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The Quality Post

Monthly Quality Improvement Newsletter
FOR THE
Division of Hospital Medicine

September 2011 • Issue 9

Greetings from Michelle & Katie

QUALITY IMPROVEMENT
DIVISION OF HOSPITAL MEDICINE

Welcome to the 9th edition of the Quality Post. In this issue we'll introduce Resident EPA's (entrustable professional activities) and let you know of the new attending role of resident evaluation. We'll also share with you the quality data we presented to the medical center at CPIC (Clinical Performance Improvement Committee).

Can we trust residents to discharge patients?

In 2005 the ACGME launched the **Outcomes Project** with the goal of measuring educational outcomes in evaluating residency education programs. They focused on 6 competencies: **Patient Care, Medical Knowledge, Professionalism. Systems-based Practice, Practice-based Learning and Improvement, and Interpersonal Skills.**

These competencies attempt to capture the professional framework of becoming a physician. Unfortunately, they are difficult to assess and confusing to define. Most of us end up doing a global assessment of the trainees we work with- at some point we have the gut feeling that they "get it." To bridge this gap between competency-based education, clinical practice and gut feelings, our residency faculty have begun to implement entrustable professional activities (EPAs). EPAs enable attending physicians determine if residents can be "entrusted" to work independently in specific clinical activities.

This year we hope to implement our first EPA to determine if a resident can independently create a plan for appropriate patient discharge. Residents will use their own documentation of their discharge plans, with your feedback, as the assessment tools to prove their "entrustability." This documentation will be contained in their own individual assessment portfolios that will be followed by each resident's CHEF advisor over the course of their training.

This year the Medicine Residency will embark on evaluation of the EPA of the safe discharge for residents with a focus on **communication, appropriate transfer of care and clear, concise discharge documentation.** Jeff Kohlwes, Sumant Ranji and Krishan Soni discussed faculty roles in the EPA evaluation on the Monday Lunch on September 12th.

Coping with Stress

Stress is unavoidable, but it doesn't have to be damaging. When managed correctly, strain can positively impact productivity and performance. Here are three things you can do to make stress work for you:

- **Recognize worry for what it is.** Stress is a feeling, not a sign of dysfunction. When you start to worry, realize it's an indication that you care about something, not a cause for panic.
- **Focus on what you can control.** Too many people feel bad about things they simply can't change. Remember what you can affect and what you can't.
- **Create a supportive network.** Knowing you have somebody to turn to can help a lot. Build relationships so that you have people to rely on in times of stress.

Responding to ARHQ Patient Safety Indicators

Did you know that all patient charts are reviewed for potential complications after discharge? A computer algorithm scans the charts looking for clues of potential post-operative sepsis or retained foreign objects. Coders in the Medical Records Department then verify the coding and assign the potential complication to a physician. Given the way the complications are found and coded, there are often inaccuracies in the coding of these complications and the responsible physician. We rely on physicians to verify the accuracy of the coding.

That's where you come in.

If you are assigned a potential complication, you will receive an email from Medical Records asking you to reply to the email and **answer two questions within 5 days of receiving the emails**:

1. Were you the physician responsible for event described above. If not, who do you believe is the responsible physician?
2. Do you agree that this case was accurately coded as a complication or adverse event? If not, why not?

Below is the text of the email:

From: Blum, Michael - Chair, Medical Records Cmte
Sent: Friday, June 10, 2011 4:49 PM
To:
Cc: Garcia, Sheree; Marshall, Jacquelyn
Subject: ePHI: Potential Complication or Adverse Event – Response Required (MRN:11654908)
Importance: High

Dear Dr.

All UCSF patient discharges are reviewed for adverse events and specific quality indicators. Increasingly, these events and indicators are publicly reported. Many are based on the Agency for Healthcare Research and Quality (ARHQ) indicators that can be referenced here <http://www.qualityindicators.ahrq.gov/> .

The initial screening is automated and we commonly find issues with either the attending assignment, documentation or the coding of the incident as an adverse event or complication. We rely on the physicians involved in the case to verify the accuracy of the coding and their responsibility for the incident.

