IPRO Quality Awards

Each year IPRO recognizes outstanding achievement by healthcare providers and stakeholders throughout New York State with our Quality Awards.

We salute the 2018 honorees.

Data Longjohn, MD, Skope Medical Care P.C.

INTERNAL MEDICINE

In recognition for quickly developing and implementing well organized systems to monitor, assess, and improve the quality of care they deliver to their patients.

ABOUT SKOPE MEDICAL CARE PC

Skope Medical Care PC has been serving the Wyandanch community and surrounding areas for 17 years. The practice offers comprehensive primary care services. Dr. Data Longjohn works hard to deliver high quality and cost-effective care in a welcoming environment. The practice is committed to providing quality care to patients and their families by educating them about their well-being and how they can become engaged partners in their care.

BACKGROUND AND OBJECTIVES

- Skope Medical Care PC enrolled in the New York State Department of Health's Advanced Primary Care (APC) project through its partnership with Northwell Health.
- The APC project is an integrated care delivery and payment model that ties together service delivery and reimbursement to promote improved health and health care outcomes that are financially sustainable.
- The specific goal of APC is to promote comprehensive, patient-centric primary care in an effective collaboration among primary care, other clinical care (known as "the medical neighborhood") and community-based services.
- The Department of Health places a deliberate focus on coordinated care for patients with complex needs, with an effective use of health information technology (HIT), including electronic health records, data analytics, and population health tools. Financial and technical support is offered to primary care practices in the transformation to advanced primary care.
- A shift is made from encounter-based payment to alternative payment systems that support the services and infrastructure needed for advanced primary care. Performance measurement is intended to be focused, aligned and meaningful to patients, payers and clinicians.

APPROACH

IPRO developed a customized curriculum with Skope Medical Care PC that incorporated training and guidance to implement workflow changes and achieve transformation milestones.

- Skope Medical Care PC first provided an initial self-assessment tool that allowed IPRO to better understand the practice.
- IPRO and Skope Medical Care PC worked together to outline a plan that focused on the practice's areas of competency, as well as areas needing improvement.
- The two organizations collaborated closely to fulfill the goals of APC, which required the practice to move through several transformation milestones.
- Skope Medical Care PC worked diligently with IPRO to demonstrate progress toward achieving APC. The practice implemented various workflow redesigns, which allowed them to capture the data needed to demonstrate evidence of areas of improvement. For example, the practice implemented new workflows for capturing after-hour telephone encounters, tracking referrals, documenting telephone encounters, tracking completion of advance directives, implementing a patient satisfaction survey, creating care plans, and established methods for tracking various measures for quality improvement and population management. The practice had both clinical and non-clinical staff trained on these new office protocols.
- Skope Medical Care PC was very engaged in fulfilling the goals of APC, as demonstrated by incorporating ideas and suggestions made by IPRO into its daily workflow.
- Quality reports on core measures were also undertaken to track improvements.

Data Longjohn, MD, Skope Medical Care P.C.

(continued)

RESULTS

Skope Medical Care, PC had a relative improvement rate of 32% for influenza immunizations given, comparing 2016–17 to 2017–18.

CONCLUSIONS

Skope Medical Care PC faced challenges in attempting to maximize the benefits of using its electronic health record (EHR) for patient engagement and tracking quality improvement initiatives. At the beginning of the transformation, the practice was not optimizing the use of the EHR for care coordination, population management, care plan tracking, referral tracking, quality measure tracking, and patient engagement. The practice was not aware of certain capabilities and how to use various functions, such as the patient portal, using the registry for population management, developing care plan templates, and telephone encounters to track care coordination.

IPRO assisted the practice with incorporating these functionalities into its workflow. Skope Medical Care PC developed better workflow for patient engagement and put together best practices to ensure that their patients became more engaged in their overall health.

Throughout the course of the project, Skope Medical Care PC created well-organized workflows and tracked progress to ensure better outcomes. IPRO tracked the improvement of influenza immunization as one quality measure, and saw an increase in the number of patients who received the vaccine due, in part, to modifications in practice protocols. The practice also saw an increase in the number of patients who completed their advance directives, improved referral tracking and developed workflows for population management. The sustainability of APC will allow the practice to more easily achieve New York State Patient Centered Medical Home recognition in the coming months.

The members of the team included

- Dr. Data Longjohn
- Office Manager Dawari Longjohn, RN.

Louis A. Buzzeo, MD

In recognition of exemplary performance, commitment to continuous quality improvement, patient and family engagement, and dedication to ensuring that all individuals receive the care they need and deserve.

ABOUT LOUIS BUZZEO, MD

Louis Buzzeo, MD operates a medical office in Sleepy Hollow, New York. He practices general internal medicine, specializing in hypertension and kidney disease, and is one of two nephrologists associated with Phelps Memorial Hospital Center. His primary care office is located in a building that is connected to the hospital, where Dr. Buzzeo has privileges and is an active and committed member of the medical staff. He has been at this location since 1988. He is a solo practitioner and is supported in his practice by only one staff member, Celeste Buzzeo, RN, his wife, who fills the roles of both nurse and office manager.

BACKGROUND AND OBJECTIVES

In the new, complex and rapidly changing healthcare environment of transitioning to electronic health records, patient-centered care and value-based care, while continuously improving quality, safety, accessibility, and outcomes, small primary care practices (≤15 clinicians) are at a disadvantage. The time, energy, and skill sets required to be successful in this new environment compete with the capabilities needed to engage with and care for patients. Solo practitioners especially are at a disadvantage. For this reason, for the last decade the Centers for Medicare & Medicaid Services (CMS) has funded special technical support for small practices to assist them in participating in various quality improvement projects. Each project has had specific goals and measurable objectives.

PARTICIPATION IN A WIDE RANGE OF PROJECTS

Dr. Louis Buzzeo and his nurse/office manager Celeste Buzzeo, RN have successfully participated in the following projects with IPRO:

- 2011: Electronic Health Record (EHR) Adoption
- 2012: EHR Meaningful Use (MU), Cardiac Population Health Initiative (CPHI), Physician Quality Reporting System (PQRS)
- 2013: EHR Meaningful Use, CPHI, PQRS-EHR Reporting
- 2014: EHR Meaningful Use, CPHI, PQRS-EHR Reporting
- 2015: MU-HIT (Health Information Technology), Cardiovascular Health (CVH), Adult Immunizations, PQRS, Value Modifier (VM)
- 2016: MU-HIT, CVH, Adult Immunizations, PQRS, VM
- 2017: SURS, CVH, Adult Immunizations
- 2018: SURS, CVH, Adult Immunizations

APPROACH

During each of these projects, the practice worked with IPRO to understand and implement the various workflow changes and redesigns that allowed it to capture data and create reports to track and carefully document various areas of improvement while providing care and attention to patients.

