thequalitypost

in this issue

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

June 2016 • Issue 66

Greetings from Michelle, Nader and Sasha

QUALITY IMPROVEMENT
DIVISION OF HOSPITAL MEDICINE

Welcome to the 66th edition of The Quality Post. In this issue we feature a piece on the "What Matters to You?" concept and the True North Board. We also highlight a sickle cell improvement project, an above and beyond story, and data on our 4+1 metrics.

True North Board

Have you seen the Medicine UBLT True North Board near the 14M Nurse Station? Each UBLT will have one in the coming months where leaders, frontline staff, and patients can see a high-level view of what the unit is prioritizing and progress to date.

What is the purpose?

1) To make data visible to patients and front line staff members
2) To align work in the unit with the True North metrics set up by the organization. These metrics fall into five pillars or domains that UCSF Health has prioritized: Safety and Quality, Experience, People, Value, Growth. These five pillars are the things that UCSF cares most about!

Every 4 months our UBLT will focus on a different pillar. The People category is ongoing because happy staff/providers = happy patients!

What are the elements of the board?

Target: Where are we now and what do we hope to achieve to influence the UCSF organization goals?
Tactics: What interventions have we come up with to achieve our targets?
In Process: Data that we are collecting on a regular basis to understand if our interventions are working
Problem Solving: Data that we collect to understand the problem we are trying to solve

Want to join our Medicine UBLT True North Board report-outs? Feel free!
2-2:15pm every Tuesday by the 14M Nursing Station.

"What Matters to You?"

In a 2012 NEJM article, Dr. Michael Barry and Susan Edgman-Levitan introduced the concept of asking, "What matters to you?" rather than, "What is the matter?" in the context of shared decision making.

Popularized by the Institute for Healthcare Improvement (IHI), "What Matters" is a simple, yet powerful concept that is essential to creating personal engagements with patients and their family members, a deeper understanding of what really matters to them, and is the foundation of developing genuine partnerships for co-creating health.

"It is more important to know what sort of person has a disease than to know what sort of disease a person has,"
-Hippocrates
approximately 2,400 years ago.

What if every clinician asked "What matters to you" at every encounter? How can we reliably embed this question into our routine habits at UCSF to provide more patient-centered care?

Source Institute for Healthcare Improvement:
http://www.ihi.org/resources/Pages/AudioandVideo/WIHIWhatMatters.aspx

Sickle Cell Pathway

Starting in April 2016, Ari Hoffman and Aylin Ulku began leading an effort to improve care for our patients with Sickle Cell Disease (SCD). Sickle Cell Disease can be seen as a microcosm for the broader challenges facing a system like UCSF Health when it comes to population health management.

The lessons learned from these efforts to improve care of a targeted population by leveraging the power of data-driven systems change and our regional partnerships apply to populations with overlapping but distinct health challenges.

For example, the referral, follow-up, and coordination of other patients with chronic pain, or the negotiation of novel at-risk contracts with managed Medi-Cal providers to improve the health of high-utilizer populations would certainly apply beyond the diagnosis of SCD. As health care reimbursement continues to shift from volume to value, lessons like these hold the potential for true wins in health care value.

What is the problem we are trying to solve?

SCD represents an important challenge for UCSF Health. The payer mix at UCSF is changing as a result of the Affordable Care Act, **with increasing numbers of Medi-Cal patients**. Of all 30-day readmissions to U.S. hospitals in 2010, patients with SCD had the highest rate, with a national average of 33%. Among non-elderly Medicaid super-utilizers (defined as patients with four or more hospital admissions per year), SCD was the fifth most common admitting diagnosis in 2012. At UCSF, there were 197 adult patients with a diagnosis of SCD with any encounter with UCSF between October 2014 and September 2015. During that time, 21 were admitted to the hospital, and of those 11 were admitted once, while the remaining 10 were admitted 52 times.

