

IN THIS ISSUE:

Update on Incentive Metrics P.1

QI committee Take-Aways P.3

Leadership Tip of the Month P.4

Hot Topics in QI P.4

FEATURE:

Stories from Case Review P.2

The Quality Post

Monthly Quality Improvement Newsletter FOR THE Division of Hospital Medicine

APRIL 2011 • Issue 4

Greetings from Michelle & Katie

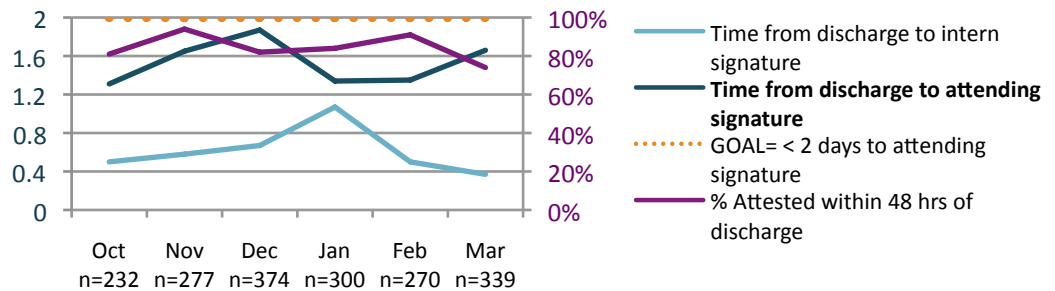
QUALITY IMPROVEMENT
DIVISION OF HOSPITAL MEDICINE



Welcome to the fourth issue of the Quality Post. In this issue, we'll update you on how we are doing with Division Incentive Metrics, tell some stories from Case Review and provide you with QI committee take-aways.

Division Incentives

Goal	Progress towards Goal	Baseline and Current Data		Jan 2011 to June 2011
Decrease average time to attending signature of discharge summaries to <2days from DC.		Average time to attending signature for CY 2010:		4 of 6 months
		CY 2010 5.8 days	Q1 2011 1.6 days	

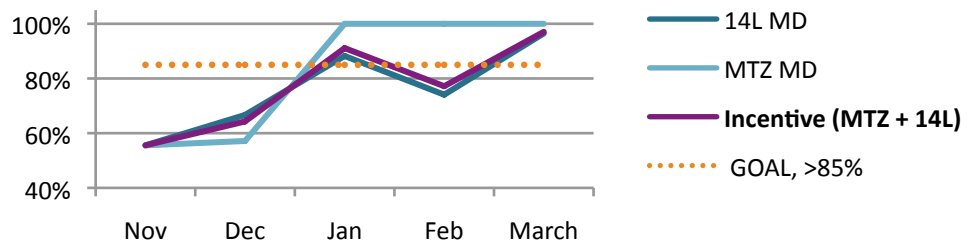


Maintain 30 day overall readmission rates <15% for patients >65.		Readmission Rates:		4 of 6 months
		Baseline data CY 2008: 16.5% CY 2009: 15.5% CY 2010: 13.2%	Q1 2011 13.2 %	

Maintain HCAHPS: Communication with Doctors Top Box score above 80%		HCAHPS Top Box Score:		4 of 6 months
		CY 2010 84%	Q1 2011 63%*	

* Data Preliminary

Improve MD hand hygiene rates to >85% on 14L		MD Compliance:		4 of 6 months
		2010 HH 54%	Q1 HH 87%	



= On target to achieve incentive goal, keep up the good work!

= Lower than target performance – action needed, ask Diane for tips.

Stories from case review

These cases have important implications for attendings that we hope you'll take to heart your next time on the wards. Let Diane know if you have questions or thoughts, we hope to make this a regular part of how you hear about important cases.

Case 1: The Attending Physician will see you now...

A patient was transferred from Zion Surgical service to Parnassus Medical service following abdominal surgery complicated by wound infection and candidemia. She proceeded to have wound drainage, fevers and hypotension. The surgical housestaff visited the patient once a week and wrote notes in between intermittently from Zion. No attending note was documented for about 3 weeks. The medicine attending, suspicious of abdominal infection and fistula, requested attending involvement. The patient was taken to the operating room and found to have a grossly purulent abscess involving $\frac{3}{4}$ of the incision and extending past fascial planes, consistent with an enterocutaneous fistula. Her diagnosis was felt to be delayed for several weeks during which she continued to be hospitalized and ill.

Key Take-Aways for Faculty:

- Consultant engagement and attending oversight may be variable once a patient is transferred to Medicine.
- Despite transfer, patients often still have subspecialty needs
- When further consultant involvement is desired, in person assessment, with attending oversight and documentation, may need to be specifically requested.
- It is the role of the Medicine Attending to facilitate this if housestaff teams are having difficulty

Case 2: Is this a Consult or a Curbside?...

