

Experiment with Leadership Styles

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Division Incentive Metrics

## Greetings from Michelle and Sasha

QUALITY IMPROVEMENT  
DIVISION OF HOSPITAL MEDICINE

Welcome to the 52<sup>nd</sup> edition of The Quality Post. In this issue we feature a piece on going to the gemba and share an update on Lean. We also bring you the SHM Pain Management Guide and data on our Division Incentive Metrics.

## Going to the Gemba

Gemba is a Japanese word meaning "the real place." In the context of Lean, *going to the gemba* means going to the location where the action is taking place and where value is created. It is a simple yet powerful approach in our QI toolbox to help us define the problem we are trying to solve and to generate ideas for improvement.

The activity demonstrates a key tenet of the Lean, respect for frontline workers. Rather than assuming you know the answers from a distance, this approach requires that you go to where the work is performed and engage frontline staff directly. Dwight Eisenhower illustrated this concept elegantly,

**"Farming looks mighty easy when your plow is a pencil and you're 1,000 miles from the corn field."**

Here are guidelines for making the most of your visit to the gemba.

**First**, know your purpose and ask yourself "Why am I going to observe? What am I trying to learn?"

**Second**, do your best to leave all assumptions and opinions behind – this exercise isn't about what you *assume* is going on or what you *heard* is going on. A successful gemba walk requires a deep curiosity to discover what is **really** going on.

**Third**, consider using a framework to help you make sense of what you observe and to help communicate that with others. For example, you can focus your time looking for different types of waste (e.g. overproduction, waiting, inventory, motion, etc.)

**Fourth**, remember that you are observing a snapshot in time and not everything can be seen on the surface. Be sure to test and validate your observations with those doing the work.

## Keep Experimenting with Different Leadership Styles

To grow as a leader you must dive into projects and activities, interact with different kinds of people, experiment with new ways of getting things done – and try out various leadership styles.

Most learning involves some form of imitation (and understanding that nothing is "original"). So stop viewing authenticity as an intrinsic state. It's really an ability to take elements you have learned from others' styles and behaviors and make them your own.

But don't copy just one person's leadership style; tap many diverse role models. There is a big difference between totally imitating someone and borrowing selectively from various people to create, modify, and improve your own leadership style. It's OK to be inconsistent from one day to the next. That's not being a fake: it's how you figure out what's right for new challenges and circumstances.

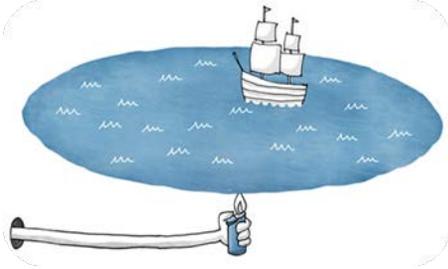
Adapted from "[The Authenticity Paradox](#)" by Herminia Ibarra.

Monthly Quality Improvement Newsletter for the Division of Hospital Medicine

April 2015 • Issue 52

## Updates in Lean

At a recent Lean Visioning meeting we asked ourselves why certain interventions: Admission time out, Tee Time, RNs on Rounds, MDR changes etc. were embraced and largely adopted and others were met with resistance. We analyzed successful and failed interventions and came up with key principles through which every proposed intervention should be evaluated.



**1. Know your scope** (i.e. Don't boil the ocean)  
Ensure the team understands the problem you are trying to solve and the metrics you will use to evaluate success.

*Tee Time was a focused intervention, which was designed to improve DBN times and its success was evaluated by that criteria.*

**2. Demonstrate the value of interventions.**  
Interventions that are perceived as value-added are easier to adopt. This involves both careful selection of interventions and conscious messaging of early wins.

*The ATO succeeded because nurses found it valuable to improving patient care. 14<sup>th</sup> floor Nurse Mangers sought out success stories and broadcasted them to all nurses.*



**3. Integrate changes into existing workflow and make interventions more efficient or work neutral.** Making a change to an existing process or integrating improvement to an existing workflow makes for easier adoption of change.

*Changing MDR to include interns was easier than a work around that involved paging the interns after MDR to rejoin rounds and get updates. Adoption was immediate and sustained.*

**4. Audit and Feedback are essential:** When the “work” to be done includes new ways to communicate or complex care processes, change will be hard to sustain without an audit and feedback process.

*It was only with regular audits and performance feedback that the ATO and Tee time were sustained.*



## Updates in Lean

How have we built upon the work we started during the last round of Inpatient Kaizens wrapped up last year?



