BHMC Performance Improvement Appraisal/Evaluation CY 2022

Broward Health Medical Center continuously strives to reduce healthcare disparities by providing 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 2022 included 8:00am daily safety huddle, monthly patient tracers, infection control surveillance rounds and selected quarterly point prevalence studies, weekly HAC huddles, unit shift huddles, monthly leadership meetings, Administrator on Call (AOC) rounds, Workplace Violence Harm Reduction with the facility Safety Officer. Core measures performance above national benchmarks. Received The American College of Surgeons Commission on Cancer Accreditation, successful reattained the disease specific certification for Advanced Palliative Care. Regulatory goals for 2023 include successful completion of The Joint Commission tri-annual survey, successful re-accreditation of the disease specific certification for Comprehensive Stroke and in collaboration with Joe DiMaggio Childrens hospital participate in the Childrens Hospital Solutions for Patient Safety Bundles.

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

<table>
<tr><th>PI Indicators</th><th>Goals 2022</th><th>Outcomes</th><th>Actions 2022</th><th>Goals 2023</th></tr>
<tr>
<td>CMS Core Measures</td>
<td>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</td>
<td>There has been continued compliance with the core measures for 2022 YTD…
<table>
<tr><th>Metrics</th><th>CMS Benchmark</th><th>BHMC Facility Rate</th></tr>
<tr><td>OP 18b</td><td>160</td><td>208</td></tr>
<tr><td>OP 23</td><td>69%</td><td>50%</td></tr>
<tr><td>OP 29</td><td>91%</td><td>95%</td></tr>
<tr><td>STK 2</td><td>95%</td><td>97%</td></tr>
<tr><td>STK 3</td><td>72%</td><td>58%</td></tr>
<tr><td>STK 5</td><td>90%</td><td>90%</td></tr>
<tr><td>STK 6</td><td>94%</td><td>97%</td></tr>
<tr><td>HBIPHS 5a</td><td>62%</td><td>100%</td></tr>
<tr><td>PC 1</td><td>2%</td><td>1%</td></tr>
<tr><td>SEPSIS BUNDLE</td><td>58%</td><td>52%</td></tr>
</table>
</td>
<td>• Initiated Patient throughput committee in ED, metrics reviewed at daily safety huddle.
• Concurrent abstractions for HBIPS and Stroke. Drill down of case variances to identify process opportunities. Hired Sepsis coordinator – to have concurrent review of practice.
• Continued multidisciplinary Program specific committee meetings.
• Continued multidisciplinary education (Updates, Standard & Expectations)
• Rolled out Nursing Sepsis Bundle
• Hired Joint/Spine Coordinator.</td>
<td>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.

Increase Leapfrog score to achieve letter A in 2 years.

Achieve CMS 3 Star Rating
Achieve TJC Advanced Palliative Certification.</td>
</tr>
<tr>
<td>HCAHPS</td>
<td>Achieve National Average or Above National Average</td>
<td>
<table>
<tr><th>Metrics</th><th>CMS Benchmark</th><th>BHMC Facility Rate</th></tr>
<tr><td>Overall Rating</td><td>70%</td><td>62%</td></tr>
<tr><td>Recommend</td><td>69%</td><td>61%</td></tr>
</table>
</td>
<td>• Continued initiatives:
o Partnered with PG for Boot camps on Nurse Leaders and hourly rounding.
o Structured validation by Nurse Managers
o Standardized Shift Huddle</td>
<td>Achieve National Average or Above National Average ranking.</td>
</tr>
</table>

PI Indicators	Goals 2022	Outcomes	Actions 2022	Goals 2023
		<table><tr><td>Comm Nurses</td><td>85%</td><td>77%</td></tr><tr><td>Comm Doctors</td><td>79%</td><td>72%</td></tr><tr><td>Comm Medicines</td><td>61%</td><td>53%</td></tr></table>	○ 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 • Revitalized 4 non-negotiable processes. ○ Purposeful Rounding ○ Bedside shift report ○ Commit to sit. ○ Discharge phone calls • 60-day pilot on 3 inpatient units (4NT, 5NT, 4AT) for PharmD Students to discuss new medications and will use new handouts for the patient to take home to assist with discharge information.	
CLABSI	CMS benchmark = 0.909	• 7/16,941=0.41	• IP rounds facility wide. • Daily surveillance to monitor labs, identify and verify infections, analyze data. • Collect patient demographic data, line days. • Identify risks, assess daily need/removal. • Monitor bundle compliance during prevalence rounds: dressing, Biopatch, Curos cap. • Education, HIIN, AHRQ CUSP program • Nurse driven action plans. • Daily CHG bathing for all patients in house with a central line. • Skills fair with Clinical Education • Peripheral draws for blood specimens • Discuss each CLABSI infection in weekly huddles with management and administration to determine lessons learned. • Provide monthly reports to each individual unit. • Continue to monitor use of femoral site for central lines. • Fast facts related to CLABSI prevention. • Standardize daily line rounding form for BHMC and SFCH. • Medline Vascular assessment and evaluation	Below CMS benchmark
CAUTI	CMS benchmark 0.720	6/10,959=0.55	• Increase surveillance to all nursing units. • ED engagement in preventing insertion.	Below CMS benchmark

