thequalitypost

in this issue

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

June 2015 • Issue 54

Greetings from Michelle and Sasha

QUALITY IMPROVEMENT
DIVISION OF HOSPITAL MEDICINE

Welcome to the 54th edition of The Quality Post. In this issue we feature a piece on handoffs and the Holdover Improvement Project. We also bring you a LEAN management update, an Above and Beyond story, and data on our Division Incentive Metrics.

Handoffs for Faculty

Resident handoffs receive significant patient safety scrutiny and for good reason. Poorly conducted handoffs result in the omission of care tasks, misunderstandings, errors, and adverse events.

But what about handoffs for faculty? Google "medicine faculty handoffs" and you get a list of tools to facilitate resident observation in the handoff process. Google "hospitalist handoff" and you get a systematic review by Vineet Arora in JHM 2009 that found no studies, but did find consistent consensus recommendations for the use of a verbal handoff supplemented with written signout in a structured format or technology solution. Technology solutions were associated with a reduction in preventable adverse events, improved satisfaction with handoff quality, and improved provider identification.[1]

Should we be adopting I-PASS along with our residents? I-PASS is a pneumonic - **I**llness severity, **P**atient summary, **A**ction list, **S**ituation awareness and **S**ynthesis by receiver. Use of the mnemonic along with resident training and faculty development was associated with improved patient safety.[2] Medical errors decreased by 23% following the intervention, compared to the pre-intervention baseline (24.5 versus 18.8 per 100 admissions, *P*=XX) and the rate of preventable adverse events dropped by 30% (4.7 versus 3.3 events per 100 admissions), while non-preventable adverse events did not change.

As we work to evaluate and improve the holdover process for housestaff teams, it won't be long before we turn our eye to the faculty services.

1. Arora, VM et al. (2009), Hospitalist handoffs: A systematic review and task force recommendations. J. Hosp. Med
2. Starmer AJ, et al., I-PASS Study Group, Changes in medical errors after implementation of a handoff program. N Engl J Med. 2014 Nov 6;371(19):1803-12.

Jumpstart Your Role as a New Team Leader

Being new isn't easy – even for leaders. When you step into a new role, take time to learn and get to know your team. Don't be afraid to over-communicate.

Change makes people nervous, because everyone wants to know where you're going to take the team. Be open and transparent about what you're thinking, and outline a 30-day plan.

Even if you don't yet know your strategy, you can talk about your values, priorities, and observations, and tell people what you want to learn about and evaluate.

Ask lots of questions and be approachable. Meet with all of your direct reports for at least an hour to ask about what they enjoy doing and what they aspire to do in the next few years. And get your hands dirty – do the work your team does.

Adapted from "5 Tips for New Team Leaders" by Jeanne DeWitt.

Holdover Improvement

Starting the fall of 2014, under the leadership of Sumant Ranji, Jonathan Duong, Trevor Jensen, James Harrison and a team of others have been working on a large-scale effort to improve the holdover process.

① Why does this matter

- ~40% of all admissions to our teaching medicine are holdovers
- DHM Safety culture survey results in 2013 revealed room for improvement around shift changes/transfers
- Informal feedback from residents and attendings revealed considerable frustration with current holdover process

② Why do we know from the literature?

Most literature on handoffs relates to day to night transfers & little is known about the educational value of handoffs

Common themes across studies:

- Handoff Environment
- Standardization and Uniformity
- Designated Transfer of Care/Accountability
- Information Transfer
- Closed loop Verification
- Perceptions/Acceptance/Satisfaction

③ What is the goal of the improvement project?

Maximize the utility of the **face-to-face** handoff by improving the:

Efficiency
Educational Value
Safety

④Needs Assessment Part 1: Cross-Sectional Observational Study

Observed 61 holdover signouts
(Including both floor and ICU patient handoffs)

Key Results:

For all observed holdovers:

- The median entire holdover signout duration was 14.3 minutes (range: 7.3 - 43.0 minutes).
- The receiving team closed the loop for 100% of holdovers.
- Teaching moments from team members occurred in 32.8% of holdovers.
- Immediate constructive feedback occurred 0% of holdovers.

For a subset of observed holdovers:

- The median resident presentation lasted 13.4 minutes (range: 5.4 – 21.3 minutes).
- The patient data portion, all of which can be found in our electronic medical record (EMR), made up a median 8.3 minutes (57.0%) of the entire holdover signout.

