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FEATURE:

The Quality Post

Monthly Quality Improvement Newsletter
FOR THE
Division of Hospital Medicine

January 2012 • Issue 13

Greetings from Michelle & Katie

QUALITY IMPROVEMENT
DIVISION OF HOSPITAL MEDICINE

Welcome to the 13th edition of the Quality Post. In this issue we'll update you on what we've learned about our high user populations and introduce our plan for the new Medicine Discharge Coordinator, Catherine Monetta. For our regular features, we give you some takeaways from Case Review and, as always, give you the latest updates on our Division Incentive Metrics.

Understanding our High Users

There are many hypotheses about why patients are readmitted to the hospital. However, most focus on patients readmitted only once. To understand why patients come back over and over again, different theories may need to be developed.

Under the leadership of Mike Hwa, a DHM QI team (Michelle Mourad, Ryan Greysen, Marwa Shoeb, Maria Novelero, and Katie Quinn) has examined demographic, clinical, and social data as well as process measures associated with discharge quality for a high user population. Their initial findings suggest the frequently admitted patient is uniquely different from the patient who only returns once.

Here's a snapshot of their most interesting findings:

Average Age	51
UCSF PCP	93%
ETOH/Drugs: Active or History	17%
Psychiatric Illness	55%
Housed	76%
PCP Appt. at Discharge	57%
Post Discharge Phone Call	56%
Home Support at Discharge	45%
Number of ED Visits	372

In comparison to the total medicine population, the high users had a lower case mix index (1 vs 1.5) and shorter average length of stay (5 vs 5.5). The top five principle diagnoses were: sickle cell pain crisis, pneumonia, COPD, renal failure, and persistent vomiting, which also differed significantly from the general medicine population.

Given their complexity, a high-intensity multidisciplinary intervention may be necessary to reduce future readmissions. The team will work with individuals from DGIM, Case Management, and the ED to identify and pilot focused interventions for this population in the coming months.

Effective Feedback

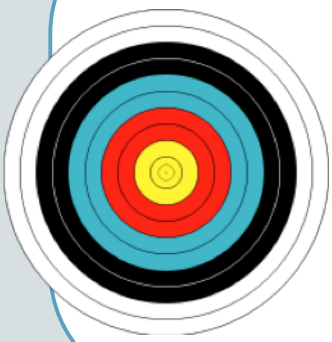
Giving effective feedback is challenging, but essential to a working relationship. Most leaders rarely give enough feedback to change behaviors. To give effective feedback, follow these steps:

Be specific. Feedback needs to be actionable. Avoid generalized adjectives. Instead, describe the behavior using concrete examples to back up your impressions. "When you disappear during rounds it gives me the impression you aren't prioritizing your learning."

Make it timely and Do it often. Get in the habit of praising good performance and identifying areas for improvement. Don't be afraid to give feedback in the moment. Both constructive and congratulatory feedback are more effective when given immediately.

Reconnect. Receiving tough feedback can be alienating. After giving tough feedback remember to reconnect. Check in to ensure that your feedback was heard and understood. A simple question like, "Does that feedback make sense?" can close the loop and ensure that they reflect on the feedback Checking in also encourages further dialogue and lets your charge feel that they can come to you in the future for advice.

Discharge Coordination comes to Parnassus



Scope

Help identify high risk patients and intervene as needed.

1. **Diabetes** (diagnosis (new or established) or changes to regimen)
2. **COPD** (diagnosis (new or established) or changes to regimen)
3. **High User/readmissions (> 6times/year)**
4. **Patients identified as high risk by the Medicine Team and/or nursing staff, case management, social work (at time of admission)**

Tracking

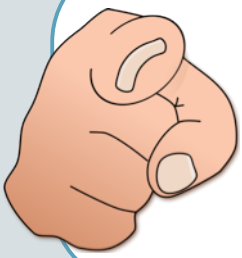
1. Patients assessed and intervened on
2. Interventions provided

Needs Assessment

- Assess Health Literacy/ Understanding of Disease process
- Assess Safety of Living situation/ Social Support
- Assess Functional Status and need for PT/OT
- Assess Understanding of medications and medication access
- Assess need for more specialty care: Diabetes or COPD follow up
- Assess understanding of discharge plan and follow up
- Assess ability to get to follow up appointments
- Assess Readiness for discharge

Interventions

- PT/OT consults
- Pharmacy Teaching for high risk meds
- Diagnosis Specific Teaching (inhalers/insulin)
- Ensure Meds Covered by Insurance prior to DC
- Medications Provided on DC
- Home Health Ordered
- Timely Follow Up
- Pulmonary Rehab Referral
- Diabetes Clinic Referral
- *Virtual Team* email re: discharge plan



What Can You Do?

