Performance Improvement Appraisal CY 2020 and Goals and Objectives for CY 2021

Broward Health North 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 North 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 North 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, AHCA, 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.

Initiatives for 2020 include continuous patient tracers, unit shift huddles, and our total harm reduction program as a part of our journey to becoming a High Reliability Organization (HRO). Broward Health North participated in the Health Innovation and Improvement Network (HIIN) project to decrease mortality and morbidity, in the AHRQ Pressure Ulcer Prevention Collaborative, and the STRIVE project with the FHA.

Listed below is a summary of the PI activities of Broward Health North that reflect the hospital endeavors to reduce the mortality and morbidity and to assure patient safety. Broward Health North will continue to work towards these goals during 2021.

PI Indicators	Goals	Findings	Actions	Objectives for CY 2021
IMPROVE CORE MEASURES				
CMS / TJC Core Measures	Achieve Top Decile for indicators that are at or above national average rate. Achieve national average or above rates for indicators that are below the national average rate.	Data collected: • ED 1 and ED 2: retired • IMM: retired • VTE 6: retired • STK 7 of 8 indications at 100% and top decile, all above National average. Compared to 2018 STK – 1 (STK 8) of 8 indications at 100% and top decile, all above National average. 2020: 0 Fallout in STK1- 100% 2020: 0 fallout in STK2- 100% 2020: 1 fallout in STK 3 97.14% 2020: 3 fallouts in STK-4 96% 2020 5 fallouts in STK 5 98.0%	• Concurrent screening of all new admissions with real time intervention to assure compliance • Continue to collect the data and drill down on fallouts to identify improvement opportunities • Continue to educate new employees to core measure standards and expectations. • Continue to coach and remediate all employees and physicians as necessary. • Interdisciplinary Patient Flow Team at BHN to improve patient flow and reduce ED boarding times. • Multidisciplinary sepsis committee • SEPSIS story board submitted by BHN	Achieve top decile for 90% of all indicators. Improve sepsis compliance to 55% or greater

		2020: 6 Fallouts in STK 6 98% 2020: 1 Fallout in STK 10 99.7% Compared to 2019: 3 Fallout in STK- 1 99.2% 2019: 2 fallouts in STK-2 99.3%, 2019: 2 fallouts in STK 3 95.1%% 2019: 1 fallout in STK-4 97.7%, 2019 5 fallouts in STK 5 98.0% 2019: 2 Fallouts in STK 6 99.3% 2019: 1 Fallout in STK10 99.7% SEP –2020 was 78.4% improved compared to 2019, it was 64%. volume increased from 247 cases (2019) to 385 (2020). • OP 1: retired • OP 2: retired • OP 3B No patient sample consistent with 2019: no population. • OP 4: retired • OP 5: retired • OP 18: 2020: 2019 YTD was 184.33 • OP 20: retired • OP 21: retired • OP 23: retired • OP 29: 2020 is 100%, the same as in 2019 (100%) • OP 30: retired	titled "THINK. TREAT, STOP SEPSIS THPRUGH a MULTIDISCIPLINARY APPROACH" was displayed during Institute of Health Care Improvement (IHI) Scientific Symposium Dec. 2020	
IMPROVE OUTCOMES				
Mortalities	Below Crimson National Average for all hospitals	• The overall risk-adjusted mortality rate was 2.8% (316/11130) compared to 2019- 1.61% (216/13434). Crimson Cohort: 2.59% • The risk-adjusted AMI mortality rate was 4.2% (8/189) compared to 2019 – 3.0% (7/231). Crimson cohort: 4.65%. • The risk-adjusted heart failure mortality rate was 2.4% (8/342) compared to 2019 of 2.34% (9/432). Crimson Cohort rate of 1.67 %	• Continue to review all mortalities, identify trends, perform peer review when necessary, and look for opportunities to continue to decrease mortality rates. • Clinical Care Teams initiated for COPD and HF to work on standardizing care for these populations	Maintain risk-adjusted overall, AMI, heart failure and pneumonia mortality rates below the Crimson Cohort average.