Table 1: Holdover Baseline Data characteristics

		Minutes		
Total observations (N = 61)	% (n)	Median	Min	Max
Frequency of closing the loop	100.0 (61)	-	-	-
Frequency of teaching moments	**32.8 (20)**	-	-	-
Frequency of feedback	0.0 (0)	-	-	-
Duration of entire holdover signout	-	14.3	7.3	43.0
Subset of observations (N = 34)	% (n)	Median	Min	Max
Duration of patient data presentation	-	8.3	2.9	12.7
Duration of assessment and plan presentation	-	4.9	2.5	8.9
Total duration of resident H&P presentation	-	13.4	5.4	21.3
% of **presentation** consisting of patient data available elsewhere in EMR	-	62.0%	52.0%	72.0%
% of objective data to total holdover	-	**57.0%**	**33.0%**	**67.0%**
Duration of closing the loop and teaching, if present	-	1.5	0.5	16.1
Frequency of interruptions	8.8% (3)	-	-	-

Holdover Improvement

④Needs Assessment Part 2: Qualitative Study

- **Question:** What are provider perceptions of safety, efficiency and education within the holdover signout process?
- **Format:**
  - Focus groups & structured interviews
  - IM interns, residents, hospitalists, leadership
- **Instrument:** Structured questionnaire
- **Data Analysis:**
  - Audio recorded
  - Professionally transcribed
  - Analyzed by 2 investigators
  - Content analysis

⑤ The Intervention

ACCEPTING TEAM HOLDOVER STANDARDIZED FRAMEWORK

BEST PRACTICES: During Holdover Sign-out with night animal
Roles & Expectations:

Attending:

☑ Call attention to time (Keep presentations to < 7 minutes)
☑ Encourage use of computer for objective data (no reading out loud!)
☑ Prioritize discussion of HPI & clinical reasoning over restating data
☑ Emphasize night resident learning & educational points:
Provide Feedback & **ASK:** *What questions came up for you overnight?*

Accepting Team Members:

☑ Pull up primary data for review (CXRs, CT, labs) on computer
☑ Review urgency (ask when patient was last seen and how well the night animal knows them)
☑ Clarify degree to which home med list has been reviewed & confidence around med list
☑ Verify/input orders to reflect plan (diet/fluids, ppx, antibiotics)
☑ Bring up time sensitive decisions around consults and imaging orders
☑ Confirm code status order and quality of the discussion
☑ Update team designations, 1st call providers, and attending
☑ **Restate major to-do items for the day**

Holdover Improvement

⑥What did we learn from the PDSAs using the standardized framework?

- Teaching moments increased drastically.
- Compared to baseline data, the percent of objective data to total holdover reduced, which led to decreased total presentation time.

Table 2: Holdover PDSA1 characteristics

		Minutes		
Total observations (N = 13)	% (n)	Median	Min	Max
Frequency of closing the loop	100.0 (13)	-	-	-
Frequency of teaching moments	**92.3 (12)**	-	-	-
Frequency of feedback	**53.9 (7)**	-	-	-
Duration of entire holdover signout	-	12.7	7.8	14.7
Duration of patient data presentation	-	5.6	3.2	6.5
Duration of assessment and plan presentation	-	2.4	1.5	6.3
Total duration of resident H&P presentation	-	8.1	4.7	12.0
% of presentation consisting of patient data available elsewhere in EMR	-	67.0%	44.0%	77.0%
% of objective data to total holdover	-	**22.0%**	**17.0%**	**41.0%**
Duration of closing the loop and teaching, if present	-	4.7	1.1	10.0
Frequency of interruptions	7.7% (1)	-	-	-

⑦What is your role as an attending in helping improve the holdover process?

- Considering using the following language when using this framework with your teams:

  "For efficiency's sake, we'd love to keep the presentations under 7 minutes. The goal is to give more time for the HPI and your clinical reasoning and hopefully some teaching points. The objective data like meds, labs, and vital sign trends we can all review together on the computer."
- Promote this with your teams starting in July
- Send us your feedback as you start to use the framework

⑧What are the next steps?

Launch educational/messaging campaign July 1:

- Educational video, Framework & Implementation Guide will be distributed to attendings, housestaff and night animals via email, wiki, at in-person meetings

Ongoing Measurement Plan:

- PDSA data collection July-Sep
- Sep-Oct: Complete Post Observations to compare to Sep 2014 baseline

Special thanks to the Holdover Improvement team.
Please feel free to contact Sumant Ranji with any questions, comments, or concerns.

Lean Update

At a recent Lean Visioning meeting Medical Center, CPI, Performance Excellence, DHM, Residency and UBLT leadership convened to take stock of all of the improvement efforts planned for next year and to select Kaizen topics for the next few months.

What is a Kaizen?

For those of you have not participated in previous Lean efforts at UCSF and aren't familiar with the terminology, Kaizen is Japanese for "continuous improvement."