The 30-day readmission rate for adults with SCD at UCSF is 50% according to UHC data, well above the national average. A chart review of readmitted patients revealed that inpatient and outpatient care of these patients is fragmented and provided predominantly by generalists with infrequent consultation by, or follow-up with, hematologists. Best practices for SCD are available, but variably applied in the setting of fragmented care.

We can do better

A single-center study showed that outpatient follow-up visits were an independent predictor of lower readmission rates[1]. In children, a multi-modal approach to SCD that includes standardized order sets, in-service provider education, and continuous education through patient engagement led to a significant decline in readmissions and length of stay[1]. The combined use of an Emergency Department (ED) pain protocol for SCD and proactive recruitment into Hematology clinic led to fewer hospitalizations and ED visits, with an increase in outpatient visits[1].

AHRQ Agency for Healthcare Research and Quality

Elixhauser A (AHRQ), Steiner C (AHRQ). Readmissions to U.S. Hospitals by Diagnosis, 2010. HCUP Statistical Brief #153. April 2013. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb153.pdf

What is the goal?

Decrease ED and inpatient utilization in adult patients with SCD cared for by UCSF Health by June 30, 2017.

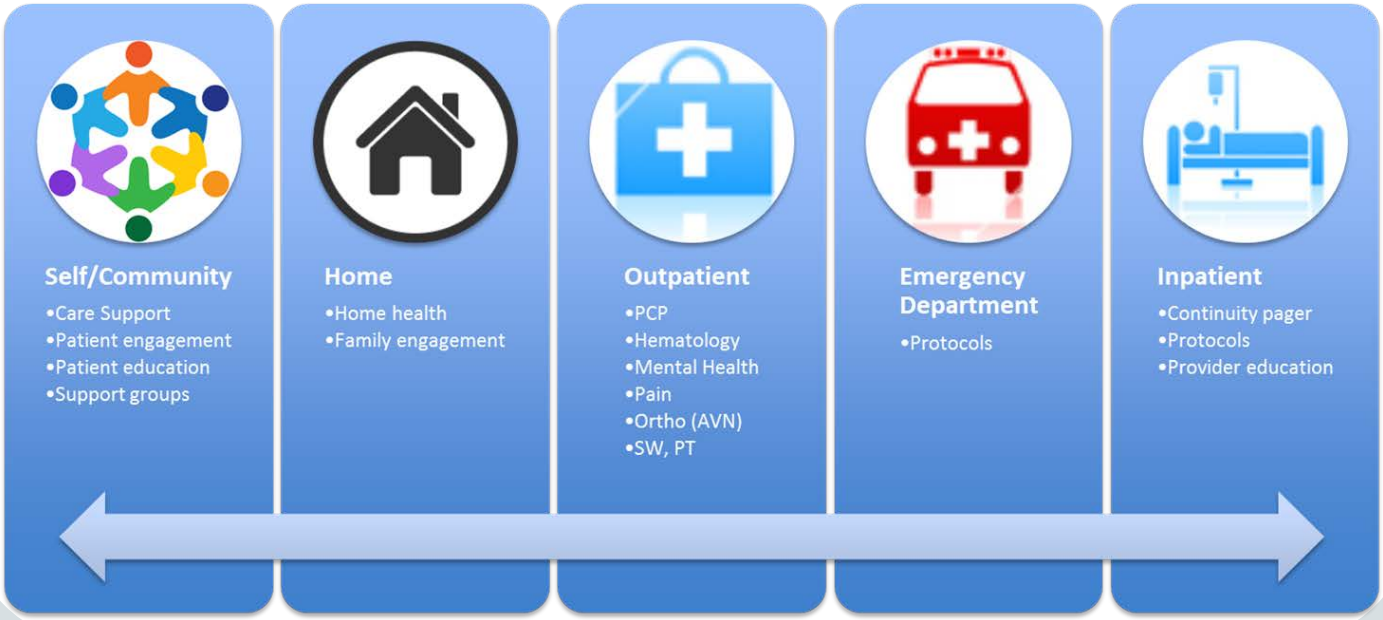
- Aim 1: Develop individualized care plans
- Aim 2: Improve post-hospital follow-up
- Aim 3: Facilitate the formation of an SF SCD support group

Sickle Cell Pathway

Comprehensive Sickle Care Plan

The Pacific Sickle Cell Regional Collaborative (PSCRC) is working to improve the care of patients with SCD through patient engagement, provider support, and regional coordination. Regional efforts include creation of a SCD patient registry, local support groups, and primary care provider education. Working with the PSCRC, we propose a comprehensive care team to improve the outcomes and readmission rates of UCSF patients with SCD.

