

# Quality Collaborative

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

## Hospitals and Nursing Homes Make Progress Toward Reducing Avoidable Readmissions

Since the February launch of the *IMPACT (IMprove Processes And Care Transitions)* to Reduce Readmissions Collaborative, doctors, nurses, administrators, and other key staff members from the 19 participating hospitals and their 29 nursing home partners have been addressing the challenges that arise when nursing home residents require hospital emergency department services or hospital admission. With support from the UHF, GNYHA, and Continuing Care Leadership Coalition staff, *IMPACT* participants are working in teams to develop and implement standardized protocols for transferring residents from a nursing home to an emergency department and managing them once there.

As one element of reducing unnecessary hospitalizations, team members are ensuring that emergency department clinicians have timely access to key patient information, so they can expedite treatment and, when appropriate, return the resident safely to the nursing home without hospital admission. One of the main approaches teams have taken to ensure that key patient information is conveyed appropriately across care settings is standardizing communication through “warm” hand-offs between providers. For instance, sometimes nursing homes will need to send a patient to the hospital because they require assistance with re-inserting a feeding tube or catheter. Oftentimes, this procedure does not require an inpatient admission.

Identifying the appropriate contacts in both care settings, and having a process and structure for providers to communicate with each other during the transfer process, can help avoid unnecessary readmissions. Standardizing communication during transitions promotes the effective involvement of patients, family caregivers, and other family members, because they also can provide critical patient information that may be overlooked by providers.

Teams are also working together to identify opportunities to educate nursing home staff on the early warning signs and treatment of certain common conditions,

since identifying symptoms and starting treatment as early as possible may forestall a hospital admission.

Staff from each hospital and its nursing home partner(s) have been meeting regularly since February to identify goals, pool information, draft work plans, and share effective tools.

Bringing together all the participants, learning sessions at GNYHA have provided broader educational opportunities, focusing on such topics as the value of case reviews in understanding why readmissions are occurring and ways to effectively involve family caregivers in transitions between settings. Other topics have included when to call in palliative care clinicians, the benefits of palliative care for the chronically ill, medication reconciliation across care settings, advance care planning prior to hospital discharge and in the nursing home, and the benefits of completion of Medical Orders for Life-Sustaining Treatment.

Team members have also conducted site visits—hospital staff visiting nursing homes, and nursing home staff visiting hospitals—to help build mutual understanding and to inform refinement of proposed communication processes.

GNYHA’s data analytics team has developed a data-collection tool to track discharges and readmissions between

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# Lutheran Medical Center: Why Collaboratives Have Worked for Us

GUEST COLUMNIST

**Wendy Z. Goldstein**  
President and CEO  
Lutheran Medical Center

**A**t Lutheran HealthCare, we have a historic commitment to serving a diverse community—through our 400-bed teaching hospital, Lutheran Medical Center, our extended care and rehabilitation facility, and numerous outpatient facilities in southwest Brooklyn, all offering both health care and patient support services. Although each operates independently, we make sure they collaborate so our patients move smoothly from one setting of care to the next. We are dedicated to providing the highest quality of care to all of our patients and are engaged in a number of innovative quality and patient safety programs, including those offered by GNYHA and UHF.

Lutheran Medical Center has been an active participant in the GNYHA/UHF quality improvement collaboratives for years. The collaboratives' emphasis on a multidisciplinary team approach to patient care, with standardized evidence-based care bundles/clinical protocols at the core, has been critical to our success. The collaboratives work because they provide a structure that serves as a roadmap and impose a discipline with a strict set of deadlines, while providing benchmarks for performance and opportunities to network with our peer institutions. Learning from other regional experts has been invaluable. All these benefits facilitate our team's work, ensure that competing priorities don't drive the effort

off course, and support us in achieving our goals. As a result of participating in the GNYHA/UHF *C. difficile*, Central Line–Associated Bloodstream Infection, and *STOP* Sepsis Collaboratives, we have improved outcomes of care and—equally important—implemented changes that make these results sustainable. With *STOP* Sepsis in particular, Lutheran experienced a reduction in mortality rates and became positioned to meet the requirements of New York State's sepsis regulations in a much more manageable way. Currently, Lutheran is engaged in the GNYHA/UHF *IMPACT* to Reduce Readmissions Collaborative, which will be enormously helpful to us as we improve care coordination and processes to streamline transitions from one setting to another.

