Interventions to Enhance Surgical Safety across the Continuum of Care

Good morning, everyone. We are so glad that you can join us for this webinar presentation, which is the last of our series which is focused on No Harm Across the Board for General Surgical Patients. We’re absolutely delighted to welcome the Maimonides team, who have done some absolutely wonderful work in this area in implementing interventions in both the pre, intra, and post-op arena to reduce harm across the board for surgical patients.

So we will lead today with the Maimonides team, followed by questions and answers that you may have for Maria, and facilitated by Maria for the Maimonides team before we go through the next steps and what’s coming up for the rest of 2014.

So I’d like to now introduce the wonderful Maimonides team, who have been at the helm of the multidisciplinary teams that have achieved remarkable success in reducing not only SSIs, but really a multitude of complications that can affect surgical patients. And today we’re joined by Dr. Samuel Kopel, who is the Medical Director and Chief Medical Officer of Maimonides Medical Center. He’s been in this position since the mid 1990s. His previous academic activities focus primarily on research and treatment of homological cancers such as leukemia and lymphoma, as well as cancers affecting the head, neck, lung and breast. He also serves as the principal investigator of research on acute leukemia at Maimonides and the State University of New York. He’s currently retired from patient practice and is spending full time in the CMA position at Maimonides.

He will be joined by Ms. Susan Goldberg, who is the Vice President of Organizational Performance at Maimonides Medical Center. She has been at Maimonides for ten years in her current role and oversees the Medical Center’s quality and safety program along with her Joint Commission Accreditation activities. Additionally, she leads the Patient and Family-Centered Care Committee focused on improving patient and family experience. Susan is a Registered Nurse, having received both her BSN and MPA from New York University.

So good morning Susan, and good morning Dr. Kopel, and welcome to the New York State Partnership for Patients. If you’d like to take the program away.

Good morning.

Good morning, everyone. Thank you very much for this opportunity. So we’ve been asked to talk to the group today about improving surgical safety and outcomes. You may wonder why a hematologist would be doing the presentation, but that’s because Dr. Borgen, our Chairman of Surgery, has a competing commitment and can’t be here this morning.
And we’ll be talking about the quality efforts that we’ve made actually since Dr. Borgen came to Maimonides in 2009 to assume the chairmanship role, so pretty much everything I’m presenting is during that tenure for the past five years.

And when Dr. Borgen first arrived, he announced that his primary goal for the Department of Surgery was to reduce the rate of preventable deaths in our operating theaters and in the various surgical departments, and that is the basis for the projects and the efforts we’ll be showing today.

Previous to his arrival we had always, for about ten years, been members of NSQIP, the National Surgical Quality Improvement Project, and were used to benchmarking ourselves against others. On the slide that’s now on the screen are the strategies that we employed, and these obviously will be familiar to anyone in the PI arena. We established a formal surgical safety committee. In the past five years we’ve recruited a lot of senior physicians to the Maimonides medical staff, all of whom understand that surgery is a team sport and who really completely committed to the programs that we’ll be talking about.

In addition, we’ve had complete buy in from senior leadership from the Board of Trustees and from the President of the hospital.

The teams included, obviously, as they would probably in any organization, experts from surgery, from anesthesiology, from the pharmacy, from nursing, from performance improvement, and my colleagues here with me today in the Department of Performance Improvement were really the drivers of all of these processes. Absent their obsessive commitment, I don’t think any of this would have gotten done.

And as ever in the PI arena, we relied on the data, data, data because there’s just no way to convince doctors to change practices unless you first show them the data.

We’ll divide our talk today into, as mentioned before, into preoperative arena, the conduct of the operation, and then programs that we put into place for the post-operative arena.

