New Jersey Hospital Improvement Innovation Network (NJHIIN)
Annual Update

September 29, 2017
Agenda

- Overview of New Jersey Hospital Improvement Innovation Network (NJHIIN) initiative
- Hospital-specific NJHIIN reports
- Collaborative updates
- Questions and answers
NJ HIINnovation Team

- Aline Holmes: NJHIIN Director
- Lauren Rava: PFE, falls, antimicrobial stewardship, ADE
- Angela Centellas: Data reports, pressure injuries, VTE
- Pat Dimino: CAUTI, CLABSI, STRIVE CDI
- Jennifer Barrett Sryfi: Readmissions, health disparities
- Soniya Sheth: Safe imaging, ADE
- Mary Ditri: High Reliability, behavioral health, substance abuse
- Nancy Winter: Director of Education
- Dara Elkholy: Sepsis readmissions
- Kim Hewitson: Interpreter training, OAT survey, website, newsletter, creative design
- Shannon Davila: Sepsis, HAI, surgical safety
Overview

- Funded by the Centers for Medicare and Medicaid Services
- Builds on previous four years of Partnership for Patient (PfP), Hospital Engagement Network (HEN) efforts
- Aligning the QIN-QIO 11th Scope of Work and the PfP to create the systematic use of innovative patient safety practices on a national level
Program Details

- 16 HIINs selected
- Engage the hospital, provider and broader caregiver community
- Rapid implementation of well-tested and measured best practices to reduce “harm across the board”
New Jersey HIIN

- All New Jersey hospitals are participating in the HIIN
- 66 hospitals participating in the NJHIIN
- NJHIIN works to support all New Jersey hospitals, even if they affiliate with other HIINs

Partners include:
- Quality Insights Quality Innovation Network: Healthcare Quality Strategies Inc. (HQSI)
- New Jersey Innovation Institute (NJII) Transforming Clinical Practice Initiative (TCPI)
Reduce Harm Across the Board

- Support hospitals to work on all 11 core areas of harm
  - Adverse drug events (ADE), to focus on at least the following three medication categories: opioids, anticoagulants and hypoglycemic agent
  - Central line-associated blood stream infections (CLABSI)
  - Catheter-associated urinary tract infections (CAUTI)
  - *Clostridium difficile* (*C. diff*) bacterial infection, including antibiotic stewardship
  - Injury from falls and immobility
  - Pressure Ulcers
  - Sepsis and Septic Shock
  - Surgical Site Infections (SSI)
  - Venous thromboembolism (VTE)
  - Ventilator-Associated Events (VAE)
  - Readmissions
Other Areas of Focus

- Undue Exposure to Radiation
- Multi-Drug Resistant Organisms
- Sepsis Readmissions
- High Reliability
Goals
(based on various baselines depending on metric)

- **Goal 1**
  A 20 percent reduction in overall patient harm

- **Goal 2**
  A 12 percent reduction in 30-day readmissions
### Accomplishments to Date

<table>
<thead>
<tr>
<th>HAC Topic</th>
<th>Rate of Change</th>
<th>Harm Avoided</th>
<th>Costs Saved</th>
<th>Lives Saved</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADE</td>
<td>-31% (avg.)</td>
<td>-3</td>
<td>($15,623)</td>
<td>0</td>
</tr>
<tr>
<td>CAUTI</td>
<td>-11%</td>
<td>147</td>
<td>$147,140</td>
<td>3</td>
</tr>
<tr>
<td>CLABSI</td>
<td>-34%</td>
<td>103</td>
<td>$1,750,777</td>
<td>19</td>
</tr>
<tr>
<td>C. Difficile</td>
<td>-24%</td>
<td>419</td>
<td>$4,021,302</td>
<td>96</td>
</tr>
<tr>
<td>Falls</td>
<td>-28%</td>
<td>63</td>
<td>$454,198</td>
<td>3</td>
</tr>
<tr>
<td>Pressure Ulcers</td>
<td>-24%</td>
<td>149</td>
<td>$6,021,594</td>
<td>107</td>
</tr>
<tr>
<td>Sepsis</td>
<td>-7%</td>
<td>120</td>
<td>n/a</td>
<td>120</td>
</tr>
<tr>
<td>SSI</td>
<td>-22% (avg.)</td>
<td>19</td>
<td>$397,630</td>
<td>1</td>
</tr>
<tr>
<td>VTE</td>
<td>-1%</td>
<td>-3</td>
<td>($22,104)</td>
<td>0</td>
</tr>
<tr>
<td>VAE</td>
<td>28%</td>
<td>-12</td>
<td>($208,004)</td>
<td>n/a</td>
</tr>
<tr>
<td>Radiation</td>
<td>-25%</td>
<td>431</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>MDRO</td>
<td>0%</td>
<td>48</td>
<td>$823,299</td>
<td>11</td>
</tr>
<tr>
<td>Sepsis Readm.</td>
<td>4%</td>
<td>-7</td>
<td>($111,688)</td>
<td>n/a</td>
</tr>
<tr>
<td>Readmissions</td>
<td>-7%</td>
<td>6,095</td>
<td>$53,686,416</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>7,569</strong></td>
<td><strong>$66,944,938</strong></td>
<td><strong>360</strong></td>
</tr>
</tbody>
</table>
Multi-pronged Approach

