Performance Improvement Appraisal/Evaluation CY 2021

Broward Health Medical Center 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 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 2021 included 8:00am daily safety huddle, monthly patient tracers, infection control surveillance rounds and selected quarterly point prevalence studies, weekly HAI huddles, unit shift huddles, monthly leadership meetings, Administrator on Call (AOC) rounds. BHMC participates in the Health Improvement Innovation Network (HIIN) project to reduce patient harm events. Core measures performance above national benchmarks. Completed the Joint Commission Triennial Survey Nov 2021 maintained accreditation status. Received The Joint Commission Re-accreditation certification Disease Specific Re-certifications in Re-certification in Total Hip and Knee in June 2021. Successfully completed Comprehensive Stroke in May 2021. Regulatory goals for 2022 include successful completion on disease specific TJC surveys: Palliative and Total Hip and Knee.

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.

PI Indicators	Goals 2021	Outcomes	Actions 2021	Goals 2022
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 YTD… **Metric** **Benchmark** **Result** **OP-18** **172** **204** **OP-23** **100%** **66.7%** **OP-29** **81%** **95.0%** **STK – 1** **95%** **98.2%** **STK-2** **95%** **100%** **STK- 3** **95%** **96.4%** **STK-4** **95%** **98.1%**	• Patient through put committee initiated in ED, additionally metrics reviewed at daily safety huddle. • Concurrent abstractions for HBIPS and Stroke. Drill down of case variances to identify process opportunities • Continued multidisciplinary Program specific committee meetings • Continued multidisciplinary	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

PI Indicators	Goals 2021	Outcomes	Actions 2021	Goals 2022
	Achieve Letter B grade in Leapfrog Achieve CMS 3 Star Rating	**Metric / Benchmark / Result** **STK – 5** 95% **96.7%** **STK -6** 95% **100%** **STK – 8** 95% **98.9%** **STK – 10** 95% **99.3%** **HBIPS - 1a** 100% **100%** **HBIPS - 5a** 57% **100%** **PC-01** 0% **0.0137%** **Seps-1** 44% **59.0%**	education (Updates, Standard & Expectations) • Hired Sepsis coordinator – to have concurrent review of practice • Hired Joint/Spine Coordinator.	Achieve CMS 3 Star Rating Achieve TJC Advanced Palliative Certification Achieve TJC Advanced Spine Certification
HCAHPS	75th percentile	**Metric / Benchmark / Score / %Rank** **Rating** 75th % **66%** **39th.** **Recommend** 75th % **66.2%** **43rd.** **Comm Nurses** 75th % **73.63%** **23rd.** **Response** 75th % **53.51%** **19th.**	• Continuation of FY20 initiatives: ○ Partnered with PG for Boot camps on NL and hourly rounding ○ Structured validation by NM ○ Standardized Shift Huddle ○ 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	**Reach and maintain 75th percentile ranking**

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			handout for the patient to take home to assist with discharge information.	
CLABSI	CMS benchmark = 0.687	**15/19,342 – 0.62**	• Daily multidisciplinary rounding and indication review • Presented 0800 daily huddle • Dialysis rounds • Vascular access team exchanging lines for midlines and extended dwell peripheral IVs • Resident and medical student education and Epi shadowing • Nursing and PCA competencies • Removal of catheters for elective joints.	Below CMS benchmark
CAUTI	CMS benchmark 0.774	**17/13019 - 0.73**	• Reviewed daily in 0800 huddle • HOUDINI physician unchecks disabled in IT • Daily multidisciplinary rounding and indication review • IT documentation of Foley • Resident and medical student education and Epi shadowing • Nursing and PCA competencies • Standardized products for foley care • HOUDINI physician re-education including Trauma quality • UA to UC reflex update • Removal of catheters for elective joints • Cases presented at weekly HAC meeting.	Below CMS benchmark
Surgical Site Infections	10% reduction in 2020 rate 6.05	**Colon Surgery 12/167 7.19** We remained flat and did not reach the CMS goal.	• Intense Analysis/Drill down of SSI's conducted with Epidemiology, nurse manager and	Below CMS benchmark

PI Indicators	Goals 2021	Outcomes	Actions 2021	Goals 2022
	CMS benchmark 0.754 (SIR) 10% reduction in 2019 rate 1.98 CMS benchmark = 0.726	**Hysterectomy** 5/181 2.76 We remained flat and did not reach the CMS goal.	staff involved to determine any lessons learned and opportunities for improvement • Cases referred to applicable Peer Review Committee • Multi-disciplinary Weekly HAC Meeting • Pre-procedure education about bathing • Keep track of bathing issues in pre-op for inpatient side for immediate follow up • Glucose control process • Limiting traffic in OR • Normothermia • Attire • Post op dressing changes • EVS • Patient hand hygiene wipes • Out of bed post-op • Presentation of CLASS 1 and CLASS 2 at Department of surgery.	Below CMS benchmark
C-diff	10% reduction in 2020 rate 0.304 CMS benchmark = 0.748	26/126765 0.26 We reached the facility goal and the CMS achievement Goal but not the CMS goal of zero.	• EHR hard stop for reordering C-diff antigen within 7-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 • Multi-disciplinary Weekly HAI Safety Huddle	10% reduction in 2020 rate 0.304 CMS benchmark = 0

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			• IT updates: order expiring after 24 hr., laxative reminder, diarrhea on admission question • Isolation log and rounds • Ticket to Test.	

Readmissions	Below Crimson National Average for All Safety Net Hospitals for Medicare Patients Aged 65 and older	• The Medicare AMI readmission rate for 2020 was **9.26%** which is below the National (9.62%) and decreased from last year.
		• The Medicare risk heart failure readmission rate for 2020 was **13.01%** which is above National (16.07%) and decreased from last year.
		• The Medicare pneumonia readmission for 2020 was **14.18%** which is below the National (14.7%) but above last year's rate.
		• The Medicare risk-adjusted COPD readmission rate for 2020 was **11.36%** which is above National (17.46%) and decreased from last year.
		• All payers 30-day readmission rate **10.63** national comparison was 11.50.
			• Corporate Re-admissions PI Team
			  ○ Checklist for d/c process and handoff created
			  ○ Education to CM d/c process
			  ○ F/U appt for by CM on COPD and CHF readmitted patients
			  ○ Electronic process for Population Health, Coordination of Care
			  ○ 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.
				Below Crimson 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 • On the Adult side we saw a > than 10 % decrease in MDRO (CLABSI, CAUTI and C-DIFF).	• Regional and Corporate Multidisciplinary committee • Decentralized pharmacists to units • Antimicrobial prospective audit and	Continue processes to maintain TJC Standards Reduction in

PI Indicators	Goals 2021	Outcomes	Actions 2021	Goals 2022
	10% reduction in MDROs		feedback (MedMined, Mpage, PK) • 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.	10% reduction in MDROs Maintain focus to ensure ADOT meet best practice recommendations in UTI, PNA, Bacteremia.
Hand Hygiene	Hospital-wide Achieve >90%	• CY 2021 81391 98.24% achieved hospital-wide compliance.	• 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 pushed out monthly by Quality • 200 observations per unit • HH reported at GME and RQC • IC rounds • TJC tracers	5% improvement in hand hygiene rates.