IPRO

Better healthcare, realized.

35th Annual Meeting

Thursday, June 6, 2019 12:30–3:30 p.m.
The Garden City Hotel, Garden City, NY

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

We salute the 2019 honorees.

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Antibiotic Stewardship

In recognition of exemplary performance, organization-wide commitment to quality improvement and patient engagement.

Outpatient Antibiotic Stewardship Project

ABOUT ATLANTIC DIALYSIS

Atlantic Dialysis Management Services, LLC (ADMS) was established to provide new dialysis site development, day-to-day administration and management of dialysis services and related business development activities. The Atlantic Dialysis group includes 13 dialysis facilities in the New York City area.

ABOUT ELMHURST HOSPITAL CENTER

NYC Health + Hospitals/Elmhurst is part of an integrated health care system of hospitals, neighborhood health centers, long-term care, nursing homes and home care. Elmhurst is a teaching institution with an academic affiliation agreement with the Mount Sinai School of Medicine.

PROJECT GOAL

Atlantic Dialysis Management Services, Elmhurst Hospital, and IPRO collaborated to advance antibiotic stewardship (AS) in the dialysis setting. The goal was to achieve four CMS quality improvement activities: leadership commitment, action, tracking and reporting, and education

KEY RESOURCES/DATA REPORTS

Patient education materials (e.g., Patient Role in Antibiotic Stewardship) were developed in English and Spanish; patient ambassadors and dialysis staff were provided training.

A vancomycin guide was prepared for clinician education. The guide provides a summary of indications for use, management considerations, dosing, and monitoring.

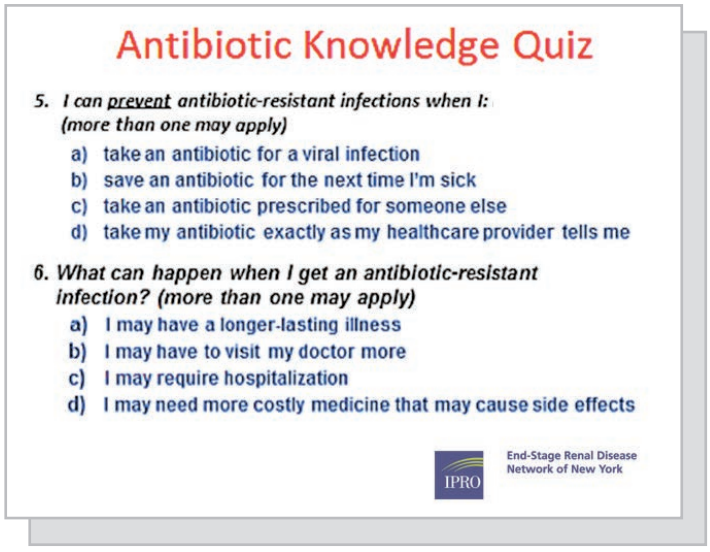
A facility-specific antibiogram was provided by Spectra Laboratories for comparison with the national ESRD population-based antibiogram. CDC patient education resources included: *Four Ways to get Ahead of Sepsis, What is Antibiotic Resistance?*, and *Do You Need Antibiotics?*

Clinician-specific antibiotic tracking and prescribing reports were made available to the 13 Atlantic Dialysis facilities. Antibiotic prescribing patterns and length of therapy data were presented to the Atlantic Dialysis group for evaluation.

Atlantic Dialysis non-nephrology antibiotic prescribing reports were created by IPRO to permit assessment of the use of oral antibiotics prescribed by providers outside of the dialysis facilities.

OUTCOME DATA

Elmhurst Hospital Center Nephrology analyzed the prescribing patterns and infection indications for oral antibiotics in New York State for the ESRD population. This was compared with the Atlantic Dialysis prescribing patterns to identify opportunities for AS.