- *Engagement of hospital leaders*: Hospital-specific reports
- *Data to drive action*: Sepsis mortality reports, CT imaging reports, antibiotic use
- *Multi-disciplinary approach*: Medical staff, nursing, pharmacy, infection prevention, support staff
- *Evidence-based framework for improvement*: CDC core elements, Surviving Sepsis Campaign, subject matter expertise
- *Synergize with partners*: QIN-QIO and NJDOH
Overview of Hospital-specific Reports

- Report terms
- Adverse event area dashboards
  - Hospital current rate compared to its own baseline rate
  - Hospital current rate compared to NJHIIN current rate
- Run charts
- Tornado charts
# Adverse Event Area Scoring Dashboard

## Hospital-Specific

### Hospital's Current Rate Compared to its own Baseline Rate

<table>
<thead>
<tr>
<th>ADVERSE EVENT AREA</th>
<th>SCORE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse Drug Events from Anticoagulants</td>
<td>4</td>
<td>Maintained 0 Rate</td>
</tr>
<tr>
<td>Adverse Drug Events from Opiates and Narcotics</td>
<td>4</td>
<td>Maintained 0 Rate</td>
</tr>
<tr>
<td>Adverse Drug Events from Poor Glycemic Control</td>
<td>4</td>
<td>Maintained 0 Rate</td>
</tr>
<tr>
<td>Warfarin Event</td>
<td>N/A</td>
<td>Not Reporting</td>
</tr>
<tr>
<td>CAUTI Standardized Infection Ratio</td>
<td>0</td>
<td>Insufficient Data</td>
</tr>
<tr>
<td>CAUTI Rate</td>
<td>3</td>
<td>Achievement</td>
</tr>
<tr>
<td>CLABSI Standardized Infection Ratio</td>
<td>0</td>
<td>Insufficient Data</td>
</tr>
<tr>
<td>CLABSI Rate</td>
<td>4</td>
<td>Maintained 0 Rate</td>
</tr>
<tr>
<td>CDI Standardized Infection Ratio</td>
<td>1</td>
<td>Reporting</td>
</tr>
<tr>
<td>CDI Rate</td>
<td>1</td>
<td>Reporting</td>
</tr>
<tr>
<td>MRSA Standardized Infection Ratio</td>
<td>0</td>
<td>Insufficient Data</td>
</tr>
</tbody>
</table>

### Dashboard Legend:

0 = Insufficient current data; comparison not possible
1 = Data is being reported, but reduction targets were not met
2 = Improvement of 0% to <20% reduction was achieved (0% to <12% for readmissions)
3 = Achieved 20% reduction (12% reduction for readmissions)
4 = Had a rate of zero (0) at baseline and maintained it
N/A = Hospital does not submit data for this measure
# Adverse Event Area Scoring Dashboard

