Synopsis of Success

The Joint Commission Resources Hospital Engagement Network (JCR HEN) was launched in 2012 and has now concluded the primary phase of its collaborative activities. Throughout the last two years, the JCR HEN supported 39 hospitals in 17 states to improve patient safety and reduce complications and unnecessary readmissions through the Partnership for Patients.

Final data submission in 2013 showed improvements in all but two adverse events and the JCR HEN participants met a national target for seven of the events. The JCR HEN team also delivered value-added education tools and the entire process fostered a new level of interactive learning and sustained best practices involving diverse stakeholders.

HEN COLLABORATION FOR PERFORMANCE IMPROVEMENT

Hospital Engagement Networks or HENs work at the regional, state, national, or hospital system level to help identify working solutions and disseminate them to other providers. Over 3,700 hospitals are operating within 26 HENs as part of the Partnership for Patients initiative supported by Centers for Medicare & Medicaid.

About Partnership For Patients

The Partnership for Patients campaign is a national project committed to addressing all forms of harm that can affect patients in hospitals. The Partnership for Patients has set the ambitious goal to reduce hospital-acquired conditions by 40% and unplanned readmissions to the hospital by 20%, all by the end of 2014. Achievement of this goal will center around 26 Hospital Engagement Networks that will work to improve patient safety, reduce complications and preventable hospital readmissions, and save lives.

The Partnership for Patients’ adverse events targeted for reduction include:

– Adverse drug events
– Catheter-associated urinary tract infections
– Central line-associated bloodstream infections
– Injuries from falls and immobility
– Obstetrical-related events, including early elective deliveries
– Pressure ulcers
– Surgical site infections
– Ventilator-associated events
– Venous thromboembolism
– Readmission to the hospitals within 30 days of discharge
JCR HEN Participants

The JCR HEN currently supports 39 hospitals across 17 states. Hospitals include critical access hospitals, academic medical centers, community and rural hospitals, and a Veterans’ Health Administration hospital. Three health systems are participating in full, or with several of their hospitals: OSF Healthcare, Regional Healthcare Partners, and Catholic Health Initiative.

See complete list of participating hospitals in Attachment A.
JCR HEN Team

During the two-year project the JCR HEN was supported by five subcontractors, known as the JCR HEN team. Each subcontractor fulfilled specific roles in the project:

**The Joint Commission Division of Healthcare Quality and Evaluation** developed and maintained the data management system (D.M.S.), managed the library of performance measures available to participating hospitals, and completed all analysis of hospital event-level data submitted to the D.M.S. by JCR HEN hospitals.

[www.jointcommission.org/performance_measurement.aspx](http://www.jointcommission.org/performance_measurement.aspx)

**EnCompass, LLC** supported collaborative learning networks held with participating JCR HEN hospitals and developed case studies focused on specific JCR HEN hospitals that demonstrated exceptional results. [www.encompassworld.com](http://www.encompassworld.com)

**Synensis (formerly known as Healthcare Team Training)** provided content and process expertise on teamwork within hospitals, and played an important role in the development of the *Hospital Executive and Physician Leadership Strategies*—a change toolkit that outlines specific behaviors and actions leaders and physicians can take to support patient safety. [www.synensishealth.com](http://www.synensishealth.com)

**Northwestern University Feinberg School of Medicine** assisted with general patient safety education programs and material, based on their Patient Safety Education Program, participated in the toolkit noted above, and assisted with other activities focused on physician engagement. [www.feinberg.northwestern.edu/chs/education/healthcarequality](http://www.feinberg.northwestern.edu/chs/education/healthcarequality)

**Social Interventions and Research, Inc.** supported the hospitals’ completion of the Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture, including online survey completion and data analysis, and completed a focused return-on-investment study related to the reduction of catheter-associated urinary tract infections (CAUTIs). [www.sirsrch.com](http://www.sirsrch.com)
JCR HEN Strengths

Strengths of the JCR HEN during the two-year contract period contributed to the impressive results achieved to date. Over the course of the contract, the JCR HEN established a strong infrastructure for education, measurement, and improvement coaching for the hospitals.