Kaizen requires us to analyze the way things really are, and then to discover how to improve our processes by testing countermeasures intended to fix problems.

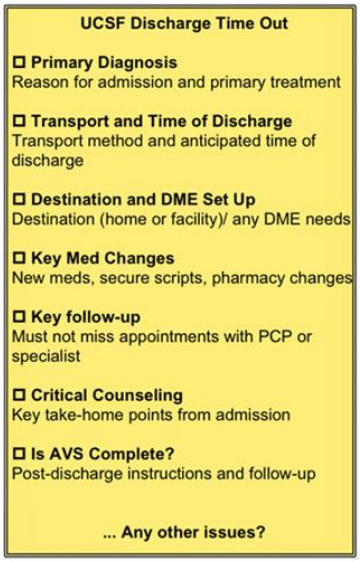
Every kaizen workshop is guided by an A3T (or team charter) that links the activity to a significant problem and establishes definite targets and milestones.

Problems chosen for kaizen should be problems that cause significant pain to the organization, but problems that can be addressed successfully in a five-day workshop and follow-up activities.

改善

Kai = Change Zen = Good

Which problems/areas have we selected for future Kaizens over the next six months?



Dates	*Topic*	*Details*
7/6 - 7/10	5S (RN Focused)	Re-do 5S of 14M/L, focused on equipment, phones, and supplies that are missing/broken. Goal is to assign responsibility/accountability for the 5S tasks, and develop an escalation plan for broken equipment
8/17 - 8/21	RN-RN handoff	Develop Standard Work for RN-RN handoff at change of shift
9/14 - 9/18	**Med Rec upon Admission***	Develop Standard Work and Communication/Education around medication reconciliation upon admission to 14M/L. This Kaizen will build on the work started by the Med Rec Committee and will include several resident champions.
11/2 - 11/6	**Discharge Time Out***	Increase adoption of DTO, remove wastes/barriers, review AVS, improve Care Team communication at time of discharge

***MD focused Kaizens**

Above and Beyond

Last month, sevaral of our hospitalists took care of a young female patient with a complex pyscho-social history and possible Munchausen by proxy. This case required a lot of time, thought, and energy, and we wanted to recognize our Goldman attendings that went above and beyond.

Aylin was the initial point person for this case, and stayed up until midnight during to the patient's index admission to try and find a bed for her.

Lynnea took care of this patient after she was readmitted for an infection, pain, and issues related to feeding intolerance. She led multiple family meetings, went above and beyond to reach out to various specialists (including pediatric subspecialists), and established a transitions plan that will ensure a seamless transition for future care providers.

If attendings had duty hours, she would have been in constant violation.

.

Carla came on service after Lynnea, and learned that the patient needed a test that she wasn't able to afford. She called the manufacturing company several times and asked them if there were any options for this patient. She found out about a program where doctors can get one free test per lifetime (in order to establish a relationship with the company) so she used her quota.

Carla was able to get the patient this important test for free!

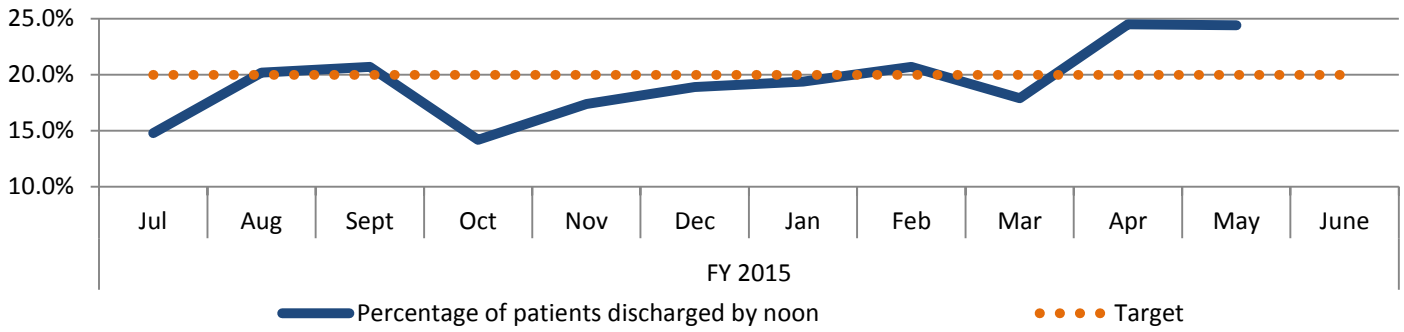
Division Incentive Metric Performance

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**	**1.68**	**1.60**	

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	34.5	37.2	

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**	76.7			

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	**24.5**	**24.4**	



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	74.8