • The risk-adjusted pneumonia readmission rate for 2022 was 7%. This was below the national average of 17% <u>Readmissions CMS 65+ report is as follows</u>: • The overall risk adjusted for all cause 30 day was 8.1% in 2022. • Total Hip & Knees and AMI readmissions were at 0%. • Pneumonia was 9% which was less than the national average of 17%. • COPD was 5.83% which was less than the national average of 19.7%. • Heart Failure was 2.78% which was less than the national average of 21.10%.	• 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	<2.1 per 1000 patient days (NDNQI)	Total Falls 2022 all units except Behavioral Health Unit (BHU) 46/24590 rate of 1.88. Of the 46 falls in 2022, 8 (18%) sustained injury of various severity injury levels ranging from 1-4. The fall is lower than the target rate of 2.1. This represents a fall rate reduction in comparison to 2021 of which there was 81/28939, 19 of 81 were with various severity injury levels ranging from 1-4 with a rate of 2.80.	• 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 9 HAPI out of 34636 patient days for a rate of 0.03 in 2022. Of those, there were: 0 Stage II 1 Stage III 0 Stage IV 6 were DTI. 2 were unstageable. 0 MDRPI This was a decrease from CY 2021 in which there were 24 HAPIs out of 39927 patient days at a rate of 0.06.	• All nursing staff periodically and annually re-educated on skin incontinence and products to use. • To reduce HAPI's, Nursing reviews for appropriate beds to assist with off-loading pressure skin areas. • Weekly skin care rounds on all units • Daily rounding by NM/ANM • Hand-off communication and skin review by staff •	Maintain hospital's low HAPU rate and maintain 0 stages 3 and 0 stage 4 wounds. Perform IA on all hospital-acquired pressure ulcers

Mislabeled	< 0.3%	There were 3 mislabeled specimens out of 184,898203207 accessions in 2022. This was an increase from 2 mislabeled specimens out of 218,565 accessions in 2021.	• 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 2%. Goal to be at zero.
DECREASE HOSPITAL-ACQUIRED INFECTIONS				
CLABSI (ICU)	<0.9 per 1000 device days	The number of CLABSI for 2022 was 1 out of 2529-line days for a rate of 0.40 compared to 2021- 3 out 4357-line days for a rate of 0.69.	• 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 Infection Preventionist 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 2022 was 0 with 1920 catheter days for a rate of 0 This outcome was significant in comparison to 2021 which was 5 for 3279 catheter days for a rate of 1.52. The Standardized Infection Ration (SIR) as reported to NHSN is as follows for: 2022- 0.0 2021- 1.47	• 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.	• Continue to discuss lines/ foleys at daily huddles. • Timely escalation to CMO for cases that do not meet HOUDINI protocol. • Continue surveillance monitoring/ HAC rounds.
Surgical Site Infections	Below National Average	For 2022: COLON: There were 2 infections out of 76 colon surgeries performed for a rate of 2.63. The Standardized Infection Ratio (SIR) reported to NHSN was 0.588. The Standardized Infection Ratio (SIR) reported to NHSN was 1.37. HYSTERECTOMY: There were 2 infections out of 194 hysterectomy surgeries performed for a rate of 0.52. The Standardized Infection Ratio (SIR) reported to NHSN was 1.288. The Standardized Infection Ratio (SIR) reported to NHSN was 1.288.	• 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. • 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	Decrease surgical site infections to below the VBP threshold as measured by SIR

MRSA Lab ID	Below CMS VBP Achievement Threshold	There were no MRSA Lab ID in 2022. Our last MRSA Lab ID was in 2019. For 3 consecutive years, the Standardized Infection Rate (SIR) reported to NHSN was 0	• Continually monitor and report outcomes for sustainability.	
CDI Lab ID	Below CMS VBP Achievement Threshold	There were 6 hospital onsets of C-Diff out of 34637 patient days. The Standardized Infection Ratio (SIR) reported to NHSN was 0.71	• Implemented C-Difficile "Ticket-to-test" to include nursing and lab to ensure adherence to C-Diff testing criteria	
HAND HYGIENE	> 95%	For FY 2022, and to meet Leapfrog criteria, BHIP converted from manual hand hygiene observations to an electronic format. Staff was educated and all PC were made accessible for staff to use in order to enter their observation.	• Continue to monitor and observe all staff, students, vendors, visitors, physicians, and medical residents for compliance. • Discuss all outliers and follow up accordingly based on HR policies for corrective actions for trends/ patterns established	Continue to monitor for compliance
IMPROVE EFFICIENCY				
ED Throughput	At or Below National Average	For 2022, ED-1b median time ED arrival to ED departure was 139 minutes and ED-2b median admit decision time to ED departure was 125 minutes.	• Daily flow meeting to include and discuss ED, Lab, Rad volumes, outliers, and TATs. • Monthly patient flow meetings led by ED Medical Director • Display ED and patient flow metrics daily. • Hospitalist bed rounds to expedite discharges.	Improve median ED throughput time to at or below national average.