No.	Goal/Overarching Strategy/Objective/Strategy/Tactic	Assigned	Due	Baseline	Target
2	**STRATEGY: Ongoing evaluation of our patient population and areas of risk to identify innovative approaches for achieving and maintaining top-decile performance in safety**				
3	**Decrease rate of patients being admitted to Critical Care within 24 hours of admission(failure to rescue).**		**12/31/2012**	**14%**	**10%**
4	Implement failure to rescue plan	Garzon-Rivera	2/1/2012		
5	Review cases of all patient transfers to any higher acuity level of care within 24 hours of admission	Garzon-Rivera	2/1/2012		
6	Roll out EWSS hospital wide	Garzon-Rivera	2/1/2012		
7	Conduct sepsis screening	Garzon-Rivera	2/1/2012		
8	Review rapid response cases transferred to a higher level of care	Garzon-Rivera	2/1/2012		
9	Review all code blues outside of critical care	Garzon-Rivera	2/1/2012		
10	**Reduce catheter-associated infections (central venous catheters, PICCs, arterial lines, urinary catheters) CLABSI**	**Hall**	**12/31/2012**	**0.25**	**0.00**
11	**Reduce catheter-associated infections (central venous catheters, PICCs, arterial lines, urinary catheters) CAUTI**	**Hall**	**12/31/2012**	**0.95**	**0.75**
12	Implement catheter-associated infections plan	Garzon-Rivera	4/1/2012		
13	Revise policies for venous and arterial line management that are evidence based	Garzon-Rivera	2/1/2012		
14	Establish Hudson County interfacility collaborative to prevent selected infections due to medical care	DeChirico	2/1/2012		
15	Implement NHSN-CDC bundles hospital wide	DeChirico	4/1/2012		
16	Conduct mandatory annual clinical practitioner competency	Sardinas	4/1/2012		
17	Create clinical MEM and non-clinical MEM	Sardinas	4/1/2012		
18	**Reduce incidence of postoperative physiologic and metabolic derangement**	**Hall**	**12/31/2012**	**1.00**	**0.72**
19	Implement postoperative physiologic and metabolic derangement plan	Curci	3/1/2012		
20	Conduct literature search to develop standardized preventative protocol	Sardinas	1/15/2012		
21	Develop a pre-surgery/cardiac cath risk assessment	Curci	3/1/2012		
22	Add to pre-op checklist to flag at-risk patients	Curci	3/1/2012		
23	Trend and analyze patterns in cases with post-operative acute renal failure	Curci	3/1/2012		
24	**Reduce the incidence of postoperative abdominal wound dehiscence in abdominopelvic surgical patients**	**Hall**	**12/31/2012**	**3.13**	**0.81**
25	Implement postoperative abdominal wound dehiscence plan	Simeone	6/30/2012		
26	Partner with medical records to identify wounds intentionally left open vs. dehiscence secondary to complications	Simeone	1/30/2012		
27	Review all cases coded as wound dehiscence 2009-2010	Simeone	2/28/2012		
28	Identify patients at risk for wound dehiscence and post-op sepsis **(HOLD)**	Simeone	3/31/2012		
29	Develop multidisciplinary assessment tool **(HOLD)**	Simeone	3/31/2012		
30	Standardize the language for documenting changes in wound quality and wound progression **(HOLD)**	Petrucelli	5/31/2012		
31	Provide education for physicians, PAs, RNs, and medical records coders **(HOLD)**	Petrucelli	6/30/2012		
32	**Increase percent of Summit Avenue diabetic patients who have annual eye and dental exam (Delete)**	**Kharode**	**12/31/2012**	**90%**	**95%**
33	Assess patients with diabetes to see if they have had annual exams		3/31/2012		
34	Identify diabetic patients and schedule annual exams	**Kharode**	3/31/2012		
35	Add metric to performance improvement scorecard and monitor monthly	**Kharode**	3/31/2012		

Jersey City Medical Center Patient Safety Clinical Quality Council Scorecard 2012