## Hospital Compared to NJHIIN

<table>
<thead>
<tr>
<th>Adverse Event Area</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse Drug Events from Anticoagulants</td>
<td>LOWER</td>
</tr>
<tr>
<td>Adverse Drug Events from Opiates and Narcotics</td>
<td>LOWER</td>
</tr>
<tr>
<td>Adverse Drug Events from Poor Glycemic Control</td>
<td>LOWER</td>
</tr>
<tr>
<td>Warfarin Event</td>
<td>Not Reporting</td>
</tr>
<tr>
<td>CAUTI Standardized Infection Ratio</td>
<td>Insufficient Data</td>
</tr>
<tr>
<td>CAUTI Rate</td>
<td>LOWER</td>
</tr>
<tr>
<td>CLABSI Standardized Infection Ratio</td>
<td>Insufficient Data</td>
</tr>
<tr>
<td>CLABSI Rate</td>
<td>LOWER</td>
</tr>
<tr>
<td>CDI Standardized Infection Ratio</td>
<td>HIGHER</td>
</tr>
</tbody>
</table>

**Dashboard Legend:**
- LOWER = Hospital's most current rate is lower than the current NJHIIN Rate
- HIGHER = Hospital's most current rate is higher than the current NJHIIN Rate
- Insufficient Data = Hospital not reporting current data
- Not Reporting = Hospital does not submit data for this measure
Each chart displays your hospital's numerator and denominator used to calculate the rate and only the aggregate NJHIIN data.

Please note the following:

- If your hospital does not report on a measure, the run chart will be blank.
- Standardized Infection Ratio (SIR) measures will only display a rate when the predicted value is greater than or equal to 1.

Please see pg. 2 of the report for more details.

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**SAMPLE HOSPITAL**

**SSI Rate for Hysterectomy**
Surgical Site Infections per 100 Procedures (NHSN Measure)

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016Q1</th>
<th>2016Q2</th>
<th>2016Q3</th>
<th>2016Q4</th>
<th>2017Q1</th>
<th>2017Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infections</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Procedures</td>
<td>655</td>
<td>136</td>
<td>100</td>
<td>109</td>
<td>125</td>
<td>129</td>
<td>118</td>
</tr>
<tr>
<td>Hospital Rate</td>
<td>0.92</td>
<td>0.74</td>
<td>0.00</td>
<td>0.92</td>
<td>0.80</td>
<td>0.00</td>
<td>0.85</td>
</tr>
<tr>
<td>NJHIIN Rate</td>
<td>0.71</td>
<td>0.51</td>
<td>0.30</td>
<td>0.26</td>
<td>0.30</td>
<td>0.45</td>
<td>0.40</td>
</tr>
</tbody>
</table>

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**SAMPLE HOSPITAL**

**SSI - Hysterectomy SIR**
SSI Standardized Infection Ratio for Hysterectomy (NHSN Measure)

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016Q1</th>
<th>2016Q2</th>
<th>2016Q3</th>
<th>2016Q4</th>
<th>2017Q1</th>
<th>2017Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Predicted</td>
<td>4.13</td>
<td>0.85</td>
<td>0.65</td>
<td>0.74</td>
<td>0.79</td>
<td>0.87</td>
<td>0.85</td>
</tr>
<tr>
<td>Hospital Rate</td>
<td>1.45</td>
<td>0.70</td>
<td>0.40</td>
<td>0.50</td>
<td>0.53</td>
<td>0.62</td>
<td>0.88</td>
</tr>
<tr>
<td>NJHIIN Rate</td>
<td>0.38</td>
<td>0.70</td>
<td>0.40</td>
<td>0.50</td>
<td>0.53</td>
<td>0.62</td>
<td>0.88</td>
</tr>
</tbody>
</table>
The tornado charts contain your hospitals data charted next to that of all hospitals reporting data for these measures. The most current complete year's aggregate data is shown.

**Note:** Only Standardized Infection Ratio data is standardized. Standardizing the data accounts for variations in exposure and incidence as well as risk factors, promoting more fair comparisons.
Hospital-specific Reports

- Preview reports sent to HIIN hospital leads on September 28
  - Review and contact us with any questions
- CEOs will receive a final copy October 13
Adverse Event Area
Collaborative Updates
Adverse Drug Events

- Opioid Misuse Series
  - New Jersey epidemiology of opioid misuse, abuse, addiction and overdose related death;
  - Regulations and requirements;
  - Drug diversion within facilities;
  - Impaired health care professional;
  - Acute pain management;
  - Chronic pain management;
  - Opioid-related addiction and issues in the very young and very old;
  - Legal implications for health care professionals related to inappropriate opioid prescribing; and,
  - An overview of opioid prescribing, abuse, diversion and addiction.

