

Quality Collaborative

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

IMPACT Collaborative Wraps Up

The *IMPACT (IMproving Processes And Care Transitions)* to Reduce Readmissions Collaborative held its culminating session in October 2016, celebrating three years of improving transitions across care settings. Developed in 2014 by GNYHA and UHF, the Collaborative initially focused on improving transitions between hospitals and nursing homes, streamlining efforts to coordinate care and reduce avoidable readmissions and transfers to the emergency department. In February 2015, the Collaborative expanded its scope to add home health care organizations.

GNYHA, in conjunction with its long-term care affiliate, the

Continuing Care Leadership Coalition (CCLC), supported 19 participating hospitals and their 28 nursing home partners in making strides toward the Collaborative's goals:

- building and strengthening relationships
- developing standardized processes for communication and information transfer between care settings
- incorporating patients and caregivers in the care transition process

While the first two years of the Collaborative focused on creating a strong foundation for communicating across facilities, the third, final year helped teams home in on problem areas and effectively hard-wire changes to administrative and clinical processes.

Assessment data and anecdotal feedback from hospital and nursing home teams indicate that evidence-based care transition processes are being put into practice. Specific milestones include:

- dedicated communication lines between nursing homes and hospitals
- new tools to improve communication and information transfer between care settings
- earlier identification of clinical symptoms of patient deterioration in the nursing home
- a checklist of signs that trigger palliative care consultations

The past year's programming focused on executing "warm" handoffs, increasing clinical capacity in the nursing home, and

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Culminating Session

On October 27, 2016, GNYHA hosted the *IMPACT* Collaborative In-Person Culminating Session for participating hospitals, nursing homes, and home health care organizations. The 30 attendees highlighted best practices related to sepsis prevention, community-based palliative care, and electronic solutions for care transitions and handoffs. GNYHA also distributed a toolkit with materials that were compiled and developed based on hospital and post-acute care providers' experiences with the *IMPACT* Collaborative.

GNYHA and UHF are proud of the accomplishments achieved by this dedicated group. This multi-year effort meant finding common ground across provider culture and communication styles to ensure the safety and well-being of patients as they transition across care settings.

New York State Partnership for Patients Continues Hospital Engagement in CMS Initiative

The New York State Partnership for Patients (NYSPFP), a joint initiative of GNYHA and the Healthcare Association of New

York State, is transitioning to a new phase of the Centers for Medicare & Medicaid Services (CMS) Partnership for Patients initiative. September 23rd marked the end of the Hospital Engagement Network (HEN) 2.0 program, in which 150 hospitals achieved significant reductions in adverse events and costs.

The 2015–16 HEN 2.0 initiative was a continuation of HEN 1.0, or the first wave of the Partnership for Patients, which ran from 2011 to 2014. The overarching goals of the program were to reduce hospital-acquired conditions by 40% and preventable readmissions by 20%, each from a 2010 baseline. Hospitals participating with the NYSPFP exceeded the 40% goal in several conditions, including device-related infections and surgical site infections, with significant improvements in almost all other topic areas. Hospitals also came close to meeting the CMS readmissions goal, reducing potentially preventable readmissions by over 16%.

Over the course of the four-year HEN program, UHF provided support to the NYSPFP through hands-on project management and technical assistance focused on performance improvement to a cohort of hospitals

in New York City. Additionally, UHF's expertise in infection prevention helped to shape programming designed to reduce the number of hospital-acquired infections.

and nationally, hospital-specific data analysis and dashboards, and information sharing through a statewide network of motivated hospitals. ■

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On September 29, CMS awarded the NYSPFP a new Hospital Improvement Innovation Network (HIIN) contract, which will allow the partnership—together with IPRO, already a strong NYSPFP ally and now a HIIN subcontractor—to continue its work in supporting hospitals' patient safety and quality efforts. Under this new contract, the NYSPFP hopes to build on participating hospitals' momentum to achieve the new CMS goals of reducing hospital-acquired conditions by 20% and readmissions by 12%, each from a 2014 baseline. In this project, GNYHA and its partner organizations will continue to offer individualized and on-site support, comprehensive education and training opportunities, conferences and webinars with patient safety and quality leaders both locally

IMPACT (continued)

engaging the patient/family caregiver in advance care planning.

