thequalitypost

in this issue

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

April 2016 • Issue 64

Greetings from Michelle, Nader and Sasha

QUALITY IMPROVEMENT
DIVISION OF HOSPITAL MEDICINE

Welcome to the 64th edition of The Quality Post. In this issue we feature a piece on the importance of keeping an open mind as a leader and practice feedback interventions. We also present information about our note writing improvement efforts, the UBLT growth cycle, and data on our 4+1 metrics.

Practice Feedback Interventions

Abridged and Adapted from Brehaut et al.

With the increasing availability of data to drive improvement we can look to decades of experience around how to give data feedback effectively:

1. Recommend actions that are consistent with established goals and priorities, especially if those goals are explicit, specific, time-bound, recipient-defined, and challenging but attainable

2. Recommend *specific* actions and those that are under the recipient's control

3. Provide feedback repeatedly and near in time to the actions that drive the metric so recipients can track their own improvement

4. Benchmark performance against something meaningful - published standards, a peer group, or the recipient's past performance

5. Provide feedback in more than one way - for example, verbal and visual communication

6. Reduce cognitive overload when giving feedback and make extra detail optional - often this means reducing the number of metrics, simplifying visuals, or condensing numerical information

7. Construct feedback through social interaction - activities consistent with this approach might include establishing rapport or trust between feedback providers and recipients, engaging in self-assessment around target behaviors before receiving feedback, developing feedback-seeking skills for the recipients, or engaging in dialogue with peers as feedback is provided

8. Address the credibility of the information and the quality of the data source

The Best Leaders Keep an Open Mind

We often think of great leaders as having the conviction of their beliefs—they're not pushovers. But the most successful leaders actually show a willingness to be persuaded. How can you do this, particularly on issues where you're not objective?

Keep your hand on the dial. When debating a decision, envision turning a dial: all the way to the right represents absolute certainty, and all the way to the left signifies none.

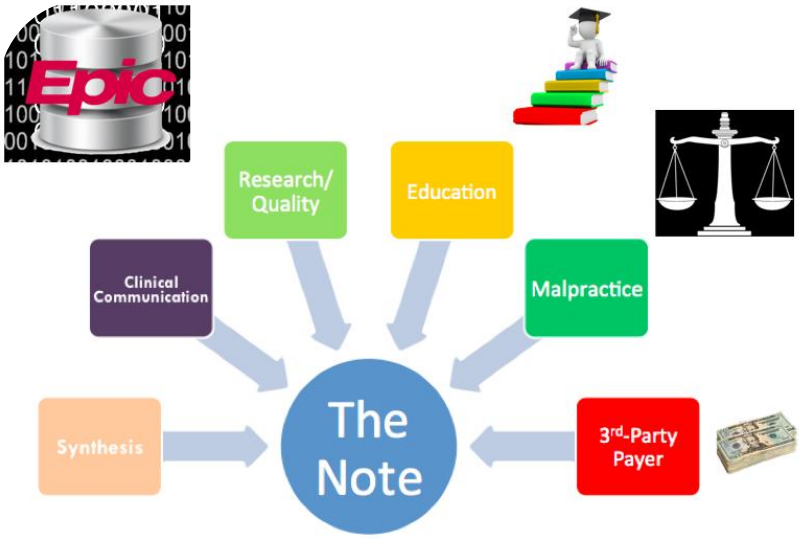
Recall a moment of opacity, when you couldn't see a situation clearly, or when something you were so sure was right turned out to be wrong. Whenever you're feeling overly confident, remind yourself of that moment, and seek counsel.

Kill your darlings. It can be tough to change your mind about long-held beliefs. But the quicker you acknowledge that an idea (even a beloved one) is unworkable, the sooner you'll move on to the right course of action.

Source Harvard Business Review: Adapted from "The Best Leaders Allow Themselves to Be Persuaded," by Al Pittampalli

Note writing Improvement

Who is the audience for your progress note?