Antibiotic Stewardship

CMH
Columbia Memorial Health
An affiliate of ALBANY MED

In recognition of exemplary performance and organization-wide commitment to quality improvement in implementing antibiotic stewardship in the outpatient setting.

ABOUT COLUMBIA MEMORIAL HEALTH

Columbia Memorial Health (CMH) is a multispecialty practice with a hospital and 34 outpatient practices spanning three counties. CMH serves approximately 1,100 patients per day in the outpatient arena; its hospital is licensed for 192 beds, and its emergency department serves 30,000 patients a year. Fourteen primary care offices and 34 physicians, nurse practitioners and physician assistants comprise the primary care network, which also spans three counties. CMH is the sole provider of medical care in a number of rural communities. It provides an extensive team-based care model that includes case managers, pharmacists, behavioral health specialists, diabetic educators, asthma educators, care coordinators, and patient navigators, in addition to traditional primary care team members. Quality of care is the top priority for CMH, and the implementation of antibiotic stewardship was a natural fit with CMH's quality directives.

TEAM

Ronald Pope, DO, CMH, Vice President of Medical Services, Care Centers

Shanda Steenburn, Pharm D, CMH Director of Pharmacy

Sarah Mottoshiski, LPN, CMH, Clinical Informatics Supervisor, Information Systems

Teresa Lubowski, IPRO Lead, Outpatient Antibiotic Stewardship Initiative

OVERVIEW

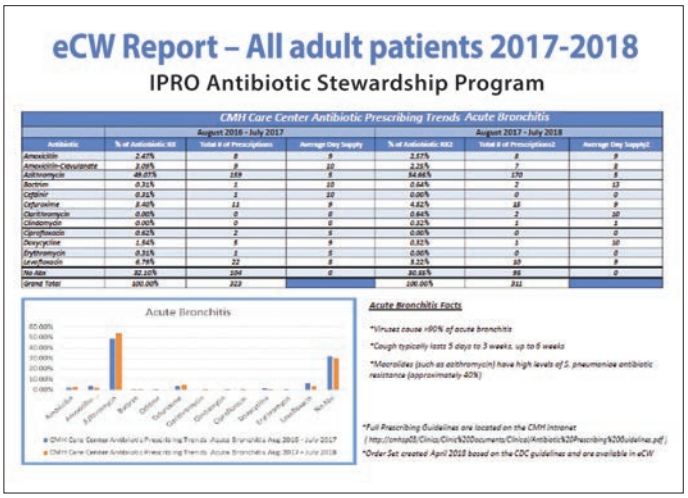
Columbia Memorial Health collaborated with IPRO, beginning in 2016 to initiate/expand antibiotic stewardship (AS) in the outpatient setting – including the emergency department, (ED), physician offices, and urgent care. IPRO provided educational resources for both providers and patients. The resources were developed by multiple sources including IPRO, CDC, and the New York State Department of Health (NYSDOH).

The Vice President of Medical Services, Care Centers and the Director of Pharmacy provided IPRO with information about providers practicing in the outpatient care centers and a de-identified data report from the ED electronic health record (EHR). The EHR data were analyzed by IPRO and a report was provided to the practice site with identified areas of opportunity for AS.

IPRO created antibiotic prescribing reports using Medicare claims data specific to the outpatient practices. The reports summarized the antibiotic prescribing patterns by system and practice. Practice-specific data were presented to the practice leadership teams along with detailed reports for benchmarking with system level data. IPRO provided infection-specific reports to the CMH team to allow for comparison of prescribing patterns to national guidelines.

Medicare claims reports were used as a template to create similar reports in the system EHR (eClinical Works). The NYSDOH guidelines were used as the template to create order sets in the EHR to promote guideline-based antibiotic selection at the point of care. The EHR intervention supports sustainability of AS in the health system.

The CMH team invited IPRO to present on the topic of AS to the medical residents at the University of New England College of Osteopathic Medicine.



