

Quality Collaborative

A Partnership Sponsored by the Greater New York Hospital Association and the United Hospital Fund

Challenging the Next Generation of Antibiotic Resistance

While the dangers of incorrectly prescribing or using antibiotics—including the growth of antibiotic-resistant “superbugs”—are becoming better understood, how to address the problem has become a growing challenge for hospitals, nursing homes, and other health care providers. Changing patterns of resistance makes it difficult to define and implement prudent antibiotic-prescribing practices. It is an obstacle familiar to the Greater New York Hospital Association (GNYHA) and United Hospital Fund (UHF), who partnered in 2010 to help acute care and long-term care facilities establish

antimicrobial stewardship programs for effectively managing antibiotic use.

To address today’s challenges, GNYHA and UHF are partnering once again, with the support of a UHF grant. Together, they will work with metropolitan-area hospitals to assess current practices, barriers to optimal antibiotic use, and the need for stewardship programs. The findings will inform further guidance for hospitals and other health care providers that can benefit most from it.

GNYHA and UHF will also develop a learning network to support stewardship programs in area hospitals. Participating hospitals will benefit from the expertise of pharmacy and infectious disease specialists, key revisions to a toolkit of resources created in 2010, and additional technical support.

The new effort is being designed to complement recent work by the Centers for Disease Control and Prevention, which has created an electronic database—the Antibiotic Use and Resistance Reporting Module—to track and control drug-resistant bacteria nationwide. The database will also offer the first antibiotic-prescribing index, which can be used to identify regional prescribing patterns and track results and inform best practices.

Making Strides on Avoidable Readmissions

At its one-year anniversary, the *IMPACT (IMprove Processes And Care Transitions)* to Reduce Readmissions Collaborative is living up to its name. The 19 hospitals and 28 nursing homes participating in the collaborative are reporting significant strides on improving communications between the two types of institutions—a key to achieving the initiative’s goals—with programmatic support from the Continuing Care Leadership Coalition, a GNYHA affiliate.

Established in early 2014 by GNYHA and UHF, the collaborative is helping participants create specific processes for improving the transfer of patients between nursing homes and hospital emergency departments or inpatient care, and back again, and to embed those processes in each institution’s practice. Gathering in December 2014 to share successes, challenges, lessons learned, and plans for sustainability, nine of those partnerships reported achievements including:

- Dedicated communication lines between nursing homes and hospitals;
- New tools to improve communication and information transfer between settings;

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The Power of Mutual Respect, a Culture That Sustains Quality

GUEST COLUMNIST

Pamela Brier
President and Chief Executive Officer
Maimonides Medical Center

Recognizing the importance of teamwork to patient-centered care, we at Maimonides Medical Center have worked for more than a decade to build a culture of mutual respect among all staff, from physicians and nurses to clerical and other support services staff. Creating an environment in which a culture of mutual respect could flourish was not easy; it has taken patience, constant nurturing, and a collective sense of humor. Initially, there was reticence on the part of clinicians, nurses, and other staff, but together with our clinical and administrative leadership, we were able to engage most of our faculty and voluntary clinicians who now demonstrate their commitment to the culture of mutual respect by monitoring hotlines, coaching one another, and collaboratively solving problems.

The GNYHA and UHF performance improvement collaborative model makes a great deal of sense for our approach and has enormously benefited the Maimonides staff. The project facilitation and feedback provided by GNYHA and UHF have been effective and valuable, as has the creation of a forum for learning successful strategies from other institutions working on the same issue, through the various improvement collaboratives. The network of local experts from other hospitals developed by GNYHA and UHF has helped us identify patient safety interventions that

can sustain our improvement efforts. The Maimonides approach is to identify unit-specific problems using data, and then pilot-test evidence-based interventions where we support the multidisciplinary team as they address the problem. We apply this team- and unit-based approach to a range of challenges, including identifying patients at risk for readmission, starting well before they are discharged—and then, roll out the intervention across other units.

The NYS Partnership for Patients (NYSPFP) is a recent illustration of how Maimonides put its core values of respect for the patient, family, and all staff members into action. With help and coaching from GNYHA and UHF, Maimonides was able to realize significant achievements in improving outcomes, including a 46% reduction in hospital-acquired venous thromboembolism rates between 2010 and 2014, and zero central line-associated bloodstream infections in the intensive care unit between 2013 and 2014. Such accomplishments have helped enhance our focus on patient outcomes, including their careful measurement, and dedication to teamwork and mutual respect, to ensure a productive and satisfying work environment and advance patient care.