- Stop by Catherine's office to refer a patient, ask her for help with complicated discharges
- Refer patients during MDR rounds
- Participate in the virtual team to provide updates to PCPs, home care nurses, and outpatient specialists

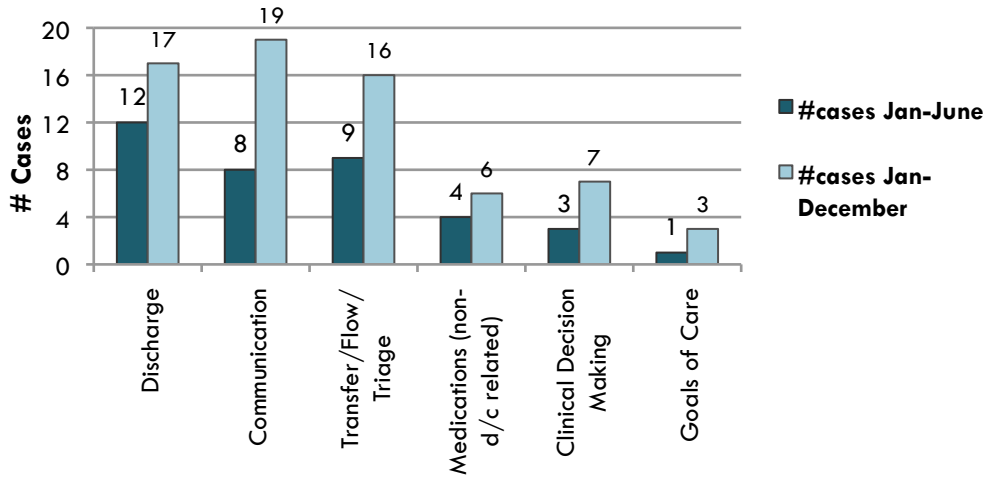
Case Review Summary Themes

Though we learn a tremendous amount from individual cases, and a powerful case can be the impetus for a new quality initiative, aggregating cases into themes is also incredibly important. Rather than focusing on a single case (n of 1), thematic summaries show areas of persistent problems where existing interventions may not be effective. This month rather than cases we bring you the themes of case review.

Case Summary: January – December

- Total Cases Reviewed: **60**
- Average Cases per Month: **5**
- # General Themes Identified: **6**

Case Summary by Theme



Discharge Problems Identified

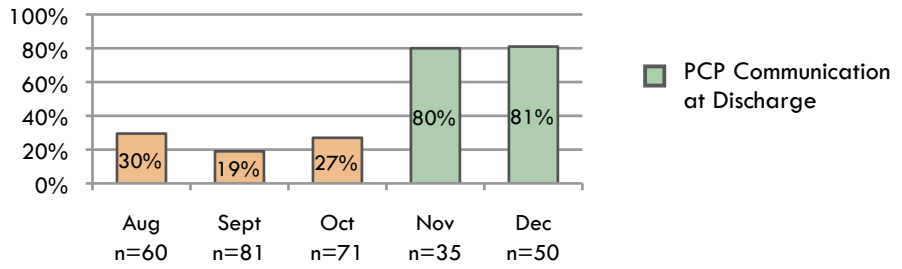
- Medication Omissions/Errors **(6)**
  - Junior providers writing list independently
  - Workflow challenges to providing double check/communication among all providers
- PCP Contact at D/C **(3)**
  - None in the last 6 months
- Communications with specialists at DC **(2)**
- Patient Understanding of discharge instructions
- Follow up Appointments delayed **(2)**
- Delivered Meds not sent home with patient **(1)**
- Lack of documentation of medicine issues on neurosurgery service **(1)**

Communication Issues Identified

- Inter-Team **(11)**
  - Consult vs. curbside
  - Miscommunications about recommendations
  - Lack of communication/oversight
- Intra-Team **(5)**
  - Authority Gradient
  - Attending Oversight
  - Miscommunications
- Handoff
  - RN-Team **(9)**
  - Goals of Care Confusion
  - RN not reaching Team
  - Team not communicating with RN

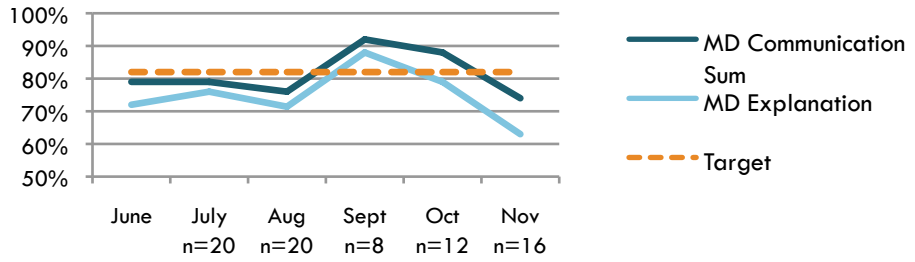
Division Incentive Goals	Progress towards Goal	Baseline Data	FY 2012
Communicate with UCSF PCP >80% of time		PCPs reported receiving information at discharge >80% of the time: 6%	7of 10 recent months

July	August	Sept	Oct	Nov	Dec
30%	40%	22%	55%	**80%**	**81%**



Achieve HCAHPS: Communication with Doctors Top Box score above 82%		FY 2011 HCAHPS Top Box Score: 79%	7of 10 recent months

July	August	Sept	Oct	Nov	Dec
78%	71%	**92%**	**86%**	74%	



Achieve MD hand hygiene rates of >85% on all Medicine Floors: 14L, 14M, MTZ 5E/W		2010 MD HH Compliance: 89%	7 of 10 recent months

July	August	Sept	Oct	Nov	Dec
89%	**86%**	**88%**	**97%**	**96%**	**89%**

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%	**83%**	**83%**	**81%**	**83%**

Calendar of Events

Resident QI Lunches

M&M type format for Quality Cases:
Jan 20
Feb 17

Faculty QI Lunches

Jan 9: Medicine Discharge Coordinators
Feb 13: Sepsis Task Force Update

Center for Health Professions

Jan 17: Leading Change for Health Care Reform