thequalitypost

in this issue

Monthly Quality Improvement Newsletter for the **Division of Hospital Medicine**

May 2015 • Issue 53

Greetings from Michelle and Sasha

QUALITY IMPROVEMENT
DIVISION OF HOSPITAL MEDICINE

Welcome to the 53rd edition of The Quality Post. In this issue we feature a piece on patient-centered behaviors and the Patient Engagement Project. We also bring you the Meds to Beds Program, Best Practice Apex Lists, a Case Review Update, and data on our Division Incentive Metrics.

Which Patient-Centered Behaviors Do We Often Forget About?

When we think about patient-centered care we often focus on the relationship between the physician and the patient, but what other high-yield and low cost patient-centered behaviors are worth promoting at our institution?

How can we re-design our system to reliably deliver care that matters to patients, care that is more individualized, transparent and respectful?

Those of us that attended SHM this year left inspired with some concrete ideas that may not immediately come to mind when thinking about patient-centered innovations:

What if we allowed our patients to **wear their own clothes?**

What if we **limited vital signs** and alarms at night to **promote sleep**?

What if we **stopped ordering dietary restrictions** that we know patients can't adhere to at home?

What if we designed a standardized process for asking patients, **"What matters to you?"** instead of "What's the matter?"

What if we created a process on admission where we **offered to print photos** for our patients to put in their rooms?

We **CAN** make the hospital a place that supports our patients as unique individuals while treating their disease.

The possibilities are endless! Please email Sasha with any additional patient-centered ideas you may have.

Sharing Doubts Up Front Helps Persuade Others

If you want to persuade an audience, you need to show them that you're trustworthy. In ambiguous or controversial situations, many people think it's best to sweep small doubts or uncertainties about their message under the rug.

But evidence suggests that signaling these doubts immediately before delivering your argument can actually help establish trust. The key is sequencing: Start with a small weakness or drawback, then use the word "but" before delivering your main message.

A doctor who says, "No vaccine in the world is without the occasional adverse event, but this vaccine is extremely safe and has been used to protect millions of children," strengthens her trustworthiness and credibility. This message would feel different if the weakness followed, rather than preceded, her main point.

Adapted from "How Doctors (or Anyone) Can Craft a More Persuasive Message" by Steve Martin.

Patient Engagement Project (PEP)

Shared decision-making (SDM) has been shown to be an important tool for improving patient engagement and health care outcomes. Though SDM is a key component of patient engagement, many hospitalists struggle with how to incorporate it into daily patient care. Partnering with colleagues from Stanford, **Stephanie Rennke, Brad Monash, and Adeena Khan** led an NIH funded study to identify key SDM behaviors during ward rounds on general inpatient medicine and pediatrics services.