- ADE Conference – November 8

Contact Lauren Rava, lrava@njha.com
Surgical Safety

- **Enhanced Recover After Surgery**
  - Patient and family engagement, including counseling about expectations for surgery and recovery
  - State of the art analgesia
  - Early mobility and restoration of functional status
  - Avoidance of prolonged periods of fasting
  - Evidence-based best practices for preventing harms

- **American College of Surgeons/Armstrong Institute Collaborative**
  - Cohort 1 Colon Surgery

Contact Shannon Davila sdavila@njha.com
HAI Accomplishments

- Year long HAI Prevention Series; The Power of ZERO HAI Kills
- AHRQ Safety Program for ICUs Cohort2: CLABSI/CAUTI
  - October 2016 – September 2017
  - Participation: 10 hospitals; 15 units
- States Targeting Reductions in Infections via Engagement (STRIVE)
  - April 2017 – March 2018
  - Participation: 16 hospitals
- Targeted HAIs: CDI, CLABSI, CAUTI, MRSA
  - Using TAP Strategy to identify units with highest infection rates
  - TAP Workshop – Attended by participating hospitals August 2017

Contact Pat Dimino pdimino@njha.com
Targeted Assessment for Prevention
HAI Plans for 2018

- Focus on VAE prevention
- Stratify HAI data by race, age, gender
- Continue Antimicrobial Stewardship programs to reduce CDI and MRSA
- TAP workshop for CAUTI and CLABSI
Sepsis Updates

- Continue efforts for early screening and treatment
- Preventing sepsis readmissions
- Engaging patient and families in sepsis
- Other areas of interest
  - Documentation and coding of sepsis webinar October 18
  - Neonatal sepsis management webinar January 10

Contact Shannon Davila sdavila@njha.com
Sepsis Mortality

Mortality Rate for Severe Sepsis & Septic Shock
Expired While in Hospital per 100 Severe Sepsis & Septic Shock Cases
(New Jersey Discharge Data System)

NJHIN Baseline (26.1%)
NJHIN 20% Target (20.9%)

\[ y = -0.0047x + 0.2678 \]
\[ R^2 = 0.6661 \]
Engaging Patients and Families in Sepsis Improvement

- Partnering with Sepsis Alliance
- Sepsis Awareness Month
- New sepsis education handout
Sepsis Readmissions

- New data on sepsis mortality and readmissions
- Disparities of patients being readmitted (age, race, language, payer and ethnicity)

![Mortality Rate of Sepsis Readmissions](image-url)
Sepsis Readmissions Toolkit

- Patient education and family engagement
  - Patient instructions (PMAT tool, Sepsis Alliance, NJHA tool, Surviving - Sepsis Campaign)
  - Discharge checklist
  - Readmission
- Preparation for next level of care (transitions)
  - Quality improvement
- Partnering with the community
- Goals of care
- Life after sepsis
Antimicrobial Stewardship Collaborative

Accomplishments

- Monthly webinars and multiple in-person learning sessions covering
  - LTC series
    - Leadership commitment
    - Accountability
    - Drug expertise
    - Action
    - Tracking
    - Reporting
    - Education

Plans for 2018

- Engage more teams in collecting antibiotic use data
- Cover more advanced topics
  - ICU/Ventilated patient
  - Sepsis
  - Transitions of care
    - Peri-operative use
    - Pediatrics
- Continue to implement best practices

Contact Lauren Rava, lrava@njha.com
Antimicrobial Stewardship Collaborative
Results
Fall Prevention

- ~10 N.J. hospitals enrolled in the Falls TIPS Collaborative, led by Dr. Patti Dykes and her team from Brigham and Women’s Hospital

- In-person sessions in May 2017 and April 2018, 6-part webinar series over the course of one year, including coaching webinars and content webinars on behavioral health and community-based fall prevention

- Dr. Dykes and her team provide all training materials, Falls TIPS poster, instructions, logos and FAQs, as well as constant support

- Still time to join Collaborative!