The following incident has been identified as a complication or adverse event and you have been identified as the treating or responsible physician based on the following documentation:

Medical Record Visit #: 19248879 DC: 05/25/11
PSI Indicator: PSI 15 - Accidental puncture or laceration
Documentation:

Why respond to the emails?

As the public reporting of complications increases, it is important both to the Medical Center and physicians that we obtain an accurate report of complications. Our complications are tracked on the Divisional Level as well. It won't be long before complications are tracked on an individual basis as well, so if you weren't responsible for the retained sponge, you deserve the chance to say so.

How are we doing?

We are pleased to report that our response rate has increased dramatically in the last quarter, but we are still falling short of the Med Center Goal of a 100% response rate:

GENERAL MEDICINE
Response Rate Jan – March 2011

	Total	Percentage
A. Response	1	**17%**
Agree	0	0%
Disagree	1	100%
Referred	0	0%
B. No Response	5	**83%**

GENERAL MEDICINE
Response Rate April - Jun 2011

	Total	Percentage
A. Response	8	**89%**
Agree	6	75%
Disagree	2	25%
Referred	0	0%
B. No Response	1	**11%**

CPIC Report Out #1: Hospital Acquired Complications (HACs) and Mortality

Hospital Acquired Complications:

This is the first year we are reporting our rates of HACs based on UHC coding. After obtaining the data from UHC, cases are validated with chart audit to test for the accuracy of coding diagnoses prior to reporting, and to do analyses on variances. In the case of **HA respiratory failure** and **HA VTE** we perform better than UHC comparison rates.

HACs (*as applicable*)		***per 100***	***UHC Comparison Groups***
C-Diff	28/4,400	**.48%**	.25-.5%
HA Sepsis	35/4,400	**.79%**	.75-1.3%
HA Respiratory Failure	38/4,400	**.86%**	1-2%
HA VTE	21/4,400	**.48%**	.5-1%
HA-UTI	4/4,400	**.09%**	.05-.1%
CRBSI	8/2,801	**0.28%**	n/a

Mortality:

Until this year, the medicine service had not reviewed all deaths on the medicine service, given our high volume of palliative care deaths, relying instead on referrals from SCHMRC. **This year we began an in depth analysis of our mortality**, examining the volume of unexpected deaths. Specifically looking at PNA and Sepsis deaths, unexpected deaths had fewer coded comorbidities and lower rates of organ failure, but were more likely to have dementia, poor functional status and were more likely to be from long term care institutions and placed on comfort care earlier.

Mortality (*as applicable*)		***O/E***	***UHC Comparison***	***AAMC Comparison***
Overall	236/4412	**0.98**	0.65	0.64
Pneumonia		**0.67**	0.62	0.60
Sepsis		**0.89**	0.60	0.61

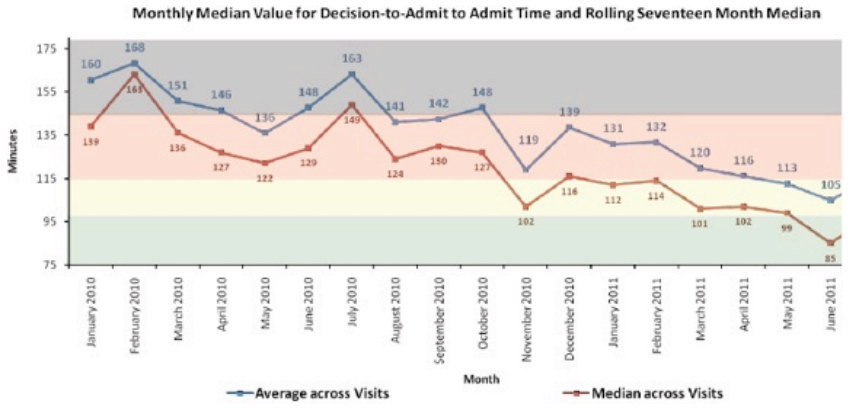
Room for Improvement:

- Great work on surveillance and prevention of Hospital Acquired Complications
- Be sure to clearly document co-morbidities and organ failure with pneumonia and sepsis, even for those with goals of care that mean they are placed on comfort care early.