RESULTS

The practice has achieved consistently high, indeed exemplary, performance in all projects, for example:

- Successfully selected, adopted, implemented, and meaningfully used an electronic health record system (MEDENT) in 2011 and every year thereafter.
- Prevented an unnecessary visit to the emergency department and may have saved a patient's life in 2012 by using the EHR's Clinical Visit Summary to engage a patient and family to immediately report elevated blood pressures.
- Consistently scored in the top 10% of all practices participating in quality improvement projects related to cardiac care (Million Hearts®), immunization rates (influenza, pneumococcal, herpes zoster).
- Scored in the top 1.7% of all 207,151 participating practices nationally in the 2016 CMS Value Modifier incentive.
- Achieved a perfect Merit-based Incentive Payment System (MIPS) Composite Score of 100 points in 2018 based on meaningful use of electronic health records, improvement activities, and performance on quality measures.

CONCLUSIONS

With appropriate external support, small physician practices can improve and perform at the highest level—providing excellent, high-quality, cost-effective care to patients and families while continuously introducing new technologies, redesigning workflow, and meeting new CMS requirements.

Acacia Network

In recognition of collaboration and support of IPRO's Everyone with Diabetes Counts (EDC) Program for the past 10 years.

A Ten-Year Partnership Serving New York Seniors (2008–2018)

ABOUT THE ACACIA NETWORK

In the 1960s and 1970s, young, visionary men and women who were part of the Puerto Rican Diaspora dedicated their lives to creating a better place to live for New York's Latino community. They built culturally attuned housing, social service and healthcare systems that became the foundation for New York State's Acacia Network. The Network honors its founders by continuing their vision of integrated health and housing programs, and by reinvesting in communities through innovative programming, employment opportunities and affordable housing ownership. The Network is committed to preserving Latino community-based organizations that have been their communities' backbone since the late 1960s.

BACKGROUND

Acacia Network values the long-standing contributions of its seniors celebrating their role in families and communities. Senior center programs, supported in New York City by the NYC Department for the Aging (DFTA), and, in Buffalo, supported by the Erie County Department of Social Services, offer bilingual, culturally meaningful social services, advocacy, information, and counseling in a welcoming and friendly environment.

The Acacia Network has partnered with IPRO to educate underserved Medicare beneficiaries with diabetes since 2008 through the Everyone with Diabetes Counts diabetes self-management education program. This six-session program educates and empowers seniors with diabetes by helping them understand and manage their disease through lifestyle changes and engaging in informed discussions with their healthcare professionals about blood sugar control.

RESULTS

Since the Acacia/IPRO partnership began, more than 400 older adults from 10 New York City senior centers have graduated from EDC workshops. Eight Acacia staff members have also been trained as group leaders through IPRO's train-the-trainer program.

Acacia seniors who attended IPRO's diabetes self-management education programs increased self-efficacy and knowledge about their condition and reported improvements in their vegetable consumption and level of physical activity.

Through this work, Acacia Network has helped achieve its mission: to partner with its communities, lead change and promote healthy families in healthy neighborhood environments.

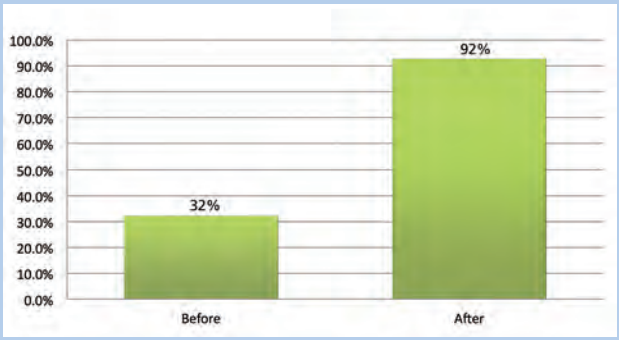
Program Graduates, Arturo Schomburg Senior Center

Healthy Ways to Handle Stress

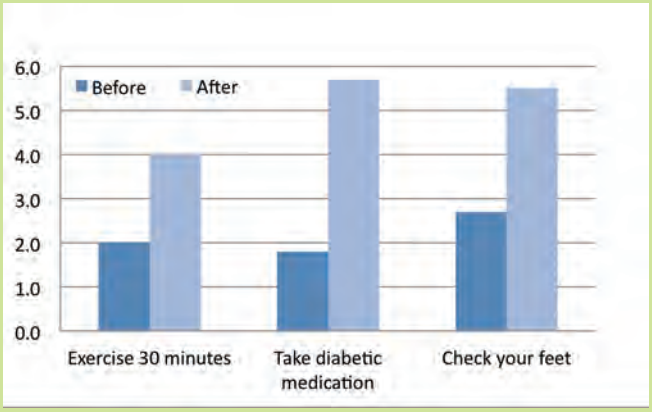
Initially only 27% reported knowing healthy ways to handle stress and by the end, 92% of participants were confident they knew how to best manage their stress.

What is the Best Way to Care for Your Feet?

Prior to the diabetes classes, only 32% of participants were able to correctly answer what was the best way to care for their feet. Once the classes were completed, 92% of participants answered this question correctly.



Average Number of Days Per Week



Overall, participants reported they exercised, checked their feet, and took their diabetes medication more often after taking the diabetes classes than they did before taking the class.

Program Graduates, Arturo Schomburg Senior Center

KCS
WWW.KCSNY.ORG
THE KOREAN COMMUNITY SERVICES OF METROPOLITAN NEW YORK, INC.
뉴욕한인봉사센터

In recognition of partnering with IPRO to educate Korean Medicare beneficiaries living with diabetes in their native language.

ABOUT KOREAN COMMUNITY SERVICES OF METROPOLITAN NEW YORK

Korean Community Services (KCS) envisions a world in which immigrant communities remain grounded in their heritage and work together with the broader community to build a better society at large. KCS' mission is to be a bridge for Korean immigrants and the wider Asian community to fully integrate into society and overcome any economic, health and social barriers so that they become independent and thriving members of the community. KCS accomplishes this mission by providing culturally competent programs in the areas of aging, education, immigration, workforce development, public health, and mental health.

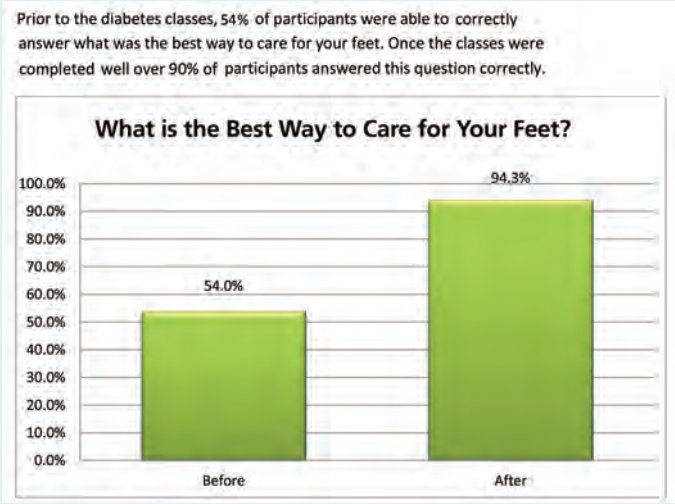
BACKGROUND

The IPRO/KCS partnership has helped Korean older adults with diabetes understand and better manage their condition. Program participants learn about disease self-management tools from KCS staff who are certified in the Everyone with Diabetes Counts (EDC) program by IPRO staff.