So in the preoperative arena, in the past five years we have insisted that every patient coming to the OR, at least all inpatients coming to the OR, be assessed with a preoperative risk assessment with the POSSUM score, which is a comprehensive evidence-based preoperative risk assessment tool that looks at a bunch of physiologic factors and surgical factors, assigns a morbidity and mortality likely outcome to the case. And in all those cases where the POSSUM score is high, we very much urge, without insisting on it because there are emergencies obviously, that a second opinion be obtained from another attending surgeon. The upshot of this has been that we are operating on fewer hopeless cases. And fundamentally the results we’ve seen related to this have to do with better case selection, not that we’re doing better operations
or are more skilled at anything than anybody else. It’s simply that we’re being more selective in who we operate.

As far as additional things that were implemented in the preoperative arena was a program that really began in the past year that was sponsored in part by the fact that Maimonides is part of a group of hospitals that owns a malpractice insurance company. The insurance company asked us to come up with programs that would reduce surgical complications, and if we were successful at doing that, they would actually have an incentive for us of a lowering of our malpractice premium rate.

One of the programs that we came up with in this process was a mandatory preoperative medical assessment for any inpatient who now is going to the operating room. So the program as it was initially organized was that anyone admitted to the hospital, for whatever condition, who during the course of their hospital stay required an inpatient surgical intervention, that person could not go to the operating room without an immediate preoperative repeat medical assessment. And that was true for all ASA three and four cases. So that any seriously ill patient, almost by definition, an inpatient going to surgery would fit those criteria, must, before they go to the OR, have a repeat evaluation. If the patient’s private physician was unavailable for this purpose, we have a hospitalist service that’s here 7/24, and a hospitalist could stand in for the patient’s physician and do that evaluation.

At the present time, well over 90% compliance with this requirement for a preoperative assessment, and we have had some successes in conditions being noted by the hospitalist or the internist seeing the patient and in canceling or changing the approach.

The plan is to now apply this same procedure of a preoperative evaluation to all outpatients coming, or same day patients coming, for surgical procedures to our hospital, and that will be the goal for 2014.

In addition, Maimonides has had a partial, and now nearly complete, electronic medical record, and we have used the EMR to facilitate best practices, and I’m sure this is true at probably every hospital listening in this morning, so we’ve used mandatory pathways to reduce the risk of venous thromboembolism for appropriate antibiotic selections and for a variety of other things.

In the perioperative arena, we have insisted on a preoperative checklist and time out. That’s true for everyone. And we’ll show you the example of how we do that. For the post-op, as the operation is completing we now have a requirement, not yet 100% I will confess but getting better every month, which began in the past year for a post-operative debriefing by the team to make sure that the patient is going to their next treatment venue in the best possible condition.
The other things that were done also in conjunction with the incentive program from our malpractice insurer had to do with team steps training. In the past year we undertook training of 100% of the perioperative services of 300-plus individuals, everything from surgeons, anesthesiologists, residents, nurses, technicians, the personnel in the post-operative recovery unit in the surgical ICUs, etc. Everyone went through a full blown team steps training off campus. And then we had onsite training where we closed the operating rooms for a half a day and trained and retrained 300 people. The intent was to anchor the team steps mechanisms and the briefs, the debriefs, the huddles, and as everyone else does, we also used rapid cycle PDCA for small changes.

The next slide shows the pre-procedure time out. This form is visible on a computer flat screen in every OR where the team gathers in front of the computer in a solemn procession. And it goes through every single item. There’s nothing in here that’s different than what’s done in other places, it’s just that we have managed to, especially with the help of team steps training, to get everyone’s attention. All activity ceases as we go through this.

The following slide shows the items that we cover in our post-operative debrief. Among the surgeons, the anesthesiologist and the nurses confirming the final procedure, confirming that the various pathology specimens are correctly labeled, the plan for intubation/extubation, the plan for disposition and whether anything unusual happened in this particular case that warrants additional attention.

And as the case is finished, the item at the very, very bottom, the wanding, we have a system for wanding the patient because all our sponges have a chip implanted in them with a radio frequency device that allows us, in some cases, to tell if we’ve left a sponge behind.