Notes are important for both facility and professional fee billing but they serve other purposes too:

- **Synthesis**: an opportunity at the end of the day to review data and rethink the patient
- **Clinical communication**: consultants and the next attending on service often read your notes
- **Research/Quality**: chart review and natural-language processing of notes drives research; the words you use affect expected mortality calculations
- **Education**: medical students and residents learn from how we frame patients
- **Malpractice**: notes are discoverable in lawsuits

What does adequate billing look like in a progress note?

Remember, billing (based on coding) is looking for detail in three areas: subjective, physical exam, and assessment & plan.

- *Subjective*: answers to medical school type symptom questions: how much does it hurt, what makes it better/worse, etc.
- *Examination*: vitals (automatically inserted by the note template) + 3-5 organ system assessments (see example tables)
- *Assessment/plan*: reviewing labs or imaging and ordering new things is considered more work

Good news is that best two out of three wins! So never fear if you don't like writing a lot under the subjective part; just do good work in the other two sections.

Level 2 Example	cough worse with inspiration, no chest pain	**37.2 120/80 92** **Gen**: NAD, fatigued **Heart**: RRR, no m/r/g **Lungs**: right lung base inspiratory crackles, symmetric excursion	# sepsis due to community-acquired pneumonia: **established**, **improving**, oxygen need down to 2L # AKI: **established**, **worsening** in the context of poor PO intake, **give IVF** 1 liter bolus

Level 3 Example	since last night has had sharp left-sided chest pain worse with inspiration; no coughing or fevers	**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	# chest pain: **new**, pleuritic pain c/f PE, reviewed **CXR** which shows no effusion or consolidation, order **EKG**, order **CTA** chest # AKI: established, improving

Note writing Improvement

A Case of Error-Forwarding:

Susan Penney from risk management recalled a recent malpractice trial at UCSF where copied notes played a role.

A patient with recurrent biliary strictures was brought into the hospital for an ERCP. An anesthesia resident helped administer conscious sedation, which included 50 mcg of IV fentanyl. Near the end of the procedure, the patient became pulseless and the team performed CPR. The patient soon had a return of spontaneous circulation, was treated in the hospital for several days, and ultimately went home neurologically intact.

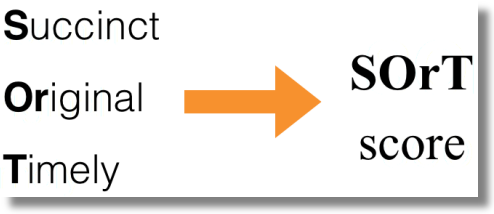
At a subsequent malpractice trial it was revealed that the resident had documented that they had given 500 mcg of fentanyl. This was a documentation error but it was unfortunately copied into subsequent notes a total of 11 times. The UCSF legal team had to use data from the Pyxis to verify the resident's appropriate medication administration but Susan remarked how difficult it was to convince a jury that something that was repeated 11 times was not true.

Next Steps

Can we automatically measure aspects of note quality?

It is challenging to define a high-quality note and even harder to measure it in a sustainable and scalable way.

However, we can likely agree that a note that is succinct, signed in a timely fashion, and contains original text (as opposed to copy/pasting) is a higher quality note.



With Epic 2015 comes the opportunity to measure the provenance of note text. Could we create a "SOrT score" to measure progress note quality in an automated, large-scale way?

Can we improve our progress note templates to make them more efficient to write and/or easier to read?

- APSO instead of SOAP note organization could make it easier to find key information when scanning through prior notes
- Incorporation of problem list stewardship, given that the problem list is an important component of MyChart, CareEverywhere, and the patient's future healthcare encounters
- Smart text removal/editing project – what should be done with I/O's, medication list, and the inpatient quality bundle

Teaching Points for Residents

- Copy forwarding is inevitably error-forwarding
- Rather than presenting from a copy forwarded progress note, consider using the Daily Rounds worksheet
- A discharge summary is more like a movie trailer than a complete retelling

Special thanks to Nader Najafi and Aylin Ulku for their ongoing efforts to improve note writing.
Please contact them with any questions or concerns.