RESULTS/CONCLUSION

Korean Community Services' partnership with IPRO has resulted in more than 100 Medicare beneficiaries from the Korean community completing the EDC program in their native language. This partnership has also resulted in the training of four KCS staff members as EDC leaders through IPRO's train-the-trainer program.

KCS seniors who attended IPRO's diabetes self-management education programs increased self-efficacy and knowledge about their condition and reported improvements in medication adherence and stress management.



Korean-American Seniors Learn How to Better Manage their Diabetes

IPRO's 34th Annual Membership Meeting

NewYork-Presbyterian Brooklyn Methodist Hospital

In recognition of commitment to educating Brooklyn's older adults in diabetes self-management.

NewYork-Presbyterian Brooklyn Methodist Hospital and IPRO Team Up to Educate Brooklyn Older Adults in Diabetes Self-Management.

ABOUT NEWYORK-PRESBYTERIAN BROOKLYN METHODIST HOSPITAL

A voluntary, acute care teaching hospital, NewYork-Presbyterian Brooklyn Methodist Hospital endeavors to provide excellent healthcare services in a compassionate and humane manner to the people who live and work in Brooklyn and its surrounding areas. NewYork-Presbyterian Brooklyn Methodist Hospital is affiliated with Weill Cornell Medicine—a medical school that is among the nation's most highly regarded in patient care, medical education and research. This hospital is also a member of the NewYork-Presbyterian Regional Hospital Network, which provides access to top-ranking physicians and comprehensive resources, including some of the best thought leaders in the medical field.

BACKGROUND

NewYork-Presbyterian Brooklyn Methodist Hospital offers a multidisciplinary team of physicians specializing in diabetes, including endocrinologists. The team also includes vascular specialists, urologists, ophthalmologists, podiatrists, and cardiologists—all of whom provide care for people with diabetes.

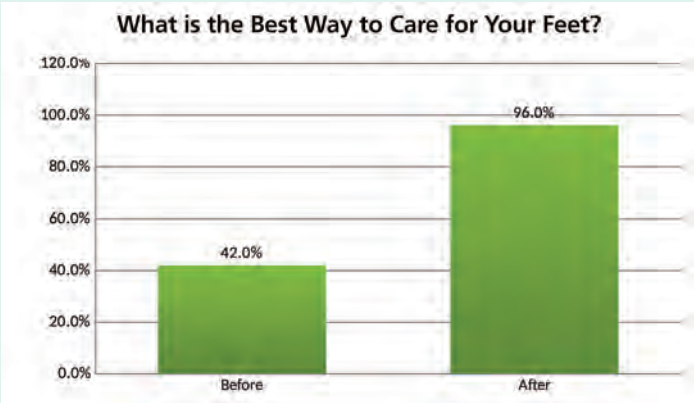
Many of the hospital's diabetes patients have participated in IPRO's Everyone with Diabetes Counts (EDC) diabetes self-management education programs.

RESULTS

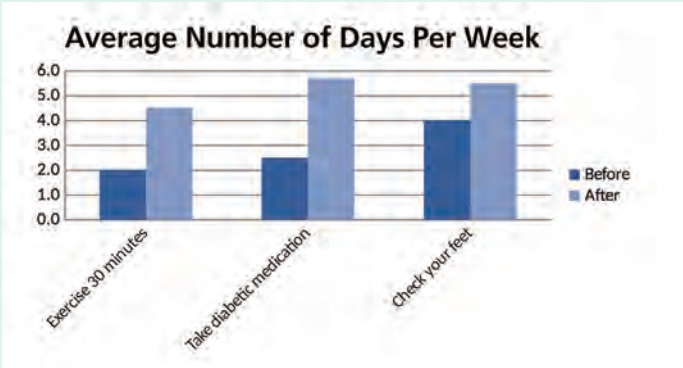
The IPRO/NewYork-Presbyterian Brooklyn Methodist Hospital partnership has helped more than 80 older adults in Brooklyn understand and better manage their diabetes.

NewYork-Presbyterian Brooklyn Methodist Hospital patients who attended IPRO's diabetes self-management education programs improved self-efficacy and knowledge about their condition and reported improved medication adherence and an increase in vegetable consumption.

Initially only 71% reported knowing healthy ways to handle stress and by the end, over 95% were confident they knew how to best manage their stress.



Prior to the diabetes classes, approximately only forty-two percent of participants were able to correctly answer what was the best way to care for your feet. Once the classes were completed, well over ninety five percent of participants answered this question correctly.



Overall, participants reported they exercised, checked their feet, and took their diabetes medication more often after taking the diabetes classes than they did before taking the classes.

Gale Grunert

Manager of Case Management, Lewis County General Hospital

In recognition of her commitment to reducing her hospital's 30-day readmission rate and her ongoing collaboration with IPRO.

ABOUT LEWIS COUNTY GENERAL HOSPITAL

Lewis County General Hospital is a critical access hospital (CAH) with 25 beds, serving the people of Lewis County. With 26,865 residents, Lewis County is the fourth least populated county in New York. The hospital is affiliated with St. Joseph's Hospital Health Center in Syracuse.

ABOUT THE LEWIS COUNTY CARE TRANSITION COALITION

The Lewis County Care Transition Coalition's initial meeting was held June 3, 2016, with Gale Grunert, manager of case management for Lewis County General Hospital, as chairperson.

- The coalition holds monthly meetings. The meetings are facilitated by IPRO in collaboration with the Central New York Care Collaborative, as part of New York State's Performing Provider Systems (PPS) Delivery System Reform Incentive Payment (DSRIP) program.
- Members of the coalition include Central NY Care Collaborative (PPS DSRIP), Lewis County Department of Social Services, Lewis County Office for Aging/NY Connects, Northern Regional Center for Independent Living (NRCIL), St. Joseph's Home Health Agency, Health Home, Regional Health Information Organization (RHIO), LCGH Primary Care Physician Office, and Mountainview Prevention Services.

MS. GRUNERT'S ACCOMPLISHMENTS: JANUARY 2016–DECEMBER 2017

- Created a new Care Transition program.
- Revitalized Care Coordination/Complex Care Community Consortium meetings to discuss patients who are serviced by several community organizations (8/2016).
- Facilitated Lewis County General Hospital's implementation of the LACE tool to identify patients who are at a higher risk for 30-day hospital readmission (10/2016). This tool identifies these patients by assigning scores to each of four factors, which are totaled to obtain a risk score.
- Increased community awareness of a new ministry volunteer outreach program that helps seniors to better manage at home.
- Partnered with the EMS Council to create a method for EMS personnel to inform service providers of individuals in the community who are at risk for hospital readmission.
- Due to her leadership of the coalition, Ms. Grunert was asked to become a member of the Lewis County Community Service Board (2016).
- Through the consortium, created a Community Universal Referral Form, which was disseminated by the Care Transition Coalition (6/17).
- Developed a Peer Support Program with NRCIL to assist behavioral health/substance use disorder patients in the emergency department (fully implemented 12/17).
- Began implementing the Better Outcomes for Optimizing Safe Transitions (BOOST) Program (11/17). Started follow-up telephone calls post acute patient discharge using the "8P" screening tool, which helps identify patients' risk for post-discharge adverse events, in order to prompt for inpatient departmental referrals that enhance patients' discharge planning.
- Created hospital policy for collaborating with community-based organizations during discharge planning.
- Ms. Grunert was appointed to the subcommittee for the Lewis County Alcohol and Substance Abuse Council. (2017).