We propose a similarly multi-modal approach to SCD across the continuum of care:



Next Steps

- Needs Assessment: what do patients tell us they need?
- Review current protocols and baseline data
- Patient enrollment into registry
- Roll-out care pathway with inpatient continuity pager, outpatient Heme support, Care Support, and protocols
- Audit and feedback cycles

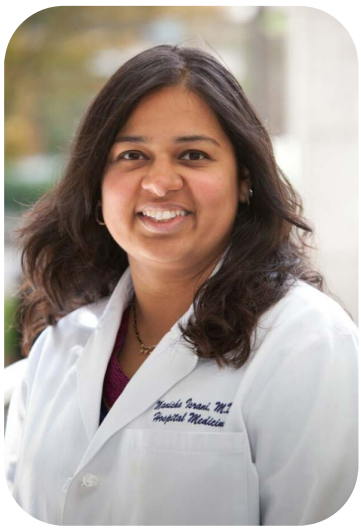
Special thanks to Ari Hoffman and Aylin Ulku for their ongoing efforts to improve care for our sickle cell patients.

Please contact them with any questions.

Above and Beyond

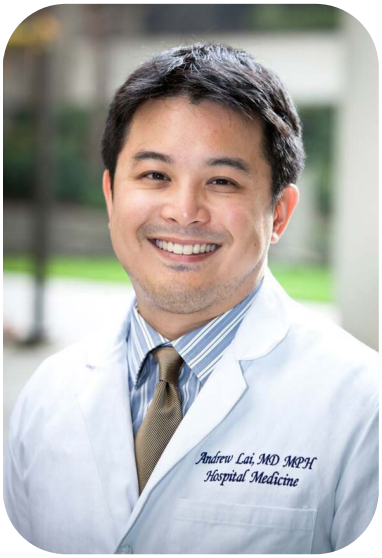
A few months ago, a retired UCSF nurse sent in a thank you letter for a wonderful experience. An elderly man she helps take care had recently been hospitalized. Below are excerpts of her letter:

Whenever family or people I know become ill, I always refer them to UCSF. They are always well cared for.



Dr. Manisha Israni kept me updated as to his condition; was always available to me & his son & treated him with compassion.

Within a day or so, he was transferred to General Medicine/observation on the 14th floor.



She cared for him until Dr. Andrew Lai took over. How blessed were we! They also kept his PCP updated as to his condition.

When I worked at U.C.S.F, I had not embraced the Hospital Medicine MD's concept. I felt when I was ill, I wanted access to & to be visited by my own PCP. I still feel this way, however, these physicians provided the most comprehensive; caring & compassionate rational care for a 90 year old that we could imagine. They were terrific. They have completely turned my head around to this concept.

So I e-mail this to you to thank you for what you strive to do for our clients at U.C.S.F. This care delivery system is the best I know of in the area. Yes, I've known people at other institutions locally as far as Stanford.

Please keep up the great work & thank these people for their care. I did as well while I was there.

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**	**80.1**	70.5	70.6			

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**	**1.55**	**1.54**	

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**	**92.6**	**90.3**	

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	19.6	16.7	**23.2**

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**	**20.7**	**22.1**	

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**	**75.3**	69.4	

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**	**3.21**		

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%	37.1	**52.1**	**51.5**	**50.8**	**62.2**	**52.1**	**59.3**	45.6	**66.7**	**63.4**	**57.4**	