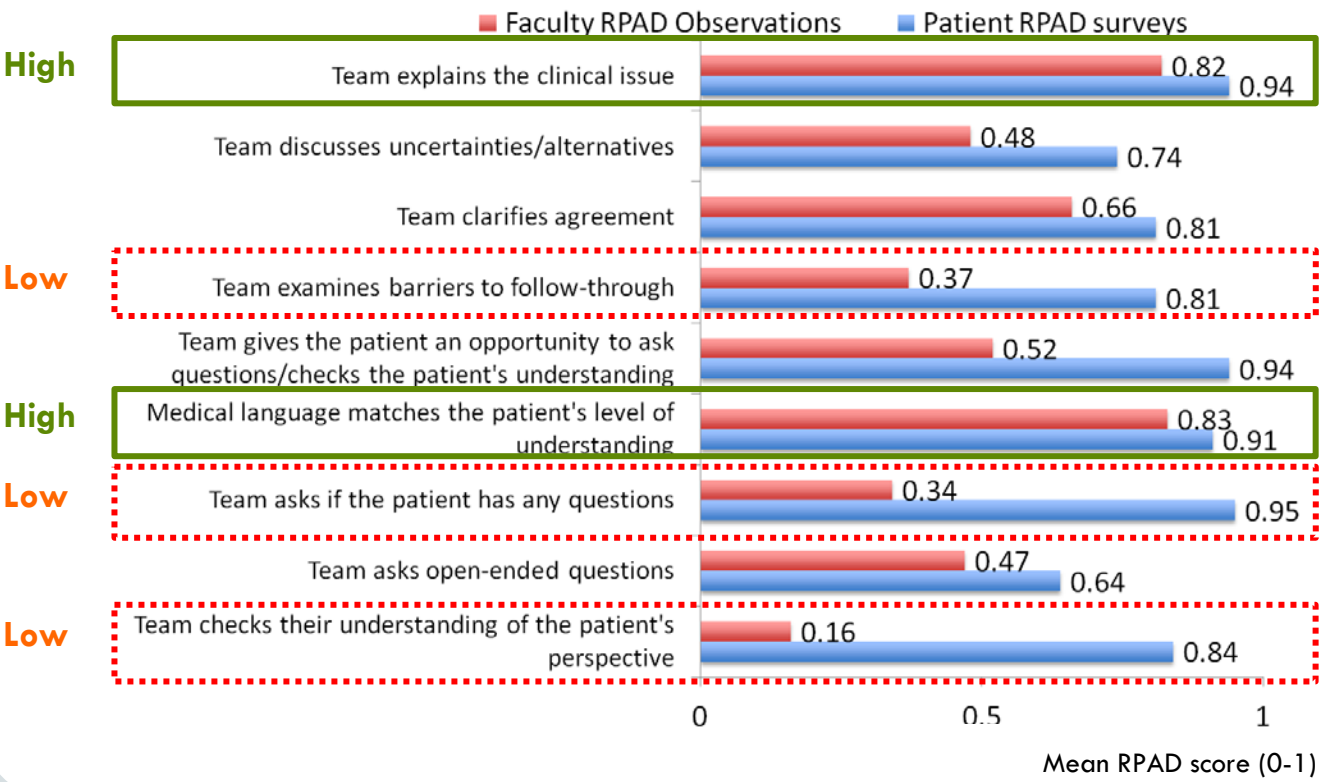
What did they measure?

Using they Rochester Participatory Decision-Making Scale (RPAD) – a validated 9-item survey – the team did the following observations:

- 15 teams (6 medicine, 9 pediatric)
- 49 ward rounds (20 medicine, 29 pediatrics)
- 115 unique patient encounters (44 medicine, 71 pediatric)

Results – RPAD Items

9 matched behaviors were scored: 0 (absent), ½ (partially present) or 1 (fully present)



Results

- **Patients on average scored their inpatient teams higher than faculty observers by 32% (p=0.004)**
- Patient and faculty observer assessments were correlated (r=0.68) except for "Team checks their understanding of the patient's perspective"

Conclusions

- Patients had a higher perception of the extent of SDM occurring during rounds than faculty observers
- Both identified similar strengths and weaknesses – revealing opportunities for improvement
- Patient perceptions may overestimate the extent of SDM on rounds

Patient Engagement Project (PEP)

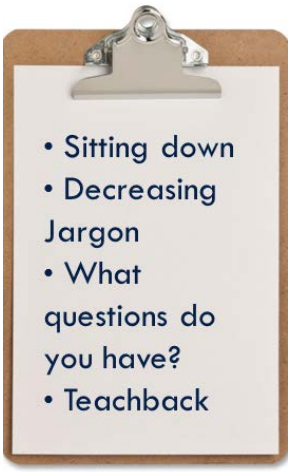
How does PEP fit in with Past and Present DHM communication efforts?

2013 Katie's Bedside Coaching

Communication Checklist
Beginning
• Knock and ask to enter the patient's room • Address patient by name and acknowledge family • Introduce yourself by name and role (use the whiteboard)
Middle
• Avoid jargon and offer interpreters • Explain how long things will take and what happens next
End
• Summarize plan of care and check for understanding • Assure ability and willingness to follow plan • Encourage questions of patient and family • Thank the patient and family

2014-2015 Patient Engagement Project (PEP)

2015 Volunteer Observer



What did we learn from the PEP project that can help us plan communication coaching efforts moving forward?

- We know that certain key behaviors (e.g. team asking if patient has any questions & teachback) are not happening consistently
- **Success in behavior change requires a high intensity intervention**
- Shared decision making is more helpful when goals have been set for the patient interaction beforehand
- Rounds work better with a clear framework, structure and expectations

What are our current plans for FY16?

