MINUTES – DRAFT
QUALITY IMPROVEMENT AND PATIENT SAFETY COMMITTEE
May 10, 2017

Quality Improvement & Patient Safety Committee
John Ostuni, Chair, MD, Chair, *Westbury*
Evelyn Dooley Seidman, MD, Vice-Chair, *Westbury*
Samuel Gelfand, MD, *via telephone*
Greg Pinto, MD, *via Web*
Barry Rabin, MD, *via telephone*

MSSNY Staff:
Moe Auster, Esq., MSSNY Staff, Division of Governmental Affairs
Pat Clancy, MSSNY Staff, Division of Governmental Affairs
Carrie Harring, MSSNY Staff, Division of Governmental Affairs
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1. Welcome and Roll Call

2. Approval of Minutes:
The minutes of May 10, 2017 were unanimously approved.

Dr. Ostuni said that on page two of the minutes there were two bundled payment models that would hold hospitals financially responsible for 90-day episodes of care. The first was a comprehensive joint replacement and the other was related to cardiac care. The cardiac bundle has now been eliminated. The joint replacement bundle has been limited. The number of hospital localities required to participate in that has been significantly reduced. When they refer to the bundle, what they were talking about is essentially everyone would be paid fee-for-service for Part A and Part B but, after a year, they would look back to the whether the overall spending had exceeded or was below a certain benchmark. If the benchmark was exceeded, then the hospital would be responsible for paying back to the government the amount by which it exceeded the threshold. The joint replacement went into effect in April 2016 but it was only going into effect in certain regions across the country. In the Buffalo area they stopped it from going forward. It is going forward in the New York City area. Dr. Ostuni said that the big problem they have in long term care is that frequently we get people coming into the nursing home in their 80ôs having tons of surgery and after 30-days they donôt count against the hospital or the surgeon. Dr. Ostuni asked that on the next paragraph was there was any change to the three-day rule for observation counting toward the three-day rule? Moe said that he believes that has not changed.

3. Presentation by Emily Lutterloh, MD, MPH, NYSDOH Director, Bureau of Healthcare Infections "Collaboration to Launch Antibiotic Stewardship Programs (CLASP) in Long Term Care Facilities"
There was a presentation by DOH on the CLASP project. Slides were reviewed on screen; committee members also have a hard copy. DOH has had four projects since 2010 and initially the focus was on the best practices to control and prevent C. Difficile infection (CDI). There was some interest by the CDCôs in getting nursing homes to use the long term care facility component. The CMS final rule revised the requirements that LTCFôs must meet to participate in Medicare and Medicaid program. The requirement to have an antibiotic stewardship program is coming up as is the requirement to have a trained prevention infection and control officer. The CDC released guidelines specifically related to nursing homes in 2015. The guidelines are similar to the hospital guidelines and have the seven core elements listed, including leadership, accountability, drug expertise, actions to improve use, monitoring prescription, use and resistance and reporting information to staff and education. This is information from CDC that we looked at while developing our project.

DOH sent an informational message to all NYS nursing homes in March 2017 inviting them to participate in the CLASP project. The DOH would guide them and help them get started with stewardship in their facility with a particular focus on UTIôs. It started in May 2017 and will continue through April 2018. DOH started data collection in May. The goals are to get facilities to implement one or more elements of a stewardship program, focus is on appropriate use of antibiotics when a UTI is suspected and to have some reporting to the UTI module in NHSN. The participating facilities have committed to a year and this all voluntary. There have been several

educational webinars. A questionnaire was completed at the beginning and they will also complete a questionnaire end of the project year about what stewardship components have been implemented. DOH also asked them to keep track of antibiotics starts that may possibly be related to some general UTI data an implement one of the activities of Core Elements of Stewardship and we have some who are optionally reporting on the NHSN UTI modules. We also have a smaller group of seven facilities who have expressed an interest in doing more. We told our participants that if you are interested in working more intensively with us, we are willing to do that. They are doing everything the larger group is doing but they are also using NHSN to report UTI data for the entire 12-months of the project.

Here is some preliminary data from the 621 nursing homes. There are 18% in our project. The number completing the pre-project survey was 95%. The number that submitted antibiotic tracking sheets in May 2017 was 65. Most of them have a leader for the impact of activities for the use of antibiotics, itôs about ¾. There was a lot of involvement with the medical director. We were mainly working with the infection preventionist in nursing homes. The pre-survey data shows what intervention the facility uses to antibiotic use and these are based on our pre-project survey. Very few have an antibiotic review process.