PI Indicators	Goals 2022	Outcomes	Actions 2022	Goals 2023
			• 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	
Surgical Site Infections	CMS benchmark 0.873	Colon surgeries: 7/136 =5.14 TAH- Hysterectomy: 1/172 =0.58	• Monitor infection rates for all class I and II surgeries and report to appropriate stakeholders. • Monitor COLO and HYST infections and report to NHSN and stakeholders. • Daily surveillance of ER log, admission log, micro reports, OR schedule. • Weight based dosing for antibiotics, re-dosing as necessary. • Plan for ERAS, glucose monitoring. • Discuss each SSI with management and administration to determine lessons learned. • CHG wash night before and morning of surgery. • Nurse driven action plans. • SSI PIT Team	Achieve CMs Benchmarks for SSI Colon and TAH
C-diff	CMS benchmark = 0.487	16/136,544=1.17	• Daily review of surveillance including admission log, ER log, and microbiology results/monitor labs, identify and verify infections, analyze data. • Review of daily isolation patients with real time intervention for EMR orders. • Review antibiogram and discuss at IPCC and Antimicrobial Stewardship committee. • CDIFF: Place patient on enhanced contact precautions per policy and monitor compliance with bleach-based disinfection. • Intense analysis of all CDIFF cases including antibiotic indications and all room changes. • Prevalence rounds for isolation, PPE use, equipment disinfection compliance. • Utilize Biofire as a component of the antimicrobial stewardship program to	Achieve CMS benchmark.

PI Indicators	Goals 2022	Outcomes	Actions 2022	Goals 2023
			discontinue or prevent use of inappropriate antimicrobials. • House wide education provided related to Bristol stool scale. • Prevention of CDIFF antigen order if a positive lab within 30 days currently exists. • Cancellation of order if stool not collected. • ED triage mandatory question about diarrhea. • WHO hand hygiene program. • Review Antibiogram & discuss at Infection Control Committee (ICC) & Medical Care Evaluation (MCE) committee. • Continue to participate in Antimicrobial Stewardship. • Ticket to Test Criteria • Continue to monitor CDIFF alerts.	
Readmissions	Below CMS National Average for All Safety Net Hospitals for Medicare Patients Aged 65 and older	• The Medicare AMI readmission rate for 2022 was 13.9 % which is same as the National Rate (14%) • The Medicare risk heart failure readmission rate for 2020 was 21.1% which is same as National Rate (20.2%) • The Medicare pneumonia readmission for 2020 was 16.8% which is below the National Rate (19.9%) • The Medicare risk-adjusted COPD readmission rate for 2020 was 18.6% which is below National (19.3%) • All payers 30-day readmission rate 15.9 %- same as national Rate (14.6%)	• Corporate Re-admissions PI Team o Checklist for d/c process and handoff created. o Education to CM d/c process o F/U appt for by CM on COPD and CHF readmitted patients o Electronic process for Population Health, Coordination of Care o 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 • HF Medical Director • HF Clinic • Respiratory therapy developed COPD d/c plan with ambulation and DOE assessment.	At or Below CMS National Average for All Hospitals for Medicare Patients Aged 65 and older.
Antimicrobial Stewardship	Continue processes to maintain TJC Standards	• Maintained focus on ASP standards.	• Regional and Corporate Multidisciplinary committee • Decentralized pharmacists to units • Antimicrobial prospective audit and feedback (MedMined, Mpage, PK)	Continue processes to maintain TJC Standards 10% reduction in MDROs

<table>
<tr><th>PI Indicators</th><th>Goals 2022</th><th>Outcomes</th><th>Actions 2022</th><th>Goals 2023</th></tr>
<tr><td></td><td>10% reduction in MDROs</td><td></td><td>• 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
• Reviewed quarterly the days of therapy per diagnosis.</td><td>Maintain focus to ensure ADOT meet best practice recommendations in UTI, PNA, Bacteremia.</td></tr>
<tr><td>Hand Hygiene</td><td>Hospital-wide Achieve >95%</td><td>CY 2022- 100% achieved hospital-wide compliance.</td><td>• 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 is pushed out monthly by Quality.
• 200 observations per unit
• HH reported at GME and RQC
• IC rounds
• TJC tracers</td><td>Maintain 100 % compliance in hand hygiene rates.</td></tr>
<tr><td>Mortalities</td><td>Below National Average for All Hospitals for Medicare Patients Aged 65 and older</td><td><table><tr><th>Mortalities (Q3 (2019)-Q2 (2022)</th><th>BHMC Mortality Rate</th><th>CMS National Rate</th><th>National Compare</th></tr><tr><td>Mort- 30 - AMI</td><td>12%</td><td>12.6%</td><td>Same</td></tr><tr><td>Mort-30-HF</td><td>10.7%</td><td>11.8%</td><td>Same</td></tr><tr><td>Mort-30-PN</td><td>13.7%</td><td>18.2%</td><td>Same</td></tr><tr><td>Mort-30-STK</td><td>15.4%</td><td>13.9%</td><td>Same</td></tr><tr><td>Mort-30-COPD</td><td>9.6%</td><td>9.2%</td><td>Same</td></tr><tr><td>Mort-30-CABG</td><td>3.1%</td><td>2.9%</td><td>Same</td></tr></table></td><td>• 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 same as the CMS cohort rates</td><td>Maintain risk-adjusted overall, AMI, heart failure, pneumonia & COPD, CABG mortality rates below the CMS average.</td></tr>
</table>