thequalitypost

in this issue

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

Dec 2015 • Issue 60

Greetings from Michelle, Nader and Sasha

QUALITY IMPROVEMENT
DIVISION OF HOSPITAL MEDICINE

Welcome to the 60th edition of The Quality Post. In this issue we feature a piece on notewriting and an update on our UBLT/Divisional Cost per Case efforts. We also present information about our Discharge Time Out revamp, a new Cantonese Interpreter service, an Above and Beyond piece and data on our 4+1 metrics.

Progress Note Billing – It Doesn't Take Much!

Level 2

History: cough worse w/ inspiration, no chest pain

Exam:
37.2 120/80 140
Gen: NAD, fatigued
Heart: RRR, no m/r/g
Lungs: right lung base inspiratory crackles, symmetric excursion

Medical Decision Making:
sepsis due to community-acquired pneumonia: **established**, **improving**, oxygen need down to 2L

chronic afib: **established**, **worsening** heart rate control in the context of infection, **give metoprolol 5 IV**

Level 3

History: since last night: sharp L-sided chest pain worse w/ inspiration; no cough or fevers

Exam:
37.2 120/80 115
Gen: NAD, fatigued
Heart: tachycardic, regular, no m/r/g
Lungs: CTAB, symmetric excursion
Abd: +bs, soft, NT
Skin: warm, no rashes
Psych: normal mood and judgment

Medical Decision Making:
chest pain: **new**, pleuritic pain c/f PE, reviewed **CXR** which shows no effusion or consolidation, order **EKG**, order **CTA** chest

C. diff colitis: established, improving

Know How to End an Innovation Project with Grace

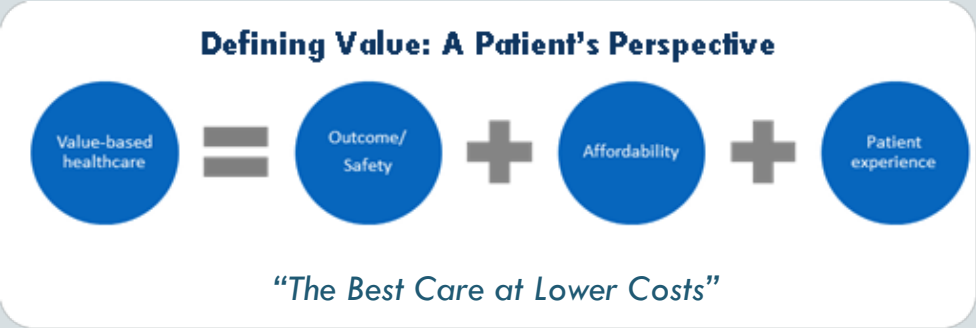
"Breaking up" with an innovation project is never easy, especially if it's an initiative your team still believes in passionately. But when it's clear that an idea isn't going to pan out, perpetuating it can sap your organization's innovation capacity and energy. Here's how to end a project to produce a positive outcome:

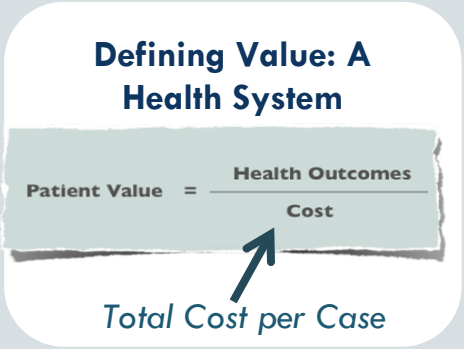
- Compare the results to the goals. If you were clear from the beginning about what success will look like, you can collect data to assess whether the project is still on track.
- Acknowledge what else you could be doing. Don't be afraid to admit there are other – possibly more worthwhile – projects your team and resources could be working on.
- Remind your team of what you've learned. A failed project isn't necessarily a waste of time. If you learned how to run a certain type of experiment, you've gained valuable knowledge.

Adapted from "How to Break Up with an Innovation Project," by Scott Anthony.

Focusing on Cost Per Case

The meaning of "value" in healthcare – very roughly defined as the output of healthcare per unit of cost – may differ widely whether considered from the perspective of the patient, provider or payer.

