THREE-YEAR FINAL REPORT
PARTNERSHIP FOR PATIENTS • NEW JERSEY

Working Together to Make Healthcare Better

Partnership for Patients HealthCare.gov

NJHA

PARTNERSHIP FOR PATIENTS – NEW JERSEY
Three-Year Final Report

The New Jersey Hospital Association's Institute for Quality and Patient Safety and 62 of its member hospitals participated in Partnership for Patients-New Jersey as one of 27 Hospital Engagement Networks. After three years, the project is complete and the results are impressive - over 13,730 total cases of harm were averted and healthcare costs savings were projected to be over $120 million.

This final report, which covers 2012-2014, details the results for each healthcare-associated condition and how those results impacted New Jersey's patients and residents.

This national initiative was developed by the U.S. Centers for Medicare and Medicaid Services to improve the quality, safety and affordability of healthcare. The two goals of Partnership for Patients-New Jersey were: to ensure quality care and improved safety for patients by reducing the incidence of healthcare-associated conditions and reducing preventable complications that lead to readmissions.

The three-year initiative concluded in 2014, but New Jersey's hospitals will continue to take what they learned and use that knowledge to sustain and expand on their achievements, to make healthcare better and safer for New Jersey.

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HOSPITAL-ACQUIRED CONDITIONS (HACs) KEY ACCOMPLISHMENTS AND RESULTS

HAC TOPIC	OUTCOME MEASURE	SOURCE*	BASELINE
Adverse Drug Events	Warfarin event – INR level outside therapeutic range (percent of patients on warfarin)	Chart Review	10.4% (2011)
Catheter-Associated Urinary Tract Infections	CAUTI Rate* (per 1,000 catheter days)	NHSN	2.27 (2010)
Central Line-Associated Blood-stream Infections	CLABSI Rate (per 1,000 central line days)	NHSN	1.40 (2010)
Falls	Total falls* (per 1,000 patient days)	NDNQI	3.1 (2011)
Early Elective Deliveries	Early Elective Deliveries (percent of deliveries before 39 weeks that were elective)	Chart Review	2.9% (1st Qtr 2012)
OB Adverse Events	Birth Trauma Injury (per 100 live births)	PSI	0.23 (2010)
	Obstetric Trauma combined (per 100 vaginal deliveries)	PSI	14.85 (2011)
	Obstetric Trauma without Instrument (per 100 vaginal deliveries)	PSI	2.45 (2011)
Pressure Ulcers	Pressure Ulcer Rate (per 1,000 discharges)	PSI	1.79 (2011)
Surgical Site Infections	SSI Rate for Colon Surgery (per 100 colon surgeries)	NHSN	4.34 (1st Qtr 2012)
	SSI Rate for Hysterectomy (per 100 hysterectomies)	NHSN	1.47 (2010)
	SSI Rate for Total Knee Replacement Surgery (per 100 knee repl. surgeries)	NHSN	1.03 (2010)
Venous Thromboembolism	Post-operative Deep Vein Thrombolism or Pulmonary Embolism (per 100 surgical discharges)	PSI	0.73 (2011)
Ventilator-Associated Event	Ventilator- Associated Pneumonia Rate (per 1,000 ventilator days)	NHSN	** New VAE measures were rolled out in 2013-2014. Baseline data is not available.

PREVENTABLE READMISSIONS

TOPIC	OUTCOME MEASURE	SOURCE	BASELINE
Readmissions	Medicare All-cause 30-day readmissions (percent of discharges)	HQSI	21.4% (July 2010 - Dec 2011)

DATA NOTES

This table shows the results of data collected from participating hospitals on hospital-acquired conditions, 30-day readmission rates, total cases of harm averted and total healthcare costs avoided. Sources of data and per-patient costs include the National Healthcare Safety Network, the National Database on Nursing Quality Indicators, Patient Safety Indicators, hospital-reported data extrapolated from chart reviews, U.S. Agency for Healthcare Research and Quality, the American Hospital Association's Health Research and Educational Trust and RTI International. Percent change rates represent pre- (baseline) and post- (current) data, as described. Cases of Harm Avoided and Estimated Cost Savings represent data from 2012-2014.

