

Make Difficult
Conversations
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Level-Loading

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Monthly Quality
Improvement
Newsletter for the
Division of Hospital
Medicine

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issue

Greetings from Michelle and Sasha

QUALITY IMPROVEMENT
DIVISION OF HOSPITAL MEDICINE

Welcome to the 55th edition of The Quality Post. In this issue we feature a piece on level-loading and the FY16 DHM priorities. We also highlight the Medical Students as High-Value Care Officers project and data on our Division Incentive Metrics.

Do We Take on Discharge by Noon for Another Year?

The case for discharge by noon (DBN) is fairly straightforward. Being stuck in the ED is bad for patients. Data shows that increased time boarding in the ED increases errors and mortality.

Unfortunately, our improvement in DBN as a medical center hasn't led to convincingly shorter ED boarding times. This may be due to an increase in patient volume or failure to tackle other processes like cleaning rooms or stewardship of step down beds. Does this mean that we don't continue our DBN efforts?

DBN still has one very important function, level loading. Imagine you are a nurse and 3 of your 4 patients are leaving at 4pm. You may not have the time to prioritize discharge teaching. Imagine your job is to sanitize the room when a patient leaves, but all of your work is clustered from 4 – 6 pm. You might not clean as effectively.

The overall goal is to achieve continuous flow, which means that a patient moves through operations in a step-by-step fashion with no waiting in between. The system is designed in such a way that supply (i.e. providers, rooms, equipment, supplies, etc.) is provided in precisely the right quantities at precisely the right time, to meet the demand requirements of the system, in "just-in-time" fashion.

The concept of evening out work and being able to balance throughput according to the capacity of the system is called level-loading.

One way to achieve this would be to change staffing at different times of the day according to need. The other way is to balance out discharges throughout the day. We'd never want all discharges before noon, just 20%.

Will we continue DBN as a metric for the Division? Help us decide!

Make Difficult Conversations Less Daunting

Difficult conversations are inevitable. But if you manage them properly, you can keep your relationships intact. First, don't think of the conversation as difficult – you'll only feel nervous and upset. Instead, frame it in a positive, less binary way. You're not giving negative feedback; you're having a constructive conversation about development.

It can help to jot down key points beforehand, but don't write a script. Try to see the other person's point of view. Ask yourself: What is the problem? And what does the other person think is the problem? If you aren't sure, acknowledge that you don't know and ask.

Then deliver the tough news in a courageous, honest, and fair way. Just don't play victim. The worst thing you can do is to ask for sympathy by saying things like "I feel so bad about saying this" or "This is really hard for me to do."

Adapted from "How to Handle Difficult Conversations at Work" by Rebecca Knight.

FY16 DHM Priorities

With the start of the new academic year, it is time to take stock of our accomplishments during the FY15 Division Incentive Metric Program and to select goals for FY16 that reflect the priorities of our Division.

Changes & Opportunities

Historically, our 5 Division Incentive metrics each year have been linked to incentive payments from the Medical Center -- \$200,000 in total. Last year, funding was provided by the Department of Medicine. This year we have the opportunity to run the program internally within DHM.

PAST DIM FUNDING



UCSF Medical Center

FY15 DIM FUNDING



UCSF Department of Medicine

FUTURE DIM FUNDING



While we still aim to align our priorities with the department and medical center, this opportunity will allow us to think creatively about our program structure and provide flexibility around the types of metrics we select.

The need for synergy



PRIORITIES	AUDIENCE
Medical Center	All
Housestaff Incentive Program	Housestaff
4+1	Teams
DIM	Faculty
UBLT/Lean	14 M/L

Priorities: What do we mean?

- Focused messaging to faculty
- Dedicated resources
- Leadership monitoring progress

How will this year's metrics be different?

METRICS	WORKPLAN PROJECTS
<ul style="list-style-type: none"> • Clear measureable • Process or outcome • Impact on patient care 	<ul style="list-style-type: none"> • Meeting of project milestones • Divisional process/structure metrics

FY16 DHM Priorities

Proposed Metrics	
Documentation & the EMR	Medication Reconciliation: Appropriate med rec on admission
High Value Care	Phlebotomy
The Patient Experience	HCAHPS MD “Explained in Understandable Way”
	HCAHPS Top Box MD Communication
Transitions in Care	Discharge Throughput: Increase % of DBN patients to >20%
Goals of Care	POLST forms /Problem List Documentation of Code Status
High Value Care	Telemetry Utilization: Decrease the percentage of patients on telemetry until discharge (with LOS > 48hrs)

Medication Reconciliation

Quality Gap:

- UCSF MedList Clinic sees patients discharged from the hospital for a comprehensive medication review.
- The team sees very high levels of discordance between the discharge summary and what the patient is actually taking at home.