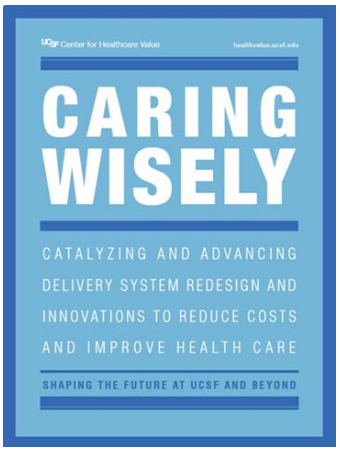




"Value in healthcare depends on who is looking, where they look, and what they expect to see," Dr. Lisa Rosenbaum has suggested. For clinicians, value may mean decreasing overuse and inefficiency, while improving compliance with evidence-based care. But for patients, creating value may signify enriching the patient experience and concentrating on patient-centered outcomes.

These differing perspectives have created a gap that must be investigated and bridged. However, at the most basic level there is general agreement that value should include cost, outcomes (or quality of care), and patient experience. And it is clear that currently there is substantial room for improvement in all of these areas."

-Excerpt from Understanding Value-Based Healthcare
Chris Moriates, Vineet Arora, Neel Shah



What is Caring Wisely?
Caring Wisely is an organized process for engaging and supporting frontline clinicians in efforts to remove unnecessary costs from healthcare delivery systems. The program was created and launched by the UCSF Center for Healthcare Value in November 2012.

How does Caring Wisely work?
The Caring Wisely program consists of 3 stages: 1) The Ideas Contest: a medical center-wide open call to all staff, providers, faculty and trainees to bring forward their best ideas for identifying areas that could be targeted to reduce inefficiencies and healthcare costs; 2) The Request for Proposals Stage: project teams are encouraged to submit proposals for intervention strategies; and 3) The Project Implementation Stage: frontline project and implementation science teams meet regularly to develop and implement an intervention strategy.

Each project has a maximum budget of $50,000 and receives project support from the Caring Wisely team. A key feature of the program is the partnership between project teams, the Caring Wisely team, and the Caring Wisely Steering Committee (comprised of executive health systems leaders in quality, operations, finance, and information technology).

We have collected more than 65 ideas and 20 full project proposals in each of the first 3 years of the program, via UCSF Open Proposals: a web-based platform enabling transparent and collaborative proposal development. Each year, 2-3 projects have been chosen for implementation. Early results show notable decreases for target groups in blood transfusions, nebulizer treatments, and operating room supply costs.

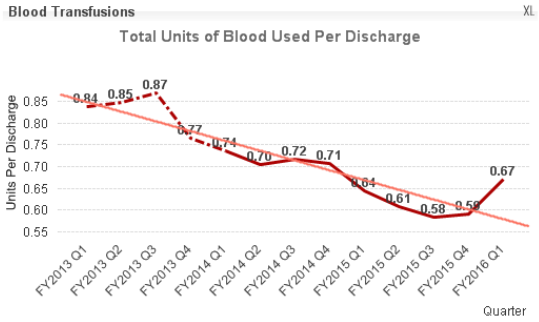
Focusing on Cost Per Case

Caring Wisely Project Cost Savings Dashboard

This dashboard tracks the cost savings of each Caring Wisely Project. In FY2014 there were two projects: Nebs No More After 24 & Blood Transfusion Reduction. In FY2015 there were two projects: Operating Room Surgical Cost Reduction Project & RADS-Reducing CT use with Apex Decision rules.

Note on plots: the dashed portion of lines represent baseline data and each plot is fit with a linear line of best fit

1 Blood Transfusion Reduction (2013-2014)



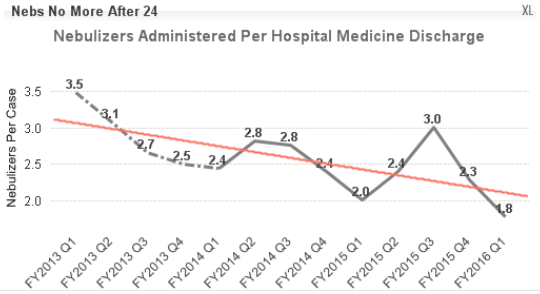
Transfusions Cost Savings

FY	Total Units	Total Cases	Avg Unit Cost	Total Cost
2013	24,846	29,899	$258.00	$6,410,268
2014	22,035	30,782	$246.25	$5,426,119
2015	19,563	32,282	$238.92	$4,673,927
2016	3,860	5,752	$245.50	$947,630