RESULTS

Through these efforts, Lewis County General Hospital decreased its 30-day readmission rate from 43.28 per 1,000 Medicare beneficiaries at baseline (2015) to 39.83 per 1,000 beneficiaries during the time period 10/1/16–9/30/17 (the most recent data available).

Patricia Bomba, MD, MACP

In recognition of her national leadership role in transforming end-of-life care planning, and her collaboration with IPRO's Coordination of Care and Transforming End of Life Care teams.

OVERVIEW

Advance care planning, MOLST (Medical Orders for Life Sustaining Treatment) and eMOLST, which helps healthcare professionals document MOLST discussions with patients electronically, align with CMS-defined priorities to engage patients and families and put patients over paperwork. The portability of MOLST and the accessibility of eMOLST across care settings as patients transition between these settings helps ensure that patients' data and goals for care move with them as they move in and out of the healthcare system.

ABOUT DR. BOMBA

Patricia A. Bomba, MD, MACP, an internationally known geriatrician and expert on palliative care and end-of-life care planning, serves as vice president and medical director, geriatrics at Excellus BlueCross BlueShield. She chairs New York's MOLST Statewide Implementation Team, is eMOLST program director and chair of the National Healthcare Decisions Day NYS Coalition. She has been a leading champion of MOLST and eMOLST, making New York's MOLST and eMOLST programs national models for capturing patients' wishes on end-of-life care.

INSPIRING OTHERS

The true impact of Dr. Bomba's work is hard to measure as one of her greatest achievements has been to inspire those who benefit from her teaching and will carry on her work. Dr. Bomba's efforts have been—and continue to be—integral to the success of IPRO's projects. She has been instrumental in the personal and professional growth of IPRO's Coordination of Care and Transforming End of Life Care team, serving as mentor, educator and action-oriented guide throughout years of collaboration.

Dr. Patricia Bomba is a

- Mentor,
- Educator,
- Subject Matter Expert,
- Action Oriented Guide, and
- 24/7 Team Member.

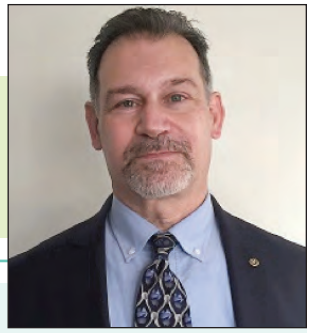
DR. BOMBA'S WORK WITH IPRO

Dr. Bomba has always been a key project partner and subject matter expert and is viewed at both the state and national levels as a pioneer in her field, with her life's work dedicated to the improvement of end-of-life care. She has consistently made herself available 24/7 to the IPRO team, multiple educational program attendees, and the broader healthcare community at the statewide level, often responding to and consulting on emergency cases.

She is a nationally and internationally recognized subject matter expert who has worked with IPRO's teams to educate professionals, patients and caregivers, and the general public in numerous venues including Learning and Action Networks (LANs) and onsite visits to hospitals, skilled nursing facilities, and continuing care retirement communities. She has consistently raised public awareness of advance care planning through her New York MOLST Update e-newsletter, radio interviews and assistance in the design of public-service railroad platform posters. She has also partnered with professionals from Mental Hygiene Legal Services to address the unique end-of-life needs of individuals living with developmental and intellectual disabilities.

Joe Caruso

In recognition of his passionate commitment to improving the public's sepsis knowledge, and for ensuring that the voice of the consumer is represented in IPRO's work to improve health care quality.



In recognition of his passionate commitment to improving the public's sepsis knowledge, and for ensuring that the voice of the consumer is represented in IPRO's work to improve health care quality.

ABOUT JOE CARUSO

A sepsis survivor, Joe Caruso is committed to increasing sepsis knowledge amongst the general public. One example of his commitment is the significant time and effort he has contributed to the AQIN Community Based Sepsis SIP.

Mr. Caruso is a communications professional who recently expanded his skill set to include real estate. He has worked in a number of settings, including a Chamber of Commerce, city and county government, a health insurance company, an office for aging, a college public opinion research center, economic development agencies, and as regional staff to U.S. Senator Daniel Patrick Moynihan and U.S. Senator Hillary Clinton.

He is a member of many community organizations in his native Utica, New York, including Rotary of Utica.

He considers himself "one of the lucky ones." Spreading sepsis education is his way to pay back and express his gratitude for survival.

Mr. Caruso works closely with the Sepsis Alliance as a spokesperson and advocate for sepsis awareness and education. His full story and video can be viewed on the "Faces of Sepsis" section on the Sepsis Alliance website.

As a member of the IPRO Community Advisory Panel, Mr. Caruso provides valuable insight and a consumer's perspective to healthcare issues, with the aim of ensuring that the voice of the patient and the public is represented.

In February 2017, Mr. Caruso shared his sepsis survival story during an interview with a local ABC news affiliate anchor as part of a health segment on sepsis.

JOE CARUSO: SEPSIS SURVIVOR STORY.

Posted on the *Sepsis Alliance* website:

August 17th, 2016

I entered the hospital on July 11, 2011 with sepsis, the result of a meningococcal infection (*Neisseria meningitidis*). After a week in a coma, and significant organ failure, I emerged eight days later, one of the lucky ones. One year later, I am well, having been spared removal of gangrenous toes, and with my heart back to normal.

In my case, I believe infection was facilitated by dental work. I had three root canals—in one hour—performed by one endodontist, followed by the placement of three posts to allow for the re-cementing of a bridge by another dentist (a prosthodontist), in an another hour, in a different location. The next day, I felt fine, but by evening, a bit more sore. By the following evening, I was in excruciating pain.

The following morning—three days after the initial dental work—I called the endodontist, and after mentioning the little bump behind my front teeth, he said, "that's infection, I'll prescribe an antibiotic."

By the next day (Monday), the little bump had grown into a Chiclet-sized pillow of abscess, but I was feeling better. Yet another dentist looked at it on Wednesday, and said he'd aspirate the puss, but nothing came out. He said not to worry; the bump on the roof of my mouth would be gone by Friday. It wasn't and when I called to tell him so, he said it would be, soon, not to worry. I then left on a week's business trip to the West Coast, which each of the three dentists knew about.

