IN THIS ISSUE:
Create a Happier Team P. 1
Why do Low Income Patients Prefer the Hospital? P. 1
Living PRIDE P. 2-3
“Day of Admission” Kaizen P. 4-5
Division Incentive Metrics P. 6

Greetings from DHM QI!
QUALITY IMPROVEMENT
DIVISION OF HOSPITAL MEDICINE

Welcome to the 31st edition of The Quality Post. In this edition we explore our involvement in the Medical Center Living PRIDE initiative and continue our journey with LEAN performance improvement. We also bring you the regular feature of our Division Incentive Metric performance.

Why do Low Income Patients Prefer to Seek Care from Hospitals?

If you have been to your doctor lately you know that long wait times, packed schedules and confusing insurance coverage are standard practice, that is – if you are lucky enough to have a primary care doctor. Faced with these challenges it is no wonder that some patients prefer to receive care in the hospital rather than in a doctor’s office. Data consistently show that patients with low socioeconomic status (SES) receive health care differently than their high-SES counterparts; low-SES patients use less preventive care and are more likely to become acutely ill and require urgent hospital care, a pattern not explained by lack of insurance.

Investigators at the University of Pennsylvania reasoned that if we are to reduce avoidable hospitalizations and ED visits as a way to controlling costs and improving health care quality, we must understand the factors that drive patients to the ED.1 Penn researchers interviewed low-SES Philadelphia patients on why they choose to visit the hospital/ED over a primary care physician. There results uncovered three key drivers of hospital use.

- **Quality:** Many participants described a greater sense of trust in the quality of hospital care than in ambulatory care.
- **Convenience:** Emergency care, the participants said, can be accessed via ambulance for urgent complaints and provides a “one stop-shop” for services; outpatient care required a great deal of transportation coordination for participants, most of whom did not have their own car.
- **Cost:** Uninsured participants often could not afford fees for regular visits to see a doctor or specialist, leaving them no choice but to rely on hospital charity care when they became ill. For patients covered by Medicaid, the direct financial cost of an emergency department visit and physician office visit were similar; however, the overall cost of outpatient care was higher because of the additional time and expense required for specialty visits or additional testing recommended by the primary care provider.

This study debunks the perception that patients need to be “educated” about proper use of emergency resources and illuminates how we have build a health care system that incentivizes these choices.

1 Kangovi, S et al. Health Aff July 2013 32:71196-1203

Create a Happier Team

Happy, engaged employees are good for an organization. Research shows they are more creative, produce better results, and are willing to go the extra mile. What’s more, happiness is contagious; it creates a virtuous cycle that leads to further engagement.

To bring more of that into your team, focus on what psychologists have identified as the three pathways to happiness: pleasure, engagement, and meaning. Consider whether you are actively encouraging these things in your people.

- Do they enjoy their relationships and their environment at work?
- Do they laugh?
- Do they fill roles that fit their skill sets and offer appropriate challenges?
- Do they feel they’re a part of something that matters?

If the answer is no to any of these questions, brainstorm how you can adjust the team environment to bring more happiness in.
Living Pride

It isn’t only our Division who is working on Communication with patients, Living Pride is an organizational initiative afoot to improve the way every provider from hospitality to attending communicates with patients.

It’s the same communication principles in a different format…

The principles of AIDET are remarkably similar to those in our communication checklist.

**Acknowledge** patients by name and let them know you are happy to be taking care of them.

“Good afternoon, Ms. Devore. We’re happy you’ve made it up to the floor.

**Introduce** yourself with your full name and your role in their care.

Introduce others and speak well of them.

“My name is Susan and I’ll be your nurse until 7pm today, then I’ll introduce you to Katie, who is one of our most compassionate and responsive night nurses.

**Duration** Keep in touch to ease waiting times. Let patients know when things will happen and how long they will take.

“As we discussed we ordered you an MRI. The tests tends to take about an hour and can be noisy, but they provide ear plugs. Everyone does their best to make it happen within 12 hours, but may be delayed if there are emergency cases.