### Care Partners Program

Vision: Deliver inpatient care that leverages the collaboration of a multidisciplinary team

#### MD-RN Program:



#### Admission Time Out (ATO)

- RN pages 1st call MD
- MD calls RN to go over the prompt

UCSF Admission Time Out
RN pages first call after admission assessment to review
<input type="checkbox"/> <b>Name, Code Status, and Isolation</b> Verify patient name, code status, isolation needs
<input type="checkbox"/> <b>Working diagnosis</b> Reason for admit, differential, co-morbidities
<input type="checkbox"/> <b>Urgent Tests and Treatments</b> Critical meds, tests, procedures, parameters
<input type="checkbox"/> <b>RN Clinical Concerns</b> Current patient status issues e.g. nausea/pain/AMS
<input type="checkbox"/> <b>Lines, Drains, Access, and Diet</b> Nurse provides update on diet, IV access, foley
<input type="checkbox"/> <b>Consult Services Required</b> Specialty MD, PT/OT, SW, RT, SLP, Nutrition
<input type="checkbox"/> <b>Estimated LOS and After Hospital Needs</b> Initial projection of discharge milestones and dispo
... Any other issues?



#### Daily Morning Huddle

- Pre-rounds: "RN name & Number" in Apex patient list
- Rounds: Invite RN via cellphone (353-9111 + RN number + #)
- RN goes over prompt; MD explains plan of the day

UCSF	RN Prompt for Morning Rounds
<input type="checkbox"/> <b>Attachments</b> Tele/CPO, IV's, Foley	<input type="checkbox"/> <b>Patient/Family experience</b>
Optional: Constipation?	Optional: Sitter needed?
<input type="checkbox"/> <b>Mobility</b> ADL's Decubitus Ulcers	<input type="checkbox"/> <b>Disposition</b> Inpatient level of care Estimated day of DC Home needs (e.g. PICC, O <sub>2</sub> )
Optional: Adequate PO intake?	Optional: Goals of care?
<input type="checkbox"/> <b>Pain control</b>	
<b>REGISTERED NURSE</b>	



#### Discharge Time Out (DTO)

HSL Resident Project

- Reminder page at 9:30
- MD calls RN to go over the prompt

UCSF Discharge Time Out
<input type="checkbox"/> <b>Primary Diagnosis</b> Reason for admission and primary treatment
<input type="checkbox"/> <b>Transport and Time of Discharge</b> Transport method and anticipated time of discharge
<input type="checkbox"/> <b>Destination and DME Set Up</b> Destination (home or facility)/ any DME needs
<input type="checkbox"/> <b>Key Med Changes</b> New meds, secure scripts, pharmacy changes
<input type="checkbox"/> <b>Key follow-up</b> Must not miss appointments with PCP or specialist
<input type="checkbox"/> <b>Critical Counseling</b> Key take-home points from admission
<input type="checkbox"/> <b>Is AVS Complete?</b> Post-discharge instructions and follow-up
... Any other issues?

#### What is the plan for the next iteration of Inpatient Lean work?

- Performance excellence, DHM and UBLT leadership will continue to meet over the next few months to build on previous value stream mapping to identify areas in need of improvement.
- The plan is to move forward using a similarly broad focus as last time and to select an issue that affects all patients on 14 M/L during the continuum of care.
- We will hone in on one area that still needs performance improvement and that helps achieve a UBLT goal (e.g. MD-RN Explain in a way you can understand, MD-RN communication across care, the Patient Daily schedule). The next round of Kaizens is slated to start this summer.

We would love your input on the focus for the next round of Kaizens.  
Please email Sasha Morduchowicz with your thoughts.

# SHM Pain Management Guide

## Improving Pain Management for Hospitalized Medical Patients A Society of Hospital Medicine Implementation Guide



Pain is a major public health problem affecting more American adults than heart disease, cancer and diabetes combined. **More than 116 million adults in the U.S. suffer from chronic pain, and federal expenditures for pain care total \$99 billion a year.** The negative physiological, psychological and social consequences of pain are well documented. A number of advances have occurred in recent decades to improve the quality of pain management.

Despite these advances, a number of gaps remain in the quality and safety of pain management provided to patients. Hospitalized patients continue to experience moderate to severe pain.