Team expertise
The JCR HEN team brought clinical, teaching, performance improvement, analytical expertise, project management, and leadership experience to the project, as evidenced by:

- The project director’s and project manager’s clinical, performance improvement, and project management expertise
- Six Sigma-trained clinical consultants assigned to hospitals as coaches
- Subcontractors’ contributions and participation in onsite Kaizen (“workout”) events, development of new toolkits focused on change, and the ongoing adjustment of strategies and assistance with education
- The Expert Advisory Council who contributed to webinars with hospitals and offered guidance to the JCR HEN team on leadership, physicians, and culture issues
- Access to The Joint Commission's statisticians and measurement experts
- Access to JCR’s education and publication experts

Data power
The D.M.S. is a Web-based portal and system built to support the JCR HEN Partnership for Patients activities. Available 24/7, it offered helpful features to JCR HEN hospitals such as:

- Served as the main communication portal with JCR HEN hospitals
- Provided flexibility to hospitals through a selection of metrics
- Delivered an analytical method for aggregating HEN-level data
- Stored all educational materials and tools for easy access
- Provided links to all recorded webinars and learning sessions
- Posted upcoming meetings and other key updates
- Supported hospitals’ selection of metrics for each event and data entry for those metrics
- Displayed hospital and HEN-level run charts (trend lines) of all outcome and process rates for measures being used by JCR HEN hospitals, for each hospital-acquired condition (HAC), and readmission
- Displayed a dashboard on each hospital’s D.M.S. home page that showed trends for all events and a Harm Across the Board report showing the count of patients affected by event, by month (see Attachments B and C for examples)
- Provided blogging-type functionality to promote dialogue among hospitals
- Profiled and celebrated hospitals’ success stories through a rolling banner on the home page
Support
Technical and consultative support was provided to each JCR HEN hospital, including:
- A trained JCR consultant was assigned to each hospital and developed a relationship with the hospital staff person assigned to manage this project (project director)
- Consultants provided weekly coaching calls to assist hospital teams with their improvement activities and emphasized the use of Robust Process Improvement™ tools and change strategies
- Weekly email updates were sent to all hospitals’ project directors and executive sponsors with key information and guidance for continuing their work

Monthly affinity group calls (collaborative learning sessions) were held for each event, including frontline staff from participating hospitals and led by one of the JCR HEN consultants. The affinity groups promoted the interactive exchange of ideas among hospital staff members. For example, a Pressure Ulcer affinity group call was held the third Thursday of every month with many JCR HEN hospitals’ wound care nurses participating; they shared successes and challenges with each other. These were recorded and posted on the D.M.S. for hospitals not able to attend the call.

Completion and interpretation of the AHRQ Hospital Survey on Patient Safety Culture were offered to all hospitals. Nine hospitals in Year One and 7 hospitals in Year Two accepted this offer, including set-up and management of the online survey, data analysis, and interpretation of results for each hospital’s subsequent action. Three of these hospitals received more complex reports that included comparison across years. Ten other hospitals provided data previously collected, requesting additional analysis and interpretation which was provided (subcontractor Social Interventions and Research completed this work).

Education
Education was offered virtually through prerecorded lectures and live webinars (recorded for continuing access), supplemented by additional training materials, handouts, and tools. Examples of these sessions and materials included:
- Prerecorded lectures specific to each adverse event and general patient safety topics, as well as content on strategies for launching effective performance improvement and change management to achieve sustained gain
- Live topic-specific webinars by experts, usually serving as guests on affinity group calls (see list on page six)
- Tracers (system and patient levels) for each adverse event, based on The Joint Commission’s tracer methodology
- Two change packages that served as educational tools for leaders, physicians, and frontline staff (described in Highlights and Accomplishments)

Marketing
JCR developed and provided hospitals with a publicity kit to assist them with promoting their participation in the Partnership for Patients campaign with internal audiences as well as their local communities.