OUTCOMES

Antibiotic stewardship intervention sustainability was achieved with creation of AS reports and order sets in the EHR. Infection-specific patient education resources were included with all of the order sets.

Antibiotic Stewardship

NYU Langone Health

In recognition of organization-wide commitment to quality improvement and exemplary performance in advancing antibiotic stewardship in the outpatient setting.

ABOUT NYU LANGONE HEALTH

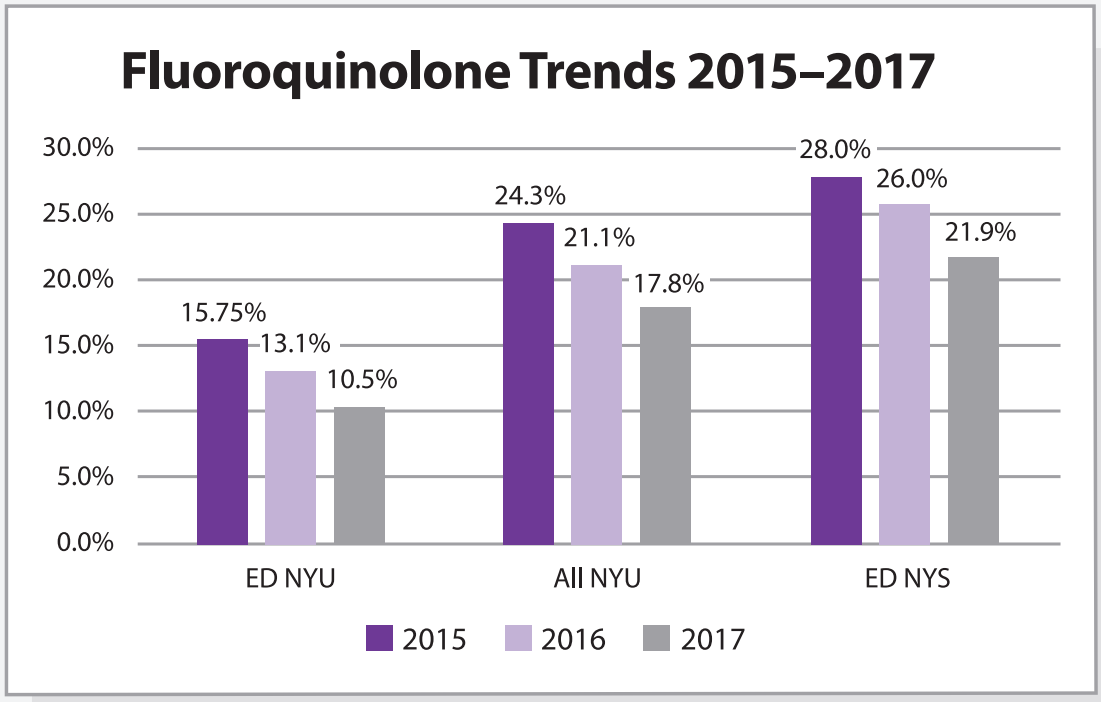
NYU Langone Health is one of the nation's premier academic medical centers. Located in the heart of Manhattan, with additional facilities throughout the New York City area, NYU Langone consists of six inpatient locations. Specialists at NYU Langone treat a full range of medical conditions in both inpatient and outpatient settings at locations throughout New York City's five boroughs, as well as in Florida; New Jersey; Long Island; and Westchester, Putnam, and Dutchess counties.

OVERVIEW

Beginning in 2016, NYU Langone Health collaborated with IPRO to initiate/expand antibiotic stewardship (AS) in the outpatient setting including the emergency department (ED), urgent care and physician offices. The team included **Lisa Anzisi, Pharm. D.**, the manager of pharmacy utilization for the clinically integrated network; **Vinh Pham, MD**, lead for the inpatient AS committee; and committee members. Using Medicare Part B and Part D claims data, antibiotic prescribing reports were provided to NYU to inform the group on AS opportunities in the outpatient practices. The messaging increased provider awareness about recommended treatment options, duration of therapy and antibiotic complications. A trending evaluation of quinolone prescribing in the ED revealed a decrease in prescribing from 2015 to 2017.