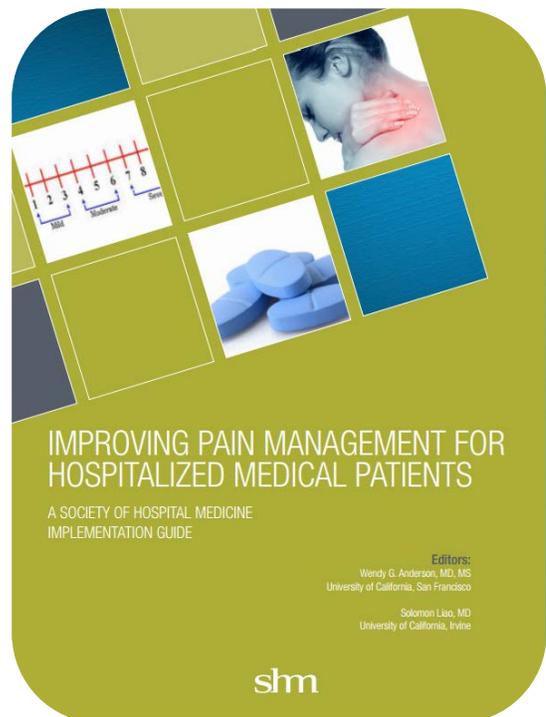
As frontline physicians in hospitals and leaders of quality improvement programs, hospitalists find themselves in the cross-hairs of these national problems of inadequate pain treatment and opioid misuse.

**Edited by Wendy Anderson** and Solomon Liao from UC Irvine, this guide was developed to provide practical advice to hospitalist physicians and other leaders who are developing programs to improve pain management in their services and facilities.

The focus is on medical patients, though many of the principles described are relevant to patients recovering from surgical care who are increasingly co-managed by hospitalists.

**The guide is available on the SHM website and our DHM wiki (search “pain” on the homepage).**

**We encourage you to check it out!**



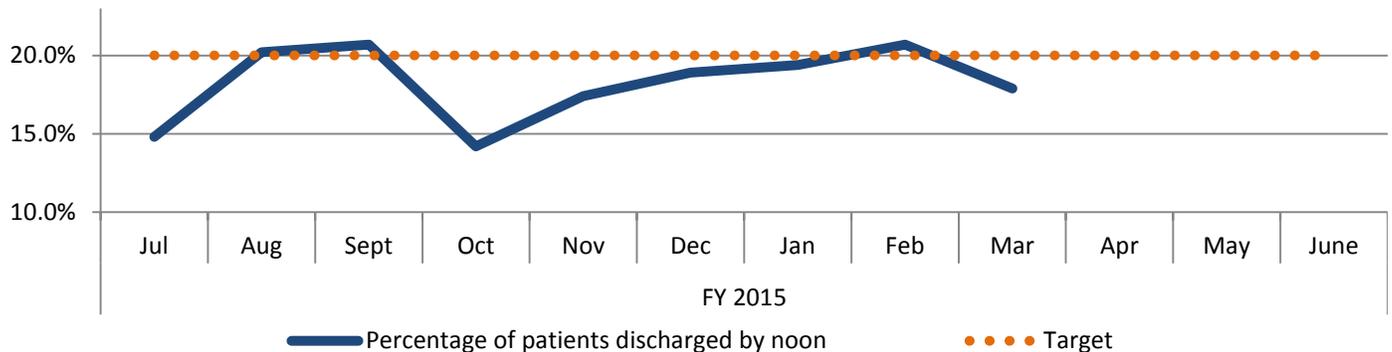
## Division Incentive Metric Performance

Decrease number of total phlebotomy draws by from 2.05 to 1.9 sticks (7.3%) per hospitalized patient per day								3 of 12 months					
FY2014 Baseline	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
2.05	1.96	2.02	1.97	1.91	1.82	1.85	1.72	1.70	1.57				

Decrease total telemetry hours / DHM discharges from 35 hours to 30 hours (15%)								6 of 12 months					
FY2014 Baseline	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
35 hrs	24	32.5	28.8	32.1	35.0	30.2	34.6	39.3	45.7				

Achieve HCAHPS Communication with Doctors Top Box score above 80%								6 of 12 months					
FY2014 Baseline	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
74.6%	72.5	82.1	74.6	72.2	93.8	76.7	73.7						

Achieve 20% of hospital medicine discharges by noon								6 of 12 months					
FY2014 Baseline	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
15.7%	14.8	20.2	20.7	14.2	17.4	18.9	19.4	20.7	17.9				



Improve 14-day UCSF PCP follow-up appointments scheduled, with appointments scheduled by 5 days after discharge, to 80%								3 of 12 months					
FY2014 Baseline	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
68%	64.1	75.5	80.5	81.1	74.2	61.4	75.9	76.2					