Saved to Date: $2,721,586

Saved FY15 vs FY14: $752,606

2 Nebs No More (2013-2014)



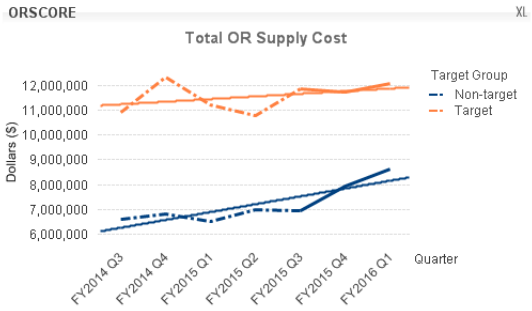
Nebs No More Cost Savings

FY	Total Nebs	Total Cases	Nebs Per Case	Cost Per Neb	Cost Per Case	Total Cost
2013	13,777	4,730	2.91	$108.68	$316.55	$1,497,284
2014	13,602	5,216	2.61	$108.68	$283.41	$1,478,265
2015	12,920	5,313	2.43	$108.68	$264.28	$1,404,146
2016	1,623	913	1.78	$108.68	$193.20	$176,388

Saved to Date: $112,158

Saved FY15 vs FY14: $74,120

3 ORSCORE (2014-2015)



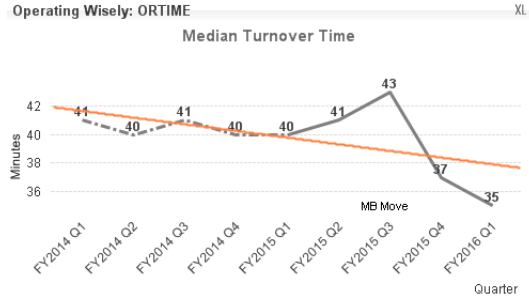
ORSCORE Cost Savings Target Services

Service	Base N Cases	Interv N Cases	Base Avg Cost	Interv Avg Cost	Avg Cost Diff
NeuroSurg	2932	2329	$7,045	$7,314	$268.55
OHNS	2310	1952	$1,502	$1,384	($118.23)
OrthoPedics	4914	4103	$4,320	$3,952	($368.48)

Saved to Date: NA

Annualized Savings: $1,742,658

4 Operating Wisely: OR TIME (2014-2015)



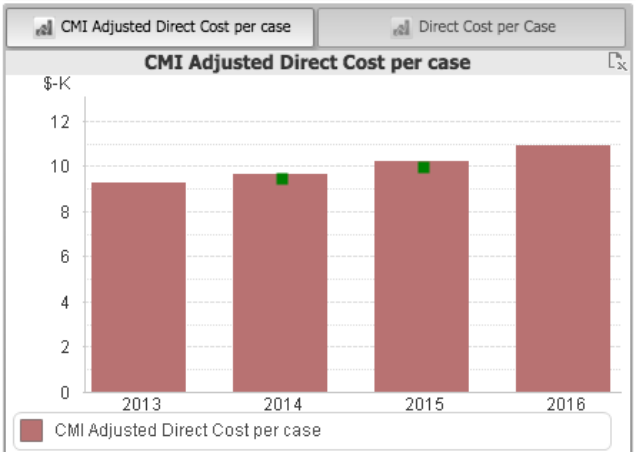
Operating Wisely ORTIME Cost Savings

FY	Ncases	Median Turnover Time
2014	6004	41
2015	7514	40
2016	2646	35

Focusing on Cost per Case

Despite all of the incredible high-value care efforts taking place across the institution, direct cost per case has been rising over the past few years and USCF is one of the most expensive hospitals in the country (95th percentile!).

How are we doing?



How is cost per case measured?

Total Cost Per Case: All costs attributable to care for a patient during hospital stay [+ 72 hrs prior to admission]

Direct Costs: The cost of providing care directly to a patient (nursing care, supplies, drugs, tests, PT/OT, etc)

Indirect Costs: Operating costs ("keeping the lights on, "administrative salaries, etc) attributed to patient's care based on total direct costs and LOS

**If we decrease direct costs, the amount of indirect costs attributed to our service will also decrease

Medicine Service Cost Data

	Discharges	Days	ALOS	CMI	UHC Index	Opp.Days	Cases ICU %	ICU Days %	Day Reducti LOS
Medicine	5,853	32,836	5.61	1.55	1.09	2,955	18.0%	17.4%	9.9%