The following goal has been chosen as one the Housestaff Incentive Program metrics for this year as well as a target for an upcoming Kaizen event:

Increase % of patients who have had all medications reconciled before discharge from our previous 12-month average of 61% to a 2015-16 average of 70%.

Adopting this as a priority would ensure DHM alignment with the Residency Program, and also allow us to harness the momentum of other ongoing efforts around this important topic.

The participation of attendings working overnight and on Goldman would be critical. Ward attendings would also need to encourage their team to achieve the goal.

Phlebotomy



- **With several months under our belt where we have achieved our goal of less than 1.9 sticks per hospitalized patient per day, should we commit to sustaining current performance at a more ambitious goal?**
- Do we need to continue tracking this to embed this into our culture?
- Given that this is a new metric without a clear benchmark, how will we know when we've strived for the optimal target?

HCAHPS

This year we achieved above 80% for the HCAHPS Top Box score for physician communication for 5 of 12 months, an unprecedented achievement for our division! We took a slightly different approach and focused our improvement activities on the Explained in an Understandable Way question (one of the three MD communication questions that roll-up into the Top Box score).

Should we select a Top Box goal like we've done in the past? Or narrow our focus by selecting a goal for the “Explained in an Understandable Way” question?

YOUR CARE FROM DOCTORS

5. During this hospital stay, how often did doctors treat you with courtesy and respect?
- 1 Never
 2 Sometimes
 3 Usually
 4 Always

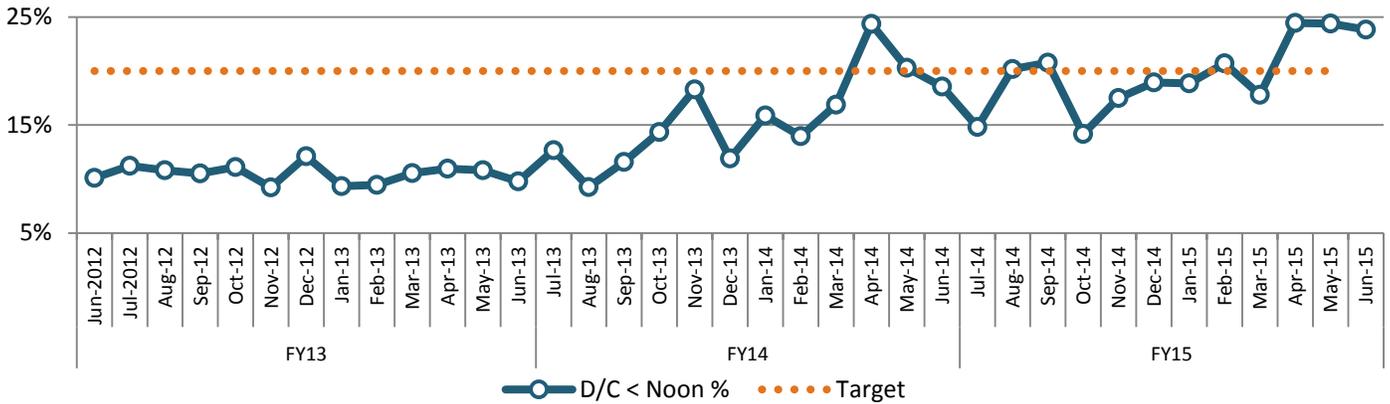
6. During this hospital stay, how often did doctors listen carefully to you?
- 1 Never
 2 Sometimes
 3 Usually
 4 Always

7. During this hospital stay, how often did doctors explain things in a way you could understand?
- 1 Never
 2 Sometimes
 3 Usually
 4 Always

FY16 DHM Priorities

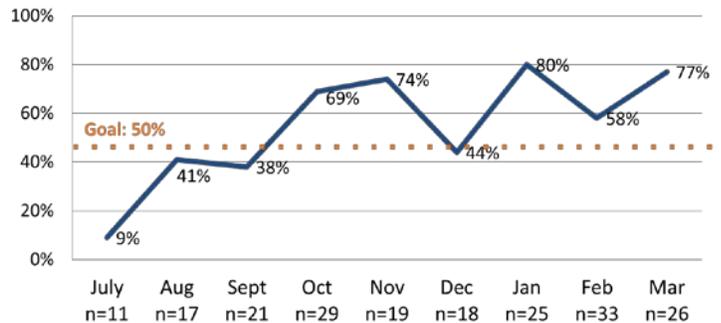
Discharge by Noon

- Improving the percent of patients discharged by noon will likely continue to be a priority for the Medical Center, the 14M/L UBLT, and potentially the Housestaff Incentive Program
- Although we've embedded this into our culture over the past several years, without continued focus, this metric will likely not sustain based on systems changes alone

