thequalitypost

in this issue

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

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Greetings from Cat, Nader and Jenica

QUALITY IMPROVEMENT
DIVISION OF HOSPITAL MEDICINE

Welcome to the 69th edition of The Quality Post. In this issue we feature a piece on the similarities and differences between QI and Lean. We also review Probate Conservatorship and Medical Probate, showcase initial data on Avoidable Hospital Days, and have a piece summarizing the Clinical Reflections conference last week. Lastly, we introduce the DHM True North Quality Metrics for this year.

Similiarities and Differences Between QI and Lean Methodologies

With UCSF Health continuing its efforts to fully adopt the Lean Management System and Lean methodology of systems improvement, many are questioning the similarities and differences between Quality Improvement (QI) methods taught by the Institute of Healthcare Improvement (IHI) and Lean systems improvement methods.

The IHI released a White Paper entitled "Comparing Lean and Quality Improvement" in 2014 in which theycontend that the IHI approach to QI and Lean are complementary ways of approaching healthcare improvement, and that integrating perspectives and methods of the two approaches has the potential to strengthen both QI and Lean.

Both methods emphasize the importance of the patient's perspective, as well as the people who work in healthcare organizations. Both approaches also provide a simplified heuristics for defining quality problems, identifying changes, and testing them to arrive at sustainable solutions. For IHI-QI, the heuristic is the Model for Improvement that incorporates successive Plan-Do-Study-Act (PDSA) cycles in each improvement project; for Lean the heuristic is the A3 approach to problem solving in which frontline teams go to the "gemba", or where the work is performed, to fully understand the background/current state of the problem, set a target state, perform a gap analysis and develop countermeasures to achieve the target.

Thus, QI and Lean have more similarities than differences, and the most successful organizations will likely adopt components of each to continuously improve the care delivered to patients.

When Expressing Gratitude, Don't Focus on Yourself

Practicing gratitude — making a deliberate point of being thankful for the positive things in your life — is good for your happiness and well-being. But when we express our gratitude to others, we have a tendency to talk about ourselves when we should be thinking about them.

Often when we get help and support, we want to talk about how the favor made *us* feel: "It let me relax…" or "It makes me happy…." But expressing gratitude shouldn't be all about you. Helpers want to see themselves positively and to feel understood and cared for, which is difficult for them to do if you won't stop talking about yourself.

So the next time you thank someone, try "other-praising" instead. Acknowledge and validate your benefactor's actions: "You go out of your way…" or "You're really good at…." Doing so will strengthen your relationship with that person.

Harvard Business Review: Adapted from "Stop Making Gratitude All About You," by Heidi Grant Halvorson

Probate Conservatorship and Medical Probate

A 82 yo male residing in a SRO with h/o dementia, HTN, afib on anti-coagulation, CHF, and COPD presents with sub-acute worsening of mental status and cognitive functioning. He is now requiring more care than home health can provide, and needs placement. He does not have known next of kin. He lacks insight and judgment into his situation and repeatedly scores < 10 on a mini-mental status exam. You wonder if he would be an appropriate candidate for conservatorship, but are unsure as to what your options are and how to proceed.

What can be done for this patient?

- ✓ Full assessment of living situation: Can we bring more resources to this patient? Reach out to outpatient case management team
- ✓ Documentation in chart of lack of medical decision-making capacity and no identified next of kin
- ✓ Post-acute placement
- ✓ Consider initiating Probate Conservatorship vs. Medical Probate process

What is Probate Conservatorship?

- Court proceeding where judge appoints someone to manage personal and/or financial affairs of an individual lacks mental capacity to make decisions for themselves due to a medical (not psychiatric) condition
- Most often initiated through county Public Guardian's office OR family hiring a private lawyer OR family pursuing conservatorship for free through local Superior Court
- If patient determined to be incompetent, SW beginsprocess to find viable decision maker. If no surrogate decision maker is found, the Public Guardian's office is contacted to present the case
- Two parts to referral packet:
  - Referral Form (SW)
  - Capacity Declaration and Attachment (MD)
- Can take up to 3-5 weeks for temporary conservatorship and longer for permanent conservatorship

What is Medical Probate?

- A court petition that allows a medical practitioner the legal right to give informed consent for medical procedures and to authorize temporary placement of an incapacitated patient at a post-acute facility
- The petition lasts up to 90-120 days from the time the patient is placed outside of UCSF
- Once the petition expires, one of the following occurs:
  - If patient is determined to have decision-making capacity, patient resumes his/her decision making rights
  - If patient remains incapacitated, the facility medical director assumes responsibility for patient's decisions OR the facility pursues Probate Conservatorship
- MD completes Medical and Capacity Declaration form
- Take 2-3 weeks for Med Probate to be approved once forms received

Probate Conservatorship vs. Medical Probate: What are the Differences?