- Building on the PEP project, we plan on launching a Peer Observation Program
- Utilizing medical students for low inference behavior observations

Want to contribute to the development of these programs?

- All are welcome to attend the 14M/L UBLT Patient Experience Meetings. Email Sasha for more information.

Special thanks to Stephanie Rennke, Brad Monash, and Adeena Khan for their incredible work on this project and for sharing their insights on how we can move this important area of work forward!

Med to Beds Program

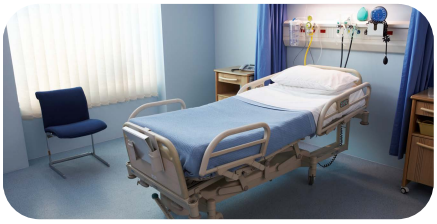
UCSF Medical Center

Walgreens

Joining forces to provide patients with a worry-free discharge

What is Med to Beds?

A delivery *service* that brings patients discharge medications to their room at no additional cost.



How can this service help your patients?

Convenience

- Saves patients a trip to the pharmacy after leaving the hospital
- Eliminates the worry about getting medications on their way home

Personalized care

- UCSF Doctors and Walgreens Pharmacists work together to make sure patients have the right medications before leaving the hospital
- Pharmacists are available to answer any last minute medication questions while patients are still in the hospital in-person via phone or FaceTime
- The Meds to Beds team works with patients' insurance plans to maximize benefits

Improved Medication Safety

- Working with the nursing staff, the team reviews each patient's medications and side effects
- The team also helps with the medication reconciliation process

We encourage you to spread the word with your patients! Postcards are available by the 14 Moffitt Nursing Station.

Patient Information

Name: _____

Date of Birth: _____/_____/_____

Phone number: (_____) _____ - _____

MRN: _____

Meds to Beds Service Is it Right for You?

- ☐ I want to have my medications delivered to my hospital room before I go home
- ☐ I want to know my co-pays before I go home
- ☐ I want to save a trip or avoid transportation issues in picking up my medications
- ☐ I want to avoid waiting in line at the pharmacy when picking up my medications

Please Select a Choice Below

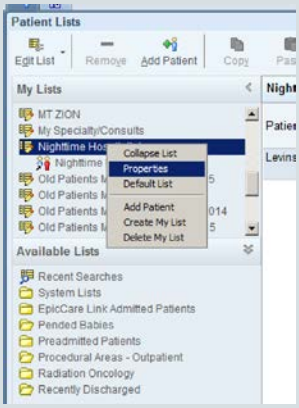
- ☐ Yes, I want Bedside Delivery Service
- ☐ Maybe, I need more information about the service
- ☐ No, I am not interested
- ☐ Patient currently unable to respond

For more information please contact Myra Pascua, PharmD, Clinical Manager, Walgreens @ UCSF.
Email: Myra.Pascua@walgreens.com

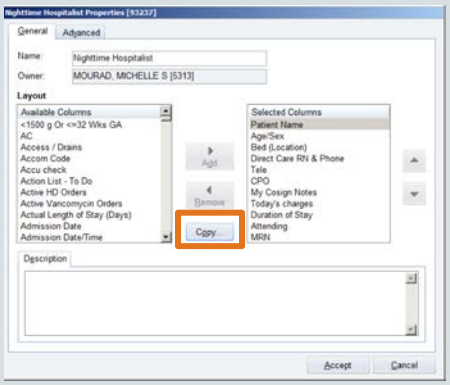
Best Practice APeX Lists

It's happened to us all. Every time we come on service we add a new team list to our favorites and click through the various elements you need to compose your list. Or perhaps you've already created your custom list that you use faithfully, but you've been missing out on all the new list elements we are creating to make our team lists more effective.

