

**MSSNY's LONG TERM CARE SUBCOMMITTEE MINUTES**  
**January 24, 2018**

**Long Term Care Subcommittee**

John Ostuni, MD, Vice-Chair  
Steven Kaner, MD  
Ruth Kleinman, MD  
Gregory Pinto, MD  
Jay Slotkin, MD  
Joan Cincotta, MSSNY Alliance

**MSSNY Staff**

Pat Clancy, Staff, Division of Governmental Affairs  
Moe Auster, Esq., Staff, Division of Governmental Affairs  
Anna Cioffi, Staff, Division of Governmental Affairs

**Invited Guest: Presentation of the NYS Sepsis Care Improvement Initiative**

Marcus Friedrich, MD, MBA, FACP, Chief Medical Officer, Office of Quality & Patient Safety, NYS Department of Health

**Welcome and Introductions:** Dr. Ostuni welcomed the subcommittee.

**1. Approval of the Minutes:** The minutes of September 27, 2017 were approved.

**2. Presentation by Marcus Friedrich, MD on the New York Sepsis Program:**

Dr. Friedrich is a practicing primary care physician and is doing primary HIV care in the community. His main job is in the Department of Health, where he is the Chief Medical Officer of the Office of Quality and Patient Safety. He is in charge of sepsis, cardiac, stroke, primary care, and a host of other initiatives in the state. He provided the following slides to the group:

**Sepsis in New York State**

- Approximately 50,000 patients are diagnosed with severe sepsis or septic shock. Almost 30% of adults, 9% of children, die in hospitals.
- Early detection coupled with appropriate interventions can improve the chances of survival for patients with sepsis.

**Background**

- In 2012, sepsis was beginning to be recognized as an issue, fueled by: national interest; local interest (stop sepsis campaign in New York City, IHI and Rory Staunton which led to a NY state initiative in 2013 requiring hospitals to develop clinical protocols for adults and children and submit to DOH for approval that included evidence informed protocols for early recognition and treatment for severe sepsis and septic shock; ongoing clinical and non-clinical staff training protocols and reporting data to DOH/IPRO.

**Department Actions:**

- Created a sepsis advisory group, developed a data dictionary, data collected quarterly, 70 variables, convened a group of clinical advisors from different pediatric subspecialties to develop a one-hour bundle for pediatrics.
- Data collection started Q2, 2014.
- Hospitals have the ability to correct data.
- Audit of data.
- Increasing alignment with CME-SEP-1.
- Allow sampling in hospitals.

**Quarterly Data Reports from/to Hospitals**

## Hospitals to DOH/IPRO

- Quarterly reported severe sepsis and septic shock cases up to two-months after closure of quarter.
- Including all transfer cases.

## DOH/IPRO to Hospitals

- Quarterly performance reports included; demographics, protocol exclusions, protocol implementation, treatment variables, treatment bundles and time zero transfers.
  - Quarterly performance report includes demographics, protocol exclusions, protocol implementation, treatment variables, treatment bundles and time zero, transfers.

## **Annual Public Report**

- Describes the quality of care and outcomes for patients treated for severe sepsis/septic shock at NYS hospitals.
- Data reported for 174 hospitals.
- First report of its kind in the nation.

## **Outcome Measures in Report**

- Crude adult (18 years and older) in-hospital mortality rate.
- Crude pediatric (0-17 years) in-hospital mortality rate. (Note: More variability due to significantly smaller numbers of pediatric patients and lower mortality rate.)
- Adult risk-adjusted mortality rates (RAMR)
  - Accounts for patient demographic factors, sepsis severity and chronic conditions.
  - Adjustment is necessary to compare rates across hospitals.

## **Results of Analyses**

After adjusting for patients factors, the odds of dying are

- 21% less for adult patients for whom a protocol was initiated at the hospital compared to patients for whom a protocol was not initiated.
- 27% less for adult patients who receive all of the recommended treatments within three hours compared to patients who do not receive all of the recommended treatments.
- 26% less for adult patients who receive all of the recommended treatments within six-hours compared to patients who do not receive all of the recommended treatments.

## Next Steps ó Focus on Quality Improvement

- Variation in mortality rates = quality improvement opportunity to improve and saves lives.
- Data collection improvement and alignment with CME.
- Analysis to evaluation relationship between protocol adherence measures, specific interventions, patient/care characteristics and outcomes in adults and pediatrics.
- Analysis by linking UAS/MDS state data and sepsis database, data sharing with hospitals.

## Summary

- NY State Sepsis initiative to shift focus on quality improvement.
- Linking clinical data to outcomes by using NY State HIT infrastructure to improve care.
- Using the APD for further improve quality of care.

Dr. Ostuni asked that it looks like both the bundles in adult and pediatric side have to be done very quickly and it seems like that is the emergency room rather than in-patient. Are we looking into the wait time in the emergency room till these patients are seen or their bundle is put in place?

Dr. Friedrich responded by saying that when we risk-adjust data, the age is one of the bigger adjustors. We adjust for age in our risk-adjust mortality measurements but we also have it by age group and it has been shown that sepsis is deadly in every age group and some age groups more deadly than in other age groups but we have enough cases of younger people also dying from sepsis. We think these evidence-based protocols can make a difference in the hospitals by treating this. Of course, patients with higher

core morbidity load - the older population is more prone but once we risk-adjust it, this is taking into account and the core morbidities including diabetes and other chronic diseases, this risk-adjustment can actually make a difference in the hospitals by treating this.

D. Ostuni asked about the mortality data is it broken down further than just over 18? Do we have the adult population by decade? Having been a clinician for many years, sepsis is frequently a terminal event, and the mortality in the over 80 group has got to be high. How do you work that into your data so it doesn't skew the effect of the bundles?

