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FEATURE:

The Quality Post

Monthly Quality Improvement Newsletter
FOR THE
Division of Hospital Medicine

MAY 2011 • Issue 5

Greetings from Michelle & Katie

QUALITY IMPROVEMENT
DIVISION OF HOSPITAL MEDICINE

Welcome to the fifth issue of the Quality Post. In this issue, we'll update you on our the DOM Innovation challenges submitted by members of our Division, which is also the topic of our Monday Lunch. We also included our regular features: QI Committee updates and Division Incentive Metrics.

Partnership for Patients

It's been 11 years since the IOM published their landmark study "To Err is Human," but many policy makers and pundits question whether any true progress has been made. To address the ongoing need for improvements in patient safety, the Obama Administration recently launched a federal reform initiative: **Partnership for Patients**. This program seeks to:

1. Prevent patients from getting injured or sicker in the healthcare system
2. Improve transitions from acute care hospitals to other care settings

by establishing partnerships that will identify and support models of healthcare that promote the best possible care of their patients.

Funds will be given to acute care hospitals and community based organizations. The focus will initially be on well established evidence based interventions such as BOOST and Project RED.

Partnership for Patients focuses on reducing **preventable harm**. It is critical that CMS can clearly identify and define "preventable." If this is achieved, there is a great chance that this partnership will have a significant impact on the safety of the care we deliver to patients.
Learn more on Bob's blog
or at
www.healthcare.gov/center/programs/partnership.index.html

Creative Brainstorming

Creative Brainstorming is a facilitation technique used to engage participants to generate many ideas in a short period of time. Physicians have traditionally been poor brainstormers as we get bogged down in issues of practicality and feasibility. Thus we've made brainstorming is the topic of our May QI school.

- Gather a large number of creative ideas
- Identify general and process improvement opportunities
- Determine problem areas to analyze
- Identify possible causes
- Generate possible solutions
- Develop framework for an implementation plan

Some basic ground rules when conducting these sessions are as follows:

Suspend judgment. Refrain from judging ideas

Piggy backing is encouraged. Let each idea spark further ideas and build on the creativity of others. Suggest a new twist on their idea rather than criticizing it

Think out of the box. We will worry about the realities of implementation later

Focus on quantity, not quality. The quality will come later when we refine the brainstormed list

We will document all ideas. We will rank, prioritize and assign ownership later.

1 Condolence Cards for Inpatient Deaths

Led by Larry Haber, the goal of this QI innovation is to increase the number of condolence cards written on the medicine service by decreasing the barriers to card writing. Larry notes that condolence cards have been shown to help both physicians and patients through the grieving process.

The cards will be conveniently placed in the "Death Packet" of paperwork completed for each death, along with an instruction sheet regarding the purpose of the project, instructions for use and sample words of condolence. Residents will be surveyed regarding their condolence card use and attitudes before and during project implementation

How you can help:

- **Help your team decide if there are patients for whom the card might not be appropriate**
- **Encourage your residents to bring the cards to attending rounds so that you can fill them out as a team.**

The cards can be placed in any **campus** mail box without postage and will be mailed by Patient Relations

2 Follow Up Care for the Uninsured

Tired of giving directions to Tom Wadell, Cat Lau and Heather Whelan are helping teams get better follow up care for uninsured by identifying patients who might qualify for Health San Francisco.

Using a list of uninsured pts in the hospital Cat and Heather are:

- Helping teams identify uninsured patients
- Linking teams to Meher to identify patients who will qualify for Healthy SF
- Educating teams on how to refer patients to Healthy SF by requesting an appointment at the SF health plan office where they will get enrolled and will be given a primary care appointment in two weeks.

How you can help:

- **Follow up with the social worker if your team gets an email about an uninsured patient.**
- **If eligible for Healthy SF, encourage your team to fill out a Yolanda request for an appointment at the Healthy SF office.**
- **Make sure the patient leaves with a copy of their discharge summary**
- **Work with your SW to inform the patient about what they will need to bring to this appointment: proof of SF residency, forms of identification, and their hospital discharge summary.**

WANT TO GET YOUR UNINSURED PATIENT FOLLOW-UP CARE?

HERE'S HOW!

1) Receive an e-mail from us identifying your pt as uninsured and contact floor social worker to determine if pt is eligible to enroll in Healthy SF.

2) If pt eligible for Healthy SF, send a "Follow-Up Appointment Request Note" in Notewriter to Yolanda Jones with pt's address and phone # and request to have appt set up at SF Health Plan office to enroll in Healthy SF. If pt not eligible for Healthy SF, determine alternate f/u plan with SW and case manager.

3) Inform patient of their Healthy SF appt and let them know at this appt they will be assigned a medical home, PMD, and have f/u medical appt arranged within 2 wks.

4) Provide pt brochure on Healthy SF (sent with initial e-mail to team) that outlines required documentation pt must bring to Healthy SF appt.

5) Include Healthy SF appt under "F/U Appointments" in D/C summary.

6) Check box on D/C summary that pt received copy of D/C summary. Print D/C summary and give patient a copy. Instruct them to bring this with them to Healthy SF appt.

QUESTIONS? FEEDBACK? E-MAIL CAT LAU AT CLAU@MEDICINE.UCSF.EDU OR HEATHER WHELAN AT HWHELAN@MEDICINE.UCSF.EDU

3 Brown Bag Meds (still in pilot)

Do you ever wonder how many of the patients you discharge can't fill or don't pick up their medications? Wonder no more. Data from post discharge follow-up calls suggest that 7-17% of patients don't get all of their medications at discharge. About 4-6% represent patients who minimize the importance of new meds and another 4-6% were prescribed meds that were non-formulary. If only there was a way to get patients their medications before discharge.