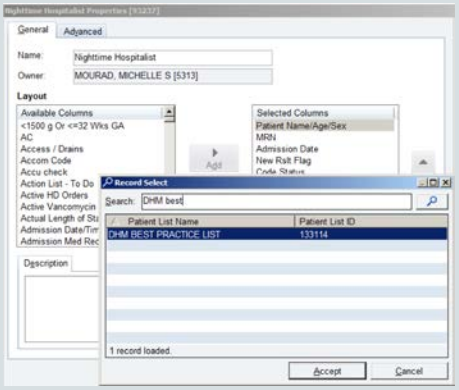
No more! We've now created some "best practice" lists that have all the elements you need to navigate time on service!



Right click on your team list and select properties



Select "Copy" to find another team list and copy its columns



Search for the "DHM best practice" list

With everything you need to make documentation and billing go smoothly, this list will be updated regularly as we add new features to the team list.

Medicine C (5 Patients) — Last refreshed: 2201 — Search Mission Bay Patients

Patient Name	Age/Sex	Bed (Location)	Direct Care RN & Phone	Tele	CPO	My Cosign Notes	Today's charges	Duration of Stay	Attending	MRN
	50 y.o. / M	620A-L1					9923X - PR SUBSEQUENT HOSPITAL CARE,LEVL TBD BY CODER (Andrew Ryan Lai, MD)	9d	Andrew Ryan Lai, MD	
	85 y.o. / F	1404-1E	Liza 81597;;				9923X - PR SUBSEQUENT HOSPITAL CARE,LEVL TBD BY CODER (Andrew Ryan Lai, MD)	10d	Andrew Ryan Lai, MD	
	86 y.o. / M	11IC-14	Patricia ;;;;				9922X - PR INITIAL HOSPITAL CARE,LEVL TBD	21h	Andrew Ryan Lai, MD	

We've created a similar list for housestaff entitled: Medicine Resident Best Practice

This list contains many of the same goodies, but also contains PT discharge recommendations, a check on Med Rec, PCP and the patient's next follow up appointment.

Medicine Resident Best Practice (7 Patients) — Last refreshed: 2138 — Search Mission Bay Patients

Patient Name	MRN	Unit	Bed (Location)	Age/Sex	Direct Care RN & Phone	Tele	CPO	Code Status	Current PCP	Exp Disch Date	PT Discharge Disposition	Discharge Med Rec Complete?	Next Appt
		14L MEDICINE	1435-B1	76 y.o. / F	Hubert 81323;			FULL	MILLIGAN, CATHLIN H.				
		14L MEDICINE	1462-B1	83 y.o. / F	Cherry 80195;			FULL	HUYNH, JACK SIEU KIET		Skilled nursing facility		
		14M MS-HI-ACUI	1403-1E	67 y.o. / F	Liza 81597;;			FULL	PROVIDER, NAME UNKNOWN				
		14L MEDICINE	1453-B1	62 y.o. / M	Anh 80194;			FULL	PATEL, PRANJALKUMAR HASMUKHBHAI	05/09/2015	To be determined		
		13I M/S ICU	1354-10	69 y.o. / M	Patricia ;;			UnCosigned	STEIGER, SCOTT JEFFREY				05/28/2015

Case Review Update

The Case:
54F w/ morbid obesity admitted after a home syncopal episode, found to have submassive PEs. Cards & IR consulted to discuss R/B/A of possible catheter-directed thrombolysis. IR then involved Anesthesia, intubated the patient, and was about to proceed when Medicine became aware of these events. After further Medicine/IR attending discussions, this plan was aborted given c/f possible micro-ICHs contributing to the syncopal event, which would have been a contraindication. She ultimately did well without catheter-directed thrombolysis and dc'ed home on lifelong anticoag.

Case findings:

- No "Consult To IR" order was entered into APEX: the MS4 called in the consult (w/ direct R2 supervision) w/ Medicine's perception that it was an evaluation-only consult, while IR's perception was evaluation and proceed w/ the procedure given apparent clinical urgency.
- There was suboptimal communication within the Medicine team (ex: MS4 seemed aware of IR's plan to proceed w/ thrombolysis but did not communicate early enough w/ team), between Medicine/IR (as above), and between IR/Anesthesia (did not discuss possibility of MAC vs intubation).
- "Syncope" was not listed as a problem in the note's A&P (nor verbally communicated), which may have helped the IR team be more aware of this event and thus consider all potential contraindications (currently no checklist exists).
- From IR's perspective, there are no "low-risk" procedures, and they assume a referring team's attending is aware of all consult requests.