Probate Conservatorship

- Requires approval of Public Guardian's Office
- Takes longer to approve than Med Probate
- It is PERMANENT

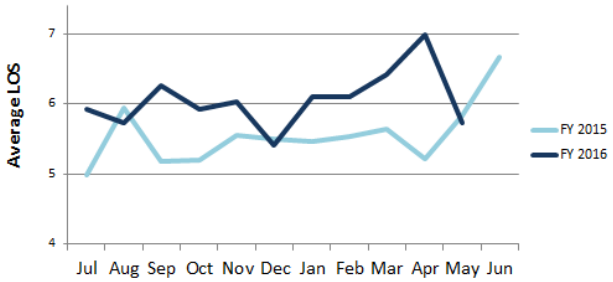
Medical Probate

- Processed by UCSF Legal Affairs Office
- Generally quicker than Probate Conservatorship and allows patients to be placed faster
- It is TEMPORARY and thus facilities need to consider other avenues for decision-making once it expires

Decreasing LOS: Collecting and Analyzing Avoidable Days Data

Background

- UCSF remains one of the most expensive places to provide care
- One of the largest drivers of cost is LOS
- After falling in 2015, LOS on Medicine is rising again (even after adjusting for CMI)

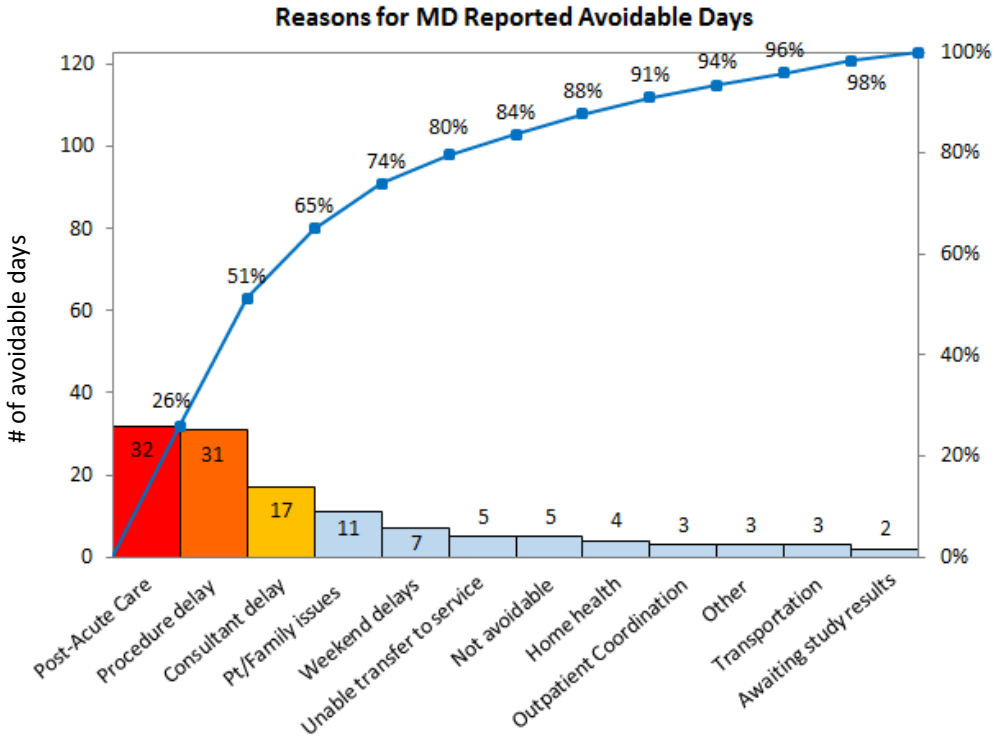


Current State

- We have data on delays in discharge (Mourad, Patel)
- Delays <u>during</u> hospitalization are less well-characterized
- Case managers are marking reasons for delays during MDR, but we're not capturing the physician's perspective
- We collected daily surveys from physicians on reasons for delays that result in an extra day in the hospital (i.e. avoidable days)