In one case, a patient admitted with aspiration pneumonia was found to have an ECG suspicious for ischemia during the call night. Cardiology saw the patient and diagnosed demand ischemia in the setting of hypotension. Although the team wasn't familiar with ST elevations in demand ischemia, they trusted the consultant's opinion and were reassured that the consulting team was involved. In the afternoon on the post call day, the troponin returned elevated at 6. Review of interim ECGs revealed increasing ST elevations and evolution of ST elevation MI. The day cardiology team did not know of the patient and at the time of involvement, confirmed ST elevation MI diagnosed beyond the catheterization window.

Key Take-Aways for Faculty:

- Providing clarity about *curbside* vs. *formal* consultation is the role of both the primary and consulting team.
- A curbside is only appropriate for a general question, not specific to any one patient. e.g. *What labs should be followed in a patient on Daptomycin?*
- If the consultant needs patient specific information, or to see the patient, a full consultation should be agreed upon.
- Curbsides may not have the benefit of attending oversight. If confusion regarding the need for full consultation exists, it can be helpful to ask for the opinion of the attending consultant.
- A consultant's name should not be documented in the medical record if a curbside question was answered.

Error Disclosure Do's:

- Have the Attending MD lead the disclosure
- Involve nursing
- Seek help from Risk Management, particularly in cases which are multidisciplinary, complicated, or where significant harm occurred
- Apologize
- Maintain the relationship with the patient and family
- Inform that there will be an investigation with follow up to the patient and family
- Seek debriefing for yourself and your own medical team from an objective resource (chaplain or palliative care social worker)

Error Disclosure Don't's:

- Document emotion or blame in the medical record
- Avoid the patient/family
- Speculate
- Deflect blame to others
- Project your own emotional response (ie. feelings of guilt) in the disclosure

QI Committee Take-Aways

Discharge improvements and Patient Satisfaction presented to QI Committee this month presenting their data and project plans.

Discharge Improvement

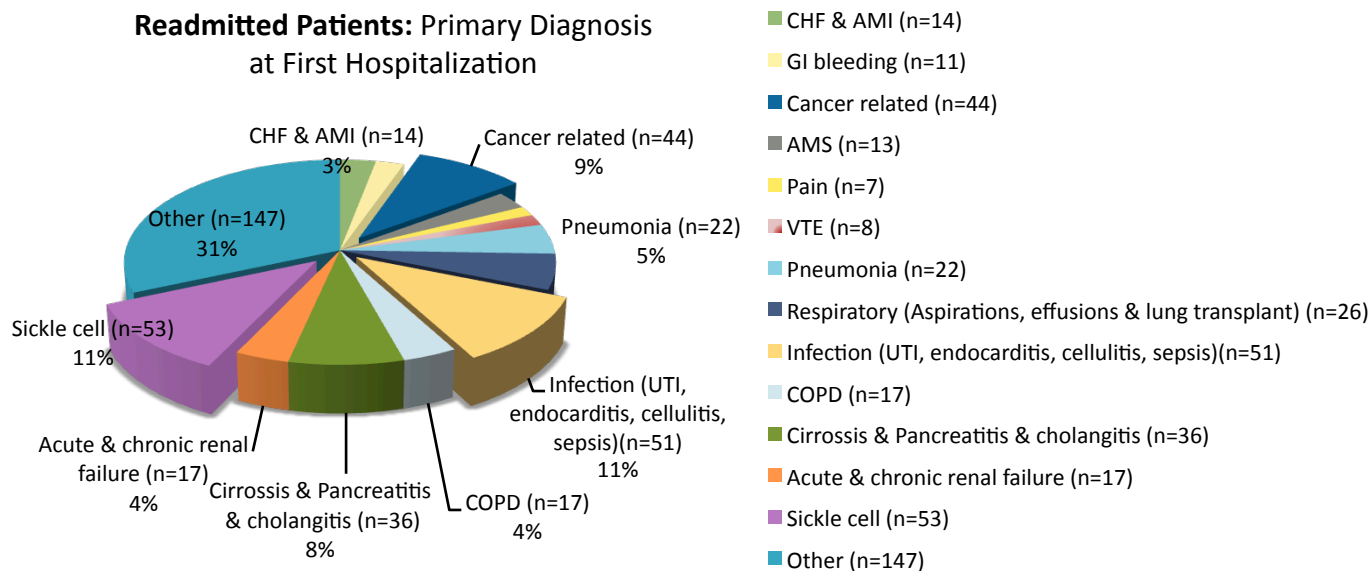
Ref	Indicator	Target	Stretch	CY 2010	Q3 2010	Q4 2010
FY 2011 Division Incentive Metrics						
1	10 Day Overall Readmissions, ALL (%)	6	3	7.1	6.5	7.1
2	10 Day Overall Readmissions, >65 (%)	6	2	6.5	5.5	7.4
3	30 Day Overall Readmissions, ALL (%)	15	12	14.6	15.4	14.2
4	30 Day Overall Readmissions, >65 (%)	15	12	13.3	13.5	14.0