Contact Lauren Rava, lrava@njha.com
Venous Thromboembolisms

- Assessing the Risk for Venous Thromboembolism (VTE) in Hospitalized Medical Patients – March 17, 2017
  - Importance of identifying VTE risk factors, performing a thorough assessment for VTE risk, and initiation of VTE prophylaxis if risk is significant even with vague or missing symptoms.

- Anticoagulant Education for Patients Diagnosed with VTE - Oct 30, 2017, 12 noon – 1 p.m.
  - DOAC limitations & use in routine clinical care
  - The Joint Commission’s Discharge Instructions / Education Materials for Venous Thromboembolism (VTE): A Comprehensive Approach to Medication Management

Contact Angela Centellas, acentellas@njha.com
Pressure Injuries


Accomplishments 2017

- Identified changes in terminology from pressure ulcer to pressure injury and staging
- Reviewed pressure injury updates from the international perspective
- Defined appropriate documentation for the use of the term unavoidable pressure ulcer
- In-Person Conference – Nov. 1 at NJHA Princeton, NJ

Plans for 2018

- Faculty lead – Mary Brennan
- Targeted outreach – High and low performers

<table>
<thead>
<tr>
<th>Measure</th>
<th>Percent Change from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAPU (NQF 0201) Rate, Stage 2+</td>
<td>-23%</td>
</tr>
<tr>
<td>PSI-3: Decubitus Ulcer Rate Stage III or IV</td>
<td>59%</td>
</tr>
</tbody>
</table>

Contact Angela Centellas, acentellas@njha.com
Children’s Safe Imaging Collaborative

Update

Contact Soniya Sheth, ssheth@njha.com
#SCANSMART:
Children’s Safe Imaging Collaborative
Scope of Work

- NJHIIN and N.J. Council of Children’s Hospitals teamed up to focus on the use of CT scans on children with minor head injuries discharged from the ED.
- Collaborative started September 2016
- 47 hospitals committed to reducing the overall # of CT scans done on children by 20 percent
- Provided hospital-specific data highlighting the number of CT scans ordered on patients seen and treated for minor head injury prior to discharge from the ED (based on 9 ICD-9 & ICD-10 codes)
Scope of work, *cont.*

- Receive quarterly data in the form of a tornado graph with all hospitals unidentified to monitor and evaluate improvement in reduction of CT scans.

- Hosted educational webinars with expert speakers to all member hospitals highlighting, use of the Pediatric Emergency Care Applied Research Network Head Injury/Trauma Algorithm (PECARN), risk of radiation in children, and the nurses role in reducing CT Imaging.

- Engage in hospital-to-hospital best practice and policy sharing
Collaborative Goals

Goals:

- Hospitals that have lower rates than the median of the Emergency Department Head CT Scans for Pediatric Patients (0-17 years of age) graph will assess current practice to determine if any improvement can be made.

- Hospitals that have higher rates than the median of the Emergency Department Head CT Scans for Pediatric Patients (0-17 years of age) graph will reduce head CTs by 20 percent from their current standing.

Achieve Goals By:


2. **The Right Way** – have protocols in place to reduce dual-phase head and chest CT imaging.

3. **The Right Radiation Dose** – use of size-specific pediatric CT imaging protocols.
ED Head CT Scans Without Contrast for Pediatric Patients (0-17 years of age), by Hospital, 2017Q1-02
Ranked by Percent of Minor Head Injury Discharges

- Statewide, 18.8%
- Median, 22%

Notes:
1. Less than 20 discharges in sample
2. Discharge data not available
Accomplishments

- Sent PECARN lanyards to all participating hospitals to be used by ED providers and staff
- Developed and created #SCANSMSRT patient resource and educational toolkit
- Toolkit sent to all EDs the week of Sept. 11

<table>
<thead>
<tr>
<th>Time</th>
<th>Sum of Numerator</th>
<th>Sum of Denominator</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept 2015-Aug 2016</td>
<td>4940</td>
<td>20077</td>
<td>24.6%</td>
</tr>
<tr>
<td>Sept 2016-July 2017</td>
<td>2962</td>
<td>14791</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

Percent Change: -18.6%
Accomplishments, cont.
Accomplishments, cont.