Dr. Freidrich responded he thinks that this is the cure for all the value-based diseases going forward. It has been shown in my personal experience but also looking at the data it is inherently complicated. You mentioned wait times in the emergency room. The coding of the patient, like once the patient leaves the hospital, suddenly he is in a bundle versus the practitioner who has no idea why he was in the bundle and why he was in the hospital. These are all issues that are inherently complicated and I am very curious how CMS and some of the Medicaid bundles will work out in the long run for the practitioners but, of course, wait time in the emergency room is a factor and this needs to be looked at going forward.

Dr. Slotkin commented that this work is incredibly important. Dr. Freidrich responded by saying that they focus on hospital first. The nursing home environment is totally different. Dr. Friedrich indicated that the direction is pretty clear in that the nursing home arena needs to be targeted and indicated that the smaller hospitals are doing better than the big academic centers and we were looking for a reason. The staff in the smaller hospitals may be better educated than in the large academic center where thousands of people are touching patients. It shows that smaller hospitals have better mortality rates than the large centers. Moe asked if that was true cross different regions across the state. Dr. Friedrich responded by saying that overall it is true.

Pat Clancy said that the Home Care Association is developing a sepsis initiative across the state. HCA received a grant from the Health Foundation, received the grant and are providing education awareness to the health community including physicians about sepsis. Al Cardillo will make a presentation at the next meeting

On the stats regarding the SHIN-NY, Val Gray has recognized the concerns of a lot of the physicians have about the adoption and implementation of EHR and Dr. Freidrich said that they are still in the process of adopting this and the numbers look encouraging.

### **Report on Long Term Care Home Care Task Force**

Moe noted that that meeting was on October 10, 2017 and the focus was on the implementation of the Medicaid face-to-face requirement. The face-to-face requirement was exempted from Medicaid Managed Care which is really where the vast majority of Medicaid recipients are enrolled. While six-million people or so are enrolled in Medicaid in New York, about five-million were exempted from the requirement for the Medicaid face-to-face requirement. Initially, there had been little complaints about the paperwork associated with it.

There was a discussion as well about Medicare face-to-face as a result of a resolution that came from this subcommittee. It was a resolution adopted by MSSNY at the House of Delegates in 2017 and went to the AMA. The AMA did not adopt what MSSNY recommended and simply re-affirmed existing policy which called for greater education about the challenges associated with face-to-face. Moe had discussions with the AMA chief regulatory staff person who indicated that this is on the AMA's list of regulatory issues. Last year, Trump Administration contacted entities across the country looking for suggestions in relieving Medicaid regulatory burdens. When the AMA put together this list, this was one of the things that had been put on the table.

We talked about the sepsis program and about a home care/hospital physician collaborative to receive grants, to find better ways for physicians, home care and hospitals to coordinate with each other and to help with streamlining the prompt evaluation of patients to assess their risk for falls. We also talked

about this community para-medicine program which was actually introduced in the budget. The Governor's 2018 budget contains a piece that would enable, provided there is a connection with the hospital and the physician, EMTs, to provide non-emergency home care services. We have expressed concerns about it and the home care communities have also expressed concerns about it. One of the areas of concern is the collaborative would have to disclose how generally they are going to coordinate with the home-bound patients with treating providers. This can potentially be a positive program but why there is not a greater requirement to disclose to the home bound patients treating physicians that these services are being provided through an EMT. Not surprisingly, the Nurses Association has issues with it as well.

Dr. Slotkin added that in terms of the role of the paramedics, that it was a good idea to bring it up because everything is changing with Mt. Sinai is driving to have this hospital/home project for paramedics. What's happening both in the nursing home and in the home care, the patients are getting more and more complicated and people are pushing for these new models.

Dr. Ostuni talked to Dr. Dooley Seidman about the role of the medical director being required for a home care agency. In hospice the default decision goes to the medical director who can sign charts. There are so many opportunities in home care with these hospital home care programs and Dr. Ostuni thinks there is a place for physician leadership. He suggested that if the committee feels strongly about it, they should write a resolution. Dr. Ostuni said that he thought that we had discussed that and had taken a position as a committee, for a medical director at the home care agencies.

### **HOD Resolutions**

Dr. Ostuni said there were two resolutions discussed. Pat said that we are going to be discussing them at the Quality meeting. The first one is as follows;

**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. Ostuni proposed this because people come to the emergency room that are so frail with falls, back pain, fractures, can't ambulate well and it is inappropriate really for them to be in an acute hospital. However, the three day rule but the necessity of the three-day rule applies here. Dr. Ostuni said that what happens is that they keep getting bounded back to an inappropriate setting which is their home and then finally come in with an emergency. The resolution calls for the attending physician and the emergency room physician and the social worker to agree that this patient should go directly to the nursing home. The committee agreed to support this resolution.

### **The Long Term Care Committee**

The second resolution is as follows:

*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; and*

*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.*

This committee proposed a trust fund for long term care which was passed by the House of Delegates two years ago. Obamacare had a long term care committee which compiled an extensive report which initially did not recommend a funding mechanism. Subsequent meetings of that committee came out and

ultimately recommended a trust fund. Pat Clancy recommended putting a resolved in both resolutions that we transmit a copy of the resolution to the AMA for its consideration. With no objections the Long Term Care Committee approved it.

**Committee Appointments**

Dr. Dooley Seidman will be retiring at the end of this. There was discussion about a new chair and Dr. Slotkin indicated that he could be considered if there is staff support.

**Adjournment:** Next meeting will be held on April 2018