Mission and goodwill
JCR gifted many JCR publications and toolkits to the hospitals in December 2012 to help them on their performance improvement journey.
EXPERTS PARTICIPATING IN WEBINARS AND AFFINITY GROUP CALLS

Elliott Main, MD – Adverse obstetrical events, including early elective deliveries
Brian Jack, MD – Readmissions reduction
Suzanne Mitchell, MD – Readmissions reduction
Gregory Maynard, MD, MSc, SFHM – Venous thromboembolism prevention
Keith Kaye, MD, MPH – Infection prevention
Barbara Soule, RN, MPA, CIC, FSHEA – Infection prevention
Bona Benjamin, BS, RPh – Adverse drug events
Shekar Mehta, PharmD – Adverse drug events
Jeannell Mansur, RPh, PharmD, FSMSO – Adverse drug events
Irene M. Jankowski, RN, MSN, APRN, BC, CWOCN – Pressure ulcers

Patient Advocates: Bob and Barb Malizzo, Ann White, Chrissie Blackburn, Jan Englert, Sherri and Jerod Loeb, PhD, Victoria and Armando Nahum, Allison Clay, MD, Patty Skolnik
Partnerships and Networking

The JCR HEN staff collaborated with staff from the other 25 HENs to learn from each other and share effective strategies for reducing harm to patients. All materials developed under this contract were shared with others and sent to the national content developer for posting on the national community of practice website for broader access by others.

JCR HEN team members established and maintained collegial and collaborative relationships with other contractors, Quality Improvement Organizations (QIOs), and HENs, including:

- Participated in weekly “HEN House” calls and hosted calls for four months
- Provided development and financial support for a program in Illinois about surgical site infections (included QIO and several other HENs with hospitals in Illinois)
- Participated in Ohio KePRO/Ohio Hospital Association HEN steering committee for health care-associated infections (HAIs)
- Attended several QIO calls planned by state hospital association HENs for other HENs with hospitals in those states (FL, TX, MS, IL, OH, AL)

JCR HEN team members also actively and continuously participated in the planning and delivery of national pacing events, affinity group meetings (including co-chairing readmissions), and other Partnership for Patients calls (e.g., WIHI talk show, Health Research and Educational Trust (HRET) leadership week in Indianapolis)

JCR initiated the idea for a pediatric patient safety pacing event for HENs, and collaborated with the System for Patient Safety (the HEN supporting children’s hospitals) and the National Content Developer (CMS contractor supporting educational programs) to plan the pacing event (held on May 6, 2013). Discussion continues about expanding such an event for all participating hospitals in 2014.

JCR provided onsite HAC-related educational sessions (pressure ulcers, readmissions) to other HENs and their hospitals, discussed analytical approaches for multiple outcome measures with other HENs in the same situation, and explained The Joint Commission’s early elective deliveries (EED) measure during a HEN House call when EED was added in April 2012, connecting them with The Joint Commission staff person to gain more information.

JCR also collaborated with March of Dimes and purchased EED-related patient pamphlets and posters for the hospitals that provide obstetrical services.
**Highlights and Accomplishments**

The JCR HEN team has contributed to national efforts in diverse ways.

It developed and shared multiple education tools and products with other contractors and HENs, including:

- Recorded webinars with clinical experts
- Submitted 100 individual hospital stories describing success with reducing specific events in monthly reports (through December 2013)
- Provided patient- and system-level tracer tools for all 10 targeted events
- Completed three case studies for hospitals that have reduced the occurrence of more than six of the ten targeted events (written by subcontractor EnCompass, LLC and sent with September 2013 monthly report)
- Collated Joint Commission publications and toolkits related to surgical and product/equipment safety in an effort to create national affinity group resource templates for all HENs to share with their hospitals

JCR developed *Patient Safety Initiative: Hospital Executive and Physician Leadership Strategies*, a guide to help motivate and energize health care leaders to assess gaps in their organizational safety culture, engage key influencers for change, set goals for targeted improvement, implement proven safe practices, and reinforce key behaviors to ensure high-reliability performance improvement.

**Part I** focuses on hospital executive leadership strategies and includes seven components: board engagement on patient safety, safety culture debriefing, safety leadership rounds, teamwork training and skill building, daily safety briefing, senior executive adopt a work unit, and best practices of execution

**Part II** focuses on physician leadership and includes eight components: medical leaders build patient safety structures, physician communication at the bedside, physician involvement in unit-based huddles, physician leadership of unit-based patient safety meetings, harm reduction rounding checklists and evidence-based guidelines, multidisciplinary teamwork training, physician leadership of post-adverse event debriefs, and managing challenging behavior

Subcontractors Synensis and Northwestern University Feinberg School of Medicine assisted with the guide.