	Days
ICU Days	5,729
Med Days	27,137

UB Class/Major Category	Cases*	Direct Cost	Direct Cost % Ttl	Total Cost	Direct Cost Per Case	Total Cost Per Case	Direct Cost PC % Total	Direct Cost Per Day	Total Cost Per Day
Medical and/or Surgical Unit	*5,595*	*37,520,401*		*66,137,880*	*6,706*	*11,821*	*39.44%*	*1,383*	*2,437*
Intensive Care Unit	*1,054*	*18,407,911*		*31,134,623*	*17,465*	*29,539*	*102.71%*	*3,213*	*5,435*
Daily Room & Board	**5,853**	**55,928,312**	**56.20%**	**97,272,503**	**9,555**	**16,619**	**56.20%**	**1,702**	**2,960**
Drugs	**5,833**	**13,624,474**	**13.69%**	**19,446,063**	**2,336**	**3,334**	**13.74%**	**414.92**	**592.22**
Services	**5,747**	**27,095,652**	**27.23%**	**44,917,007**	**4,715**	**7,816**	**27.73%**	**825**	**1,368**
Supplies	**2,386**	**2,117,150**	**2.13%**	**3,666,677**	**887**	**1,537**	**5.22%**	**64**	**112**
Others	**2,375**	**756,952**	**0.76%**	**1,312,061**	**319**	**552**	**1.87%**	**23**	**40**
Grand Total	**5,853**	**99,522,541**	**100.00%**	**166,614,310**	**17,004**	**28,466**	**100.00%**	**3,031**	**5,074**

*This number represents the max cases that is used by this UB Class Group

Daily Room & Board make up 56.2% of our Direct Costs. Thus, decreasing **Length of Stay (LOS)** is a high-yield strategy for decreasing costs.

FY15 Services

Respiratory: $5.5M

Labs & Path: $5.4M

Emergency Dept: $4.4M

Imaging: $3.3M

Periop: $1.8M

Rehab Services: $1.6M

Blood Services: $1.3M

Dialysis: $1.1M

Special thanks to Chris Moriates and Victoria Valencia for leading these efforts for our Division and at the Medical Center level. Please feel free to contact them with any questions, comments, or concerns.

Discharge Time Out (DTO) Revamp

Coordination amongst team members, patients and family members during the discharge process facilitates a safe and seamless care transition. MD-RN communication on the day of discharge is a key part of that process. Help us revamp our Discharge Time Out (DTO) effort!

Discharge Time Out (DTO)

HSL Resident Project

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

UCSF Discharge Time Out

☐ **Primary Diagnosis**
Reason for admission and primary treatment

☐ **Transport and Time of Discharge**
Transport method and anticipated time of discharge

☐ **Destination and DME Set Up**
Destination (home or facility)/ any DME needs

☐ **Key Med Changes**
New meds, secure scripts, pharmacy changes

☐ **Key follow-up**
Must not miss appointments with PCP or specialist

☐ **Critical Counseling**
Key take-home points from admission

☐ **Is AVS Complete?**
Post-discharge instructions and follow-up

... Any other issues?

Less than 1 minute could save you 15 clarifying pages or more.

It's time for the...
Discharge Timeout
Check in before check out

"During our discharge check-in, we realized that the patient was going to be unable to pick up her pre-approved medication at her pharmacy that evening. We were able to give her pm dose early to ensure she did not miss her dose that day."
-14L RN

What is your role as the attending?

- Reinforce the importance of MD-RN communication on the day of discharge
- Encourage your housestaff to break away from rounds to page the RN and perform the DTO
- Remind them that this could improve patient safety, RN satisfaction, and could save clarifying pages later on in the day.

On Call Cantonese Interpreter now available!

Language Access Compliance

- Always use a professional interpreter.
- In-person = scheduled
- Video/Telephone = on-demand
- Only Certified Bilingual Clinicians & Staff are permitted to discuss clinical matters directly with patients in their preferred

Current Services

Parnassus
Spanish M-Sun, 8:00 AM – 11:30P M
Page 443-WORD
Mission Bay Hospitals
Spanish M-Sun, 8:00 AM – 11:30 PM
Russian, Cantonese, Mandarin M-F 8:00 AM – 5:00 PM
Use Voalte Phone ["Language" Interpreter Hospital]

Proposed Services

Parnassus
Cantonese, Mandarin M-F, 8:00 AM – 5:00 PM
Page 443-6207

Requesting On-Demand Support

- **Page 443-6207 and wait for call back**
- Requests are triaged based on medical necessity
- Flexibility is appreciated when coordinating assignments with Same-Day Interpreter
- If Same-Day interpreter is unavailable, pages are answered by Dispatch

Tips: Effective use of an Interpreter

- Let the interpreter know what to expect before starting the conversation
- Address the patient, not the interpreter (1st person)
- Communicate as you do with all your patients
- Keep a comfortable pace allowing time for interpretation

Above and Beyond

Last month, several of our hospitalists took care of a male patient with intermittent bowel obstructions requiring four UCSF admissions to be resolved. The patient and his wife spent 36 nights over the course of 12 weeks at UCSF, and were incredibly grateful for the care they received from the entire medical team and staff at UCSF. Below are a few paragraphs from the thank you letters the patient's wife wrote to our hospitalists.