Perhaps there is. The Brown Bag meds project is looking for ways to collaborate with the Millberry Union Wallgreen's to fill medications and work to troubleshoot insurance issues.

How you can help: ***(once the project goes live)***

- **Help your team identify patients who might not have a way to pick up essential meds after discharge.**
- **Encourage your teams to fill out the prescription the day before discharge.**
- **Use the clerks to fax the med list over to Walgreens and confirm receipt of the prescription**

4 LEP Patient Empowerment

Led by Sara Iobst, the Limited English Proficiency (LEP) Empowerment team is working hard to make it easier for you to communicate with your patients. To improve access to and utilization of interpreter services on 14M and 14L, they have created a tool (see card on right) to empower patients to request interpreter services.

The cards, available for all Chinese-speaking LEP patients are written in easy to understand language that encourages patients to ask for interpreter services if they feel they are needed.

How you can help:

- **If you notice that your Chinese-speaking patients does not have an empowerment card, please ask the 14L/14M clerk where you can find one**
- **E-mail Sara Iobst (Saraswati.iobst@ucsf.edu or the LEP Empowerment Team (LEPempowerment@gmail.com) with any questions or ideas.**

QI Committee Take-Aways

Hand Hygiene and Door to Floor presented to QI Committee this month presenting their data and project plans.

Hand Hygiene

- Hand Hygiene rates have substantially increased since October 2010.
- To sustain this level of performance, the Hand Hygiene group is working on a number of initiatives including recruitment of new observers, screen savers and direct observation with Just in Time coaching.

Current challenges:

- Just In Time coaching (how do we change the culture so that real time feedback is encouraged and providers are more receptive to coaching?); committee members expressed interest in serving as "just in time" coaches.
- Consider incorporating HH into new QI/Patient Safety elective.
- Committee believes we should promote a culture where feedback is welcomed and encouraged

Action Items:

- Hand Hygiene data will be shared with faculty in the newsletter and will be posted on the QI section of the bulletin board.
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ED to Floor time

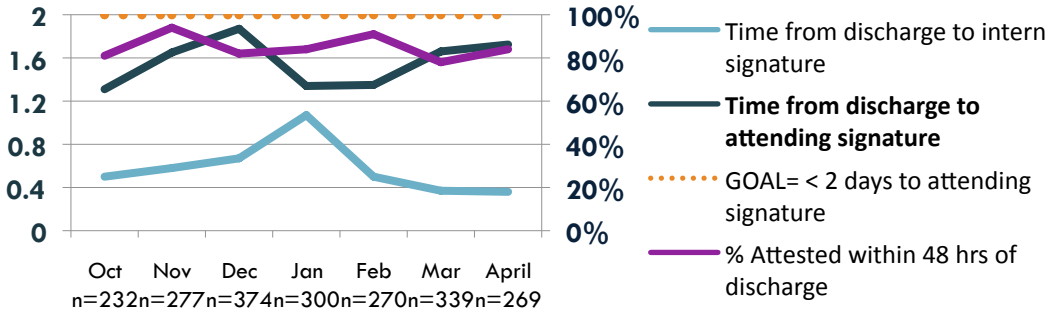
- The Division of Hospital Medicine has been a part of a working group examining Door to Floor time. In particular, we have scrutinized our own efficiency in the time from the ED's decision to admit to when we put orders in with the ED.
- There are a number of ongoing initiatives to improve Door to Floor time: One page admitting order set, Resident self monitoring of their own "decision to orders" time, HSL pathway resident consultant team.
- Questions for the QI committee include: What is the role of the current hospitalist in Door:Floor efforts? When is it ok to send a patient upstairs? What is the cost benefit of having a hospitalist in the ED?

ACTIONS:

The possibilities of both a part-time moonlighter and full time hospitalist to cover the ED were considered. Both solutions seemed expensive given that this would only affect Door to Floor time for a small segment of the population for a small segment of the overall Door to Floor time. Concerns were also raised regarding the impact this would have on resident education, as people felt that learning how to triage was an essential part of residency. More solid data is required to justify the expense.

Division Incentives

Goal	Progress towards Goal	Baseline and Current Data		Jan - 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**	2011 YTD **1.6 days**	



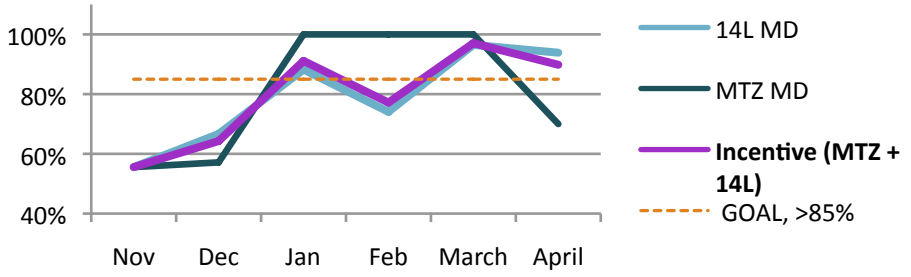
Maintain 30 day overall readmission rates <15% for patients >65.	↘	Readmission Rates:		4 of 6 months
		Baseline data CY 2008: **16.5%** CY 2009: **15.5%** CY 2010: **13.2%**	Q1 2011 **14.9 %**	

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%**	2011 YTD **88%**	

Hand Hygiene Rates 14L and MTZ



⊙ = On target to achieve incentive goal, keep up the good work!
↘ = Performance falling, analyzing data, stay tuned for actions
↓ = Lower than target performance – action needed, ask Diane for tips.

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 Cases:
May 16
June 17

Faculty QI Lunches

April 11: Stories from Case Review
May 9: Update on DOM Innovations Challenges

Center for Health Professions

May 9: Skillfully Engaging in Difficult Conversations
May 9: Working Across Personality Differences