Greetings from
Michelle & Katie
QUALITY IMPROVEMENT
DIVISION OF HOSPITAL MEDICINE

Welcome to the 10th edition of the Quality Post. In this issue we’ll explore the role of coaching in practice improvement, both in our commentary about Atul Gawande’s latest article and within our own Division. We’ll also provide you with some BOOST updates you can take back to your team and, as always, give you the latest updates on our Division Incentive Metrics.

Athletes vs Doctors? The role of coaches in Medicine.

In some professions it is perfectly natural to have a lifelong coach, and in others you are expected, at some point, to go it alone. You complete your training, you graduate, you suddenly no longer need instruction. Why, when we think of life-long coaches, do we only think about athletes and performers? Why doesn’t everyone who aspires to greatness have a coach?

Atul Gawande explores this concept in his recent article, “Personal Best” suggesting that coaches can have a role in a variety of professional fields, including medicine. “Coaches are not teachers, but they teach… Mainly they observe, they judge, and they guide.”

What can coaches offer? Coaches can help you out of a performance plateau, offering constructive feedback on your current practice, pointing things out that you may not even be aware you are doing. As Gawande explains, “You have to work at what you’re not good at. In theory, people can do this themselves. But most people do not know where to start or how to proceed. Expertise, as formula goes, requires going from unconscious incompetence to conscious incompetence to conscious competence and finally to unconscious competence. The coach provides outside eyes and ears, and makes you aware of where you’re falling short.”

Should we have more coaching in DHM? It turns out that accepting coaching is hard. Our nature as human beings resists exposure of our flaws almost on impulse. To open ourselves to scrutiny and inquiry after we have completed training takes courage. But it can also catalyze improvement and increase satisfaction with our daily practice. “The existence of a coach requires an acknowledgement that even expert practitioners have significant room for improvement.” Thanks for exploring the role of coaching in order to achieve our FY 2012 Division Incentive Metrics and improve individual practice.

For more information see Atul Gawande’s article in the October 3rd issue of The New Yorker.
Communication Checklist

In an effort to improve our care of patients on the medicine service, we continue to focus on **MD communication** as one of 4 quality and safety goals this academic year. **We need your help!**

<table>
<thead>
<tr>
<th>Achieve HCAHPS: Communication with Doctors Top Box score above 82%</th>
<th>FY 2011 HCAHPS Top Box Score:</th>
<th>7 of 10 recent months</th>
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<td>July 78%</td>
<td>August 71%</td>
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**How can you help?** Use the Communication Checklist. This checklist is the product of many of your votes on the evidence based elements you think are important to deliver in each patient encounter. Similar checklists have been implemented in hospitals across the country with great success in improving **MD communication**.

We will begin offering mandatory training sessions in October for you to learn more and practice the implementation of this tool. Subsequently, you will receive one bedside observation and coaching around your own skills in implementing these elements. Please contact Diane Sliwka with any questions.

**Beginning:**

Knock and ask to enter the patient’s room  
Address patient by name and acknowledge family  
Introduce yourself by name/role (using the whiteboard)  
Elicit concerns and repeat them back

**Middle:**

Use Plain Language and use an Interpreter  
Explain how long things will take and what happens next

**End:**

Summarize and Check for Understanding  
Assure ability and willingness to follow plan  
Encourage questions of patient and their family  
Thank the patient and family
Introducing the “DISCHARGE PHARMACY CONSULT”

Let’s face it. Pharmacists are a precious resource on the Medicine Service at Parnassus. If your team doesn’t have a pharmacy student you may be wondering how to get your patient discharge teaching by a pharmacist. That’s why we developed … the Discharge Pharmacy Consult.

Your team pharmacists are available for a DISCHARGE PHARMACY CONSULT on patients on high risk meds, Monday through Friday. As part of the consult your pharmacist will
1) Review your patient’s discharge medications
2) Provide medication teaching and a personalized medication schedule for your patient.

As a reminder, the following are medications and situations which should trigger a DISCHARGE PHARMACY CONSULT:

1. Anticoagulant medications (enoxaparin, coumadin, etc.)
2. Any injected medication (insulin, enoxaparin, neupogen, epoetin, etc.)
3. Changes to long-acting opiate regimens (fentanyl patch, MS Contin, Kadian, etc.)
4. Antibiotics needing prior authorization (i.e. linezolid, cefpodoxime, PO vanco, etc.)
5. Patients admitted with a drug related complication
6. Any other questions, concerns, or special needs you may have for patients at discharge

As pharmacists are a limited resource, to order a DISCHARGE PHARMACY CONSULT please have the medication list in the chart on the day prior to discharge.

Room for Improvement:
• Teams are often contacting pharmacists for teaching on the day of discharge. Help your team plan ahead by getting medications started early.

Rembmer to consider Brown Bag meds on 14M

We’ve partnered with Walgreens to make picking up discharge medications easier for our patients. With a quick form, your team can order medications for pick up or delivery at the Milberry Union Walgreens.

Just follow these easy steps:
1. Make sure your patient is APPROPRIATE: Ideal patients are: Insured pts who can pay the copay for their medications AND existing Walgreens customers (so that we don’t mess up med rec at their home pharmacy).
2. Have your team fill out the prescription EARLY: Walgreens has gotten busy! This allows Walgreens time to process your order.
3. Fill out the fax cover sheet: This sheet confirms the time by which you need the meds, and provides a contact number for questions. The clerks will take care of faxing the meds and will call Walgreens to confirm the Rx.

Families or patients can then pick up their medications on their way out of the hospital. We’ve recently had problems with brown bag medications being ordered for uninsured patients who cannot pay for their meds.

Please make sure to check the suitability of your patient prior to using the service!
Division Incentive Goal | Progress towards Goal | Baseline Data | FY 2011
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Communicate with UCSF PCP at discharge >80% of time | ↑ | PCPs reported receiving information at discharge >80% of the time | 7 of 10 recent months

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PCP Communication

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Achieve HCAHPS: Communication with Doctors Top Box score above 82%

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FY 2011 HCAHPS Top Box Score: 79%

Achieve MD hand hygiene rates of >85% on all Medicine Floors: 14L, 14M, MTZ 5E/W

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2010 MD HH Compliance: 89%

Schedule follow up appointments for 80% UCSF primary care patients discharged home (2 wks) and SNF (1 month)

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June 2010: DGIM PCP follow up 29%

Timely follow up Appointment

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QI School

FD Oct 15: Applied QI

Resident QI Lunches

M&M type format for Quality Cases: October 10

Faculty QI Lunches

Oct 11: Communication Checklist
Nov 14: CHR for QI projects & your QI portfolio
Dec 12: Pneumonia Core Measures

Center for Health Professions

Nov 8: Coaching employees for growth and success