Patient Safety

Strategy: Ongoing evaluation of our patient population and areas of riskto identify innovative approaches for achieving and maintaining top-decile performance in safety Measures	Chair	Responsible Party	Baseline	Target	Due Date	Total # of Strategic Tactics	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Decrease rate of patients being admitted to Critical Care within 24 hours of admission.(failure to rescue)	Hall	Garzon-Rivera	14%	10%	12/31/2012	5	1	5	5	5									
Reduce catheter-associated infections (central venous catheters, PICCs, arterial lines, urinary catheters) CLABSI	Hall	DeChirico	0.25	0.00	12/31/2012	5		1 0f 2	1 of 4	1 of 5									
Reduce catheter-associated infections (central venous catheters, PICCs, arterial lines, urinary catheters) CAUTI	Hall	DeChirico	0.95	0.75	12/31/2012	5		1 0f 2	1 of 4	1 of 5									
Reduce incidence of postoperative physiologic and metabolic derangement	Hall	Curci	1.00	0.72	12/31/2012	4	1	4	4	4									
Reduce the incidence of postoperative abdominal wound dehiscence in abdominopelvic surgical patients	Petrocelli	Simeone	3.13	0.81	12/31/2012	6	1	2	2 0f 2	3 0f 4									
Increase percent of Summit Avenue diabetic patients who have annual eye and dental exam (Delete)	Hall	Kharode	90	95	12/31/2012	2													

Quality

Strategy: Ongoing evaluation of our patient population and areas of risk to identify innovative approaches for achieving and maintaining top-decile performance in reported quality measures Measures	MD Chair	Responsible Party	Baseline	Target	Due Date	Total # of Strategic Tactics	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Decrease severe sepsis & septic shock mortality rate	Flores	LaForgia	36%	30%	12/31/2012	7													
Decrease cardiac cath w/o AMI ALOS DRG 287	Abed	Lester	3.13	1.70	12/31/2012	4													
Decrease Primary C-section rate	Bimonte	Reyes	32%	27.5%	12/31/2012	11	2	3	7 of 8	9 of 11									
Decrease CHF 30-day readmission rate	Abed	Baillie	22%	17%	12/31/2012	6			2 of 6	2 of 6									
Decrease AMI 30-day readmission rate	Abed	Baillie	16%	13%	12/31/2012	6			2 of 6	2 of 6									
Decrease Pneumonia 30-day readmission rate	Abed	Baillie	7.0%	6.0%	12/31/2012	6			2 of 6	2 of 6									
Decrease Behavioral health 30-day readmission rate	Chandak	Sacco	7.9%	7.0%	12/31/2012	4			4 of 4	4									
Increase HCAHPS pain management score	Ratner	Kozzi	65.0%	78.0%	12/31/2012	5	1	3	3	3 0f 5									
Decrease inappropriate use of PICC lines, MRIs and CTs	Garay	Kharode	0.0%	20.0%	12/31/2012	2													

Legend

- Meets or Exceeds Target
- Within 5% of Target Varience
- Outside Acceptable Target Varience
- No Target or Actual Results

No.	Goal/Overarching Strategy/Objective/Strategy/Tactic	Assigned	Due	Baseline	Target
37	**STRATEGY: Ongoing evaluation of our patient population and areas of risk to identify innovative approaches for achieving and maintaining top-decile performance in reported quality measures**				
38	Decrease severe sepsis & septic shock mortality rate		**12/31/2012**	**36%**	**30%**
39	Implement early identification of severe sepsis & septic shock	LaForgia	6/1/2012		
40	Create an early identification system	LaForgia	6/1/2012		
41	Create an E.D. universal application of the screening tool on all adult patients	LaForgia	6/1/2012		
42	Create an E.D. mandatory model in EDIMS	LaForgia	6/1/2012		
43	Complete E.D. early warning system upon transfer to floor	LaForgia	6/1/2012		
44	Educate MDs, NPs, residents, and hospitalists on screening tool	LaForgia	6/1/2012		
45	Utilize tool during admission process	LaForgia	6/1/2012		
46	Add screening protocol to the physician H&P – CC protocol	LaForgia	6/1/2012		
47	**Decrease cardiac cath w/o AMI ALOS DRG 287**	**Abed**	**12/31/2012**	**3.13**	**1.70**
48	**Decrease circulatory w/o AMI ALOS DRG 287 (Delete)**	**Abed**	**12/31/2012**	**3.13**	**2.40**
49	Implement cardiac cath/circulatory ALOS plan	Abed	6/1/2012		
50	Conduct multidisciplinary rounds	Abed	6/1/2012		
51	Provide dedicated MD or NP to coordinate care management	Abed	6/1/2012		
52	Create timely communication between consultant, attending, surgeon, and interventionalist	Abed	6/1/2012		
53	Provide feedback to MD with highest LOS using Crimson report	Lester	6/1/2012		
54	**Decrease Primary C-section Rate**	**Bimonte**	**12/31/2012**	**32%**	**27.5%**
55	Implement C-section plan	Bimonte	3/31/2012		
56	Provide peer review for all C-section cases	Bimonte	1/30/2012		
57	Conduct analysis of C-section cases and identify root causes	Lester	1/30/2012		
58	Develop action plan based on root cause findings	Lester	2/28/2012		
59	Implement action plan and control plan	Lester	3/31/2012		
60	Eliminate all elective deliveries before 39 weeks	Bimonte	3/31/2012		
61	Continue elective induction bundles	Bimonte	3/31/2012		
62	Continue elective C-section bundles	Bimonte	3/31/2012		
63	Implement baby-friendly breastfeeding plan	Bimonte	3/31/2012		
64	Develop baby-friendly breastfeeding policy	Bimonte	3/31/2012		
65	Disseminate baby-friendly breastfeeding information to physician offices and hospital staf	Bimonte	3/31/2012		
66	Educate on skin-to-skin at birth	Bimonte	3/31/2012		
67	Provide lactation consultants to support patients and staff	Bimonte	3/31/2012		
68	Provide discharge planning and follow up	Bimonte	3/31/2012		