- Article on #SCANSMART in Fall issue of NJ AAP
  - Publication released Sept. 15 with #SCANSMART pamphlet insert and PECARN algorithm card to reach 1700+ pediatricians.
Plans for 2018

- Continue to provide quarterly CT data to all hospitals until 2018.
- Collect information and data regarding pediatric radiation dosing and pediatric CT protocols.
- Survey to help guide HRET in creating a standard level of best practice and compliance when determining appropriate levels of radiation dosing in pediatric population.
  - Appropriate member of team complete the following survey at earliest convenience. https://www.surveymonkey.com/r/CTdosing
Reducing Readmissions

- Partner with Quality Innovation Network, Quality Improvement Organization (QIN-QIO)
  - Planning to convene a new Community Coalition in an underserved, high need area (Passaic)

- Partner with NJ Innovation Institute’s Transforming Clinical Practice Initiative (TCPI)
  - Exploring ways to engage physician practice settings
Reducing Readmissions

- Community-based Healthcare Navigator pilot project
  - Address community-based factors that impact readmissions (health insurance status/literacy, lack of supports, chronic condition, mental illness)
  - Trained Healthcare Navigators (Veterans) use Health COACH model to provide outreach, screening for mental health and social service needs, education, patient empowerment, care coordination, and referrals
  - 4 Navigators serving in Camden, Gloucester, Burlington & Essex, Passaic, surrounding areas
Navigator Assistance to Date

- Assisted 618 families (952 individuals)
- 135 receive long-term health coaching
  - Education on utilization/sites of healthcare, self-care
  - Assistance with medication access
  - Referrals to chronic disease management program
- 48 aided with enrolling in health coverage program
- 209 assisted with finding/setting appt. with PCP
- 113 screened and referred for mental health needs
- 507 linked to transportation, other social supports
Community-Based Measures

- ACS Hospitalizations
  - % of inpatient discharges with primary care or ambulatory care-sensitive diagnoses (1st four)
- ACS ED Visits
  - % of ED treat-and-release discharges with primary care or ambulatory care-sensitive diagnoses (1st four)
- Proxy measures of access to community-based primary care
  - Conditions better treated by PCP or resulting from poor chronic disease management
<table>
<thead>
<tr>
<th>Primary Care / ACS Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB</td>
</tr>
<tr>
<td>HIV, STDs</td>
</tr>
<tr>
<td>Virus (unspec.)</td>
</tr>
<tr>
<td>Abnormal breast/cervical findings</td>
</tr>
<tr>
<td>Diabetes</td>
</tr>
<tr>
<td>Failure to thrive</td>
</tr>
<tr>
<td>Dehydration</td>
</tr>
<tr>
<td>Alcohol/drug dependence</td>
</tr>
<tr>
<td>Depression, anxiety mood disorders</td>
</tr>
<tr>
<td>ADD, disruptive behavior</td>
</tr>
<tr>
<td>Other mental disorders</td>
</tr>
<tr>
<td>Otitis media</td>
</tr>
<tr>
<td>Heart disease (sel.)</td>
</tr>
<tr>
<td>Hypertension</td>
</tr>
<tr>
<td>Acute pharyngitis</td>
</tr>
<tr>
<td>Acute URI (unspec.)</td>
</tr>
<tr>
<td>Acute bronchitis</td>
</tr>
<tr>
<td>Asthma</td>
</tr>
<tr>
<td>GE, colitis (unspec.)</td>
</tr>
<tr>
<td>UTI (unspec.)</td>
</tr>
<tr>
<td>Perinatal (select)</td>
</tr>
<tr>
<td>Lumbago</td>
</tr>
<tr>
<td>Fever, headache</td>
</tr>
<tr>
<td>Other/unsp. chest/abdominal pain</td>
</tr>
<tr>
<td>Sprain, strain, contusion</td>
</tr>
<tr>
<td>Finger wound</td>
</tr>
<tr>
<td>Exposure (hot/cold)</td>
</tr>
<tr>
<td>Attn. to surgical dressings, sutures</td>
</tr>
</tbody>
</table>
Addressing Healthcare Disparities