*CPIC Report #2: **Efficiency and Flow***

ED Door to Floor Time

Through work begun by Mike Hwa, and picked up by Brad Monash under the leadership of Brad Sharpe, our Division has contributed to the fall in ED Door to Floor Times

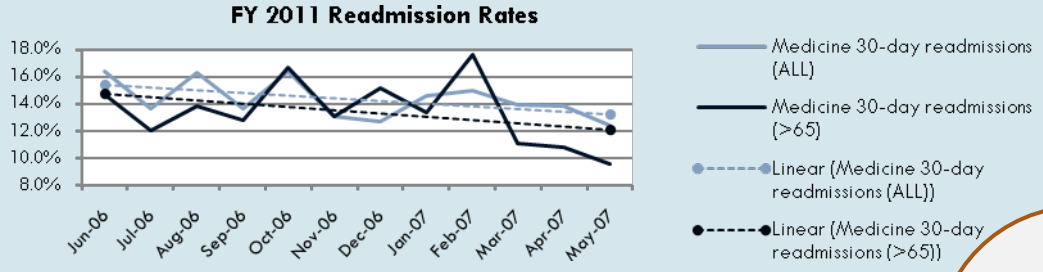


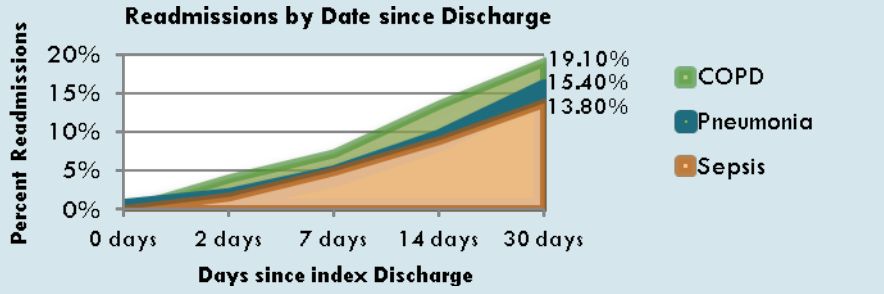
Room for Improvement:

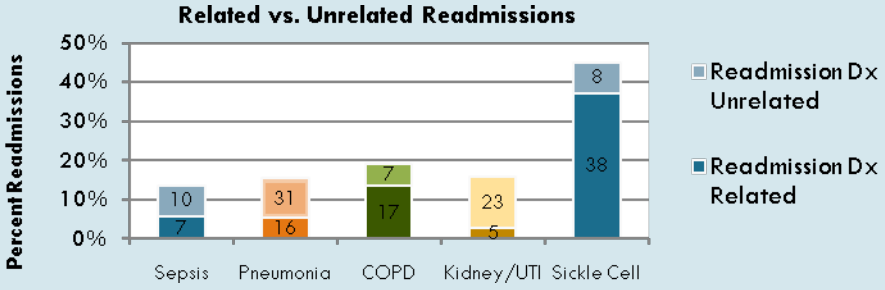
This is a collaborative (not competitive) effort with the ED. If you or your team can't make it down in time to write orders, review labs and vital signs and ask them if they might be able to write stable admit orders so that you can see the patient once on the floor.

CPIC Report out #3: Readmissions Drill Downs

***UM Indicators* (from UHC CDB)**	***n/N***	***Internal Rates*** *July 2010- June 2011 YTD*	***Internal Rates*** *July 2009 – June 2010*
Readmissions 10 day (%)	368/5551	**6.63%**	7.48%
Readmissions 30 day (%)	794/5551	**14.30%**	14.74%
Readmissions 30 day >65 (%)	320/2375	**13.48%**	13.84%







New Directions:

Readmissions by Date:
We are tackling the potentially preventable 0-7 day readmissions through better symptom management, follow up care, and maximization of resources available after discharge.

Related vs. Unrealated Readmissions:
Sepsis, Pneumonia and UTI readmissions are more likely to be unrelated.