**Explanation** Advise others what you are doing, how procedures work and whom to contact if they need assistance.

“The reason we draw your blood every morning is because we are closely monitoring your kidney function. When it stabilized, we will no longer need to check it daily.

**Thank You** Foster an attitude of gratitude for others on the team and for the patients. They will thank you back!

Thank you so much for your patience while we get your prepare your discharge. We want to make sure all members of your team have the plan in place.

Nursing Living Pride Initiatives on 14L & 14M

Nurses have their own initiative. On the medicine floors nurses will be rolling out two new key initiatives:

**What is your goal for today?**

- **Manager Rounding**: Nurse managers on 14L & 14M will be visiting all patients within 24 hours of admission to check in about their stay and proactively addressing patient concerns.

- **Nursing Handoffs at the bedside**: Instead of huddling by computers to hand off their patients nurses will be moving to the bedside to engage with patients during the handoff. They will also be asking each patient their goal for the day and writing it on the white board.
DHM Perspective
Faculty were recently asked to complete a survey about their perception of our communication efforts. We were asked about our perceptions and practice around use of our standardized communication elements.

Key Survey Results
88% of respondents believe using the communication elements improve the patients experience
88% of respondents have taught residents on their team about the communication elements
Only 10% of respondents always teach their residents about the communication elements
88% of respondents believe using the communication elements improves the quality of time spent with patients

Standardized Communication Elements

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Very effective</th>
<th>Effective</th>
<th>Neutral</th>
<th>Respondents still see high perceived-effectiveness</th>
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</thead>
<tbody>
<tr>
<td>Knock and ask to enter the patient’s room</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Address patient by name and acknowledge/introduce yourself to family</td>
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<td>Introduce yourself by name and by role (using the whiteboard)</td>
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<td>Elicit concerns and repeat them back</td>
<td>✔️</td>
<td>✔️</td>
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<td>Use plain language and an Interpreter if needed</td>
<td>✔️</td>
<td>✔️</td>
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<td></td>
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<tr>
<td>Explain how long things will take and what happens next</td>
<td>✔️</td>
<td>✔️</td>
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<td>Summarize and check for understanding</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Assure ability and willingness to follow plan</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Encourage questions of patient and family</td>
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<td>✔️</td>
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<tr>
<td>Thank the patient and family</td>
<td>✔️</td>
<td>✔️</td>
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Alignment with Medical Center Goals
Medical Center Performance currently at 50th percentile, with 1 & 2 year goals much higher at 64th & 80th.
Kaizen #3: The Day of Admission
The DHM Journey in Lean

We always say that discharge should begin on admission, but what does that mean? Last week, the LEAN team, including faculty Michelle Mourad and Alvin Rajkomar and residents Manny Diaz & Lindsey Stevens took on the day of admission, defined as the 24 hours after a patient arrives on the floor. They examined how we could set planning for discharge in motion right from the beginning.

The Unit White Board – A Tool for Interdisciplinary Communication

The team quickly realized that while APeX isn’t the answer to everything, it does hold a lot of critical information for providers that could be shared more efficiently. The team asked:

Why do clerks manually write up primary teams and first call instead of an APeX view that projects them?

And so the idea for APeX projection on to the unit white board was born. Drawing on information from APeX, the list can flag patients who have a discharge order, patients on tele or those who have a sitter. It could provide accountability for those not identifying first call in APeX. Projected on to an existing white board, patients can still be circled & starred to highlight special issues.

Nurse MD Communication – Bringing back the Critical Conversation

As an MD, hours after you see your patient in the ED and place your admission orders your patient arrives to the floor. You have no idea where they landed, how they are doing and whether the nurse understands the plan of care.

As a nurse, your new patient arrives on the floor. You’ve been told that your patient has abdominal pain, but don’t know which meds or studies should be prioritized and your patient is hungry and in pain. There are many orders to clarify.

Wouldn’t it be wonderful for the physician and nurse to exchange this vital information?

… And so the discharge “Time Out” was born, piloted and rolled out. After doing their admission assessment & review of the orders, nurses will page interns to review a standard checklist.