Each day, the abscess went down a bit more. I felt mostly fine all week, with a runny nose and the beginning of what seemed like a cold coming on, but able to function, which required intercity metro travel and face-to-face interviews with several people. After the week in California, I left on an afternoon flight home, arriving back in Albany on Monday morning, July 11, 1:30 a.m. I had been traveling with a friend who also had business out west, and who drove me home from the airport.

The next morning, I felt tired, feverish, and had a bit of a headache, but it didn't seem like anything to worry about. I had a follow-up appointment with the endodontist at 11 a.m., which I kept, although I couldn't tell you a thing about that hour. I only remember not being able to make the ten- to twelve-minute car ride home through city

streets and having to pull over to rest. Obviously, I wasn't clear-thinking or I would have realized that anyone unable to attend to such a small task must be really sick. I went home, threw myself on the bed of my second story flat, and fell asleep.

My mother, who lives 90 miles away and doesn't drive, had apparently been trying to reach me all day. She knows I always get back to her in a timely manner so when I didn't call, she was concerned and tried to find my tenants, or my neighbor. Striking out, she called the friend with whom I'd been traveling, who shared her concern—and premonition—who drove the 25-30 minutes to my house.

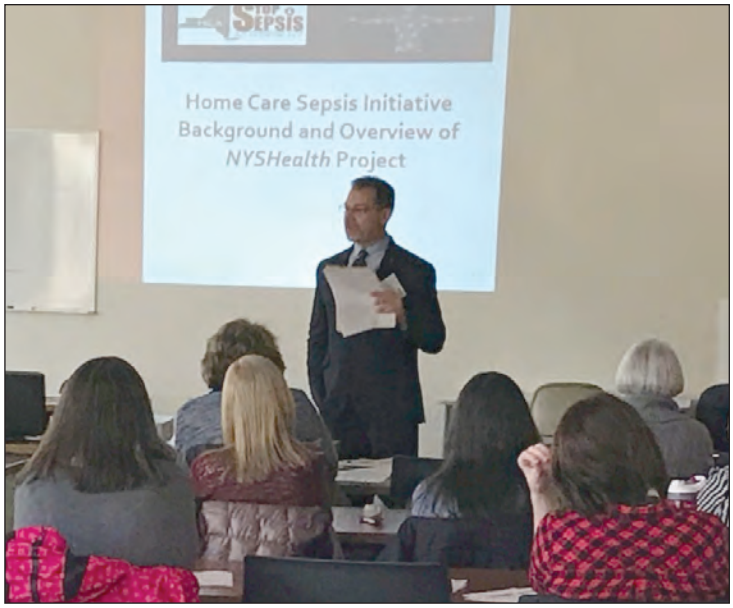
He found my car unlocked (unusual) in the front of my house, although the door to the house was locked. He kept calling to me, through my open second story bedroom window. I awakened and (remarkably) walked down a flight of stairs to let him in and another flight back up to return to my bed. My friend insisted, thankfully, on calling the EMTs, who took me to a nearby hospital. Meanwhile, as (I'm told) I waited two hours, in and out of consciousness, for a doctor in the ER, my friend was in contact with my general doctor, who is also a good friend of mine. The doctor called the ER and insisted that an ER doctor see me immediately. That changed everything, or so I'm told. Doctors and IVs were flying everywhere, and my friend was told that he should "notify the family immediately." I learned later that they were concerned that I would die before my family arrived from Utica.

In the next few hours and days, heart, lungs, kidneys, liver—everything—failed. Eight days later, I showed signs of the chance of survival. I was brought into consciousness. The ventilator tube was removed, and I started my climb back.

I'm left in a quandary about how I was exposed to the *Neisseria meningitidis* and what, if any, role the dental work and its subsequent infection played in all of this. Knowing of my own "safe" behaviors—I never drink from a glass or eat from a plate of people I know, much less people I don't know—I am left with the belief that meningococcal infection is much easier to contract than one would believe.

Fortunately, I've returned to my normal state. I know this is not the norm, and I am very grateful. I intend to find a way to pay back, to demonstrate my appreciation, and I believe that Sepsis Alliance may provide the way.

IPRO sepsis project stakeholders. From left to right, seated: Mary Forman, Eve Bankert, Beth van Bladel. Standing: Ben Baskin, Joe Caruso and Sara Butterfield.



Joe Caruso presents on the Home Care Sepsis Initiative

Al Cardillo

In recognition of his ongoing collaboration, expertise and the time and energy he puts into sepsis education for home health professionals and the public at large.

Al Cardillo and Dr. Alan Sanders discuss sepsis on WAMC's Medical Monday call-in show

HCA Initiative: Stop Sepsis at Home New York

BACKGROUND AND OBJECTIVES

Executive Vice President, Policy and Program Services Al Cardillo and the Home Care Association of New York State (HCA of NYS) have been valued project partners, collaborating with IPRO since 2000. Working on the Community Based Sepsis Awareness Special Innovation Project, Mr. Cardillo has led the way in focusing the state's home care industry on addressing sepsis early identification, management and improved patient outcomes. The unique position of home care providers who have the skills, infrastructure and direct contact with at-risk individuals in the community makes them ideally suited to combat sepsis. Mr. Cardillo's commitment to improving healthcare delivery in the home setting is evidenced through his leadership of initiatives addressing the early identification and treatment of sepsis, for which he has gained statewide and national recognition.

SEPSIS IN THE HOME AND COMMUNITY

- More than 80% of sepsis cases originate in the home and community.
- 80% of sepsis related deaths are preventable with early identification and prompt appropriate treatment.

STOPPING SEPSIS AT HOME

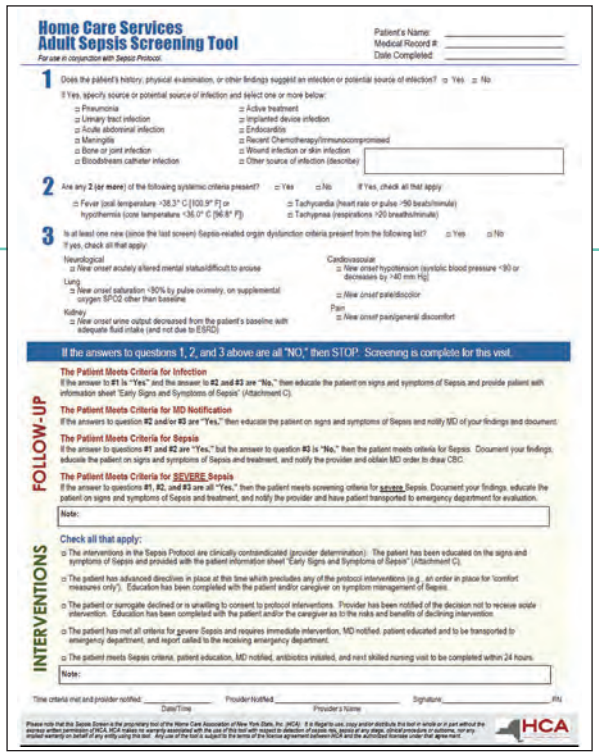
- Mr. Cardillo was the guiding force behind the development of the HCA of NYS "Stop Sepsis at Home New York" initiative, which embodies a cross-sector approach to community based sepsis education that is inclusive of home health professionals, EMS, hospitals and other key stakeholders.
- Cross-sector collaboration has enabled dialogue and a unified call to action for early sepsis recognition and management.
- Supported by a grant from the New York State Health Foundation, the Stop Sepsis at Home Initiative has provided in-person sepsis training to 131 home care agencies and related entities in eight regional training sessions across New York State. These training programs have focused on the application and use of the HCA Adult Sepsis Screening Tool.
- Mr. Cardillo has also worked extensively with the New York State Department of Health, the state legislature and the New York State Health Foundation to address social, economic and regulatory issues related to sepsis.