	Below Crimson National Average for All Hospitals for Medicare Patients Age 65 and older	• The risk-adjusted pneumonia mortality rate was 6.52% (38/583) compared to 2019= 2.6% (13/503). Crimson cohort – 3.77% • The Medicare risk-adjusted AMI mortality rate was 8.3% (3/36) compared to 2019= 9.5% (4/42). Crimson cohort – 6.99% • The Medicare risk-adjusted heart failure mortality rate was 0% (0/82) compared to 2019 – 4.55% (5/110). Crimson Cohort rate of 1.29% • The Medicare risk-adjusted pneumonia mortality rate was 6.8% (10/147) compared to 2019= 2.9% (4/138). Crimson Cohort rate of 4.24%.		Maintain Medicare risk-adjusted AMI, heart failure 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 12.63%(1224/9691) compared to 2019 = 12.63% (1351/10700). Crimson Cohort rate of 10.23%. • The risk-adjusted AMI readmission rate was 9.8% (15/153) compared to 2019 =11.83% (22/186). Crimson Cohort rate of 8.71% • The risk-adjusted heart failure readmission rate was 17% (52/308) compared to 2019= 22.3% (91/394). Crimson Cohort rate of 16.34%. • The risk-adjusted pneumonia readmission rate was 13.80% (69/500) Compared to 2019- 13.88% (63/455) Crimson Cohort rate of 10.71%. • The risk-adjusted COPD readmission rate was 2.36% (5/212) compared to 2018= 23.1% (68/294). Crimson Cohort rate of 2.76% The Medicare risk-adjusted AMI readmission rate was 9.68% (3/31) Compared to 2019- 16.1% (5/31). Crimson Cohort rate of 11.29%. • The Medicare risk-adjusted heart failure readmission rate was 17.11% (13/76) Compared to 2019 – 26.8% (26/97) Crimson Cohort of 16.74%.	• Proactive risk assessment for readmissions using an EHR based tool • Referral of patients to Population Health • 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 • Have an agreement with the Margate Health Clinic to reserve 2 appointments daily for patient follow-up • Case management to schedule follow-up appointments • System wide Multidisciplinary PI team working to reduce readmissions • Follow up calls from nursing • COPD care team to look at in house care for standardization • HF care team to look at in house care for standardization.	Maintain risk-adjusted overall, AMI and heart failure readmission rates below the Crimson Cohort average. Improve pneumonia risk-adjusted readmission rates to at or below Crimson Cohort average. Maintain Medicare risk-adjusted readmission rates for AMI and HF below the Crimson Cohort average. Improve pneumonia Medicare risk-adjusted

		• The Medicare risk-adjusted pneumonia readmission rate was 14.62% (19/130) Compared to 2019- 14.62 % (19/130) Crimson Cohort rate of 11.48% • The Medicare risk-adjusted COPD readmission rate was 3.08% (2/65) Compared to 2019-19.0% (19/100) Crimson Cohort Rate of 2.08%.		readmission rates to at or below Crimson Cohort average.
IMPROVE PATIENT SAFETY				
Falls	<2.15 per 1000 patient days	There were 138 falls out of 76417 patient days for a rate of 1.5 falls per 1000 patient days compared to 2019= 123 Falls out of 80975 patient days for a rate of 1.5 falls per 1,000 patient days. This represents an increase/decrease in falls and in rate. There were 1 falls with serious injuries out of 80975 patient days for a rate 0.0 compared to 2019= 1 fall with serious injuries out of 80975 patient days for a rate of 0.0. This represents a decrease in event and rate.	• 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 • Proactive hourly rounds • Educate staff and patients regarding fall prevention. • Analyze data for trends.	Decrease the hospital's fall rate and reduce falls with injuries by 3.5%
Hospital-acquired Pressure Injury	Below National Average	There were 8 HAPIs out of 80,981 patient days for a rate of 0.10 per 1000 patient days compared to 2019= 31 HAPIs out of 82,595 patient days for a rate of 0.38 per 1,000 patient days. Of those, 0 Stage III for a rate of 0.00 0 Stage lV for a rate 0.00 and 5 unstageable for a rate of 0.06. Compared to 2019 there were 1 Stage III for a rate of 0.01 , 1 Stage IV for a rate of 0.01 and 4 unstageable for a rate of 0.05 This represents a decrease in overall HAPIs Stage III and unstageable wounds and a decrease in Stage IV wounds.	• All nursing staff required to attend SWAT Boot Camp • SWAT nurse to documents in IVIEW for consistency • PCA Bootcamp was completed for all floor PCAs to help educate at the bedside for all levels • Perform drill down on all hospital-acquired pressure ulcers • Annual patient safety fair for 100% of staff	Decrease the hospital's HAPI rate by 3.5%
Mislabeled Specimens	Less than 7	There were 6 mislabeled specimens out of 239,661 compared to 2019 = 4 mislabeled specimens out of 229052. This represents an increase.	• 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.	Decrease number of mislabeled specimens by 3.5%. Overall goal to be at zero