Admission “Time Out”

1. Name & Code Status
   The patient name & status of code discussion
2. Working Diagnosis
   Reason for admission and leading diagnoses
3. Early Priorities and Goals
   Critical meds, tests, procedures, and parameters
   Nurse expresses clinical concerns e.g. nausea/pain
5. LDA and Diet
   Nurse to provide update on diet, IV access, Foley, etc.
6. Interdisciplinary Consults
   Specialty MD, Rehab, SW, RT/Smoking, Nutrition, etc.
7. Estimated LOS and After Hospital Needs
   Initial projection of discharge milestones and disposition.

… Any other issues?
Kaizen #3: The Day of Admission
The DHM Journey in Lean

After brainstorming ideas, it was time to talk to patients about tools we could use to foster communication. Patients varied greatly in their needs. Some were medically savvy and wanted their care team, labs, test results and future tests on an interactive display. Others wanted a guide to their hospitalization so they would know what questions to ask.

The Patient White Board – Can we make this a successful communication tool?

As we talked to patients about how we communicate with them and their families, it was hard to ignore the empty white boards in the room.

Instead of saying that the white boards needed to be replaced, we had to ask the tough question of why weren’t the boards being used now?

We came up with four strategies that might help:

- Clearly defined responsibility
- Integration into standard work
- Higher sense of accountability
- Patient empowerment

So we designed our optimal white board and work flow.

- **Nurses** are responsible for ensuring date & nurse are filled out and asking the patient their priority for the day during bedside handoffs.
- **Physicians** need to empower patients to use the board for questions and fill in their parts of the care plan.

Taking a Cue from Our Patients:

There were many patients who weren’t sure how their team could communicate better, but they worried they weren’t asking the right questions when the doctors came in the room. Other patients had caregivers for whom this was their first time in the hospital. One patient suggested we tell him which questions he should be asking.

We created a trifold that could be left on the patient’s bedside table as the room was being turned over.

Questions include those around understanding discharge milestones, home services, follow up plans and changes to diet and activity to name a few. It remains to be seen if this will prompt patient questions earlier in the admission.
**Division Incentive Metric Performance**

Achieve >60% full bundle compliance with Lactate, Blood Culture, Broad Spectrum Antibiotics, and Fluid Resuscitation

<table>
<thead>
<tr>
<th>FY 2012 Compliance</th>
<th>1 of 4 quarters</th>
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<tbody>
<tr>
<td>FY 2012 Compliance</td>
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<tr>
<td>Jan  81% Feb  86% Mar  89% Apr  78% May  85% June 77%</td>
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Achieve HCAHPS Communication with Doctors Top Box score above 80%

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<tr>
<th>FY 2012 HCAHPS Top Box Score:</th>
<th>6 of 12 months</th>
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<tr>
<td>Jan  73% Feb  74% Mar  78% Apr  77% May  77% June 88%</td>
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Promote appropriate nebulizer use and early transition to MDI; Reduce monthly nebulizer use by 15% (baseline ~1000 nebs/mo)

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<thead>
<tr>
<th>FY 2012 Baseline:</th>
<th>2 of 4 quarters</th>
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<tbody>
<tr>
<td>FY 2012 Baseline:</td>
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<tr>
<td>Jan  803 Feb  750 Mar  671 Apr  999 May  757</td>
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Achieve an average MD hand hygiene rate of >85% for Medicine/Hospitalist

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<thead>
<tr>
<th>CY 2012 by floor:</th>
<th>9 of 12 months</th>
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<tbody>
<tr>
<td>CY 2012 by floor:</td>
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<tr>
<td>Jan  88% Feb  98% Mar  100% Apr  95% May  94% Jun 95%</td>
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Respond to >80% of nurse clinical documentation improvement queries

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<tr>
<th>FY 2012 Baseline:</th>
<th>2 of 4 quarters</th>
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<tr>
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<tr>
<td>Jan  86% Feb  90% Mar  92% April  96% May  97% June 90%</td>
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