RESULTS

Project outcomes of decreased quinolone prescribing were accepted for a poster presentation at the Society of Healthcare Epidemiology of America's Spring 2019 Conference.



Care Coordination

ROME MEMORIAL HOSPITAL
An Affiliate of St. Joseph's Health

In recognition of organization-wide dedication to quality improvement, commitment to improving transitions of care for patients and caregivers through leadership of the Rome Care Transition Coalition, and strong focus on addressing social determinants of health through the Medicaid Accelerated eXchange Series Program.

ABOUT ROME MEMORIAL HOSPITAL

Rome Memorial Hospital is a non-profit health care system based in Rome, NY, providing services to patients throughout Central New York. What began as a small "cottage" hospital—serving 19 patients in 1884, its first year of operation—Rome Memorial Hospital now cares for about 6,000 patients a year in its 129 acute care beds and is home to 80 residents in its skilled nursing facility. In a year's time, the community's residents make more than 100,000 visits to its outpatient facilities for diagnostic testing and treatment.

BACKGROUND

The staff has worked within the organization and at the community level to implement evidence-based, cross-setting interventions targeting improved care management, patient and family engagement, and care coordination.

Rome Memorial Hospital leads the Rome Care Transition Coalition and is an active participant in the NYS Department of Health-sponsored MAX Series Program. With a focus on patient-centered care addressing social determinants of health factors, Rome Memorial Hospital has achieved significant reductions in readmissions, emergency department utilization and patient days for the high utilizer, multi-visit patient population.

As one of the first NYS hospitals to adopt and implement eMOLST, the hospital has expanded its use to its skilled nursing facility community. Rome Memorial Hospital has developed partnerships with key stakeholders to improve assessment for palliative care with integration into physician practices. Staff have worked to strengthen the system for referral and follow-up with patients eligible for health home case management. Rome Memorial Hospital demonstrates commitment to engagement, education and activation of its patients and community.

ROME CARE TRANSITION COALITION

A community collaborative committed to promoting smooth patient transitions based on the concept that high utilizers* of care tend to be medically complex Medicare patients.

CROSS CONTINUUM CARE TRANSITION INTERVENTIONS

- Daily review and follow-up on high utilizers for 30 days post–discharge
- Warm hand-off coordination with primary care
- Coleman Care Transition Intervention (CTI) model in home health setting
- Coordination of needs and collaboration with team on appropriateness of admission
- Proactive approach for preventable admissions (linking to services, such as IV antibiotics, home care, health homes, substance abuse counseling, peer advocates)
- Partnership with Hospice for Advance Illness Management (AIM) Palliative Care Program
- Daily meetings with hospitalists and representatives of providers across the continuum of care
- Daily huddles of primary care providers and representatives of community-based organizations taregting unmet social, clinical and behavioral needs of high utilizers
- Case managers follow high utilizer patients to promote trust and familiarity
- Patients are linked to a broad wide of community services.

RESULTS

- 67% reduction in admissions
- 73% reduction in patient days

*High utilizers: Individuals with four or more inpatient hospital stays or observation visits in a 12 month period.

Syracuse Care Transition Coalition Nutrition Sub-Committee

In recognition of the Sub-Committee's accomplishments in

- **identifying and addressing the impact of social determinants of health related to food insecurity and subsequent malnutrition on hospital readmissions,**
- **developing and promoting the *Nutrition Toolkit*, and**
- **incorporating food insecurity screening and referral as a model for community-based organizations.**