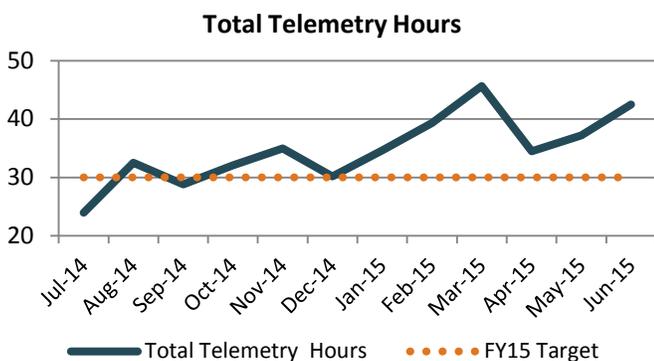


POLST Forms/Problem List Documentation of Code Status

- Goals of care discussions not being documented in APeX in a consistent and reliable way
- POLST forms not being completed for patients who have a status other than full code on discharge**
- May lead to patients receiving care not within their goals (source of several case reviews)



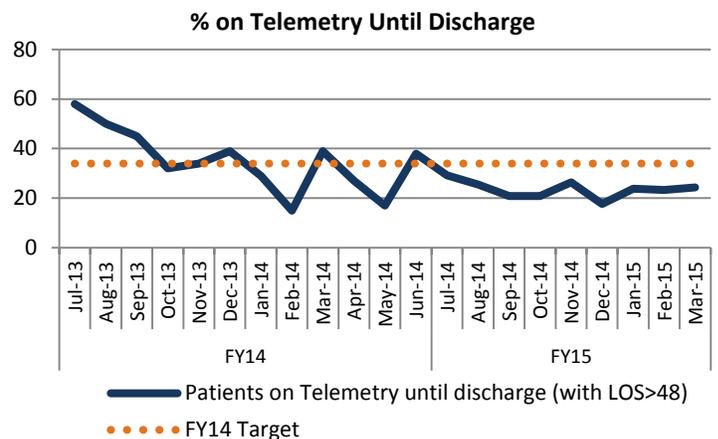
Telemetry Utilization



This year's metric, reducing total telemetry hours, was more ambitious and proved difficult to achieve. **Should we commit to focusing on this again given that there is still room for improvement?**



During the FY14 DIM program we made strides on reducing the % of patients on telemetry until discharge, and we've continued to sustain the results during FY15.



FY16 DHM Priorities

Proposed Workplan Priorities	
Transitions in Care	Holdover: Efficiency, Safety, Educational Value
Faculty Development	Peer Observation Program
Team Communication	MD/RN Huddle
Documentation & the EMR	Note Writing Best Practices: Brevity (copy forward?) and use of checklists

In addition to tackling process or outcome metrics that impact patient care, this year we plan to also prioritize workplan project milestones and set targets for divisional process/structure metrics.

Holdover Improvement



Why does this matter?

- ~40% of admissions are holdovers
- DHM Safety culture survey results revealed room for improvement around shift changes/transfers
- Informal feedback revealed considerable frustration with current holdover process

Goal: To maximize the utility of the face-to-face hand-off by improving the efficiency, safety, and educational value of the holdover process.

Progress to Date:

- Needs Assessment Complete
- Developed & Tested Holdover Framework
- Framework education roll-out planned for August



Peer Observation Program

The Quality Gap

- Many observations being performed in silos (clinical, educational, patient experience)
- No organized way to provide feedback on all concurrently
- No clear expectations for new or existing faculty on how they will be observed and receive feedback
- Observations rest in the purview of a few

Progress to Date:

- Gathering faculty input on program design
- Developing proposal
- Building on Lessons Learned from PEP project & other institutions

4 Domains



Clinical



Team/Time Management



Educational



Patient Experience

FY16 DHM Priorities

MD/RN Morning Huddle



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

MD-RN Program



Progress to Date

- Tested Huddle Process
- Printed Huddle Prompt (along with ATO/DTO) for RN name badges
- Initial messaging to faculty/residents & nursing colleagues

Note Writing Best Practices

The Quality Gap

- Residents spend a significant amount of time on daily notes
- Notes are long, difficult to read and have errors carried forward
- “Open Notes” movement may create needed impetus to improve notes

Progress to Date

- Tremendous work done by Brad & team to cut out excessive information (crept back in)
- Russ (and Michelle) charged by med center to work on note writing best practices round 2



Teaching to Choose Wisely: Medical Students as High-Value Care Officers

The "Teaching to Choose Wisely" campaign is an initiative designed 1) to prepare clinicians to implement high-value decisions, and 2) to develop educators with focused expertise in teaching the principles and practice of healthcare value.