Recommendations:

- Enter an APEX consult order for any requested IR procedure before calling/speaking with them to discuss a case. This helps us synthesize information to formulate a specific consult question to better guide our consultant.
- Remember that IR is very accessible to discuss any case! There is typically always a fellow or attending in the IR reading room (M361), and if in a procedure, they are excellent about returning messages. Their leadership has explicitly shared they appreciate our housestaff/teams coming by to discuss cases in person, as they also learn a lot from us.
- We recommended to IR to develop a standardized checklist of tPA contraindications.
- There is a nascent, multidisciplinary working group (IR, ICU, Pulm, Med) to develop a possible "PE response team", as some institutions have. Brad Sharpe will be our representative.

The Case:
82M w/ h/o TIAs, seizures, chronic dizziness, and bladder CA originally admitted from clinic w/ several days of palpitations, orthopnea, and LE edema, found to have rapid atrial fibrillation and admitted to Cardiology. Underwent TEE/cardioversion, which was c/b somnolence and delayed recognition of new acute R hemiparesis. Subsequently found to have an acute embolic L MCA CVA but outside the window for both tPA and thrombectomy. Ultimately dc'ed to SNF w/ residual R hemiparesis.

Case Findings:

- An acute CVA after a negative TEE is thought to be an extremely rare event.
- Compared to patients presenting via the ER with signs/sxs of an acute CVA, we are much less effective/efficient with in-hospital CVA recognition/management.
- There was incomplete documentation of neuro exams at admission, pre-procedure, and post-procedure (confounded by procedural sedation) in a patient with known h/o TIAs/seizures.
- There was likely limited provider knowledge of high-yield neuro exam maneuvers in a sedated patient, as well as a lack of awareness of thrombectomy as a management option in acute CVA.

Recommendations:

- From the time last seen normal, current data supports IV tPA use up to 4.5 hrs and mechanical thrombectomy up to 6 hrs, but as early as possible remains key! Be proactive in calling a Code Stroke if you have any concern.
- Use (and teach your teams!) 4 high-yield neuro exam maneuvers in an altered patient: (1) passively raise both arms and look for asymmetry; (2) assess for eye deviation and/or pupil asymmetry; (3) assess response to blink-to-threat from both sides; (4) closely assess for any e/o a new facial droop.

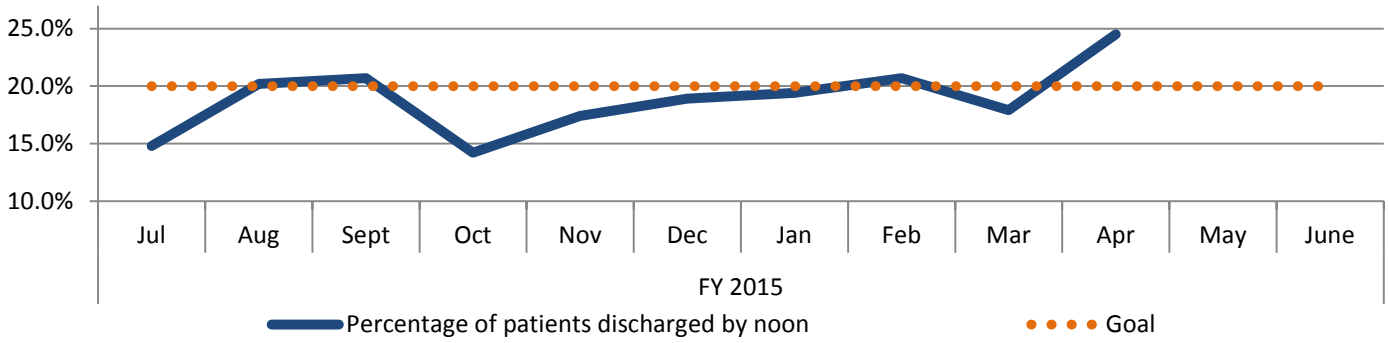
Division Incentive Metric Performance

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**	**1.66**		

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	33.8	38.8	34.3		

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	**83.0**				

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	**24.5**		



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	73.1