Another helpful tool was *Beyond the Bundles: How to Implement Best Practices at the Bedside*, a 27-page guide intended to motivate health care providers to use best practices known to help reduce adverse events. It includes a description of the best practices and operational tips for successful and consistent implementation to help reduce patient harm at the bedside. The guide also incorporates innovative strategies JCR has learned from hospitals. Health care providers can use the guide to assess gaps in their own organizational practice, engage key influencers for change, set goals for targeted improvement, implement proven safe practices, and reinforce key behaviors to ensure high-reliability performance improvement.
and sustainable performance. In addition, providers can obtain “how to” information and tips for successful implementation of best-practice components as well as links to related resources developed by other organizations.

A return-on investment (ROI) study was conducted with one of the hospitals, focused on CAUTI reduction (sent with September 2013 quarterly report). In 2014 the team will present a webinar on the ROI case study, explaining the actual costs and realized returns on the improvement project. The presentation will include strategies for maximizing returns as well as implications for other improvement projects. This work was completed by subcontractor Social Interventions and Research and initially presented during the JCR HEN CAUTI affinity call in October.

The team facilitated national outreach to new audiences, including nursing education with the Quality and Safety Education for Nurses Institute, leading to the design and delivery of an opening plenary session and patient advocate panel at the Institute’s national annual conference. The panel focused on the integration of patient and family engagement (PFE) into future nursing education programs across the nation, leading to panel members being asked to speak at other academic institutions and events.

The JCR HEN team pioneered the involvement of patients and patient advocates in the HEN’s operation by forming the first HEN patient and family advisory panel (PFAC). JCR requested that participating hospitals name a staff person and a patient advocate to this PFAC, and also invited staff from other HENs to listen in and share ideas about how to launch their own PFAC. The JCR HEN PFAC has already addressed such issues as:

- Review of levels of PFE
- Scoring hospitals’ PFE activities
- Setting up a hospital PFAC
- Stories and ideas from guest patient advocates
- Hospital examples of projects where patient input made a difference
- Identifying patients and family members to serve on PFACs
- Resources available to assist hospitals with PFACs and PFE
- Bedside huddles and shift reporting that include the patient and family
- Shared decision-making and informed consent
**JCR HEN Results**

As of November 27, 2013, more than 60% of the JCR HEN hospitals were submitting outcome data for all but one event: venous thromboembolism (VTE); see Table 1.

At the time of this report’s publication, the JCR HEN aggregate rates have met a national target for seven of the events:

- Obstetrics-early elective delivery (OBEED)
- Adverse drug events (ADE)
- Central line-associated blood stream infections (CLABSI)
- Pressure ulcers (PrU)
- Surgical site infections (SSI)
- Ventilator-associated pneumonia (VAP)/ventilator-associated events (VAE)
- Obstetrical-related adverse events

<table>
<thead>
<tr>
<th>Event (Eligible Hospitals)</th>
<th>Baseline Data Submitted</th>
<th>Data Submitted Within Past 6 Months</th>
<th>% of JCR HEN Members</th>
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</thead>
<tbody>
<tr>
<td>ADE (37)</td>
<td>26</td>
<td>26</td>
<td>70%</td>
</tr>
<tr>
<td>ADE-Hypoglycemic Related (37)</td>
<td>11</td>
<td>8</td>
<td>21%</td>
</tr>
<tr>
<td>ADE-Anticoagulant Related (37)</td>
<td>15</td>
<td>14</td>
<td>37%</td>
</tr>
<tr>
<td>ADE-Opioid Related (37)</td>
<td>3</td>
<td>3</td>
<td>8%</td>
</tr>
<tr>
<td>ADE-Readmit (37)</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>CAUTI (37)</td>
<td>37</td>
<td>36</td>
<td>97%</td>
</tr>
<tr>
<td>CLABSI (36)</td>
<td>35</td>
<td>33</td>
<td>92%</td>
</tr>
<tr>
<td>Falls (37)</td>
<td>36</td>
<td>36</td>
<td>97%</td>
</tr>
<tr>
<td>OB (27)</td>
<td>24</td>
<td>17</td>
<td>63%</td>
</tr>
<tr>
<td>OBEED (27)</td>
<td>26</td>
<td>24</td>
<td>89%</td>
</tr>
<tr>
<td>PrU (37)</td>
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<td>73%</td>
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<td>VAP (33)</td>
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<td>79%</td>
</tr>
<tr>
<td>VTE (37)</td>
<td>26</td>
<td>20</td>
<td>54%</td>
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</tbody>
</table>
At the time of publication, the JCR HEN aggregate rates are heading in the right direction for CAUTIs, other adverse OB events, injuries from falls and immobility, VTE, and readmission. Figure 1 displays the percent change in JCR HEN aggregate rates.