In the postoperative arena, we’ve instituted a large number of additional procedures and programs. One of them is medical co-management of general surgery and vascular patients. This kicked off in the latter half of the past year. We have a full-time hospitalist who is assigned to manage the patients of a single general surgical and vascular team. All patients who are in-patients who have ASA three or four classification who are not in the intensive care unit are co-managed by the surgeon, the surgical residents, and by a hospitalist co-manager. The same person and the teams over time do coalesce and begin to trust each other. And this, while we don’t yet have any data to show that it has enhanced patient safety, I can tell you that it is remarkably well received by the nursing staff on the units, not just for team building, but the nurses now know whom to call for the management of high blood sugar or hypertension or shortness of breath or what have you and don’t have to wonder whether it’s the PA one, the first year resident, or the second-year surgical resident, or whoever to call for a complication. They can always default to the hospitalist, who is always available.
As mentioned, early results are promising, but I can’t tell you that we have data, but we’re so enthused about the prospect that we are now planning to expand co-management to orthopedics and neurosurgery, and that will begin this year.

Additionally, in the post-operative arena, this year we are implementing a modified early warning system, so called MEWS. We’ve bought a device from one of the manufacturers that simultaneously tracks on the nursing unit a series of vital signs, and with software in the device that then calculates a MEWS score. And the MEWS score is actually seen on the little screen on the device. It calculates the patient’s respiratory rate, takes into account the patient’s respiratory rate I should say, the heart rate, the blood pressure, the level of consciousness, the temperature, and the urine output which is entered every two hours by the floor staff. It then generates a number, and the nursing staff have now been trained, and we’re about to implement this – the devices are being delivered actually this month and next month – in an algorithmic response to the actual score. The nurse is then empowered, if necessary, if the score is high enough, to call the critical care consult directly or at least warn the nurse manager that something is going on or default to the hospitalist. Each score has a slightly different pathway, but the point is it facilitates escalation of any new problem that arises.

In addition to that, the rapid response team has a list of all high risk patients and does an additional series of rounds on these patients at night. Those patients include anyone discharged from the surgical ICU the day before, anyone who was recently extubated, and anyone that the unit staff is particularly worried about.

Our next slide shows the actually activation protocol for the MEWS, which may be too small and too busy a slide for people to read, but fundamentally if the score is a zero or a one it’s green, and the RN first notifies a resident who reassesses the patient. If the score is yellow, it’s escalated to the nurse manager and the rapid response team. If it’s orange, additional items are put into place. And if it’s red, we can call the critical care and the rapid response team simultaneously bypassing the need to figure out which resident is on call.

On the next couple of slides we outline a program that spans the entire continuum, and that is a program that we’ve implemented in the past year for them management of patients with a BMI greater than 40. As everyone knows, obesity is felt to be a national health problem. We all see it in our hospitals. Around seven percent or so of all the patients who come to us for surgery have BMIs of 40 or greater, and we know that there are definitions out there that BMI greater than 35 fit these criteria just as well, but we chose 40 simply in the initial startup phase of the program. And as designed, the program encompasses items to be carried out preoperatively, items to be carried out during the conduct of the operation, and then a series of protocols for the post-operative management.
And as everyone knows, the challenges facing patients with high BMIs including diabetes, sleep apnea, coronary artery disease, thromboembolism, skin and soft tissue infections, all of these are more prevalent, it is felt, in the high BMI patients. The patients have challenges with mobility postoperatively, with skin sores, and we felt not enough attention had been paid to the postoperative management and the post-discharge management of these patients by including a plan for discharge that includes nutritional counseling, sleep apnea studies, pulmonary consultations if necessary, and so forth.

So the team met and tried to develop what were best practices acknowledging that there are no absolute agreement about these. We met to provide education to the various components of our surgical services. We evolved the programs and protocols for discussions of plan with the patient care and the family and the rationale for intensive evaluation. And a reasonable case for what we thought were best practices. And to train the staff about the issues that patients with high BMI face routinely.