- Both 10 day and 30 day readmission rates need improvement. Top DRGs in readmitted population: Sickle Cell, Cancer related; Infections (Cellulitis, UTI, etc). **See graph.**
- BOOST Medication Management: 17% of patients have a delay getting medications, 5% from insurance issues and 3% from incorrectly written prescriptions, and 4% from lost prescriptions and miscommunication.
- BOOST Follow Up Phone Call Data: Nice work! 81% of patients know their expected follow up appointments, 67% of which could name the time and date, another 11% are awaiting a call about appointment scheduling and 3% were told no follow up was needed. Only 4% were not aware of scheduled follow up appointments.

What can you do to help?

- Encourage your teams to ask the patient, "Do you have a plan to pick up your meds?" The nurses will also screening pts and alerting your team if a patient is high risk and should have their meds called in across the street for pick up.
- Make follow up appointments part of the discussion on rounds to make sure you and your teams are clear on a patient's needs, then communicate this to the patient.

Readmitted Patients: Primary Diagnosis at First Hospitalization



Patient Satisfaction

The Patient Satisfaction Working Group is working on a number of initiatives further understand perceptions of the patient experience and further improve patient satisfaction. Specific interventions include: Research on MD and patient perceptions (Diane, Naama, Katie); roll out of new White Boards (Cat); Distributing positive and negative comments from Press Ganey (Diane).

- Areas in need of improvement:** "Did MD explain in a way you could understand?"

What can you do to help? At the end of any explanation, say "Was I clear enough in my explanation? I'm happy to answer additional questions." Avoid phrases like "Did you understand?" as that can place the patients in an awkward position.

Areas in need of improvement: Some discharge questions are difficult for RNs to answer. Patients may leave without answers.

What can you do to help? Give patient and RN the green light to contact you if any questions arise that RN cannot answer/after discharge education.

Leadership Tip of the Month

3 Ways to Effectively Communicate Your Vision

As a leader, it's your job to craft a vision for your team, unit, or division. Once you know what that is, you need to be able to communicate it to a wide audience in a way that they can understand, relate to — and ultimately believe in. Here are three ways to do that:

1. **Repeat yourself.** To rally people around your vision, you need to remind them of your message and reinforce what you are trying to achieve. Don't worry about sounding like a broken record.
2. **Make it two-way.** Don't pick up a megaphone. Be sure to create dialogue around your message so that people hear it and understand it.
3. **Put out calls to action.** Don't just tell people what you imagine for the future, ask for their help in making it a reality. Be specific about what you want people to do and why.

Hot Topics

Quality:

<http://www.nationalprioritiespartnership.org/>

The National Priorities Partnership (NPP) offers consultative support to the Department of Health and Human Services on setting national priorities and goals for the HHS National Quality Strategy. The 48 member organizations also play a key role in identifying strategies for achieving the aims of better care, affordable care, and healthy people and communities; and facilitating coordinated, multi-stakeholder action.

http://www.nehi.net/news/press_releases/239/nehi_identifies_actions_for_reducing_wasteful_health_care_spending_by_84_billion

NEHI, an independent nonprofit national network for health innovation, today recommended a series of actions that would reduce wasteful health care spending by up to \$84 billion. Produced in collaboration with the National Priorities Partnership convened by the National Quality Forum the recommendations are outlined in “compact briefs” that identify specific steps for public and private policymakers on the following high-profile and costly health care issues: Emergency Department overuse, Medication Errors and Unnecessary Hospital Readmissions.

Hand Hygiene:

<http://www.nejm.org/doi/full/10.1056/NEJMvc0903599>

The New England Journal of Medicine is featuring a 14-minute hand hygiene video as part of its Videos in Clinical Medicine.

The accompanying article notes: “Healthcare-associated infections are a threat to patient safety and the most common adverse events resulting from a stay in the hospital.”

CALENDAR OF EVENTS

QI SCHOOL

APRIL 14: QI Methodology with Alison Stroh in Operational Excellence

DOM INNOVATION CHALLENGE

MAY 15: Project Report Due
JUNE 7: DOM Quality & Safety Symposium

RESIDENT QI LUNCHES

M&M type format for Quality Case:
APRIL 18

FACULTY QI LUNCHES

APRIL 11: Stories from Case Review
MAY 9: Update on DOM Innovations Challenges

CENTER FOR HEALTH PROFESSIONS

APRIL 18: Managing Conflict Effectively
MAY 9: Skillfully Engaging in Difficult Conversations
MAY 9: Working Across Personality Differences