The work GNYHA and UHF have done over the last year through the *IMPACT* to Reduce Readmissions Collaborative has further helped our own patient safety and quality improvement efforts. The *IMPACT* Collaborative has proven particularly useful as we've moved our core values into the

nursing homes with which we share patients and, by extension, to home care programs, and other community-based organizations as well.

In the end, combining true workforce collaboration at all levels, including our clinical leadership, with a culture of mutual respect at its core will help Maimonides continue to provide optimal care to the patients and families we serve. And, our true collaboration with the talented staff at GNYHA and UHF has helped move us toward that goal. ■

Federal Proposal Submitted to Continue Quality Improvement Work

GNYHA, Healthcare Association of New York State, and United Hospital Fund have submitted a proposal to the Centers for Medicare & Medicaid Services to continue the collaborative work they led for three years under the NYS Partnership for Patients. The proposal is a response to a federal request for proposals issued in February.

“We look forward to working with New York hospitals in this new phase of the NYS Partnership for Patients,” said Lorraine Ryan, Senior Vice President for Legal, Regulatory, and Professional Affairs at GNYHA. ■

Further in Their Careers, Fellowship Graduates Still Apply Lessons Learned

GNYHA and UHF's Clinical Quality Fellowship Program has been preparing mid-career physicians and nurses to take the lead in hospital-based clinical quality improvement since 2009. But what are the training's long-term benefits? We spoke with two graduates of the 2011–12 class to get their perspectives.

Quality Collaborative: How did the Clinical Quality Fellowship Program fit into and enhance your career?

Barbara Barnett, MD, Chief Medical Officer of Mount Sinai Beth Israel:

Before I assumed my new position, I spent most of my career as a residency director. Occasionally, clinical situations came along that proved frustrating because I did not have the tools to lead performance improvement work. Through the Clinical Quality Fellowship Program, I learned how to implement change and question the status quo. You learn how to run a meeting—leave titles at the door, have the right people at the table, get administrative support. I got the tools to engage people.

As an example, I was very frustrated with the way we handled sickle-cell patients in the emergency department; more than 90 percent were admitted to the hospital, and while many of them really needed inpatient care, there were others who could be treated and sent home, which is preferable when possible. We mapped out a different clinical process for these patients and implemented and tested rapid cycles of change to address problems we found. As a result, the admission rate declined—only between 70 and 80 percent were admitted—and length of stay for those admitted also went down.

I am pleased that the sickle cell work we did at LIJ has continued since I left, and we at Mount Sinai Beth Israel are looking to replicate this process.

QC: To share a sense of how the skills you learned continue to shape your work, can you give an example of some of your recent quality improvement work?

BB: One of The Joint Commission's core quality measures was to reduce what's known as "door-to-balloon time"—the time it takes to get certain patients with myocardial infarction, or heart attack, from the emergency room door to the insertion of a catheter guidewire with balloon (into a blocked artery, in order to restore blood flow). A key step in the process is the rapid processing of EKG tests.

When I was first presented with the challenge of shortening door-to-EKG test time, I thought the answer was simply getting more EKG technicians. But one important lesson I learned from the fellowship program is, don't assume you know the answer. Through our team's process-mapping analysis, we learned that following the EKG, the technicians routinely made a second copy of the EKG, folded it, put it in a bag, and left it at the desk, adding three minutes to the task. We discovered that we no longer needed these steps since EKGs have gone electronic, and were able to decrease processing time and critical minutes to treatment. As time-consuming as process mapping can be, we use it with every project to uncover all the nuances buried in a process.

QC: Like Dr. Barnett, you have also enjoyed an increase in responsibility since

completing the Clinical Quality Fellowship Program, haven't you?

Michael D. Gitman, MD, Medical Director of North Shore University Hospital: At the time I applied to the fellowship program, I was associate chair of the Department of Medicine of Long Island Jewish Medical Center. The program provided the career development I needed and put me in touch with its faculty mentors. I got to ask, "What were their jobs? Where did they go for answers?" These relationships were extremely helpful.