ABOUT AL CARDILLO

Al Cardillo has worked in the health field for more than 35 years, with positions in both the public and private sectors, including roles in health services development, administration, legislation, budget, provider association and other areas.

He served as executive director for health for the New York State Senate Health Committee, executive director for health for the State Council on Health Care Financing, and as program development staff for the State Division of Medical Assistance, among other public health positions. He is presently the executive vice president of the (HCA of NYS), a statewide health association composed of over 300 organizations and healthcare providers providing home and community-based care to several hundred thousand New Yorkers annually. HCA of NYS works to support providers in the delivery of high quality, cost-effective home and community-based care for the state's citizens.

Mr. Cardillo serves on numerous professional and governmental committees in healthcare, as adjunct faculty in the University at Albany School of Social Work, and as a presenter with Duke University faculty in New York sessions of the Duke Population Care Coordinator Program.



Home Care Services
Adult Sepsis Screening Tool
For use in conjunction with Sepsis Protocol

Patient's Name: _____
Medical Record #: _____
Date Completed: _____

1 Does the patient's history, physical examination, or other findings suggest an infection or potential source of infection? ☐ Yes ☐ No

If Yes, specify source or potential source of infection and select one or more below:

☐ Pneumonia
☐ Urinary tract infection
☐ Acute abdominal infection
☐ Meningitis
☐ Bone or joint infection
☐ Bloodstream catheter infection
☐ Active treatment
☐ Implanted device infection
☐ Endocarditis
☐ Recent Chemotherapy/Immunocompromised
☐ Wound infection or skin infection
☐ Other source of infection (describe)

2 Are any **2 (or more)** of the following systemic criteria present? ☐ Yes ☐ No If Yes, check all that apply:

☐ Fever (oral temperature >38.3° C [100.9° F] or hypothermia (core temperature <36.0° C [96.8° F])
☐ Tachycardia (heart rate or pulse >90 beats/minute)
☐ Tachypnea (respirations >20 breaths/minute)

3 Is at least one new (since the last screen) Sepsis-related organ dysfunction criteria present from the following list? ☐ Yes ☐ No

If yes, check all that apply:

Neurological
☐ New onset acutely altered mental status/difficult to arouse

Lung
☐ New onset saturation <90% by pulse oximetry, on supplemental oxygen SPO2 other than baseline

Kidney
☐ New onset urine output decreased from the patient's baseline with adequate fluid intake (and not due to ESRD)

Cardiovascular
☐ New onset hypotension (systolic blood pressure <90 or decreases by >40 mm Hg)
☐ New onset pale/discolor

Pain
☐ New onset pain/general discomfort

If the answers to questions 1, 2, and 3 above are all "NO," then STOP. Screening is complete for this visit.

FOLLOW-UP

The Patient Meets Criteria for Infection
If the answer to **#1** is "Yes" and the answer to **#2 and #3** are "No," then educate the patient on signs and symptoms of Sepsis and provide patient with information sheet "Early Signs and Symptoms of Sepsis" (Attachment C).

The Patient Meets Criteria for MD Notification
If the answers to question **#2 and/or #3** are "Yes," then educate the patient on signs and symptoms of Sepsis and notify MD of your findings and document.

The Patient Meets Criteria for Sepsis
If the answer to questions **#1 and #2** are "Yes," but the answer to question **#3** is "No," then the patient meets criteria for Sepsis. Document your findings, educate the patient on signs and symptoms of Sepsis and treatment, and notify the provider and obtain MD order to draw CBC.

The Patient Meets Criteria for SEVERE Sepsis
If the answer to questions **#1, #2, and #3** are all "Yes," then the patient meets screening criteria for severe Sepsis. Document your findings, educate the patient on signs and symptoms of Sepsis and treatment, and notify the provider and have patient transported to emergency department for evaluation.

Note: _____

INTERVENTIONS

Check all that apply:

☐ The interventions in the Sepsis Protocol are clinically contraindicated (provider determination). The patient has been educated on the signs and symptoms of Sepsis and provided with the patient information sheet "Early Signs and Symptoms of Sepsis" (Attachment C).

☐ The patient has advanced directives in place at this time which precludes any of the protocol interventions (e.g., an order in place for 'comfort measures only'). Education has been completed with the patient and/or caregiver on symptom management of Sepsis.

☐ The patient or surrogate declined or is unwilling to consent to protocol interventions. Provider has been notified of the decision not to receive sepsis intervention. Education has been completed with the patient and/or the caregiver as to the risks and benefits of declining intervention.

☐ The patient has met all criteria for severe Sepsis and requires immediate intervention, MD notified, patient educated and to be transported to emergency department, and report called to the receiving emergency department.

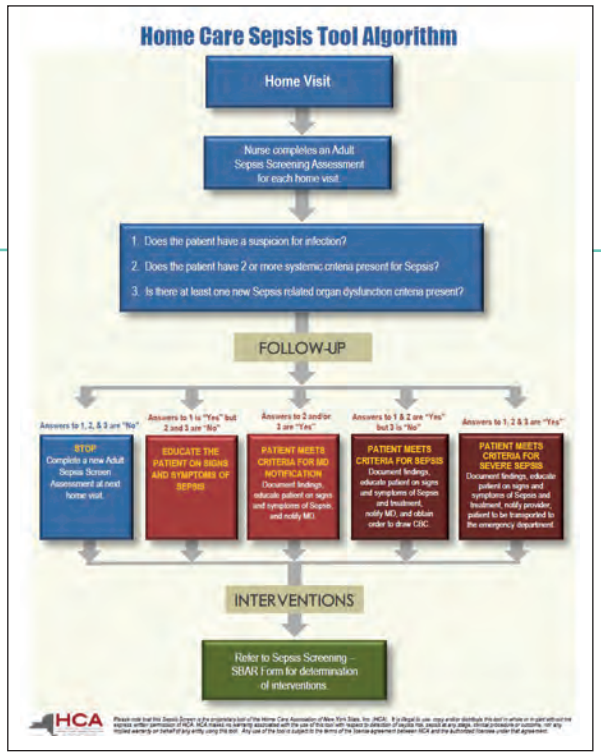
☐ The patient meets Sepsis criteria, patient education, MD notified, antibiotics initiated, and next skilled nursing visit to be completed within 24 hours.