Congratulations to Trevor Jensen, Ari Hoffman and the rest of the team for being selected this year for their project "Medical Students as High-Value Care Officers."

- They plan to create and implement a volunteer curriculum for third year medical students to act as “High Value Care Officers” while on clinical medical rotations. The curriculum is aimed at creating a proficiency-based competency education for UCSF medical students.
- Their program launches this week & they already have their first high value care officer!
- The medical school is in the process of making some of their material a required part of MS3 curriculum.
- This block will be a first PDSA.
- Two medical students that have been critical: Yi Lu, MS4, our student lead, who is working on this as part of the HPE pathway; and Brian Shaw, MS3.

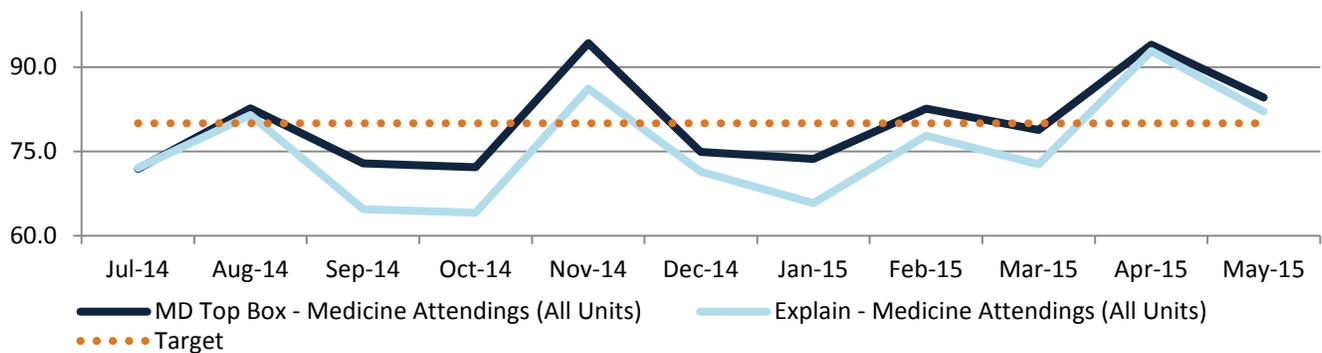


Division Incentive Metric Performance

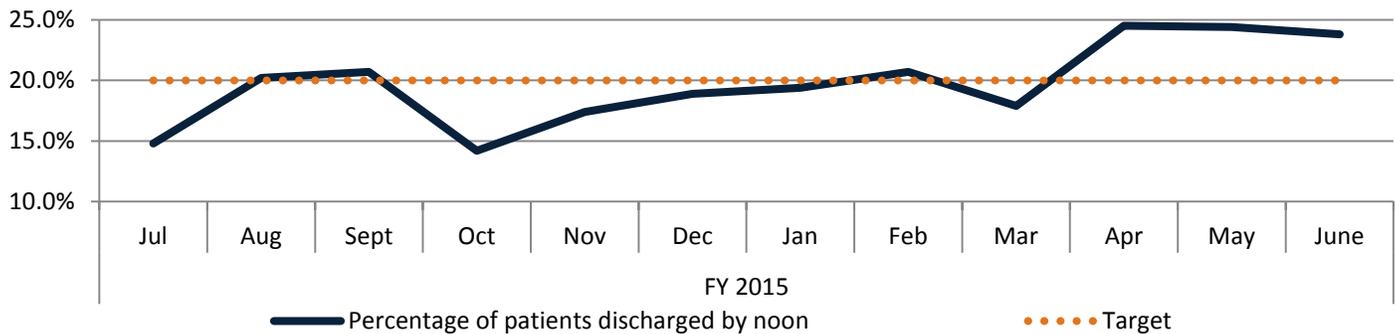
Decrease number of total phlebotomy draws by from 2.05 to 1.9 sticks (7.3%) per hospitalized patient per day								3 of 12 months					
FY2014 Baseline	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
2.05	1.96	2.02	1.97	1.91	1.82	1.85	1.72	1.70	1.57	1.68	1.60	1.54	

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	42.5	

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	96.0	84.6		



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	23.8	



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	78.4		