The next slide is a little bit complicated, but fundamentally what we've done is the preoperative medical assessment requires that the patient be seen in the PAT, in the Pre-Assessment area, even if they're coming for hernia surgery, or a lymph node biopsy or breast biopsy. In other words, it isn't the gravity of the procedure that determines whether a patient needs a preoperative assessment, it is the fact that they may be at higher risk because of the high BMI. So our rule is that every patient, regardless of the procedure, must be seen in our system for a preoperative evaluation in the PAT testing area. Is met there by a hospitalist again, specially trained for this purpose, who goes over the case one more time. The patient is given additional educational materials and a consent form that has been designed for this purpose.

When the patient arrives at the operating theater, there are different protocols for the anesthetic management including two anesthetic clinicians at the patient's bedside for either intubation or extubation. There are protocols for the conduct of the anesthesia. The surgeon does his or her operation as whatever surgical standards apply.

And then in the postoperative phase, we have some programs that have to do with we feel better postoperative pain management, limiting the use of narcotics in these patients, special protocols for management of their skin evaluations, for mobilizing the patients, and for discharge planning including a nutrition evaluation and, if necessary, a pulmonary evaluation.

All of these things are now protocolized in our electronic medical record. The program kicked off a few months ago and is working actually quite smoothly. Obviously it's way too soon for us to have reliable data on it, but it's something that we're monitoring and are keeping a registry of these patients.
The final thing that I should mention about the postoperative management is that it was the management of the obese patients that caused us to invest in the MEWS program, the Medical Early Warning System program, that I spoke about earlier, and that’s because it incorporates end title CO₂ monitoring for these patients routinely trying to get a slight head start on the possibility that they might be heading into respiratory difficulties, a head start over the way we’ve managed these patients more routinely.

In the postoperative arena for the BMI patients, there is additional protocols for wound care management, and a follow-up phone call once the patients are discharged to find out whether they are having any difficulty whatsoever.

The next few slides show results over time for the past five years or so. On the left side of the screen is a running average for postoperative pulmonary embolism and deep venous thrombosis. We’re glad that we finally have touched national and state averages, but confess that when we began we were three times the national average in this regard. And (inaudible) who is sitting here with me is the person most responsible for his obsessive and compulsive insistence that the people follow the VTE protocols. So here we’re sort of arguing that we are successful, but I’ve only come to national averages, so we’re hoping next year to be better than this.

Similarly, on the right side of the slide, we have the results of postoperative sepsis, which has also shown a decline of some 50% in the last several years.

As is true in the rest of the country, the results for colon surgery – I was about to say colon cancer surgery because I’m an oncologist, slip of the tongue, forgive me – for all colon surgery. To my eyes this looks fairly flat. And on the right side of the slide, there has been a nearly 25% decrease in surgical mortality, and I believe this has as much to do with better case selected as anything else.

So to sum up our last slide, in 2014, the plan is to go to Phase II for our team steps training. Trying to figure out what that might look like, our plan is this year to begin implementing videotaping of the preoperative time out and the postoperative debrief. It will be a sample of all cases. The camera systems and the sound systems have been installed in our operating theaters. We’re developing a set of standardized criteria for critiquing the videotapes by a team of reviewers who we hope will be objective about it. And we hope to give the teams real time, near real time, feedback about the evaluation of the videotapes.

We’re also doing something similar, by the way, in our emergency department with certain high notoriety cases. There are video cameras in the treatment bays, in the resuscitation bays, in our ER, and we use those for the same sorts of purposes.
The other steps are we are working at a preoperative evaluation for all ambulatory and same day procedure cases. We now have sufficient data through the NSQIP program to be able to actually hand out “report cards” to our surgeons that summarizes their performance as against the performance of their colleagues and national or metropolitan-area standards. And for certain high-risk cases, we feel that it really is important to have two experienced clinicians in the room, so for our whipple and major liver resections, that requirement is currently in effect.

That is our presentation, and we very much appreciate your listening to us. Thank you very much.

Thank you, Dr. Kopel, and the entire Maimonides team, Susan. Great work going on at Maimonides, and we want to thank you for sharing your work with the entire New York State Partnership for Patients and your colleagues throughout the state.

We do have a few minute set aside for questions and answers now if everyone could either raise their hand by clicking the small hand icon or typing your question into the Q&A box. We’ll get to those. We’ll also have a few minutes at the end of the program to do the same.

