Broward Health Coral Springs Performance Improvement Appraisal CY 2020 and Goals and Objectives for CY 2021

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 2021 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 participated in the Health Improvement Innovation Network (HIIN) project to decrease mortality and morbidity. Broward Health Coral Springs received Joint Commission Disease Specific re-Certification in Primary Stroke in 2018 and Minimally Invasive Colorectal Surgery in 2018 and completed their triennial accreditation survey in 2018.

The COVID-19 pandemic had an impact on our line days and infections. There were less ED visits and patient admissions during the pandemic as well impacting our patient days and ED visit number.

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. Broward Health Coral Springs will continue to work towards these goals during 2021.

PI Indicators	Goals	Findings	Actions	Objectives for CY 2021
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 2020: • ED-2b – 109 minutes better than Nat'l avg for high volume ED • PC-01 – 0.04 • PC-02 – 0.263 • PC-05 – 0.306 • PC-06.1 – 0.009 • PC-06.2 – 0.019	• 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.	Maintain compliance with measures Improve measure scores for PC05 Ongoing work with corporate to adapt sepsis tools as measure is updated.

		PC 01, 02, 03 are better than the benchmarks. PC 05 is below the benchmark • SEPSIS –77% compliance –above Nat'l avg.	• Report details in monthly quality meeting	
IMPROVE OUTCOMES				
Mortalities	Below Crimson National Average for Mid-Sized Facilities (focus: year, BHCS, conditions tab-clinical conditions)	• The overall risk-adjusted mortality rate was 0.88% (99/11224) for 2020 which is *below* the Crimson Cohort of 1.63%. • The risk-adjusted AMI mortality rate was 0% (0/5) for 2020 which is well *below* the Crimson Cohort of 1.03%. • The risk-adjusted heart failure mortality rate was 1.79% (1/56) for 2020 which is *below* the Crimson Cohort Rate of 2.67%. • The risk-adjusted pneumonia mortality rate was 2.5% (2/80) for 2020 which is *below* the Crimson Cohort rate of 4.76%. • The risk-adjusted COPD mortality rate was 0% (0/49) for 2020 which is *below* the Crimson Cohort rate of 2.68%.	• 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 Crimson Cohort average.
Readmissions	Below Crimson National Average for All Hospitals (any apr-drg)	• The overall risk-adjusted all cause 30 day readmission rate was 7.02% (734/10461) which is *below* the Crimson Cohort rate of 8.34% for 2020 • The risk-adjusted AMI readmission rate for 2020 was 0% (0/2) which is *below* the Crimson Cohort of 15.72%. • The risk-adjusted heart failure readmission rate for 2020 was 7.55% (4/53) which is *below* the Crimson Cohort of 18.54% • The risk-adjusted pneumonia readmission rate for 2020 was 11.84% (9/76) which is *below* the Crimson Cohort rate of 12.14%. • The risk-adjusted COPD readmission rate for 2020 was 13.33% (6/45) which is *below* the Crimson Cohort rate of 15.86%.	• Identify High risk patient with daily email list. • Complete High Risk Assessment with 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 on disease process. • Respiratory therapist provides inhaler teaching for COPD. • Obtain HHC for COPD/HF management when appropriate. • Multi-Disciplinary Rounds to identify high risk patient who need education and f/u care. • Obtain follow up appointment on all HF/COPD patients. • Arrange clinic appointment on all	Maintain risk-adjusted overall, heart failure and pneumonia readmission rates below the Crimson Cohort average. Improve AMI and COPD risk-adjusted readmission rates to at or below Crimson Cohort average.

			uninsured. • Arrange PCP appointment on 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.	
IMPROVE PATIENT SAFETY				
Falls	<2.00 per 1000 patient days	There were 117 inpatient falls out of 52298 patient days for a rate of 2.24 for 2020. This is an increase from 2019 rate of 2.04. There were 17 falls with injuries out of 52026 patient days for a rate of 0.33 for 2020.	• 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 on falls with injuries, including involved staff. • Continue use of bed and chair alarms • Educate staff and patients regarding fall prevention. • Analyze data for trends.	Reduce the facilities overall fall rate to below 2.0 with a 5% reduction being a rate of 1.957.
Hospital-acquired Pressure Injury	Below National Average	There were 13 HAPIs out of 31,726 patient days (SSP + days) for a rate of 0.04 for 2020. (all types included)	• All nursing staff educated on 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	Maintain hospital's low HAPU rate.
Mislabeled Specimens	Zero	There were 2 mislabeled specimens in 2020.	• 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	Decrease number of mislabeled specimens to zero.