But the key takeaway was the value of teamwork. Most doctors know how to work well alone, but rarely receive specialized training in how to lead or sponsor a quality improvement initiative, which requires teamwork.

QC: Can you give an example of a recent project in which you are still applying lessons learned from the program, in your case, teamwork?

MG: We have been working with the Institute for Healthcare Improvement on improving family meetings—in which goals and the plan of care are documented—of patients in our respiratory care unit. When these patients come to the respiratory care unit, often from an intensive care unit, many have unrealistic expectations, thinking they will go home quickly. We are working on improving how meetings are triggered, scheduled, and run to promote better patient and family engagement.

In the past, we found coordinating family meetings was difficult because schedules of physicians and other members of the team can be challenging. Not

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IMPACT (continued)

- Earlier identification, in nursing homes, of clinical symptoms and signs;
- Electronic solutions to facilitate communication across settings; and
- Triggers for palliative care consults.

“Warm” Handoffs Smooth Communication

One highlight was a threefold increase in “warm”—i.e., live communication—handoffs between clinicians in charge of hospital discharges and their nursing home counterparts in charge of admissions, minimizing errors due to miscommunication.

Implementation of standardized communication processes has increased as well, with a focus on transfers between nursing homes and emergency rooms. Despite the challenge of obtaining buy-in from clinical staff dispersed through multiple shifts, many teams have adopted transfer tools that readily summarize vital data.

What’s Ahead?

Along with this progress has come identification of new and ongoing challenges, including the need for education and training on effectively incorporating patients, family members, and caregivers in care transitions, and on

the goals of care discussions—issues that will be addressed in the collaborative’s next phase.

An exciting addition to the collaborative’s agenda has come with the inclusion, this year, of five hospital and home care provider partnerships. These teams will focus on *IMPACT*’s Phase 1 goals, as the original participants did, to improve transitions from hospital back into the community as well, expanding the collaborative’s focus across the continuum of care.

They’ll do that with GNYHA project manager and technical support helping them implement evidence-based interventions, including (but not limited to):

- Supporting direct handoffs between hospital clinicians and those who will be providing in-home care;
- Ensuring home care provider contact with patients within 24–48 hours of hospital discharge;
- Increasing the capacity of home care staff and family caregivers to recognize changes in patients’ conditions; and
- Leveraging health information technology to more effectively exchange clinical information with home health care providers.

For more information about the *IMPACT* Collaborative, contact Lorraine Ryan or Kelly Donohue at GNYHA. ■

Resistance (continued)

In an earlier project, GNYHA and UHF, in collaboration with the New York State Department of Health, provided guidance and other support to three hospitals that partnered with three long-term care facilities and collaboratively tested strategies to manage antibiotic use. One important product was an extensive toolkit supporting the development of

antimicrobial stewardship programs. A second toolkit was produced as part of a complementary project, through which GNYHA and UHF collaborated with Boston University School of Public Health and Montefiore Medical Center to determine the effectiveness of different antibiotic management strategies in reducing *C. difficile* infections. These toolkits and the related work provide the foundation for the new project. ■

Fellowship (continued)

surprisingly, family members often couldn’t attend meetings at the one time that was best for clinicians. So we have changed the planning to focus on the family members’ schedules and make sure they can attend.

We also found the organization of the meeting could be improved. In the past, the clinical team would guide the discussion. Our assessment determined that this did not serve families as well as it could; they need more opportunity to express their thoughts and feelings, which can be documented and shared with the entire team. This change has made such a positive difference, we are rolling it out to other units.

We found that leading an effective family meeting is difficult; not all physicians have been taught communication skills. So, initially, we had our palliative care physicians lead the discussion, not because palliative care was needed, but rather because they had the skills to communicate what is important with the family. Through this experience, other physicians on the team have learned how to lead meetings. As our next step, we plan to use our simulation center to teach these skills to more physicians. ■

Quality Collaborative

Quality Collaborative is published three times a year, covering the efforts of the UHF/GNYHA partnership to improve hospital quality of care and patient safety.

GNYHA is a trade association representing nearly 250 hospitals and continuing care facilities, both voluntary and public, in the metropolitan New York area and throughout the State, as well as New Jersey, Connecticut, and Rhode Island.

United Hospital Fund (UHF) is a health services research and philanthropic organization whose primary mission is to shape positive change in health care for the people of New York.

