Broward Health Imperial Point Performance Improvement Appraisal CY 2021 and Goals and Objectives for CY 2022

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 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 include continuous patient tracers and continuation / enhancement of weekly administrative huddles, unit shift huddles, and our total harm reduction program. BHIP participated in the Hospital Quality Improvement Contract (HQIC) project to increase patient safety and improve quality of life. BHIP received Joint Commission Triennial accreditation in October 2021 and Joint Commission Disease Specific re-certification in Primary Stroke in December 2021. We are scheduled for TJC recertification of Heart Failure program due in Q2 2022.

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. BHIP will continue to work towards these goals during 2021.

PI Indicators	Goals	Findings	Actions	Objectives for CY 2022
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 2021 in the following areas: • Stroke – within or above targets with all reported to The Joint Commission. 2021 data is as follows: o STK-1 DVT Prophylaxis 100% o STK-2 DC on Antithrombotic) 100% o STK-3 Anticoagulant TX for A fib = 100% o STK-4 - Thrombolytic Therapy o STK-5 Antithrombotic (by end of day 2) =94%. 2 fallouts o STK- 6 DC on Statin = 100% o STK- 8 Stroke Education = 100% o STK- 10 Assess for Rehab= 100%	• Continue to collect the data and drill down on fallouts. • Continue to educate new physicians, APP's, and employees to AHA clinical practice guidelines for Stroke standards and expectations. • Continue to stay abreast and inform the organization of new clinical practices and guideline related to the disease specific and core measure	Achieve top decile for 90% of all indicators. Perform within the top 10% decile

		• SEPSIS – CY 2021 ended at 69.03% which was a decrease from CY 2020 at 76% compliance rate. This is below CMS benchmark of 81% and above National benchmark's rate of 55% • HBIPS- 2021 with significant improvement due to IT modifications in Cerner, ongoing education to BHU physicians, APP's, and staff. We continue to share core measure outcomes within the organization at: o Medical Executive Committee o Medical Monitoring Committee o Patient Care Key Group	• Continually review and share patient outcomes and facilitate accountability when outliers and patient outcomes are compromised at various committees and implement the 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 Crimson National Average for Mid-Sized Hospitals- All	• The overall risk-adjusted mortality rate was 2.35 % (114/6137) Crimson Cohort of 2.43%. • The risk-adjusted AMI mortality rate was 1.96% (1/59) for 2021 which is below the Crimson Cohort of 3.46%. • The risk-adjusted heart failure mortality rate was 1.26% (2/159) for 2021 which is below the Crimson Cohort Rate of 2.02%. • The risk-adjusted pneumonia mortality rate was 6.34% (13/205) for 2021 which is above the Crimson Cohort rate of 3.92%. • The risk-adjusted COPD mortality rate was 0.93% (1/108) for 2021 which is below the Crimson Cohort rate of 2.78%.	• 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 Crimson Cohort average.
Readmissions	Below Crimson National Average for All Hospitals	• The overall risk-adjusted all cause 30-day readmission rate was 14.23% (853/5993) which is below the Crimson Cohort rate of 14.00%. • The risk-adjusted AMI readmission rate for 2021 was 6% (3/50) which is below the Crimson Cohort of 9.80%. Very low volume. • The risk-adjusted heart failure readmission rate for 2021 was 21.66% (34/157) which is above the Crimson Cohort of 18.54% • The risk-adjusted pneumonia readmission rate for 2021 was 19.79% (38/192) which is above the Crimson Cohort rate of 13.83%. • The risk-adjusted COPD readmission rate for 2021 was 18.69% (20/107) which is slightly above the Crimson Cohort rate of 18.00%.	• 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 • Advocating with physicians to have home care ordered whenever possible for home monitoring	Maintain risk-adjusted overall, AMI, pneumonia, heart failure and readmission rates below the Crimson Cohort average. Improve pneumonia risk-adjusted readmission rates to at or below Crimson Cohort average.