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I am proud to say that many of the collaboratives' clinical leaders and advisory workgroup members are Lutheran physicians, nurses, and administrators. For the *STOP* Sepsis initiative specifically, Lutheran

contributed expertise that was instrumental in developing the checklist that all of the *STOP* Sepsis participants implemented.

The GNYHA/UHF Clinical Quality Fellowship Program (CQFP) has been a tremendous resource for Lutheran, as well. Seven of our clinicians—four physicians and three nurses—have completed the program and integrated what they learned into their respective departments. A number of CQFP Capstone projects have resulted in presentations at national meetings, but all have been extremely valuable to us. Areas of focus include the patient experience of care, medication reconciliation for geriatric trauma patients, early recognition of sepsis in the emergency department, performance improvement in therapeutic anticoagulation, and trauma patient assessment and management. By addressing one specific area, each fellow experiences how solutions involve multiple departments and have reverberations throughout the hospital. This builds upon the interdisciplinary sensibility we advocate at Lutheran, and has further developed fellows' skills and big-picture perspectives.

We at Lutheran Medical Center will continue our longstanding, unwavering commitment to providing the highest quality of care. We have benefited enormously from the quality and patient safety programs and initiatives offered by GNYHA and UHF, and plan to continue to play an active role as clinical advisors to both organizations and the other participants in future collaboratives. ■

# Fellowship Lessons Improve Ambulatory Care

**F**or a perspective on quality improvement in the ambulatory care setting, we spoke with Amanda Ascher, MD, Medical Director, New York City (NYC) Health and Hospitals Corporation's Segundo Ruiz Belvis Diagnostic and Treatment Center. Dr. Ascher was a member of the 2010–11 class of the Clinical Quality Fellowship Program, the GNYHA/UHF intensive training program that prepares mid-career physicians and nurses to become the next generation of clinical quality improvement leaders.

**Quality Collaborative:** As health reform is taking hold, how has quality improvement changed in the ambulatory care setting?

**Amanda Ascher, MD:** From 2009 to now, we have adopted a broader range of quality improvement measures, many involving preventive care. As our focus has changed to measuring quality outcomes, rather than the number of services or procedures we provide, we are addressing challenges like length of stay and preventable readmissions. You can't focus on those, though, without involving ambulatory care clinicians. With this greater focus on outcomes, we are hiring staff to analyze these data.

**QC:** Do you have more of a connection to the inpatient setting now?

**AA:** Connecting with the inpatient setting is a work in progress. At NYC Health and Hospitals Corporation, we have an electronic medical record that integrates the in- and out-patient records so I've long been able to find out if a patient was in the emergency department (ED) or had been admitted—but only if I happened to pull up that patient's record. Now, if one of my patients is admitted to our clinic's sister hospital, Lincoln Medical and Mental

Health Center, I get an e-mail letting me know. Our head nurses also print out a report every day that shows which of our patients were admitted or in the ED, to ensure appropriate follow-up.

This is critical information as we work to reduce preventable readmissions. Our goal is to see all our patients who have been hospitalized within 30 days of discharge. For many patients, we strive to make that within seven days—when clinical assessment makes a follow-up visit a high priority by distinguishing, for example, between a patient who was in the ED because of a viral illness, which often poses less of a long-term health risk, and a patient with exacerbated congestive heart failure.

**QC:** Are you also making connections between physical and behavioral health?

**AA:** Yes, we have been working on integrating physical and behavioral health as part of our New York State medical health home project. We regularly meet with a psychiatrist from Lincoln Recovery Center, a substance abuse program co-located in Belvis, as part of our collaborative care interdisciplinary team, and we discuss patients referred to the team for depression. Our nurse care manager tracks relevant behavioral health and chronic disease metrics. We are about to hire our own psychiatrist to not only evaluate and see patients on a regular basis, but to also become a member of our collaborative care team, identifying opportunities to improve the care of our primary care patients who need behavioral health services.

**QC:** What lessons from the Clinical Quality Fellowship Program are still informing your work?

**AA:** One of my big takeaways was a piece

of feedback I received repeatedly: the mantra “smaller, smaller, smaller.” I kept thinking that since my Capstone quality improvement project was something I'd be working on for over a year, I should aim for something big. But I learned that it's too hard to effect big change—you need to focus on small differences. That lesson continues to shape my quality improvement work today, reminding me to focus on well-scoped, smaller-scale initiatives that eventually can be broadened.

