Broward Health Coral Springs Performance Improvement Appraisal CY 2022 and Goals and Objectives for CY 2023

Broward Health Coral Springs 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 Broward Health Coral Springs 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 2023 include daily safety/flow leadership huddles, on-going monthly unit tracers, unit shift huddles, patient flow concentration, core measure improvements, critical values, and our total harm reduction program. Broward Health Coral Springs received Joint Commission Disease Specific Re-Certification in Primary Stroke in 2022 and are due for our mid-cycle virtual survey in 2023. Our Minimally Invasive Colorectal Surgery certification concluded as December of 2022. TJC is no longer offering that program certification. We are on track for TJC triennial recertification survey in Quarter 2 of 2024.
Listed below is a summary of the PI activities that reflect the hospital endeavors to reduce mortality and morbidity and to assure patient safety. Broward Health Coral Springs 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: • PC-01 – 5% • PC-02 – 45% • PC-05 – 55% • PC-06 – 4% • PC-06.1 – 0.5% • PC-06.2 – 3% PC 01, and 05, are below benchmark. PC, 02, 06, 06.1, 06.2 are at or better than benchmark. • SEPSIS –68% compliance –is below benchmark	• Continue to collect the data and drill down on fallouts. • Continue to educate new employees to core measure standards and expectations. • Continue to coach and remediate all employees and physicians as necessary. • Continue Sepsis education regarding new or revised metrics. • Report details in monthly quality meeting	Maintain compliance with measures. Improve measure scores for PC -01 and 05 Ongoing work with corporate to adapt sepsis tools as measure is updated.
IMPROVE OUTCOMES				
Mortalities	Below CMS Average for Mid-Sized Facilities	• The overall risk-adjusted mortality rate was 4.63% (8/250) for 2022 which is *below* the Crimson Cohort of 17.09%. • The risk-adjusted AMI mortality rate was 11.3% (1/28) for 2022 which is well *below* the Crimson Cohort of 25.4%.	• Continue to review all mortalities, identify trends, perform peer review when necessary, and look for opportunities to continue to decrease mortality rates. • All percentages are below the cohort rates	Maintain risk-adjusted overall, AMI, heart failure, pneumonia & COPD mortality rates below the CMS average.

		• The risk-adjusted heart failure mortality rate was 2.47% (7/283) for 2021 which is *below* the Crimson Cohort Rate of 2.9%. • The risk-adjusted pneumonia mortality rate was 7.2% (7/152) for 2022 which is *below* the Crimson Cohort rate of 18.4%. • The risk-adjusted COPD mortality rate was 0% (0/23) for 2022 which is *below* the Crimson Cohort rate of 10.34%.		
Readmissions	Below CMS Average for All Hospitals	• The overall risk-adjusted all cause 30-day readmission rate was 10.12% (40/260) which is *above* the Crimson Cohort rate of 5.80% for 2022. • The risk-adjusted AMI readmission rate for 2022 was 16.67% (4/21) which is *above* the Crimson Cohort of 6.19%. • The risk-adjusted heart failure readmission rate for 2022 was 13.43 % (10/72) which is *above* the Crimson Cohort of 5.35% • The risk-adjusted pneumonia readmission rate for 2022 was 6.76% (25/144) which is *below* the Crimson Cohort rate of 6.81%. • The risk-adjusted COPD readmission rate for 2022was 3.63% (1/23) which is *below* the Crimson Cohort rate of 4.88%.	• Identify High risk patient with daily email list. • Complete High-Risk Assessment within 24-48 hours. • Readmission assessment to identify reasons and prevent future readmissions. • Refer all high risk, COPD/HF/PN to Population Health. • Nursing provides education. • Respiratory therapist provides inhaler teaching for COPD. • Obtain HHC for COPD/HF management when appropriate. • Multi-Disciplinary Rounds to identify high risk patient for education and f/u care. • Obtain follow up appointment on all HF/COPD patients. • Arrange appointments for all the uninsured. • Arrange PCP appointments for patients with no primary care physician. • Collaboration with AHCA, Medicaid Plans, and the South Florida hospital district on a discharge planning Pilot to decrease readmission.	Maintain risk-adjusted overall, heart failure and pneumonia readmission rates below the CMS average. Improve AMI and COPD risk-adjusted readmission rates to at or below CMS average.
IMPROVE PATIENT SAFETY				
Falls	Below NDNQI rates <2.00 per 1000 patient days	There were 111 inpatient falls out of 65,654 patient days for a rate of 1.69 for 2022. This is a decrease of 0.10 despite a drop in patient days. There were 22 falls with injuries out of 65,654 patient days for a rate of 0.32 for 2022.	• Monthly fall meetings lead by RM. • Analysis of nursing discrepancies with Morse Fall Risk tool. • Continue to perform post fall huddles and include patient/family whenever possible. • Perform an intense analysis of falls with injuries, including involved staff.	Reduce the facilities overall fall rate to below 2.0 with a 5% reduction being a rate of 1.957.