SYRACUSE CARE TRANSITION COALITION NUTRITION SUB-COMMITTEE

Maria Mahar, Onondaga County Department of Adult & Long Term Care Services

Mason Kaufman, Meals on Wheels of Syracuse

Susan Branning, St. Joseph's Hospital Center

Maria Meola, Crouse Hospital

Wanda Pietromonica, TheCrossings Nursing & Rehabilitation

Heather Hudson, Food Bank of Central New York

Amy Wilson, Food Bank of Central New York

Christa Baumes, Nascentia Health Options

Tammy VanEpps, CNYCC

Christine Price, ARC at Onondaga

Toni Heer, Upstate Medical Center

Debbie Adams, Nascentia Health

Kerry Dal, St. Joseph's Health Home Care

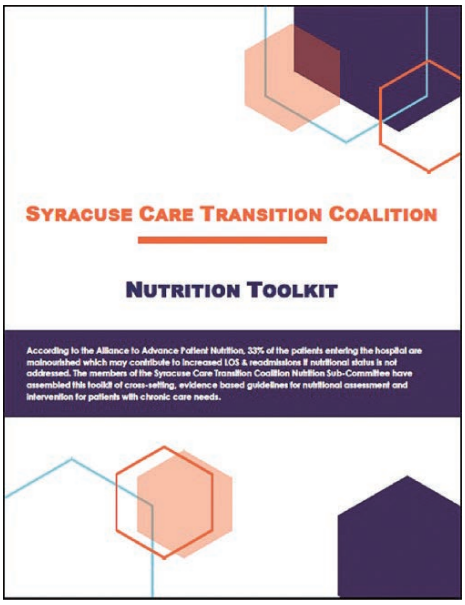
Carrie Garvin, Upstate Medical Center

ABOUT THE SYRACUSE CARE TRANSITION COALITION NUTRITION SUB-COMMITTEE

The Nutrition Sub-Committee, an integral part of the Syracuse Care Transition Coalition, was formed to address the important role of nutritional assessment and intervention for patients with chronic care needs in the community.

METHOD/APPROACH

The members of the sub-committee developed and adopted a cross-setting, evidence-based toolkit for nutritional assessment and intervention in clinical settings. The toolkit includes food insecurity/malnutrition screening tools, assessments, and related information to assist healthcare and community service providers. The toolkit also includes guidance on referral resources for immediate and long-term nutrition support with local community-based organizations.



CONCLUSIONS

Development and promotion of these resources have helped to identify and address food insecurity and malnutrition that contribute to increased length of stay and readmissions for patients receiving care in acute care settings.

The Coalition is now working on addressing the following:

- Ways in which the healthcare system can include the family in the discharge planning for these high risk clients
- An electronic method to communicate nutritional status across healthcare and community service providers involved in care management of patients (RHIO)
- A grant opportunity for community-based organizations to screen clients for food insecurity in the community at point-of-service

Nursing Homes

In recognition of organization-wide commitment to quality improvement and resident safety as well as exemplary performance in managing and preventing *Clostridium difficile.*

ABOUT BEACON REHABILITATION AND NURSING CENTER

Beacon Rehabilitation and Nursing Center is a 120 bed skilled nursing facility located in Rockaway Park, New York. Beacon's multidisciplinary team share in the provision of short and long term care and additional specialized services to secure quality care for residents served.

BACKGROUND

Beacon Rehabilitation and Nursing Center was one of a number of nursing homes that volunteered to join IPRO in a collaborative working on improving quality, specifically improving the rate of antipsychotic medication use in the long stay population and preventing and managing *C.difficile.* With focused attention to quality improvement, Beacon joined more than 450 New York State nursing homes in the quality improvement initiative.

APPROACH

Beacon took an organization wide multi-disciplinary approach to quality improvement practice and resident safety. Its team focused on and applied quality interventions at the resident level, assessing and leveraging opportunities for improvement and using data to monitor the outcomes of applied practice.

RESULTS

Beacon's team approach and quality focus resulted in an impressive 84% relative improvement in the long stay antipsychotic medication use quality measure. In addition, the facility's resident safety emphasis resulted in zero facility acquired *C.difficile* events throughout a measured 10 month timeframe.