Dr. Ostuni commented that when he started the antibiotic stewardship in his nursing home, he was a little bit concerned approaching doctors. He thought that he would meet making without someone saying we canôt do that. I thought that would be met with a lot of resistance but wasnôt. We took two areas, urinary tract infections and upper respiratory infections and got very good results. The number of UTIôs dropped precipitously and antibiotic usages. We did correlate our program with one of our big hospitals who sent a lot of patients to the nursing facility and it worked very well. This is a program that really helps.

4. Presentation by Elizabeth Dufort, MD, FAAP, Medical Director, Division of Epidemiology, NYS Department of Health Antibiotic Resistance Task Force - "NYS Department of Health Antibiotic Resistance Program"

There was a slide presentation by Dr. Dufort. Antimicrobial Resistance has nationally has been recognized over the last few years and even more every year. New York State needs to do more on a national level and in a more deliberate fashion. There have been over two million infections and 23,000 deaths estimated annually. Just last year, the CDC issued two alerts in June 2016. DOH has been working on this in NYS and we have worked furiously on candida auris. Over 140 cases between clinical and screening cases found out of about 160 nationally. MCR-1 is about four. We all know that this is of continued concern. In 2001 to 2016, the KPC or CRE was rarely recognized and not a significant widespread problem. The CDC plan and President Obamaôs plan categorizes urgent and serious threats. The CDC also had some info-graphics and data about why we need to work together. The common approach is really siloed and minimum independent efforts are more and more a part of what is going on right now with independent efforts in facilities but we really need coordinated and collaborative approaches as people cross from facility to facility.

A little over a year ago DOH started working on trying an NYS AR Prevention and Control Task Force. MSSNY as one of the first organizations the DOH called to come on board and has been involved from the start. The DOH continues to look for ways to engage the larger MSSNY groups and appropriately Pat Clancy thought of this forum for further discussion. The mission is to create partnerships, develop new initiatives and enhance collaboration to prevent and control antimicrobial resistance and reduce the burden of disease with a vision to create a NYS free of preventable disease due AR. The task force has been trying to get all the relevant partners and stakeholders to the table. DOH developed four working groups and four committees, the healthcare facility based AR prevention and control, community-based prevention and control, one health and laboratory and diagnostics. The first two primarily are the bulk where MSSNYôs opinion, involvement and coordination is sought. Each committee worked on developing AR priorities and metrics for success to be included in the NYS AR strategic approach. External partners invited to this task force included providers, professional organizations, MSSNY being one of them, and several others, hospitals and nursing home associations, academic partners and other NYS agencies. All input was sought to develop a draft strategic approach.

We inventoried existing activities at DOH including the cost project and developed a survey tool to get everyoneôs in-depth priorities and what activities to get to those goals. Over the last year DOH have developed a rough draft document and it has made a lot of progress. The aim was to send this on to the executive chamber to highlight what we think is a priority for the state and to put this into understandable format. The current working name is NYS Star Initiative. They have developed basic topic areas with five major goals/strategies which is are to increase education and awareness through educational campaigns targeted at patients, consumers and providers, enhance

optimal antibiotic use to through efforts aimed across the spectrum of heath care, faster detection of AR to enhance detection, improve control of AR through implementation of evidence-based practices and strengthen collaboration across regions and disciplines. Following Dr. Dufortôs presentation, committee members asked questions.

Moe indicated to Dr. Dufort that MSSNY has a number of communication tools with our own members, whether it is weekly or monthly newsletters and perhaps DOH could use them. Dr. Dufort indicated that more information will Dr. Dufort indicated that there will be an NYS AR Task Force Summit in Albany and via webinar on November 30th. More information will soon be available to committee members following this meeting.

5. MOC and CME Program

Miriam Hardin presented on Continuing Medical Education. She wanted to let the committee know of these arrangements that currently three of the specialty boards have with the ACCME to provide CME that counts for MOC(A) points. The whole idea behind this initiative is a simpler unified process.

- CME providers are no longer required to submit MOC applications for approval to the certifying boards that are collaborating with the ACCME. The accredited ACCME providers are able to use the ACCME program and Activity Reporting System (PARS) to register activities for these programs.
- As part of this registration process, providers attest to compliance with certifying board requirements, agree to collect the required individual participant completion data and submit it via PARS, agree to abide by ACCME to publish data about the activity on ACCMEôs website and agree to comply with requests for information about the activity if the activity is selected for an audit by the ACCME.
- The registration process is available for CME providers in the ACCME system, including state-accredited providers, providers directly accredited by the ACCME and providers that have received Joint Accreditation for Interprofessional Continuing Education.
- These collaborations offer additional choices but no new ACCME requirements. CME providers in the ACCME system have the option but are not required to offer accredited CME that meets certifying board MOC(A) program requirements and to submit activity and participant completion data through PARS to the certifying board.