		Both inpatient falls and falls without injuries are below benchmark.	• Continue use of bed and chair alarms • Educate staff and patients regarding fall prevention. • Analyze data for trends.	
Hospital-acquired Pressure Injury	Below National Average and NDNQI rates	There were 6 HAPIs out of 65,654 patient days (SSP + days) for a rate of for 0.01 for 2022 (all types included)	• All nursing staff are educated in pressure ulcer prevention, interventions, and documentation. • Weekly wound care rounds on all units by wound care nurse. • Quarterly prevalence survey • Daily rounding by NM/ANM • Education regarding proper documentation • Staging to be completed by wound care nurse or physician only. • Perform RCA/IA on all hospital-acquired pressure ulcers. • Develop skills of the unit wound care champions through monthly meetings/workshops	Decrease number of HAPI's to zero
Mislabeled Specimens	Zero	There was 1 mislabeled specimen in 2022.	• 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. • Added education to onboarding for agency and travel clinicians.	Decrease number of mislabeled specimens to zero.
DECREASE HOSPTIAL-ACQUIRED INFECTIONS				
CLABSI	CMS SIR <0.73 per 1000 device days	The number of CLABSI (ICU): 0 out of 2622 device days for a rate of 0.00% for 2022. Compared to: 3 out of 3716 device days with a rate of 0.81% in 2021.	• Increase surveillance to all nursing units. • Aggressive rounding to remove the central line. • Continue Chlorhexidine baths. • Participate in HSAG HAI program. • Continue to follow the central line bundle.	Maintain the CLABSI to below the VBP threshold as measured by SIR. Decrease the number of line days.

		This is a decrease in rate and device utilization.	• Work with intensivist group to decrease line days. • Daily monitoring by quality team • Stand down when downgrading care from ICU/CCU to remove lines prior to transfer. • Proper utilization of PICCs/Midlines	
CAUTI	CMS SIR <0.53 per 1000 catheter days	The number of CAUTIs (ICU): 1 out of 2302 catheter days for a rate of 0.43 for 2022. Compared to: 2 out of 3424 foley days for a rate of 0.58 for 2021. This was a decrease in rate and foley utilization.	• Increase surveillance to all nursing units. • ED engagement in preventing insertion. • Continue Chlorhexidine bath. • HOUDINI protocol for all patients with Foley catheter. • IT changes were made to not allow deselecting of Houdini protocol. • Participate in HSAG HAI program. • Continue to follow catheter bundle. • Work with intensivist group to decrease Foley days. • Daily monitoring by quality team • Stand down when downgrading care from ICU/CCU to remove lines prior to transfer	Maintain CAUTI rate below the CMS national average. Decrease the number of Foley days.
Surgical Site Infections (VBP rates)	CMS SIR National Average	There were 6 infections out of 192 hysterectomy procedures in 2021 for a rate of 3.13 & SIR 4.07. This was an increase from 0 infections in 2021. There were 4 infections out of 170 colon surgeries for a rate of 2.35 & SIR of 0.88 in 2021. This represents an increase from 0 infections in 2021.	• Continue to monitor recommended prophylactic antibiotic use. • Address SSI reduction strategies with medical staff surgeons • Monitor for trends. • Refer for peer review as necessary. • Continue Chlorhexidine baths for all surgical patients. • Review all surgical classifications to verify correct classification – ongoing education and posting of signs in ORs regarding wound classification. • Work with surgeons to document infection pre-op. • Work with surgeons regarding documentation of infection in operative notes • Verify weight-based dosages of antibiotics being used. • Encourage physician use of impregnated dressings that remain in place for hysterectomies. • Intense analysis of all SSI with epidemiologist and OR Director, manager, and post-operative unit manager	Reduce surgical site infections to below the VBP threshold as measured by SIR with goal of <1

			• Monitor for trends. • Implement Top Ten Checklist for SSI prevention from HRET-HIIN • Report in monthly quality meetings	
Hospital Acquired All MDROs	Target ≤0.07	There were 1 MDROs for the 2022 calendar year out of 65,266 patient days for a rate of 0.02. This is a decrease from 2021 rate of 0.06.	• Infection Prevention nurses conduct in-depth record review. • Infection Control physician leads and conducts case review. • Intense analysis of all SSI with Infection Prevention nurses and appropriate managers, staff and other healthcare providers as indicated. • Monitor for trends. • Ensure implementation of appropriate bundles and evidence-based care to prevent MDROs	Continue to maintain MDRO rates below target value of ≤ 0.07
C-diff	CMS benchmark 0.78	There were 4 cases of C-diff for a rate of 0.67. We reached the facility goal of 1.36 and the CMS goal despite an increase of over 13,403 patient days.	• ED Triage screen in place • Continue Antibiotic monitoring - pharmacist interventions and RMO. • C-diff decision tree tool re-educated in all nursing huddles. • EVS staff room cleaning re-education validation of rooms cleaning. • HH Observations (unit level and mock teams) • Staff, physician, and resident education • IT updates: order expiring after 24 hr., laxative reminder, diarrhea on admission question. • Isolation log and rounds	Maintain the C-diff rate below the CMS and facility rate.