Note: _____

Time criteria met and provider notified: _____ Provider Notified _____ Signature _____ RN
Date/Time Provider's Name

Please note that this Sepsis Screen is the proprietary tool of the Home Care Association of New York State, Inc. (HCA). It is illegal to use, copy and/or distribute this tool in whole or in part without the express written permission of HCA. HCA makes no warranty associated with the use of this tool with respect to detection of sepsis risk, sepsis at any stage, clinical protocols or outcome, nor any implied warranty on behalf of any entity using this tool. Any use of the tool is subject to the terms of the license agreement between HCA and the authorized licensee under that agreement.

HCA

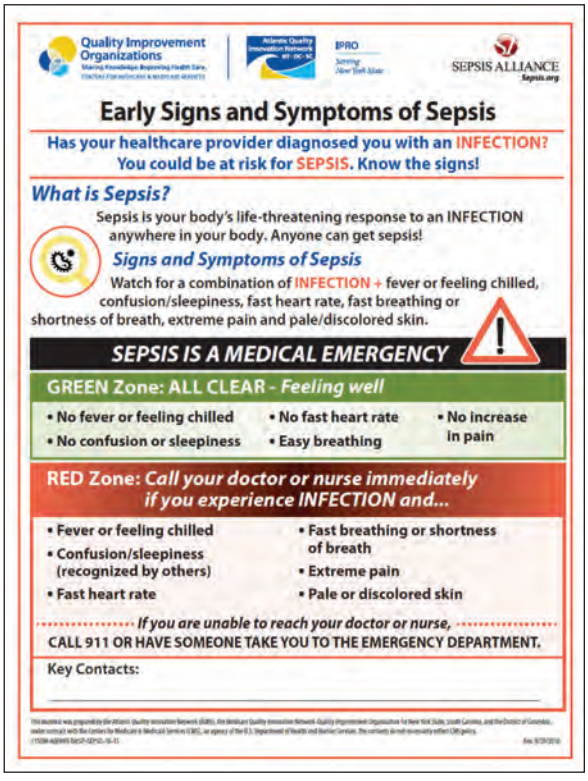


METHODS

- HCA of NYS formed a Sepsis Workgroup in 2015 devoted to research, development, refinement, beta testing and vetting for state and national input of the HCA Adult Sepsis Screening tool.
- HCA of NYS created a series of four collaborative Webinars on sepsis prevention, early recognition, treatment and implementation of the HCA Adult Sepsis Screening tool, and recruited New York State home care providers to participate.
- IPRO introduced the screening tool in Home Health Train-the-Trainer programs.
- HCA of NYS launched the Stop Sepsis at Home campaign, including a series of in-depth statewide training sessions for home care clinicians, direct-care workers and agency leaders on the use of the HCA sepsis screening tool.
- Training included technical and case-review presentations, conferencing, statewide user calls, data sharing and distribution of supportive resources.

LEADING THE WAY WITH SEPSIS SCREENING TOOL

- Through Mr. Cardillo's guidance and partnership with leading national sepsis patient advocacy organizations, The Sepsis Alliance and The Rory Staunton Foundation, and with IPRO, HCA of NYS developed a comprehensive training program aimed at educating home care providers on the use and implementation of its first-in-the-nation adult sepsis screening tool, which has been used extensively throughout New York State.
- The HCA Adult Sepsis Screening Tool, officially launched in March 2017, has gained both statewide and national recognition.
- The screening tool's contents and directives align with mandatory New York State hospital regulations and "Rory's Regulations," which specify protocols for sepsis identification and early management.



Quality Improvement Organizations
IPRO
SEPSIS ALLIANCE
Sepsis.org

Early Signs and Symptoms of Sepsis

Has your healthcare provider diagnosed you with an INFECTION? You could be at risk for SEPSIS. Know the signs!

What is Sepsis?

Sepsis is your body's life-threatening response to an INFECTION anywhere in your body. Anyone can get sepsis!

Signs and Symptoms of Sepsis

Watch for a combination of INFECTION + fever or feeling chilled, confusion/sleepiness, fast heart rate, fast breathing or shortness of breath, extreme pain and pale/discolored skin.

SEPSIS IS A MEDICAL EMERGENCY

GREEN Zone: ALL CLEAR - *Feeling well*

- No fever or feeling chilled
- No confusion or sleepiness
- No fast heart rate
- Easy breathing
- No increase in pain

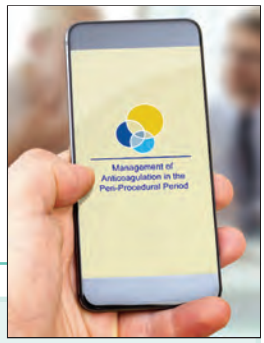
RED Zone: *Call your doctor or nurse immediately if you experience INFECTION and...*

- Fever or feeling chilled
- Confusion/sleepiness (recognized by others)
- Fast heart rate
- Fast breathing or shortness of breath
- Extreme pain
- Pale or discolored skin

If you are unable to reach your doctor or nurse,
CALL 911 OR HAVE SOMEONE TAKE YOU TO THE EMERGENCY DEPARTMENT.

Key Contacts:

In recognition of Northwell Health and Dr. Alex Spyropoulos as champions in widespread dissemination of anticoagulation management best practices.



ABOUT NORTHWELL HEALTH

Northwell Health consists of a network of 21 hospitals, three skilled nursing facilities, many specialty programs and institutes, and more than 12,000 member physicians. The system provides medical services to more than seven million New Yorkers.

ANTICOAGULANT MANAGEMENT QUALITY IMPROVEMENT INITIATIVES

Dr. Spyropoulos is the leading US expert in the perioperative management of antithrombotic medications and has lead several high impact anticoagulant safety projects with IPRO including the publication on features of electronic health records (EHRs) necessary for the delivery of optimized anti-coagulation therapy, the expert consensus of required anticoagulation-related elements that should be communicated upon discharge, and the creation of the Management of Anticoagulation in the Peri-Procedural Period (MAPPP) app, which lead to the subsequent spread and scale special innovation project that integrates MAPPP app into EHR clinical decision support. Each project has advanced practical application of anticoagulation management best practices in the realms of hospital and ambulatory settings, care transitions and perioperative care.

The Northwell Health Anticoagulation and Clinical Thrombosis Service (ACTS) clinics, led by Director Dr. Spyropoulos, provide care to approximately 5,000 patients on chronic oral anticoagulant therapy. The ACTS and the Northwell Health Informatics team have implemented the MAPPP app as part of the spread and scale special innovation project which is also supported by Northwell Health's Council for Leadership on Thrombosis (CLOT).

Dr. Spyropoulos is also a Steering Committee member and Co-Principal Investigator of the NHLBI-funded BRIDGE Trial (Douketis, et al NEJM 2015) that changed clinical practice in the periprocedural management of atrial fibrillation patients on chronic warfarin and also a panel Member of the 2008, 2012, and soon-to-be published 2018 ACCP Guidelines on Periprocedural Antithrombotic Therapy.