<table>
<tr><td></td><td></td><td></td><td>Interdisciplinary rounds to be inclusive of Hospitalist groups
Case Management rounding
Referral for follow-up appointments</td><td></td></tr>
<tr><td colspan="5">IMPROVE PATIENT SAFETY</td></tr>
<tr><td>Falls</td><td><2.1 per 1000 patient days (NDNQI)</td><td>Total Falls 2021 all units except Behavioral Health Unit (BHU) 81/28939 rate of 2.80 which is greater than the target rate of 2.1. The overall 2020 fall rate was greater than 2021 in which there were 87/39306 falls with a fall rate of 2.21 Of the 81 falls in 2021, 19 (24%) sustained injury of various severity injury levels ranging from 1-4.
.</td><td>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.</td><td>Maintain the hospital’s low fall rate and reduce falls and falls with injuries by 10%</td></tr>
<tr><td>Hospital-acquired Pressure Injuries</td><td>Below National Average (NDNQI)</td><td>There were 24 HAPI out of 39927 patient days for a rate of 0.06 for 2021.
HAPI Comparison<table><tr><th>2019</th><th>2020</th><th>2021</th></tr><tr><td>6 Stage II
1 Stage III
1 Stage IV
5 DTIs
3 Unstageable
0 MDRPI</td><td>6 Stage II
0 Stage III
0 Stage IV
6 DTIs
5 Unstageable
2 MDRPI</td><td>5 Stage II
2 Stage III
2 Stage IV
8 DTIs

5 MDRPI</td></tr></table>This is an increase from 2020 in which there were 2016 19 HAPIs out of 39299 patient days for a rate of 0.05 (excluding BHU).</td><td>All nursing staff re-educated on skin incontinence and products to use.
Weekly skin care rounds on all units
Daily rounding by NM/ANM
Education on hand-off communication to staff
Perform IA on all hospital-acquired pressure ulcers</td><td>Maintain hospital’s low HAPU rate and maintain 0 stages 3 and 0 stage 4 wounds</td></tr>
<tr><td>Mislabeled</td><td>< 0.3%</td><td>There were 2 mislabeled specimens out of 218565 accessions in 2021.This is a decrease from 2020 in which there were 4 mislabeled specimens out of 200,947 accessions.</td><td>Continue to coach and remediate employees as necessary.
Perform intense analysis on all mislabeled specimens.
Analyze data for trends.</td><td>Decrease number of mislabeled/unlabeled specimens by 10%.
Goal to be at zero.</td></tr>
</table>

			• Continue the use of bedside specimen scanning. •	
DECREASE HOSPTIAL-ACQUIRED INFECTIONS				
CLABSI (ICU)	<0.9 per 1000 device days	There were 3 CLABSIs for 5342-line days which resulted in a Rate of 1.77, and an SIR of 0.757 which is slightly above the target rate of 0.45 and the SIR target goal of 0.648	• 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 Epidemiologist for dressing change observations, just-in-time learning, and further supporting staff
CAUTI (ICU)	<1.4 per 1000 catheter days	There were 7 CAUTIs for 3954 foley days which resulted in an SIR of 1.77 which is slightly above the SIR target goal of 1.59.	• 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	Physician partnering …
VAP	Zero	There were 9 VAC, zero IVAC and PVAP in 2021 in ICU. This was a slight increase from 2020 in which there were 7 VAC, Zero IVAC, and Zero PVAP.	• Support Respiratory therapy in data collection • Continue with infection control rounds. • Educate staff regarding infection control practices. • Continue to follow bundle.	Maintain VAP rate for ICU at zero.
Surgical Site Infections	Below National Average	For 2021: There were 3 infections out of 43 colon surgeries performed for a rate of 6.98. There were 3 infections out of 121 hysterectomy surgeries performed for a rate of 2.43. This was an increase from 2020 in which there was 1 infection out of 114 colon procedures for a rate of 0.88 and 1 out of 234 hysterectomy procedures at a rate of 0.43	• Intense analysis of all SSI with epidemiologist and OR Director. Cases shared at OR committee for physician guidance and recommendations • Continue to monitor	Decrease surgical site infections to below the VBP threshold as measured by SIR

			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	
IMPROVE EFFICIENCY				
ED Throughput	At or Above National Average	OP-18b median time ED arrival to ED departure in 2021 was 144 This was below the national median time of 149 and above the top 10% of 98 minutes.	• Daily flow meeting to discuss ED, Lab, Rad volume, and TATs. Discuss outliers • Monthly patient flow and Stroke meetings led by ED Medical Director/ Stroke Coordinator • Display ED and patient flow metrics daily. • Hospitalist bed rounds to expedite discharges • Six Sigma team was established to decrease throughput times	Improve median ED throughput time to at or below national average.
Stroke		OP- 23Head CT/ MRI scan results for acute ischemic stroke or hemorrhagic stroke patients who received CT/ MRI scan interpretation within 45 minutes of ED arrival.		Improve CT MRI results for acute ischemic or hemorrhagic strokes to be at or above national average
Colonoscopy		OP-29 Appropriate follow-up interval for normal colonoscopy in average risk patients was 96% for 2021. This was below top 10% rate and above national rate.	• Continue to review documentation for compliance	Improve colonoscopy documentation for compliance in order to be at or above national average