- Support hospital collection of information on patient race, ethnicity and preferred language (REAL)
  - Identify gaps in data collection
  - Tools, resources, education for registrars on best data collection techniques

- Stratify data and report outcomes by age, sex, race, ethnicity, payor – aggregate and hospital level

  *Interpreter Training of Bilingual Healthcare Staff*

  *Everyone with Diabetes Counts*
Measuring Disparities

Disparities in Readmissions
Q2-2016
(New Jersey Discharge Data System)

30-Day Readmissions
30-Day ED Return Visits

- Total
- White
- Black/African American
- Hispanic
- English
- Spanish
- Disabilities (proxy)
Health Equity Metric

- Coming soon: Gap Assessment Survey
  - Strategies for collecting REAL data from patients
  - Identifying shortcomings in the REAL data collected
  - Utilizing data on healthcare outcomes disparities
  - Establishing a culture of health equity

- Participating in design of new metric on health equity to be used by all HIINs
Addressing Healthcare Disparities

Next Steps

- Develop a NJHIIN-level REAL data analysis report, including more granular breakdowns of race and ethnicity categories than is currently reported
- Validate the accuracy of REAL data at the aggregate level, by comparing to Census data
- Facilitate a similar REAL data gap analysis trial with a pilot hospital
- Review examples of hospital-specific REAL data reports from other HIINs
- Use NJDDCS data to develop hospital REAL data reports
Patient and Family Engagement

- Advance PFE interventions
  - In-depth webinar series around the PFE metrics identified as the greatest areas of improvement: PFE Metrics 2, 4, 5
  - PFE Conference - November 15

- Patient and family advisory counsels (PFAC)
  - Goal: for every hospital in NJ to have a PFAC

- Improve cultural competency of healthcare workers around LGBT patient issues
  - Research paper available as a resource: identifies population, data collection issues and health disparities

Contact Lauren Rava, lrava@njha.com
Patient and Family Engagement

- Integrate the “Voice of the Patient” into all of harm reduction approaches
  - Sepsis Collaborative has included education about sepsis and PFE
  - Pressure Ulcer Collaborative – disseminating brochures of hospitals to give to patients on the early identification of pressure ulcers
  - Safe imaging (head CT) – included PFCC in all sub-projects
  - Attendees at all NJHIIN in-person sessions will be surveyed on their understanding on PFE metrics and if hospitals have implemented them
Improving Safety Culture

- What is a **High Reliability Organization**?
- Teamwork-based safety culture so inevitable human mistakes do not lead to patient harm
- Based on simultaneous actions in four areas –
  - Inter-professional interventions
  - Behavioral changes
  - Structured leadership
  - Culture of safety as a core value

Contact Mary Ditri, mditri@njha.com
HRO Collaborative Details

- 12 hospitals participating
- Boot camp and on-site SSER diagnostics
- Web-based and didactic learning sessions beginning Sept. 2017
  - Sept. 22 (SEC Criteria, SSER Reporting Expectations and Initiative Roll Out)
  - Oct. 9 (Culture Design Planning Day)
  - Oct. 23 (Culture Design Day)
  - Oct. 27 (Safety Huddles and Culture Change)
  - November 2017 – May 2018 (24 programs for leadership and front-line staff)

Contact Mary Ditri, mditri@njha.com
NJHIIN Website Update

- Progress updates
- Resources (guidelines, toolkits, patient education)
- Webinar recordings

http://www.njha.com/PFP/NJTools
NJHIIN Education

www.njha.com/education

- Webinars (complimentary)
- In-person Learning Sessions (complimentary with $30 optional lunch charge)
- Archived Webinars on all HACS (http://www.njha.com/PFP/NJTools)
Next Steps

- Review your NJHIIN hospital-specific report
- Visit the NJHIIN website
- Share educational program calendar with staff
- Join the NJHA-PfP listserv for updates
  
  njha-pfp@njha-listserv.com
Questions?

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