Dr.Karaki inherited a complicated case with no easy answers. In spite of this, her incisive intelligence and gentle presence brought us constant reassurance during days of great pain and uncertainty. She brought great medical skill and deep commitment to the relationship with her patient and with me. Her approach was honest but unfailingly compassionate.
In searching for answers, Fatima was both resourceful in her own right and open to collaboration with our other physicians both inside and outside the UCSF system, something that was of the utmost importance to us. Her commitment to Don's care meant spending long hours in thoughtful examination, persevering in consultations, studying test results, and talking with us about the continuing dilemma of Don's condition. Every time she entered the room, we felt the warmth of her wide smile and the healing power of her presence. Her intelligence, responsiveness, and generosity of spirit are unparalleled.

Michelle entered the room, introduced herself, and squatted down by the bedside to be at eye level with Don, an action which immediately set the tone for this and all subsequent consultations: Don's care was to be a collaborative enterprise, a mutual search for diagnosis and treatment, honored with intelligence and compassion from the "Marvelous Mourad" as we named her. In a lifetime of medical care, with three complicated medical conditions between us, and more than 40 doctors consulting with us over forty years, Michelle is among the top three smartest physicians we have ever encountered. She has an unmatched intention for inquiry, an incisive mind, and an enthusiastic response to collaboration with her patient. Given the complications and uncertainty of my husband's condition, a physician could easily have given up, become impatient, or resorted to useless healthcare clichés.

Stephanie inherited a complicated case with no easy answers. However, she brought an energetic, fresh approach to the effort and began the investigation into diagnosis and treatment with rare ingenuity, intelligence and enthusiasm. My husband and I felt relieved to have Stephanie "on the case" at a time when we were overwhelmed by many weeks of uncertainty and pain. This, the fourth in a series of admissions over 10 weeks, felt like a failure to us and probably to the many physicians who had worked with us, but not to Stephanie. She saw us through to creating a new plan in consultation with Jonathan Turdiman, M.D., and she helped us to accept the next steps while respecting our fears and doubts.

Her quiet intelligence and gentle presence brought us constant reassurance during days of great pain and uncertainty. She brought intelligence and commitment to the relationship with her patient and with me. Her approach was honest but unfailingly compassionate. She never made idle promises or offered false information. Her commitment to patient care is unparalleled. She spent long hours in thoughtful examination, studying test results, and talking with us about the dilemma of Don's condition. Every time she entered the room, we felt the warmth of her presence. Her kindness, responsiveness, and generosity of spirit never flagged.

DHM/Residency "4+1" Priorities

Four Core Metrics:

Achieve ≥ 75% score for HCAHPS Communication MD "Explained in Understandable Way"							7 of 12 months					
FY2015 Baseline	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
74.9%	73.2	**81.1**	74.3									

Sustain number of total phlebotomy draws by achieving ≤ 1.7 sticks per hospitalized patient per day							6 of 12 months					
FY2015 Baseline	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
1.7	**1.56**	**1.51**	**1.51**	**1.64**	**1.60**							

Achieve ≥ 90% of patients who have had all medications reconciled before discharge							4 of 12 months					
FY2015 Baseline	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
77.7%	76.5	86.7	84.3	88.9	88.1							

Achieve ≥ 20% of hospital medicine discharges by noon							8 of 12 months					
FY2015 Baseline	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
20.1%	**20.4**	16.0	15.7	17.7	18.7	19.8						

Plus One Metrics:

Achieve ≤ 23% of patients on telemetry until discharge (with LOS > 48hrs)							6 of 12 months					
FY2015 Baseline	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
22.6%	**23.0**	24.2	23.6	29.0	**17.5**							

Achieve ≥ 75% patients with High-Quality AVS							6 of 12 months					
FY2015 Baseline	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
74.4%	65.1	69.1	62.0	65.0	65.2							

Achieve C Diff rate of ≤ 11.1 (per 10,000 patient days)							6 of 12 months					
FY2015 Baseline	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
9.23	16.8	**6.26**	**9.05**	**0.00**								

Achieve 50% of patients (not full code) with POLST completion							6 of 12 months					
FY2015 Baseline	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
40.2%	36.1	**46.2**	**50.9**	48.7	**62.2**							