Figure 1: JCR HEN Aggregate Percent Changes in Event Rates
Lessons Learned About Performance Improvement

Reduction of adverse events and unplanned readmissions is possible. Consistent translation of best practices at the bedside is perhaps the biggest challenge to effective and sustained change and improvement. National experts are eager to assist with reducing harm to patients, even without compensation.

There is great power in collaboration with other stakeholders. Flexibility and openness to change is paramount at all levels. Hospitals want to share with each other and eventually will engage in discussion to learn from each other, even sharing actual rates of performance. This sharing can be effectively facilitated through virtual sessions (phone calls and webinars). JCR HEN technical and operational processes for conducting virtual meetings should be standardized for the JCR HEN consultants who run affinity groups.

Onsite assistance expedites senior leadership engagement, commitment, and hospitals’ progress toward reducing harm. Virtual coaching, training, and group discussions can provide support and guidance to assist hospitals’ teams to evaluate current processes, identify gaps against best practices, generate solutions to match unique root causes, and implement change.

Staff nurses play a key role in implementing many of the best practices aimed at reducing adverse events. HEN staff communication with multiple contact persons in the hospital is more effective than limited communication through a single point person (designated project manager at the hospital).

Effective coaching requires both clinical and performance improvement expertise. The use of Lean and Six Sigma tools expedites hospitals’ analysis of current state and identification of solutions targeted to root causes.

Executives and physicians are open to receiving assistance to be more engaged. Turnover in executive positions and quality/patient safety positions contributes to an unstable environment to sustain improvement and change, necessitating orienting new staff and sometimes delays in progress.

Hospitals are using reports posted on the D.M.S., including features that allow them to print run charts and export them into reports and slide decks. New and upgraded Electronic Health Record (EHR) installations consume considerable resources and can impact attention paid to quality and safety issues. Carefully designed EHR functionality can improve the quality of patient care and prevent harm to patients.

Involving patients and families in hospital activities incentivizes health care professionals to drive change. Hospitals that have involved patients and families in performance improvement activities have changed initial plans after hearing from them.
Lessons Learned About Specific Adverse Events

**Surgical site Infections (SSIs)** Many hospitals have been instrumental in tackling SSI rates for colorectal surgery and abdominal hysterectomy patients by involving their surgeons, sharing case-specific data with the surgeons, and using standardized skin antiseptic preparation across all surgical settings and in the patient’s home prior to admission to the hospital.

**Venous thromboembolism (VTE)** Many physicians do not request or complete a VTE risk assessment upon admission because they believe that all patients are at risk for VTE. While this is true, the omission of the risk assessment often becomes a risk point and patients are not accurately screened for VTE prophylaxis. We have also learned that below-the-knee thrombolytic stockings often predispose patients to pressure ulcers and, based on research findings, are not recommended over thigh-highs.

**Ventilator-associated pneumonia (VAP)** The new CDC and NHSN definitions for VAP are difficult to collect data on and there are still areas needing clarification. We have also learned that many organizations are in the infancy stages of developing a delirium avoidance and early mobility program. However, most organizations believe they have “hardwired” the VAP bundle components into practice. It takes a multidisciplinary team to impact VAP reduction.

**Catheter-associated urinary tract infections (CAUTIs)** Many organizations have not yet implemented a nurse-initiated discontinuation protocol for urinary catheters due to inability to gain physician buy-in for the concept. Organizations have implemented standardized indications and are proactively working with physicians to obtain the discontinuation order when the urinary catheter no longer meets indications.