The ABIM were the early adopters and came on board in August 2015. Last year the pediatricians and the anesthesiologists came on board as well. The ACCME is currently negotiating with other boards to work with them on MOC arrangements. It is anticipated that sometime next year the American Board of Pathology will also become available in PARS for registration for pathology MOC. As mentioned previously, there is a system called PARS and basically everyone who is a CME provider goes into the system and reports data about their CME activities. One of the new things that the ACCME added is the opportunity to put in information about MOC activities. There is a section now for MOC(A) with the opportunity to check whichever boards apply. Each board has requirements for entry of the content areas that are to be covered in the CME activity. The ACCME provides a website, CMEFinder.org, that allows learners to search for CME activities that count for MOC(A) points. There is a section in the PARS form where it is possible to fill-in the information about the activity which will make it findable so actually it is a way to drive more learners to your MOC/CME.

This is where MSSNY is in the process with CME that accounts for MOCA points.

- In its role as an accredited provider MSSNY has not yet provided CME that counts for MOC or MOCA points.
- Four of the CME provider that MSSNY accredits, as a recognized accreditor, has offered CME that counts for MOC or MOCA points.
- The forms and processes are being developed.
- The MSSNY CME Committee determined that MSSNY should move toward providing MOC CME.
- This is an area that lends itself to collaboration between the Quality Improvement and Safety Committee and the CME Committee.

Dr. Ostuni agreed that it would be a good thing for physicians to be able to earn MOC points for the CME courses that they would be taking anyway. He thanked Miriam and asked that she keep the committee posted with any new developments.

New Business:

Dr. Ostuni has proposed resolutions for the 2018 House of Delegates and proposed the following:

Whereas, observation status is defined as outpatient service that a physician orders to allow for testing and medical evaluation of the patient's condition;

Whereas, observation status usually takes place in the emergency room after an acute event as defined by patient;

Whereas, observation status impacts our elderly population as it does not count toward the three-day rule for skilled nursing care essentially requiring the patients of a Medicare benefit; and

***Resolved**, That, in the judgement of the attending physician, the emergency physician and the social worker, that skilled nursing care is the most appropriate care for the patient that observation status will serve as the substitute three-day hospitalization for medical eligibility for skilled care.*

Dr. Maese is very supportive of this because it speaks to decreased cost of care and gets patients into the right setting of care as soon as possible. Dr. Ostuni said that what they are saying is that the two-day rule will count towards the three-day hospitalization. Moe will vet this with HANYS just to confirm that we are on the same page with that idea.

Dr. Ostuni noted that the committee was sent a Report to Congress on the Commission on Long Term that President Obama had put together in 2013. The report was silent on funding and that was the weakness of it.

The resolution that Dr. Ostuni would like to see is:

Whereas, as long term care services are received by over 12 million Americans today, with projections pushing the number to over 27 million in the next 40 years;

Whereas, the long term services can quickly exhaust private resources and, as a result, two-thirds of long term care is paid out of our Medicaid program;

Whereas, past and current discussions on our healthcare system are silent on long term care .

***Resolved**, that Medicare which now covers 100% of the first 20-days of skilled nursing facility be increased to cover the first 90-days after which, if long term care is still required, funding from a new long term care trust fund, funded by a broad-based tax.*

Dr. Dooley said they mentioned this life care annuity, a combination insurance program and Dr. Ostuni said that that is long term care insurance (private). NYS has some of the best laws when it comes to long term care. Physicians get a tax credit on their premiums. NYS has many different programs in use but only 12% of people are covered under long term care insurance.

CME Program at 2018 House of Delegates:

The CME program for the 2018 MSSNY House of Delegates is usually sponsored by this committee. However, Pat said that she has spoken to Dr. Tom Madejski and Erie County wants to do something on the substance abuse issue in Western New York.

Future Agenda Items:

Dr. Ostuni said that at the next meeting he would like to discuss Medicaid Block Grants and what that would mean for New York State. With regard to the Medicare Quality Improvement Program Practice Transformation, Clare Bradley may be able to obtain speakers on this issue. He also wanted to discuss high-deductible health insurance.

Next Meeting and Adjournment:

The committee will meet again on January 24, 2017 from 1:00 PM to 3:00 PM for the next meeting. Meeting was adjourned.