We do have two questions asking about the software EHR for your MEWS system. Katherine (sp) and Landum (sp) both are asking what is your EMR on your MEWS because the one that they are using does not have specific information?

The EMR that we have had since the 90s is the All Scripts system. So this is not a veiled pitch for it. The MEWS system is from Phillips, and we’ve helped them with some of the specifications and they’ve been able to satisfy us. It has all of the items that were mentioned in that slide, and it calculates an actual score, which is visible on the screen. The wrinkle that we had put in is the end title CO2 monitoring that took some time for them to incorporate, but it’s apparently now ready. It’s being delivered. We’ll be putting it on the units in the next month or two, so I’m not an advertisement for them. They have put the system in other hospitals, so we have high hopes for it. Anyway, it’s a Phillips system, and we chose Phillips because a lot of our other hemodynamic monitoring equipment is from Philips and it was easier to integrate with the EMR.

Yeah, I mean I can add that nursing, before we go live with this, is training the nurses without it. So they’re going to be used to assessing using the MEWS score, and the PCTs, and basically the whole team so that they’re comfortable with it before we actually go live. Obviously, you know there’s going to be some technical testing as well. But as Dr. Kopel said, basically our entire organization is using Phillips to integrate all of the vital signs and monitoring that is flowing into our EMR, so we’re very hopeful that this is going to work, and, you know, we’re enthused and we really can’t wait to get it started.
Our hope is that the MEWS will result in a lower rate of failure to rescue. Sounds like a triple negative, but I think that is identified, and many people agree, that failure to rescue is the main issue that separates the very best performing organizations from those more in the middle of the field, and we’re hoping with this MEWS score to save a couple of hours as the patient is beginning to turn sour to take action. And we’ll see.

Yeah. And finally, as most of you or all of you know, in New York State, the Department of Health has now passed legislation relative to implementing protocols to recognize sepsis early and to manage it, and this really, we anticipate, will help with that process as well. We already have our protocols, we’ve rolled them out, but I think this will really help the staff in recognizing, you know, early signs of symptoms of sepsis. So that’s another benefit that we anticipate.

Thank you. We do have someone with their hand up. Joanie, can you unmute Christine?

Go ahead.

Hi there. Good morning. I have a quick question regarding along the same line as the MEWS and the development of care for the patient with the high BMI. Who championed that for you? Did you have a critical care committee that kind of helped with that? Or did it come from anesthesia?

So the answer to that is it was championed by the insurance company that asked the surgical safety committees of all the hospitals in this insurance program to come up with ideas that would reduce surgical risk overall. And the insurance company’s calculus was actually quite simple. Obstetrics causes by far the highest dollar payouts over the system, but surgery was second, hundreds of millions of dollars in their past ten years. And since we already had a series of improvement projects in obstetrics that had gained traction, looking at surgery was obviously the next area, the next lowest-hanging fruit I guess. So there’s a committee or surgical safety experts that meets regularly. And it was that committee that evolved all those four safety programs that I mentioned, the preoperative assessment, the BMI greater than 40 protocols, the insistence that everyone one have team steps training, and the postoperative co-management. Those were the programs that the committee came up with. They worked on best practices on the protocols, and they’ve been implemented across the hospitals that participate in our insurance plan.

Just – I’d like to acknowledge one of our VPs of Nursing, Camille Scarsioto (sp), who really took the lead with, and she really has oversight over, all our ICUs, and led the team to actually implement all the protocols into the electronic medical record and facilitated this work. And she really was, on the nursing side, the champion for this, and partnered with, as Dr. Kopel said, the physicians in this endeavor.
Yeah, so you have to have a champion. Camille is clearly the nursing champion for all of these projects. But we also have, on the physician side, on the performance improvement side, Dr. Kaleya, Ron Kaleya, who is the surgical champion here at Maimonides, who lives and breathes it 24 hours a day. And if you don’t have someone pushing, pushing, pushing all the time, then a lot of these protocols wind up being elegant documents on some bookshelf gathering dust. So the people need to push it. But fundamentally we also needed to have buy in. The fact that there was an insurance incentive at the end of the rainbow concentrated everybody’s mind.