Advance care planning and goals of care continue to challenge many Collaborative participants. To address this, GNYHA held three educational sessions focused on the need to incorporate the patient and family/caregiver into the care transition process, the need for advance care planning prior to hospital discharge and in the nursing home, and the benefits of palliative care for the patients/residents. Guidelines and the requirements for using Medical Orders for Life-Sustaining Treatment, an alternative form of advance directive authorized by New York State regulation, were discussed in depth. ■

Clinical Fellows Look Beyond Inpatient Care

Recognizing the growing importance of integrated care settings, the GNYHA/UHF Clinical Quality Fellowship Program is turning more attention to challenges in outpatient and ambulatory settings. The program, which aims to identify and develop the next generation of clinical quality leaders across the greater New York region, hopes to recruit approximately 25% of its new fellows from outpatient settings for the next class, which begins in January 2017. Additionally, the curriculum will include more content specific to ambulatory care quality measurement and improvement.

We spoke with two current fellows whose “capstone projects” address outpatient and ambulatory issues about their projects.

Quality Collaborative: How did you come up with the idea of focusing on outpatient care for your project?

David Hirschwerk, MD, Northwell Health North Shore University Hospital: As an infectious disease physician, I see patients in both inpatient and outpatient settings; patients taking IV antibiotics are a vulnerable population when moving from one to the other. They get lots of attention as inpatients, but that structure can drop away at discharge. If patients aren’t seen in the right period after hospitalization, it can lead to complications or readmissions. The goal of my project is to improve follow-up from hospital to home for patients taking IV antibiotics.

After surveying the 13 doctors in my practice group, I found variation in how we arrange follow-up appointments and interest in making the procedure uniform. I audited the records of patients’ transition from inpatient to outpatient care, and I found

opportunities to improve the reliability of getting them seen in the office.

QC: What are some steps you are taking to improve the follow-up once the patient moves to an outpatient setting?

DH: Knowing that a simple technical solution would be popular with my colleagues, and the fact that we all have smartphones, I made a straightforward PDF form for everyone’s phones. The form has fields for patient demographics, reason taking IV antibiotics, clinical condition, duration of therapy, when lab work is expected, and when the patient needs to be seen again. The form gets e-mailed to our department’s administrative staff, who then schedule appointments, notify the primary care provider, and get follow-up appointments into the hospital system. For the administrative staff, this is great—it reduces hospital phone traffic a lot.

With this new system, we are making sure there’s a follow-up plan at the time of discharge. We saw this as an opportunity to re-coordinate care. We are a prominent part of the care team when patients are in the hospital and help coordinate their care. But it’s harder for us fill this role once our patients leave the hospital. If this project works, I hope it can be adopted by other subspecialties. There are lots of opportunities to bolster and enhance the way we take care of transitions.

QC: How has your project focused on outpatient care?

Stephanie Muylaert, MD, NewYork-Presbyterian Weill Cornell Medical

Center: It is my goal to decrease the total length of my glaucoma patients’ visits by 30%. Making care delivery more efficient

can improve patient safety and satisfaction, naturally, but it also has benefits for patient access—it lets us see more patients.

I started with mapping patients’ paths through the office. The data helped us isolate specific delays along the path. After talking with the team, we decided to try two approaches: a scheduling change (eliminating double-booking) and a staffing change (assigning an additional “flex” tech to be available during peak times). Involving the technicians in the decision to try both approaches was helpful for buy-in.

QC: What have the obstacles been?

SM: I had support from departmental leadership, but it was critical to “create buzz” and a sense of ownership of the project among the techs and ancillary staff. The best ways to get buy-in are to use the data (showing that problems exist, and where) and to understand staff’s motivations and incentives.