** NDNQI, NHSN and PSI data are collected for 100 percent of NJHEN hospitals (62), except the CAUTI measure, which was based on a sample of hospitals. Chart review data are collected from approximately 50 percent of participating hospitals.*

*Total cases of harm averted - 13,730 | Healthcare cost savings - About $120 million**

CURRENT	PERCENT CHANGE	CASES OF HARM AVOIDED	ESTIMATED COST SAVINGS
6.5% (4th Qtr 2014)	37.9% Reduction	2,240 cases of harm avoided	Estimated cost savings - $11.2 million
1.72 (4th Qtr 2014)	24.1% Reduction	168 cases of harm avoided	Estimated savings - $996,000
1.07 (4th Qtr 2014)	23.5% Reduction	119 cases of harm avoided	Estimated cost savings - $2 million
2.76 (4th Qtr 2014)	11.1% Reduction	978 cases of harm avoided	Estimated cost savings - $7.1million
0.9% (4th Qtr 2014)	69.9% Reduction	258 cases of harm avoided	Estimated cost savings - $1.1 million
0.19 (4th Qtr 2014)	19.8% Reduction	COMBINED FIGURE: 724 cases of harm avoided	Estimated cost savings - $2 million
9.96 (4th Qtr 2014)	33.0% Reduction		
1.79 (4th Qtr 2014)	27.1% Reduction		
1.39 (4th Qtr 2014)	22.3% Reduction	142 cases of harm avoided	Estimated cost savings - $6.1 million
2.01 (4th Qtr 2014)	53.6% Reduction	COMBINED FIGURE: 97 cases of harm avoided	Estimated cost savings - $2 million
1.32 (4th Qtr 2014)	9.9% Reduction		
0.29 (4th Qtr 2014)	71.9% Reduction		
0.62 (4th Qtr 2014)	14.1% Reduction	183 cases of harm avoided	Estimated cost savings - $2.6 million
** New VAE measures were rolled out in 2013-2014. Baseline data is not available.	** New VAE measures were rolled out in 2013-2014. Baseline data is not available.	10 cases of harm avoided (2012 only)	Estimated cost savings - $405,000 (2012 only)

CURRENT	PERCENT CHANGE	CASES OF HARM AVOIDED	ESTIMATED COST SAVINGS
19.8% (Jan - June 2014)	7.7% Reduction	8,811 cases of harm avoided	Estimated cost savings - $84.1million

** In 2014, the Agency for Healthcare Research and Quality changed methodologies in calculating cost savings associated with some hospital-acquired conditions. This chart reflects the updated methodology. Based on the prior methodology, PfP-New Jersey's projected cost savings would have been about $195 million.*

QUALITY IMPROVEMENT AREAS

ADVERSE DRUG EVENTS — Any incident in which the use of a medication (drug or biologic) at any dose may have resulted in death, a birth defect, disability, hospitalization or was life threatening or required intervention to prevent harm.

CATHETER–ASSOCIATED URINARY TRACT INFECTIONS — The most common type of healthcare-associated infection. Virtually all healthcare-associated urinary tract infections are caused by instrumentation such as a catheter inserted into the urinary tract.

CENTRAL LINE–ASSOCIATED BLOODSTREAM INFECTIONS — An infection that occurs when germs enter the body through thin plastic tubes that are placed in a large vein near the patient's neck, chest, arm or groin (a central line).

FALLS — A fall within a healthcare site that results in harm for the patient. Falls continue to be the most frequently reported event submitted to New Jersey's Patient Safety Reporting System by hospital providers.

EARLY ELECTIVE DELIVERIES — A birth scheduled by choice before the 39th week of pregnancy without a medical reason or need. Numerous studies show EEDs are associated with increased maternal and neonatal complications for both mothers and newborns, compared to deliveries occurring beyond 39 weeks and women who go into labor on their own.

OBSTETRIC ADVERSE EVENTS — Include Birth Trauma Injury, Obstetric Trauma with Use of a Medical Instrument and Obstetric Trauma without Use of a Medical Instrument.

PRESSURE ULCERS — Injuries to skin and underlying tissue resulting from prolonged pressure on the skin. Pressure ulcers most often develop on skin that covers bony areas of the body, such as the heels, ankles, hips and tailbone.

SURGICAL SITE INFECTIONS — An infection that occurs after surgery in the part of the body where the surgery took place. SSIs can sometimes be superficial infections involving the skin only. Other SSIs are more serious and can involve tissues under the skin, organs or implanted material.