			scanning.	
DECREASE HOSPTIAL-ACQUIRED INFECTIONS				
CLABSI (ICU)	<1.03 per 1000 device days	The number of CLABSI in ICU was 4 out of 2548 device days for a rate of 1.57 for 2020. This is an increase from the rate of 1.14 for 2019. Number of line days increased by 801 days compared to 2019.	• Increase surveillance to all nursing units. • Aggressive rounding to remove the central line. • Continue Chlorhexidine baths. • Participate in HSAG HAI program. • Continue to follow central line bundle • 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	Decrease the CLABSI rate in ICU to below the VBP threshold as measured by SIR Decrease the number of line days.
CAUTI (ICU)	<1.73 per 1000 catheter days	The number of CAUTI in ICU was 2 out of 2709 catheter days for a rate of 0.74 for 2020. This is a decrease from the rate of 1.92 in 2019. Number of Foley days increased by 1146 days compared to 2019.	• Increase surveillance to all nursing units. • ED engagement in preventing insertion. • Continue Chlorhexidine bath. • HOUDINI protocol for all patients with Foley catheter. • IT changes 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	Decrease ICU CAUTI rate to below the CMS national average. Decrease the number of Foley days.
VAC	Zero	There were 0 VACs in ICU for 2020 which is the same as 2019.	• Continue with infection control rounds. • Educate staff regarding infection control practices. • Continue to follow bundle. • Continue with oral care per ventilator management protocol (NUR-006-205)	Maintain VAP rate for ICU at zero.
Surgical Site Infections (VBP rates)	Below National Average	There were 8 infections out of 199 hysterectomy procedures in 2020 for a rate of 4.02 & SIR of 5.46. The rate of 2019 was 0.64 showing in *increase* in 2020.	• Continue to monitor recommended prophylactic antibiotic use. • Address SSI reduction strategies with medical staff surgeons • Monitor for trends.	Decrease surgical site infections to below the VBP threshold as measured by SIR with goal of <1

		There were 6 infections out of 157 colon surgeries for a rate of 3.82 & SIR of 1.52 in 2020. This represents a decrease from the 2019 rate of 4.79.	• 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 • Monitor for trends • Implement Top Ten Checklist for SSI prevention from HRET-HIIN • Report in monthly quality meetings	
Hospital Acquired All MDROs	Target $\leq$0.07	There were 2 MDROs for the 2020 calendar year out of 48,568 patient days for a rate of 0.04. This is a decrease from 2019 rate of 0.17.	• Epidemiology nurse conducts in-depth record review • IC physician lead conducts case review • Intense analysis of all SSI with epidemiologist 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 $\leq$ 0.07
IMPROVE EFFICIENCY				

ED Throughput	At or Below National Average	Average time ED arrival to ED departure for admitted patients in 2020 was 232 minutes; in 2019 it was 270 minutes. (Nat'l rate for very high volume ED = 312 min) Average time from ED admit decision time to ED departure was 105 minutes in 2020, in 2019 it was 108 minutes. (Nat'l rate for very high volume ED = 138 min) OP 18 Mean time from ED arrival to ED departure for discharged ED patients in 2020 was 156 minutes. In 2019 the mean time was 166 minutes. (Nat'l rate for very high volume ED= 169 min)	• Tele-tracking to monitor times • Daily bed huddles to address pending discharges and any other issues • ED metrics collected daily for patient flow • Monthly patient flow meetings led by ED Medical Director • Hospitalist bed rounds to expedite discharges • Interdisciplinary rounding for discharge planning	Continue to decrease ED throughput times. 5% goals ED1b=257 min. ED 2b=103 min. 10% goals ED 1b=243 min. ED 2b=97 min.