Thank you,

We do have another question. How far in advance before the surgical procedure are you performing the PATs?

Within a week. Typically it’s for the patient’s convenience on all elective procedures, but it’s typically done within seven days of the surgical procedure although it could be longer. There’s also obviously a preoperative assessment as the patient arrives in case there have been changes since the previous evaluation. But it’s typically just a few days before the operation. And it is, the assessment in PAT, the tool that we use for the preoperative assessment, which is now standardized, is in the electronic medical record and becomes part of the chart.

Thank you. For now it looks like we have gotten to the questions. I want to commend the entire Maimonides team and thank you for sharing with us and touching on how your quality improvement program has taken into account all of the other hospital-acquired conditions and infections and has really looked at reducing all of the other types of things that the surgical arena can affect, VTE, pressure ulcers. You mentioned all of those things, and that really has been the message of the Partnership for Patients nationwide, and in New York we also have been trying to connect all of those initiatives in your work. And so we’d like to thank you and commend you for your excellent work and willingness to share with us.

We will continue to take questions for the Maimonides team.

Joanie, next slide please. And one more.

So we’re just going to review a little bit everything that the Surgical Site Inspection Reduction Initiative has brought to you since January of 2012 when the New York State Partnership for Patients began. This should be a familiar slide. We’ve talked with you about reducing harm across the board. Here are all of the different reduction initiatives that we’ve been trying to connect for you and how the operating room team and pre-op team – pre-op, inter-op and post-op teams can affect all of these different hospital-acquired (inaudible) and infections. And our goal is to reduce harm across the board.
Next slide, Joan.

This is the New York State Partnership for Patients Surgical Site Infection Prevention Initiative one-page document which looks very busy here. It is downloadable and on the Partnership for Patients website. And it really goes through lots of the best practice criteria and the different areas within the entire continuum of surgical care. And we wanted to just remind you that it is available on the website for download for sharing with your operating room teams and staff.

Next page.

So where have we been, and what’s out there for you to share with your staff? We’ve done quite a bit of indication. We began with the no harm across the board for surgical patients. We’ve brought multiple presentations and both national and state specialists to talk about what can be done in the preoperative, intra-op and post-op arenas. We’ve just had a wonderful presentation by the Maimonides team talking about harm across the continuum. We’ve given you action plans and documents to accelerate your improvement. We began with implementing the Safe Surgery Checklist, whether it be the WHO checklist or a modified one that you have developed for your facility, and integrating it into the workflow in your surgical suites as well as the debrief. The Partnership for Patients taught multiple sessions throughout the state and educated master trainers for team steps. All of your project managers are team steps master trainers and still available to assist your master trainers in training your staff.

We’ve had iPro and the Project Joint folks present the orthopedic preoperative management to prevent SSI in orthopedic patients. And I’m sure you all remember we had internationally renowned Dr. (inaudible) Dillinger present multiple sessions on reducing surgical site infection and focused on reducing colon surgery site infection.

All of these resources and the recordings to the educational WebExes, as well as the slide decks, are available on the Partnership for Patients website. If you have any trouble finding anything or downloading anything, reach out to your project managers.

Next slide.

There are also a series of 30-minute videos focused on what you see here, the teamwork and communication, colon surgery, bowel prep, preventing surgery site infection, glucose control, oxygenation, skin prep and technical factors that may influence risk, and decolonization and prophylaxis for (inaudible) infection in surgical patients. These 30-minute vignettes are available for download. Many hospitals have accessed them, and they’re short and can be used for viewing for the resident staff, your OR staff, and your surgical staff. And they were all done with Dr. Dillinger. So they’re right on the website also.
Also available for download and most, if not all, hospitals ordered the No Harm Across the Board posters. And there was a poster for every initiative that the Partnership has focused on. This is a photo of the surgical site infection no harm poster that can be posted in your hallways and, you know, your high visible areas. A way of communicating with the staff and giving feedback for the efforts. These are still available to be downloaded also on the website. And we encourage their use.