I also learned that quality improvement work almost always boils down to culture change. Altering an electronic system to effect the change you want is not nearly as challenging as getting people to interact differently, more effectively.

Another lesson relates to seeing data differently—reframing data in a way that demonstrates broader implications. In my Capstone project, the key data point was how many patients we could provide with medication refills without their having to see the doctor. The program's faculty members helped me understand that those numbers could be reinterpreted to show saved patient care hours. To say, for example, that we were able to expedite refills for 20 prescriptions is one thing. But to show that, in May, we saved “Dr. Jones” six hours and 40 minutes of time that could be devoted to other patients really registers strongly with our nurses—and getting them on board is critical. Reframing data can also be very important where senior administrators need convincing.

**QC:** Your Capstone project was a great example of how they are supposed to work. Has it been sustainable?

**AA:** Yes; but, we are now exploring

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# STOP Sepsis Update

Nearly 200 physicians, nurses, and interdisciplinary hospital staff working in intensive care units, emergency departments, and quality improvement departments participated in a conference this summer hosted by GNYHA and UHF for *STOP Sepsis Collaborative* participants. The conference featured Derek Angus, MD, MPH, Chair of the Department of Critical Care Medicine at the University of Pittsburgh Medical Center Health System, who discussed his landmark work on sepsis. As principal investigator of the Protocolized Care for Early Septic Shock trial—the first multicenter study of alternative resuscitation strategies for septic shock—Dr. Angus explained the trial’s findings, including that early detection and vigilant, evidence-based care are critical in treating sepsis. The study also concluded that invasive treatment is not superior to alternatives. These findings are particularly meaningful to GNYHA and UHF because they validate the approach and efforts of the *STOP Sepsis Collaborative*.

Also during the summer, the *STOP Sepsis Collaborative* continued its active assistance to hospitals in implementing standard protocols of early recognition and treatment of severe sepsis and septic shock, as well as supporting hospitals to meet New York State sepsis regulations. Supporting these efforts, monthly GNYHA/UHF conference calls again gave participants opportunities to share successful strategies for capturing and reporting data and discuss operationalizing emerging

evidence in the field. The sessions also provided the opportunity for participants to directly ask representatives of the New York State Department of Health’s Office of Quality and Patient Safety and IPRO about the State’s sepsis regulations and data reporting program.

**The Work Ahead** GNYHA and UHF remain committed to keeping members informed of new legislative developments and offering educational seminars. GNYHA continues to be a strong advocate for sound public policy as it relates to sepsis, and will continue to work closely with member institutions on their internal sepsis improvement efforts. Additionally, as part of efforts to assist members in delivery system transformation and building clinical capacity outside of the acute care setting, GNYHA is planning to offer educational opportunities to long-term care facilities participating in the GNYHA/UHF *IMPACT Collaborative* as it relates to early identification and treatment of sepsis in the nursing home setting.

## About the *STOP Sepsis Collaborative*

GNYHA and UHF have partnered to lead the *STOP Sepsis Collaborative* to support hospitals’ efforts to improve sepsis care processes and reduce mortality since 2010. Through the initiative, hospitals have been provided with education via in-person conferences and webinars, tools and resources such as template protocols and resuscitation checklists, and hospital-specific performance improvement data analytics. ■

## Readmissions (continued)

partnering facilities. Hospitals and nursing homes submit data monthly for select process and outcome measurement, and GNYHA analyzes the data and provides monthly aggregate reports. These reports will help identify issues that present the greatest opportunity for improvement.

In 2015, GNYHA plans to build on the lessons from *IMPACT* by supporting hospitals in their efforts to work with home care agencies to build similar processes for transitioning patients to home post-discharge. GNYHA will also continue to support hospital and nursing home partnerships. ■

## Lessons (continued)

whether we can make the refill process even more efficient through phone renewals by involving nurses only when clinical judgment is necessary. I’ve learned that quality improvement means taking a fresh look at processes and thinking about small adjustments to make them work better, saving time or money or making things better for patients, or both. ■

## Quality Collaborative

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

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

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