COPD & Sickle Cell readmissions are more likely related suggesting we don't have good chronic dz management for these diagnoses.

CPIC Report out #4: Pneumonia Core Measures

Core Measures: July 2010 to June 2011	Average for all reporting US hospitals	Average for all reporting hospitals in Ca	UCSF MEDICAL CENTER
Pneumonia Patients Assessed and Given Pneumococcal Vaccination	93%	93%	95% of 88 patients[1]
Pneumonia Patients with ER Blood Culture Performed Prior to Antibiotics	96%	95%	95% of 105 patients[1]
Pneumonia Patients Given Smoking Cessation Advice/Counseling	97%	97%	100% of 27 patients[1]
Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s)	92%	92%	93% of 91 patients[1]
Pneumonia Patients Assessed and Given Influenza Vaccination	91%	91%	96% of 57 patients[1]

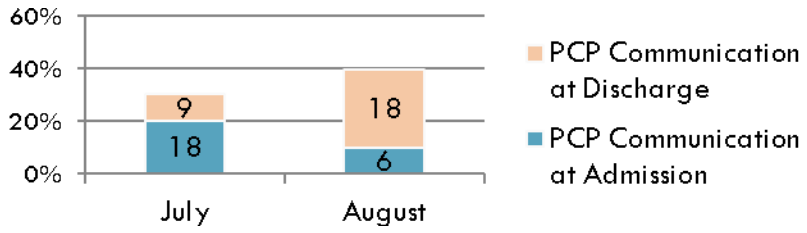
New Goals:

While we used to aim for Core Measures >90%, the new Med Center goal of 100% brings on new challenges to rapidly identify all patients with pneumonia

You can make your mark by picking appropriate initial abx of CTX & Doxy for CAP. If you are picking other antibiotics, be sure to clearly document why

Division Incentive Goal	Progress towards Goal	Baseline Data	FY 2011
Communicate with UCSF PCP at discharge >80% of time	↘	PCPs reported receiving information at discharge >80% of the time: 6%	8 of 12 recent months

July	August	Sept	Oct	Nov	Dec
30%	40%				

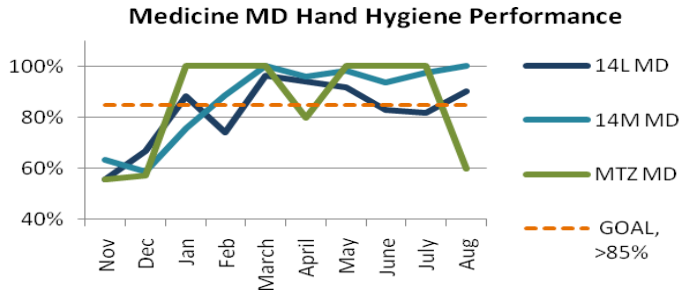


Acheive HCAHPS: Communication with Doctors Top Box score above 82%	↘	FY 2011 HCAHPS Top Box Score: 79%	8 of 12 recent months

July	August	Sept	Oct	Nov	Dec
78%					

Acheive MD hand hygiene rates of >85% on all Medicine Floors: 14L, 14M, MTZ 5E/W	◉	2010 MD HH Compliance: 89%	8 of 12 recent months

July	August	Sept	Oct	Nov	Dec
89%	**93%**				



Schedule follow up appointments for 80% UCSF primary care patients discharged home (2 wks) and SNF (1 month)	↘	**June 2010: DGIM PCP follow up 29%**	6 of 8 recent months: **October start**

July	August	Sept	Oct	Nov	Dec
59%	54%				

Calendar of Events

QI School

FD Sept 29: Project Management
FD Oct 15: Basics of QI

Resident QI Lunches

M&M type format for Quality Cases:
September 12
October 10

Faculty QI Lunches

Sept 12: Resident EPAs
October 10: Communication Checklist
Nov 14: CHR for QI projects & your QI portfolio
Dec 12: Pneumonia Core Measures

Center for Health Professions

October 5: I can't hear you are you talking to me – Improving MD – RN