CONCLUSIONS

The potential for Beacon's quality improvement success was evident early in the collaborative. Beacon's consistent focus on quality, applied practice, team presence and effective use of data to measure outcomes all contributed to the facility's successes and the sustainability of its improvements.

Nursing Homes

In recognition of organization-wide commitment to quality improvement as demonstrated by having attained and sustained a 5 STAR Quality Measure (QM) rating.

ABOUT NYU CROWN PARK

Crown Park Rehabilitation and Nursing Center is a 200-bed skilled nursing facility located in Cortland, New York. Crown Park offers short term rehabilitation, comprehensive skilled long-term care, respite care and a secure dementia unit.

BACKGROUND

Crown Park was one of a number of nursing homes that volunteered to join IPRO in a collaborative working to improve its publicly reported long stay quality measures and STAR QM rating.

METHODS

Crown Park used the educational resources and technical assistance provided by IPRO in its quality improvement activities. The team focused on and applied quality interventions one quality measure at a time, tackling areas in need of improvement, reviewing weekly data, problem solving and making systematic changes to support improved outcomes.

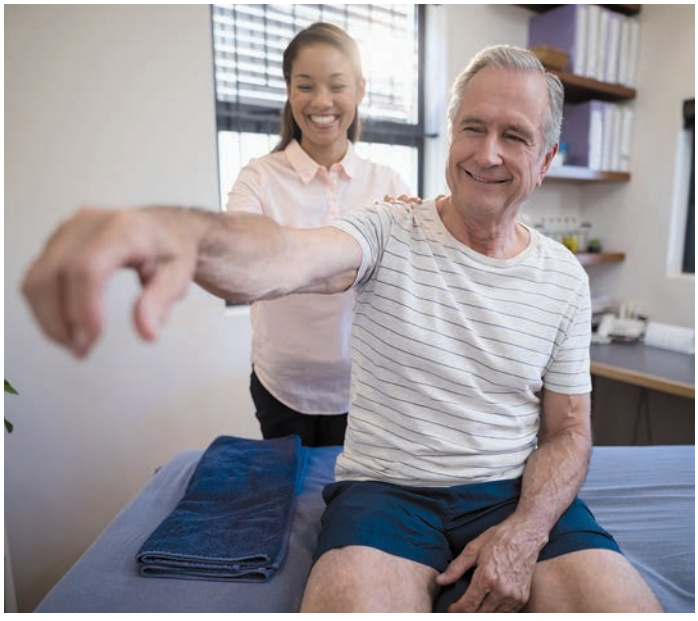
A key quality intervention included weekly CASPER report meetings inclusive of all department heads and unit managers. The meetings provided an opportunity to review the CASPER quality measure data, assess improvement progress and/or problem solve areas in need of focused attention.

RESULTS

After 18 months of implementing focused quality interventions, the facility improved its quality measure STAR rating from 1 STAR to 5 STAR and maintains the rating to date. In addition Crown Park steadily improved its composite measure score through its stepped up focus on the quality measures, and has been able to sustain a rating better than the CMS established goal.

CONCLUSIONS

Crown Park exhibited a strong commitment to this project; having established robust goals and creating an effective team to achieve its goals. Crown Park's consistent focus on the quality measures, weekly monitoring of real time data, and involvement of all departments in root cause analysis all contributed to the facility's success.



Nursing Homes

In recognition of participation in, commitment to, and success in the CMS Infection Control Pilot. These efforts resulted in a 62% relative improvement in infection control measure compliance from the initial infection control survey to re-survey; and earned the facility the distinction of having the most improved performance among nursing homes participating in the pilot.

ABOUT FRIEDWALD CENTER

Friedwald Center for Rehabilitation and Nursing is a 180-bed skilled nursing facility located in New City, NY. Its mission includes a commitment to its residents and families to deliver and sustain the highest level of care, via an educated and knowledgeable staff working in partnership.