69	**Decrease CHF 30-day readmission rate**	**Baillie**	**12/31/2012**	**22%**	**17%**
70	**Decrease AMI 30-day readmission rate**	**Baillie**	**12/31/2012**	**16%**	**13%**
71	**Decrease Pneumonia 30-day readmission rate**	**Baillie**	**12/31/2012**	**7%**	**6%**
72	Partner with physicians and office managers and volunteers for follow up appointments w	Lester	3/31/2012		
73	Strengthen post-acute care team encouraging: Higher-level practitioners	Baillie	3/31/2012		
74	Strengthen post-acute care team encouraging: Use of early-warning signs and tools	Baillie	3/31/2012		
75	Strengthen post-acute care team encouraging: Use of nurse-to-physician communications	Baillie	3/31/2012		
76	Strengthen post-acute care team encouraging: Explore and engage insurance providers in	Baillie	3/31/2012		
77	Strengthen post-acute care team encouraging: Research use of high-risk for re-admission t	Baillie	3/31/2012		
78	Enhancing teaching process via “Ask Me Three” program (HOLD)	Lopez	3/31/2012		
79	**Decrease Behavioral health 30-day readmission rate**	**Sacco**	**12/31/2012**	**7.9%**	**7.0%**
80	Implement behavioral health 30-day readmission plan	Sacco	3/31/2012		
81	Utilize clinical home model to identify frequent users of acute psychiatric care and collabo	Sacco	3/31/2012		
82	Decrease time to first outpatient appointments	Sacco	3/31/2012		
83	Decrease no-shows	Sacco	3/31/2012		
84	Increase treatment retention	Sacco	3/31/2012		
85	Expand shared decisionmaking pilot to include more consumers (DELETE)	Sacco	3/31/2012		
86	**Increase HCAHPS pain management score**	**Ratner**	**12/31/2012**	**65.0%**	**78.0%**
87	Implement pain management plan	Ratner	4/30/2012		
88	Continue participation in NDNQI pain prevalence study taking place on 6 West, 6 East, 7 W	Kozzi	1/30/2012		
89	Implement new MAR specific to pain medication administration	Ajose	2/28/2012		
90	Provide education for RNs during competency days	Kozzi	2/28/2012		
91	Provide hospital-wide awareness by acting out difficult pain management scenarios	Kozzi	3/31/2012	**Engagement**	**Council**
92	Solidify pain management consultation process with the hospitalist service and educate st	Ratner	4/30/2012		
93	Provide information regarding pain medication scheduling on white boards	Ajose	4/30/2012		
94	**Decrease inappropriate use of PICC lines, MRIs and CTs**	**Garay**	**12/31/2012**	**0.0%**	**20.0%**
95	Implement utilization reduction plan	Garay	6/30/2012		
96	Develop plan to reduce inappropriate use of PICC lines	Garay	6/30/2012		
97	Develop plan to reduce inappropriate use of MRIs and CTs	Garay	6/30/2012		

Jersey City Medical Center Patient Safety Clinical Quality Council Scorecard 2012