Education and re-education regarding Foley catheter insertion techniques and maintenance are key along with including ancillary staff such as physical therapists, transporters, etc., in the education. Organizations are beginning to address Foley catheter insertion for case times less than 3 hours and utilization of Foley catheters in the emergency department.

A significant issue with larger institutions is that, as they are decreasing Foley catheter days significantly, infection rates are not demonstrating the same reduction. This issue highlights the need for these organizations to now concentrate on evidence-based care of patients who do have a catheter to prevent associated urinary tract infections.

**Injuries from falls and immobility** There is a difference between skid resistance and gripper socks. The gripper socks have a tripping effect and can cause falls.

**Obstetrical-related adverse events** There is an update to the definitions of latent and active phases of labor based on centimeters of dilation. The American Congress of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine have developed algorithms for managing labor at each phase.

“When clinicians work together and commit to prevention of harm, hard-stop policies are accepted and effective.”
Early elective delivery (EED)  When clinicians work together in the organization and commit to prevention of harm, hard-stop policies are accepted and effective.

Readmissions  To successfully reduce readmissions, teams must engage continuum-of-care resources by partnering with community agencies and health care organizations to improve transitions from hospital to home or the next setting. It is important to develop new alignments with community pharmacists for post-discharge care and consider listing both new and discontinued medications on the patient’s discharge summary.

Have family members complete the patient care plan throughout the inpatient stay, coached by staff. Examine the patient’s depression status as it relates to readmission and review patterns of common causes of readmissions. Use patient experiences (stories) to reinforce the importance of teach-back methods with staff.

Central line-associated blood stream infections (CLABSIs)  For sustained reduction of CLABSIs teams must engage the patient and family in precise care of the central line. Include all patients beyond the critical care units and all transferred patients. Assure safe and correct specimen collection techniques for valid diagnosis.

Adverse drug events (ADEs)  ADEs associated with the three high-risk drug categories are consistently addressed with individual patients when a critical lab value indicates the need to take action. However, many hospitals have not aggregated these events to truly understand the scope of the problem. This finding was new for many hospitals and often requires assistance from IT to avoid manual aggregation.

Pressure ulcers (PrUs)  Unit-based skin care champion programs are not as widespread as we would have hoped. In addition, hospitals are looking for help to prevent device-related pressure ulcers and care of obese patients to prevent PrUs.

“To successfully reduce readmissions, teams must engage continuum-of-care resources by partnering with community agencies and health care organizations to improve transitions from hospital to home or the next setting.”
Looking Forward: Next Steps

For the JCR HEN participants, it is vital to continue giving the highest priority to achieving results and meeting the campaign goal to reduce the occurrence of 9 HACs by 40% and unplanned 30-day readmissions by 20%. JCR is aggressively working with the hospitals to secure their data for each event and guide them toward sustained improvement and reduction of harm to patients.

Specific tasks include:
- Implement the work plan for Option Year One (2014), with increased attention on required elements, more aggressive education and coaching plans to assist new hospitals and currently enrolled hospitals to achieve Partnership for Patients aims, and opportunities for focused onsite visits to hospitals needing more intensive, hands-on coaching
- Begin the new year with an accurate assessment of each hospital’s performance as defined by Z scores, self-assessment, and the JCR HEN team’s analysis
- Review and revise educational modules for each adverse event and readmission, based on new learnings and an accelerated promotion of the rapid-cycle Plan-Do-Check-Act tests of change
- Identify and complete onsite visits to hospitals with specific need for more intensive assistance and coaching

The JCR HEN is also targeting improved processes for sharing learning and strategies, such as:
- Continue promoting hospitals’ participation in JCR HEN monthly event-specific group calls
- Standardize and improve technical and operational processes for conducting virtual group meetings
- Begin participating in hospital-based adverse event team meetings in an effort to promote rapid-cycle tests of change
- Continue promoting hospitals’ PFE activities
- Gauge hospitals’ interest in participating in a JCR HEN Staff Nurse Advisory Council (to be established in 2014)
- Promote use of new Hospital Executive and Physician Leadership Strategies change toolkit to drive hospitals’ culture to focus on patient safety
- Continue meeting contract deliverables toward receiving third-year option