BACKGROUND AND OBJECTIVES

Friedwald Center for Rehabilitation and Nursing is one of five New York nursing homes that volunteered to work with IPRO on a year-long CMS Infection Control Pilot. Through the pilot IPRO provided technical assistance to help nursing homes improve infection control processes and practices, as well as compliance with the Infection Prevention and Control Conditions of Participation in Long Term Care.

APPROACH

The pilot incorporated an initial infection control survey and re-survey. The survey included an assessment of 164 infection control policy, practice, and documentation measures within 20 domains. The outcome of the initial survey guided the improvement action plan and the technical assistance provided to the participating nursing homes; the re-survey assessed the progress and impact of quality improvement interventions.

The approach to the technical assistance provided by IPRO included meeting with staff, review of initial survey areas and noted opportunities for improvement, review of regulatory guidelines, provision of educational materials and resources and periodic follow-up discussions.

RESULTS

Friedwald demonstrated a 62% relative improvement in the rate of infection control measure compliance from the initial survey to re-survey and attained the most improved performance of all nursing homes participating in the pilot.

CONCLUSIONS

Friedwald's success is a direct result of the staff members' team building approach, focused adherence to day-to-day practice; drill down of infection control protocols; audits of compliance; ongoing staff education; and most importantly, the nursing home's use of data monitoring and analysis in quality improvement practice and problem solving.

Quality Payment Program

INTERNAL MEDICINE ASSOCIATES OF AUBURN

In recognition of organization-wide commitment to quality improvement and exemplary performance in the practice's ongoing transition to an Alternative Payment Model (APM) / Advanced APM.

QUALITY PAYMENT PROGRAM (QPP), MERIT BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Internal Medicine Associates of Auburn has worked diligently to align its workflows with MIPS performance categories, achieved a perfect 100 score in 2017, and based on current data, is projected to attain perfect performance in 2018.

The practice's successful participation in a performance improvement program implemented by one of its health plans further demonstrates its ongoing commitment to providing the highest quality care to patients; exceeding 2017–2018 target performance rates on measures related to disease prevention and chronic disease management.

ABOUT THE PRACTICE

Internal Medicine Associates of Auburn is a private group physician practice located in Auburn, New York. Established in 1975, the practice has enjoyed a long and distinguished history of health care delivery. Today Internal Medicine Associates of Auburn includes five physicians, board certified in family and internal medicine as well as three nurse practitioners certified in family and adult medicine. The practice's history demonstrates commitment to the residents of Auburn and surrounding communities.

METHODS OR APPROACH

Since 2015, in addition to MIPS, Internal Medicine Associates of Auburn has participated in multiple value-based quality programs with a variety of payers, including Medicare, Medicare Advantage, Medicaid, and commercial insurers. Each program, unique in its own design, is based on capturing data, such as HEDIS measures, annual wellness visits, chronic disease management, transitional care management, and medication adherence.

Starting in 2017, the practice worked closely with IPRO to ensure that its workflows and data collection aligned with the MIPS program, while minimizing disruption of their current and ongoing initiatives.

RESULTS

Internal Medicine Associates' performance scores have consistently reached the highest tier possible, an indication of ongoing focus on patient care, teamwork and organization. For performance year 2017, the practice's MIPS score reached 100 points resulting in a 1.88% positive payment adjustment for payment year 2020. This performance was maintained for 2018 and is expected to hold for 2019.

CONCLUSIONS

The entire staff at Internal Medicine Associates of Auburn works together toward achieving the broader objectives of the practice. Each staff member understands that what they do today impacts the future success of the group. With attention on quality, patient care and satisfaction, outcomes and cost, there is a common understanding that the practice is accelerating from fee-for-service to value-based healthcare. The practice remains acutely aware of the need to adapt to meet the changing healthcare environment, while continuing its commitment to deliver the highest quality of care to their patients.

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