Having a doctor on board to be a “physician champion” of quality improvement efforts is hugely important. You also really have to be thoughtful about leadership structures and how to work within them—understanding your organization and individual work incentives helps identify who’s going to be most effective for a certain change.

QC: Where do you see your project headed?

SM: Once we have tested the changes, we will get buy-in from the other doctors in standardizing procedures—logistical matters of testing, emergency visits, surgical scheduling, and other protocols. There’s a real opportunity in ophthalmology for efforts like this—most quality work in this field focuses on clinical outcomes, not process. ■

Successful Antibiotic Stewardship Initiative Concludes at Hospitals and Begins at Nursing Homes

GNYHA and UHF hosted a well-attended symposium on their Antibiotic Stewardship Program (ASP) in November, featuring guest speakers from the Centers for Disease Control and Prevention (CDC), the Louis Stokes Cleveland Veterans Affairs Medical Center, and Case Western Reserve University. Program faculty presented on successes from the past 18 months of inpatient activities and future work in antibiotic stewardship in the long-term care setting.

The symposium officially concluded the hospital ASP initiative and launched a new effort for long-term care providers. Over the coming months, GNYHA/UHF will work with nursing homes to increase awareness of antibiotic prescribing, use, and stewardship practices and support improvement efforts through policies and direct intervention; an additional recent one-year grant from UHF to GNYHA will support these efforts. GNYHA/UHF will invite nursing homes from GNYHA's long-term care affiliate, the Continuing Care Leadership Coalition, as well as the New York–Reducing Avoidable Hospitalizations project (funded by the Centers for Medicare & Medicaid Services), to participate in an ASP certificate training program. These nursing homes are currently working on improving transitions and implementing policies that will reduce utilization related to six high-impact conditions. The curriculum for the new initiative will offer an opportunity to participate in the

ASP Certificate Program to incorporate strategies for combating antibiotic resistance and increasing appropriate antibiotic prescribing in the nursing home setting. The value of such training is clear: in nursing homes, 40–75% of antibiotics are prescribed incorrectly, and nearly 50% of antibiotics may be given longer than necessary.*

The nursing home initiative replicates the successful GNYHA/UHF strategy in hospitals, which trained more than 200 clinicians from over 80 hospitals. Participating hospitals notably advanced their inpatient antibiotic stewardship efforts by using a collaborative approach to both identify immediate opportunities for improving antibiotic use and leverage the resulting improvements to adopt facility-wide policies.

As with the hospital initiative, the nursing home program will emphasize a multidisciplinary team approach to ensure the proper use of antimicrobials, identify target antibiotics to monitor, and reduce illness caused by multidrug-resistant organisms. The program will offer practical coaching on opportunities to curb antibiotic misuse and overuse related to specific conditions and patient populations. Program faculty will provide guidance and support to participants as they develop plans to test and implement antibiotic stewardship interventions. Finally, the program will require an institutional commitment to conduct the following activities:

- Commit clinical staff to attend the GNYHA/UHF certificate training program and act as the institutional champions for antibiotic stewardship
- Complete an assessment of the nursing home's current antibiotic stewardship practices
- Conduct point-in-time studies directed by the program faculty to identify areas of opportunity
- Select, develop goals for, and implement one or more nursing home antibiotic stewardship core elements derived from the CDC Core Strategies
- Participate in GNYHA/UHF educational webinars on ASP implementation strategies

GNYHA and UHF's intent with the structure of the overall program and, in particular, the requirement to commit personnel, is to help nursing homes develop a sustainable infrastructure and implement practices to combat antibiotic resistance. ■

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 more than 160 member hospitals and health systems, in the metropolitan New York area and throughout the State, as well as New Jersey, Connecticut, and Rhode Island.

United Hospital Fund is an independent, nonprofit organization working to build a more effective health care system for every New Yorker.



*Daneman N et al. April 2013. Prolonged Antibiotic Treatment in Long-term Care. *JAMA Intern Med* 173(8):673–82.