UBLT Update

In March 2016, the UBLTs began a four month improvement cycle focused on "Growth." Those in the outpatient setting are focusing on access. On the inpatient side, in order to meet increasing demand for UCSF services we are focusing on the FY16 UCSF organizational goal to increase the number of discharges by 1% this fiscal year.

The Medicine service census has increased by 8% in the last fiscal year. While we have been filling our beds, our Average Length of Stay (ALOS) has increased. Therefore, it is crucial that we focus on eliminating waste in our system and reducing avoidable days to optimize patient flow and throughput.

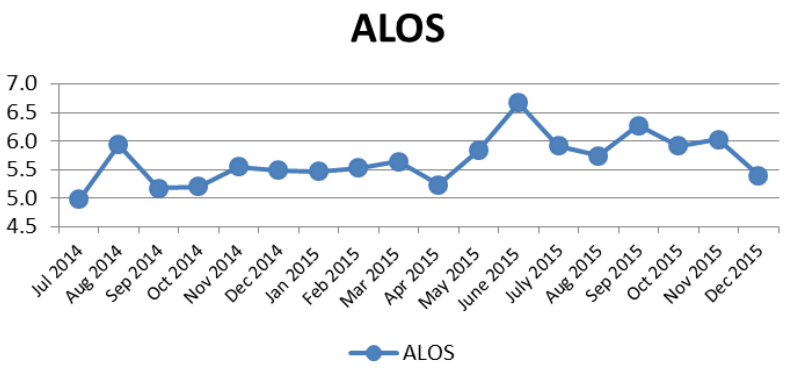
CPI Growth Cycle
March-June 2016

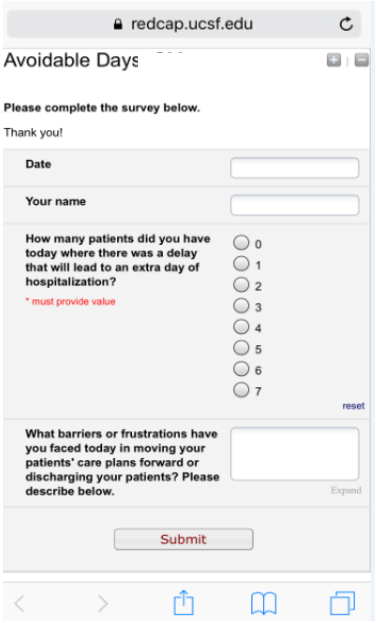
What are our targets?

- Achieve 20% DBN in April-June 2016
- Reduce # of case manager reported avoidable days by 5% in June (compared to April as a baseline)

What activities are underway?

We are in the process of collecting data on reasons for avoidable days from case managers. Our goal is to identify some low hanging fruit that is within our control (e.g. lack of pre-procedure communication) and to collect data to inform large-scale systems improvements at the UCSF Health level (e.g. assess the availability of weekend services)





How can you get involved?

Starting in late April we will begin collecting data from attendings to learn the most common reasons for avoidable days.

We are excited to use a new tool to gather this information, an application called **Murmur** (developed by Dimiter, Nader, and Alvin). This will allow us to gather real-time feedback, straight from your smartphone, while you're on the wards.

We know you are busy on service and plan to limit each day's surveys to 1-2 minutes of your time. The goal is that your feedback will drive solutions to issues that are not typically discussed during case review or attending feedback lunch but are challenging nonetheless.

Join our weekly UBLT meetings (Tuesdays, 2-3pm M1296). All are welcome!

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**	**76.3**	66.7	**85.2**	**89.5**	**79.5**	64.9				

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**	**1.51**	**1.50**	**1.42**	**1.45**			

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	88.7	89.3	89.1	**90.2**			

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	17.1	18.5	18.9	18.3	**23.8**	16.8	18.2		

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**	**22.1**	**21.2**	**18.3**	**20.0**			

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	65.7	64.6	**78.5**	**78.4**			

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**	**3.35**	**3.03**	**5.61**	**3.03**	**2.92**			

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**	43.8	**53.8**	44.1	**58.3**			