The expert consensus manuscript for anticoagulation-related elements that should be communicated upon discharge has been recently accepted for publication in the Joint Commission Journal on Quality and Patient Safety.

ANTICOAGULATION DISCHARGE COMMUNICATION ELEMENTS

1. Was the primary indication for use of the anticoagulant clearly documented?
2. Was an assessment of fall risk clearly documented?
3. Did documentation indicate whether the patient was new to anticoagulation therapy or a previous user?
4. If new, was start date of anticoagulation therapy provided?
5. Did documentation indicate whether treatment is intended to be acute (short term) or chronic (long term)?
6. If acute (short term) was total duration of therapy provided? (was there a stop/end date?)
7. Date, time, and strength of last dose given documented? (all must be present for Yes)
8. Date, time, and strength of next dose due provided? (all must be present for Yes)
9. If on Coumadin (warfarin), was the target INR or INR range documented?
10. If on Coumadin (warfarin), were the last 2 INR lab results provided (with dates and results)?
11. If on Coumadin (warfarin), was the date provided for when the next INR was due?
12. Was the most recent serum creatinine or creatinine clearance evaluation provided (with date and results)?
13. Was the patient provided with educational material?
14. Was an assessment of patient/caregiver understanding of the education documented?
15. Was documentation of patient/caregiver education and understanding communicated to the next provider?
16. Was contact information provided for the anticoagulation management prescriber/physician?
17. Was patient referred to an anticoagulation management service? (e.g. Coumadin/warfarin clinic)

Glens Falls Hospital

In recognition of commitment to quality improvement in anticoagulation management and sharing of evidence-based best practices through health informatics innovation.

ABOUT GLENS FALLS HOSPITAL

Glens Falls Hospital is the largest hospital between Albany, New York and Montreal, Canada. It is the most comprehensive healthcare system for New York's Warren, Washington, northern Saratoga, Essex, Hamilton and northern Rensselaer counties. In addition to the main campus in Glens Falls New York, it also operates 29 regional healthcare facilities. The hospital's quality improvement, pharmacy, medical and surgical teams are currently focused on revising policy related to perioperative management.

BACKGROUND AND METHODS

Nancy Huntington, PharmD, pharmacy director, has been instrumental in establishing systematic anticoagulation management across the healthcare system's primary care practices. Both Dr. Huntington and Kevin Gallagher, MD, chief medical information officer, are working to integrate IPRO's Management of Anticoagulation in the Peri-Procedural Period (MAPPP) app into the health system's electronic health record as active clinical decision support. Dr. Gallagher is optimizing the use of advanced health informatics technology, SMART on Fast Healthcare Interoperability Resources (FHIR), a set of open specifications to integrate apps with electronic health records, portals, health information exchanges, and other health IT systems.

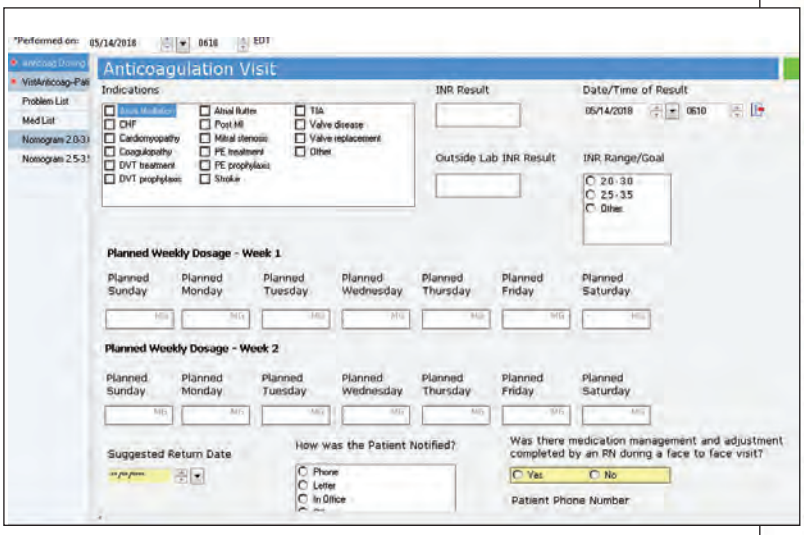
Dr. Gallagher is using this technology to ensure that the app is replicable, giving the MAPPP application the potential to be used across electronic health record platforms nationwide.

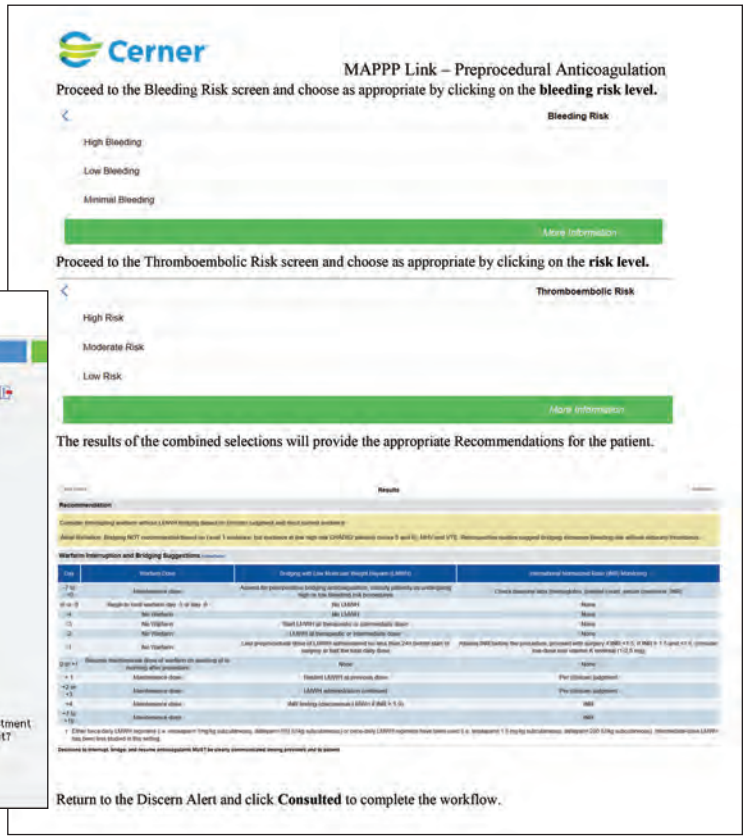
IMPROVING WARFARIN MANAGEMENT

- Glens Falls Hospital formalized and standardized anticoagulation treatment guidelines and clinical processes by replicating the Specialty Cardiology anticoagulation management system.
- This system used a nurse-driven clinical practice algorithm for warfarin management.
- This algorithm demonstrated a highly reliable time in therapeutic range for warfarin, which is a quality indicator.
- The project leaders configured the clinical practice algorithm and additional standardized patient education within the electronic medical record.

RESULTS

Results included the promotion of uniform management of warfarin throughout the healthcare system's primary care practices.





June 5, 2018 - The Garden City Hotel

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