So where are we? What do our numbers look like? This is the overall SSI sur-rate from an HSN. And overall, for all of the infections that HSN monitors, (inaudible) hysterectomy, colon, and orthopedic, we’ve had a three percent decrease in New York. Our goal, and the Partnership for Patients’ goal, was 20%.

So, we’ve done very, very well, and all those you see in green, why are we going to be spending the remainder of 2014 talking to you about colon? I think this slide demonstrates that perfectly for us. We have had great success in hip, as you see, is 40% reduction since 2010. Hysterectomy, 26% reduction statewide. And (inaudible), 52%. We are, unfortunately, seeing 27% increase in colon SSI standard infection ratio.

And here is just a different run chart showing the same thing. There’s that 27% increase in colon surgery site infection.

This is a slide provided by the national content developer Mathematica that is showing the other hospital engagement networks working in the Partnership for Patients across the country. The redlines and where they meet, and the 20% all the way on the right is the goal. Twenty percent reduction. The benchmark currently and our target is that dotted line. And, as you see, New York is significantly far away from the right side. So we have some work to do in colon surgery site infections.
There is an increase across the country in colon surgery site infections. This is showing over 2,500 hospitals across the country. And, as you can see, the standardized infection ratio is climbing.

Next slide, please.

We do have some good news and some high performing hospitals in New York State. For colon surgery site infection, we do have 50 hospitals within the state, within the Partnership for Patients, that have an SIR at or below the benchmark of .504. We have 27 hospitals in the state that sustained a rate of zero for the last six months. That’s significant. I hope you know who you are and continue that great work and are willing to share your good practices, much like Maimonides has just done for us today. And they have proven it can be done.

Hysterectomy, 79 hospitals have an SIR at or below the CMS benchmark of .6. And 45 have sustained a rate of zero for the last 12 months.

(inaudible), we have 56 hospitals in New York that have sustained a rate of zero for six months.

All of those hospitals should congratulate themselves. Pat yourselves on the back. Share with your project managers and your colleagues throughout the state. We want to encourage you also to consider submitting a success story that we would submit to CMS. And we really appreciate those efforts. They are showing.

Next slide, please.

So, again, here is a run chart of the top 75% of hospitals performing. And we are seeing an 18.7% improvement in colon surgery SIR rate for those hospitals. So there are hospitals throughout the state that are successfully reducing colon surgery infection.

Next slide, please.

So, we hope that we’ve just shown you why the Partnership for Patients is going to be focusing on the colon surgery site infection reduction, and we are pleased to announce that on April 2nd, a WebEx from 7:00 a.m. to 8:00 a.m., Dr. Robert Cima, Professor of Surgery from the Mayo Clinic in Rochester, Minnesota, will be introducing the New York State Partnership for Patients advanced colon bundle. We’ve put together a colon bundle for you based on the best practices, and he’s going to begin the conversation and the content of the advanced colon bundle. We encourage large participation for anyone involved in colon surgeries. And then Dr. Cima is coming in person on May 5th and 6th to Syracuse and to the Greater New York Hospital Association site in New York City. We will have some remote sites for those unable to travel. The registration for that should be out this week where you can actually start setting up your
teams. We’re hoping that our promotion of this and discussion of this will encourage your surgeons, anesthesiologists, entire OR team, to clear their schedules for those four hours on May 5th and May 6th.

Next slide, please.

I believe we’re at the end there. I did want to take some more questions. We do have a question asking how many hospitals are in the New York State Partnership for Patients. I believe our current count is at 172 hospitals throughout New York. And then, of course, it’s a CMS program nationally, and there are 26 other hospital engagement networks all working on the same work that you’re all doing.

If we have any more questions at this time, please type them in or raise your hand. I want to thank the team at Maimonides again. Wonderful program for us this morning. And all of the staff. And all of you for joining us this morning.

And with that I think we’ll close it. Everyone have a wonderful day.

Thank you.

Thank you.