Patient Safety

Strategy: Ongoing evaluation of our patient population and areas of riskto identify innovative approaches for achieving and maintaining top-decile performance in safety	Baseline	Target	Chair	Responsible Party	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
Patient safety - Strategic Plan Measures																
Decrease rate of patients being admitted to Critical Care within 24 hours of admission. (failure to rescue)	14%	10%	Hall	Garzon-Rivera	14%	9%	18%									
Reduce catheter-associated infections (central venous catheters, PICCs, arterial lines, urinary catheters) CLABSI (Hospitalwide)	0.25	0	Hall	DeChirico	0.94	0	0									
Reduce catheter-associated infections (central venous catheters, PICCs, arterial lines, urinary catheters) CAUTI (Hospitalwide)	0.95	0.75	Hall	DeChirico	0	0	0									
Reduce incidence of postoperative physiologic and metabolic derangement	1.00	0.72	Hall	Curci	0	22.2	0									
Reduce the incidence of postoperative abdominal wound dehiscence in abdominopelvic surgical patients	3.13	0.18	Petrocelli	Simeone	0	0	0									
Increase percent of Summit Avenue diabetic patients who have annual eye and dental exam **(Delete)**			Hall	Kharode												
2011 - Strategic/ Regulatory					Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
1. Rate of healthcare-associated infections with clostridium	0.30	0.25	Hall	Dr. Grigoriu	0.26	0.57	0.28									
2a. Falls Rate (Falls/1000patient days): Med-Surg/CC	4.15	2.4 or <	Hall	P. Petrucelli	5.26	4.02	2.08									
2b. Falls Rate (Falls/1000patient days): Behavioral Health	4.49	4.05	Hall	P. Petrucelli	3.3	5.88	4.18									
3. The percent of patient encounters in which care-givers perform with all three key hand hygiene procedures correctly.	86%	88%	Hall	V. DeChirico	85%	88%	87%									
4. MRSA Infection Rate (hospital acquired)	0.10	0.05	Hall	V. DeChirico	0.00	0.14	0.14									
5. Elective induction bundle compliance:	100%	100%	Hall	L. Reyes/ Dr. Bimonte	100%	100%	100%									
6.Elective Induction	16%	15%<	Hall	R. Dalalian/ Dr. Bimonte	10.3%	14%	14%									
7. Rate of Adverse Drug Events using IHI trigger tool. (HR e-i)	0	0	Hall	M. Curci	0	0	0									
8. PCI in 90 minute compliance.	100%	100%	Hall	L. Semenoff	100%	100%	100%									
9. Total number of codes outside critical care/ED.	3.75	0	Hall	C. Garzon-Rivera	3	4	8									
10.. RRT calls per 1000 discharges	18	25	Hall	C. Garzon-Rivera	38.6	23.4	44									

Quality

Measure	Baseline	Target	Chair	Responsible Party	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
QUALITY - Strategic Plan Measures																
Decrease severe sepsis & septic shock mortality rate	36%	30%	Flores	LaForgia	27%	36%	21%									
Decrease cardiac cath w/o AMI ALOS DRG 287	3.13	1.70	Abed	Lester	2.55	3.79	3.35									
Decrease Primary C-section rate	32%	27.5%<	Bimonte	Reyes	18%	30%	16.4									
Decrease CHF 30-day readmission rate	22%	17%	Abed	Baillie	22%	30%										
Decrease AMI 30-day readmission rate	16%	13%	Abed	Baillie	16%	13%										
Decrease Pneumonia 30-day readmission rate	7%	6%	Abed	Baillie	12%	4%										
Decrease Behavioral health 30-day readmission rate	7.9%	7% or <	Chandak	Sacco	8.5%	5.7%	2.4									
Increase HCAHPS pain management score	65.0%	78.0%	Ratner	Kozzi	62%	70%	64%									
Decrease inappropriate use of PICC lines, MRIs and CTs	0.0%	20.0%	Garay	Kharode												
2011 Strategic / Regulatory					Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
1. Pressure Ulcer: Pressure ulcer incidence (Med-Surg).	0	2.8		P. Petrucelli	After 1st Quarter											
2. Pressure Ulcer: Pressure ulcer incidence (ICU/CCU)	0	7.0		P. Petrucelli	After 1st Quarter											
3. AMI appropriate care score.	100%	100%		Dr. Abed	100%	100%	100%									
4. CHF appropriate care Score.	100%	100%		Dr. Abed	100%	100%	100%									
5.. SCIP appropriate care score.	100%	100%		Dr. Holmes	100%	100%	100%									
6. PNEUMONIA appropriate care scorecard	100%	100%		Dr. Bessette	100%	100%	100%									
7. STROKE Defect Free Score	100%	100%		M. Lopez	100%	100%	100%									
8. Immunizations appropriate care score	na	100%		Nurse Mgr	70.2%	82.8%	78.7%									
9. IED appropriate care score	na	na		Dr. Bessette												
10. OET appropriate care score	na	100%		Dr. Bessette	37.8%	100%	99.2									
11. OED appropriate care score	na	na		Dr. Bessette												
12. OPM appropriate care score	na	na		Dr. Bessette												
13. OST appropriate care score	na	na		Dr. Bessette												
14. VAP rate	0.62	0.31		C. Garzon-Rivera	0.00	0.00	3.56									

Legend

- (Green) Meets or Exceeds Target
- (Yellow) Within 5% of Target Varience
- (Red) Outside Acceptable Target Varience
- (Light blue) No Target or Actual Results