DECREASE HOSPTIAL-ACQUIRED INFECTIONS				
CLABSI	<0.80 per 1000 device days	The number of CLABSI were 15 out of 13465 device days for a rate of 1.11 compared to 2018= 13 out of 12953 device days for a rate of 1.0. This is a decrease in both rate and device utilization. The Standardized Infection Ratio (SIR) as reported to NHSN 2020:0.647 2019: 0.739	• Increase surveillance to all nursing units. • Aggressive rounding to get the central line out. • Continue the Centurion Guardian Program. • Continue Chlorhexidine bath. • Continue to follow central line bundle	Decrease infection rates to below VBP achievement thresholds with an ultimate goal of zero.
CAUTI	<0.89 per 1000 catheter days	The number of CAUTI were 9 out of 10954 catheter days for a rate 0.82 compared to 2019= 18 out of 11685 catheter days for a rate of 1.54. This represents a decrease in rate and device utilization. The SIR as reported to NHSN 2020:0.389 2019: 0.073.	• Increase surveillance to all nursing units. • Continue nurse catheter withdrawal protocol. • ED engagement in preventing insertion. • Continue Chlorhexidine bath. • Coordinate with surgeons to prevent unnecessary perioperative insertion • Continue HOUDINI protocol for all patients with foley catheter. • Participate in HSAG HAI program. • Continue to follow catheter bundle	Decrease infection rates to below VBP achievement thresholds with an ultimate goal of zero.
PVAP	0 per 1000 ventilator days	There were 9 out of 27270 ventilator days compared to 2019= 3 VAP out of 5007 ventilator days. This is an increase.	• Epidemiology staff prospective surveillance of VAE signs and symptoms in order to alert Respiratory, Nursing, and Physicians before VAP develops. • Continue with infection control rounds. • Educate staff regarding infection control practices. • Continue to follow bundle.	Decrease PVAP rate to zero.
Surgical Site Infections	Below National Average	There were 0 total abdominal hysterectomy SSI out of 4 hysterectomy procedures for a rate of 0.00 compared to 2019= 0 total abdominal hysterectomy SSI out of 11 hysterectomy procedures in 2018 for a rate of 0.00. Major decrease in total number procedures performed. The SIR as reported to NHSN was 2020:0.363 2019: 0.00 There were 4 colon SSI out of 71 colon procedures performed for a rate of 5.63 compared to 2019 = 12 colon SSI out of 106	• SSI Six Sigma PI team to concentrate on class II colon and hysterectomy infections. • Continue tracking all colon infections even the ones that do not meet reportable definition. • Continue to monitor recommended prophylactic antibiotic use. • Address SSI reduction strategies with medical staff • Monitor for trends. • Refer for peer review as necessary. • Drill down on the infection related to colorectal surgery to identify trends.	Decrease surgical site infections to below the VBP threshold as measured by SIR.

		colon procedures for a rate of 11.32. This represents equal number of total colon SSI and a lower total number of colon surgeries performed. The SIR as reported to NHSN 2020: 2019= 2.426	• Continue Chlorhexidine bath. • Epidemiology Medical Director to meet with Surgeons with SSI cases • Multidisciplinary team drill down on all SSIs	
MRSA Lab ID	Below CMS VBP Achievement Threshold	The Lab ID MRSA bacteremia rate was -4 out of 80,981 patient days for a rate --- infections per 1000 patient days compared to 2019= 10 out of 85,264 patient days for a rate of 0.12 infections per 1,000 patient days This is a decrease. The SIR as reported in NHSN 2020:0.454 2019=0.68	• Staff education regarding what Lab ID event means and how to prevent accidentally causing false positives through delayed collection. • Hand hygiene • Blood culture performance competency • Ensure optimally appropriate antimicrobials by balancing clinical necessity and optimal patient care with negative consequences of inappropriate use. • Antibiotic duration, indication and PPI indication documentation. • IV to PO policy • Physician documented indication, duration a required field in the orders. • Debrief with staff involved after HAI identified. • Utilize HEN change packets, webinars, and best practice resources in action plan making. "	Decrease infections to below the VBP threshold as measured by SIR
CDI Lab ID	Below CMS VBP Achievement Threshold	The Lab ID C. Dif. Infection rate was 28 out of 80981 patient days for a rate of 3.46 infections per 1000 patient days compared to 2019= 27 out of 85,264 patient days for a rate of 3.17 infections per 1,000 patient days The SIR as reported in NHSN 2020:0.543 2019: 0.529	• Staff education regarding what Lab ID event means and how to prevent accidentally causing false positives through delayed collection. • Hand hygiene program • Analysis of causative risk factors in all positive cases such as age, SNF resident, recent antibiotics, proton pump inhibitor use • Isolation precaution	Decrease infections to below the VBP threshold as measured by SIR
IMPROVE EFFICIENCY				
ED Throughput	At or Below National Average	• ED-1: retired • ED-2: retired	• Patient Flow team • ED stakeholders team • Bed ahead • Code Purple policy	Improve median ED throughput time to at or below national average for very high volume ED.