Finally, the JCR HEN will continue collaborating with other HENs and federal partners and publicize JCR HEN activity (e.g., JCR website, marketing and press releases, and articles).
# JCR Hospital Engagement Network Participating Hospitals
## as of December 8, 2013

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<tr>
<th>Hospital</th>
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<td>Regional Care - Eliza Coffee Memorial Hospital</td>
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## Sample: Hospital-level Dashboard

### JCR-HEN Dashboard

**Individual Hospital Measure Rates**

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**Measure Names:**

- **ADEHypo-O1:** Percent Incidence of Severe Hypoglycemic Episodes
- **CAUTI-O4:** Catheter-Associated Urinary Tract Infection per 1000 Catheter Days (CAUTI) Event
- **CLABSI-O5:** Central Line-Associated Bloodstream Infection Event
- **Falls-O6:** Total Fall Per 1000 Patient Days
- **OB-O2:** Birth Trauma: Injury to Neonates
- **OBEED-P1:** Percent of NICU Admissions Accounted for by Early Elective Deliveries
- **PrU-O6:** Pressure Ulcers: Hospital-Acquired Pressure Ulcers
- **Readmit-O1:** Percent 30-Day All-Cause Readmissions
- **SSI-O1:** Percent of Clean Surgery Patients with Surgical Infection
- **VAP-O2:** Ventilator-Associated Pneumonia (VAP) Rate per 1000 Ventilator Days
- **VTE-O2:** Postoperative pulmonary embolism or deep vein thrombosis
- **ADEHypo-O1:** Percent Incidence of Severe Hypoglycemic Episodes
- **ADEINR-O1:** Percent of Patients Receiving Warfarin With INR Outside Protocol Limits
- **ADEOp-O1:** Naloxone use in patients on opioids (ADEOp-O1)

#N/A
Example: Hospital-Level Harm Across the Board Report

Individual Hospital Harm Across the Board (HAB)

This "Harm Across the Board" (HAB) chart was created for your hospital using the data you have submitted to the JCHEN every month, for the outcome metrics for each targeted event. It "translates" your rates into the number of patients harmed within each event category, based on the outcome numerator data you have submitted. The chart is intended to make the number of persons harmed more visible to hospitals, rather than simply reviewing rates. These charts will be posted on each hospital’s home page on the D.M.S. and updated every month. There are some caveats and cautions we bring to your attention as you review the chart:

- These charts cannot be used to compare across organization. The JCHEN will not use them that way either, nor will these be shared with anyone but your own organization.
- Not all "harms" are equal. Depending on the measure, high numbers for some measures are not necessarily worse than low numbers on other measures.
- This is not a statistical process control chart, so we don’t really want to draw comparisons between time periods (months). Without the denominator values, we don’t know if the differences are improvements, deterioration, or something in between.

At best, the chart and numbers of events offer a snapshot related to number of patients affected for a particular organization during a particular period of time.

A blank cell indicates that no data were submitted for that measure/time period.

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Measure Names:

- CAUTI-04: Catheter-Associated Urinary Tract Infection per 1000 Catheter Days (CAUTI) Event
- CLABSI-05: Central Line-Associated Bloodstream Infection Event
- Falls-06: Total Fall Per 1000 Patient Days
- OB-02: Birth Trauma: Injury to Neonates
- OBED-01: Percent of NICU Admissions Accounted for by Early Elective Deliveries
- PRU-06: Percent of Patients with Hospital Acquired Pressure Ulcers
- Readmit-0.1: Percent 30-Day All-Cause Readmissions
- SSI-01: Percent of Clean Surgery Patients with Surgical Infection
- VAP-02: Ventilator-Associated Pneumonia (VAP) Rate per 1000 Ventilator Days
- VTE-02: Post-operative pulmonary embolism or deep vein thrombosis
- ADEHypo-01: Percent Incidence of Severe Hypoglycemic Episodes
- ADEINR-01: Percent of Patients Receiving Warfarin With INR Outside Protocol Limits
- ADEDp-01: Naloxone use in patients on opioids (ADEp-01)
- ADE-01: Adverse Drug Events per 100 Admissions