VENOUS THROMBOEMBOLISM— A blood clot that develops in the vein due to immobilization.

VENTILATOR–ASSOCIATED PNEUMONIA — A type of lung infection that occurs in people who are on breathing machines in hospitals. Ventilator-associated pneumonia typically affects critically ill persons that are in an intensive care unit.

READMISSIONS — Defined as a patient admission to a hospital within 30 days after being discharged from an earlier hospital stay. One example of an unplanned readmission would be someone who is readmitted to the hospital for a surgical wound infection that occurred after his or her initial hospital stay.

THE WORK CONTINUES

PATIENT AND FAMILY ENGAGEMENT

NJHA is building on the successes of its patient and family engagement activities to promote a healthcare system that is safe and truly responsive to patient and family needs, priorities, goals and values.

To foster an environment where hospital leaders incorporate the philosophy of patient and family engagement in every aspect of their day-to-day operations, NJHA will:

- Encourage patient safety rounds conducted by patient/family advisors, change huddles and bedside change-of-shift reporting through interactive learning sessions
- Examine "best practice" strategies that have been used to make healthcare safer for patients and families, including those from diverse backgrounds
- Provide a set of tools and strategies for patients and their families to use to ensure their safe care in the hospital. Materials also will be made available to partners including clinics, pharmacies and advocates to help train and coach the communities they serve
- Identify vulnerabilities in clinical care (medications, surgeries, care transitions, home care) where patient engagement could play a critical role, notably in areas where populations are at risk for disparate care, or cultural and ethnic nuances that influence involvement in care
- Address a set of medication and patient safety best practices for patients and families, based on the experience of patients and families in the healthcare environment.

REDUCING SEPSIS

New Jersey's statewide inpatient severe sepsis mortality rate is close to 30 percent, with a national rate ranging from 20 to 50 percent. Quality improvement agencies, including the Centers for Medicare and Medicaid Services and National Quality Forum, have made reducing sepsis rates a national healthcare priority.

NJHA has developed the New Jersey Sepsis Learning-Action Collaborative whose mission is to spread evidence-based sepsis interventions beyond intensive care units and emergency departments to medical-surgical patient populations. The collaborative is utilizing a systems-based approach to harness the combined power of physician and nursing leadership, executive support, clinical expertise, unit-based engagement and information technology to reduce sepsis.

The goals of the collaborative are to have all New Jersey hospitals implement sepsis early recognition screening and standardized sepsis treatment protocols, and to have every hospital reduce its severe sepsis mortality rate by 20 percent.

IMPROVING ACCESS TO BEHAVIORAL HEALTH SERVICES

In the last five years, the number of emergency department visits by southern New Jersey residents whose primary diagnosis was a behavioral health condition increased by 20 percent. On average, more than 100 people a day from southern New Jersey come to the ED with behavioral health as their primary concern. In 2013, 39 percent of the inpatient admissions from southern New Jersey residents had a primary or secondary diagnosis of behavioral health.

NJHA is working together with its members and their community partners to align the goals of all providers – county, state, not-for-profit acute care, for-profit private and community-based providers – with the identified needs of behavioral health patients and provide a system of care that promotes early detection and access to community-based services.

These efforts include the South Jersey Behavioral Health Innovation Collaborative, a joint initiative with Cooper University Health Care, Inspira Health Network, Kennedy Health, Lourdes Health System, Virtua, NJHA and the Camden Coalition of Healthcare Providers.

The collaborative will evaluate the current behavioral health landscape and provide innovative recommendations on how to improve the system. The project includes engaging key stakeholders, including patients, families and providers, in an effort to better identify the challenges they face.

ADDRESSING HEALTHCARE DISPARITIES

Eliminating disparities in healthcare is a national priority. For over two decades, research has documented persistent gaps in healthcare quality disproportionately affecting Americans from specific racial and ethnic backgrounds. Minorities have a higher prevalence of diabetes, stroke, asthma, cancer, hepatitis B and C, HIV/AIDs, kidney disease and obesity.

Disparities are of great concern to New Jersey, one of the country's most diverse state. It serves the nation's fourth largest Asian population and seventh largest Hispanic population.

NJHA's efforts are focused on:

- Achieving health equity by helping better link patients to a usual primary care source
- Ensuring access to quality, culturally competent care for vulnerable populations
- Improving data collection and measurement of health data, including race, ethnicity, sex, primary language and disability status.

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