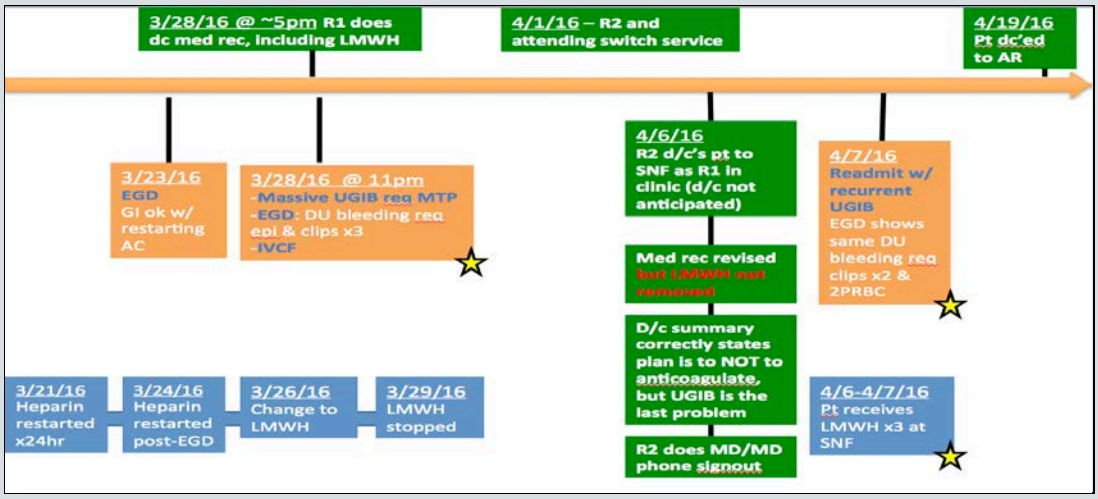
Avoidable Days Pilot

- **Physician reported avoidable days**
  - Started May 2016
    2 months data (5/1 - 6/30)
  - 134 responses
  - 123 avoidable days captured
- **Daily surveys via Murmur software (SMS link to Redcap) asking:**
  1) which patients had avoidable days?
  2) why? [free text]
- **Weekly review of responses to:**
  - categorize the delay
  - determine if avoidable or not



Clinical Reflections Case Summary

68 yo M with COPD, HTN, OSA admitted in Feb '16 for elective spine surgery with complex > 6 week post-op course notable for acute R segmental PE, PEA arrest, colonic perforation s/p ex-lap for R colectomy and ileostomy, septic shock, and ARDS. Transferred to medicine and switched from heparin gtt to LMWH for treatment of PE. Noted to have ostomy bleed on 3/19 and LMWH held for 48 hours for GIB. Remaining hospital course outlined below.



How did this preventable adverse event and readmission happen?

Active Errors	R2 did not remove LMWH from d/c med list	SNF MD did not identify discrepancy between d/c med list and d/c summary
Contributing Factors	Med rec performed 1 week prior to d/c D/c day/time not anticipated D/c performed by R2 (w/ 5 other discharges) Team switch near time of d/c	Different recollection of content of MD/MD s/o UGIB listed as last problem in d/c summary
System Errors	No review for discrepancies between d/c orders and active	No standardized MD/ MD signout format

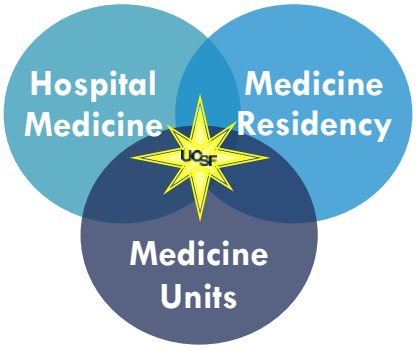
What can hospitalists do to help prevent similar adverse events in the future?

- Review d/c meds by Previewing the AVS in the "Discharge" APeX tab
- Champion and use "Day of Discharge Rounds" (created by Michelle Mourad) with real-time team review of d/c med rec if possible

Day of Discharge Rounds

- Barriers to Discharge: What were they, how have they been met, if not met then proceed with SOAP presentation
- Medication Changes: confirm meds to be stopped and new meds on discharge; discuss need for PMD notification, pharmacy consult
- Follow-up Plans: Confirm ordered and arranged
- Pending Tests: Note pending tests and plans, notify PMD as needed
- Home Care/SNF Orders: ensure orders in, PMD notified

DHM True North Quality Metrics



FY2017 True North Quality Metrics	FY2016 Baseline	July	Aug
#SleepVitals Discharge ≥45% of patients with sleep promoting TID vital signs (8 out of 12 months)	15%	33%	48%
#DeliriumOrder Complete delirium order set for Nu-Desc positive patients within 12 hours (4 out of 6 months)	APeX report in progress	No data	No data
#AVS Achieve ≥ 75% of patients with High-Quality AVS (6 out of 12 months)	69%	56%	61%
#MDexplain Achieve ≥ 77% score for HCAHPS "MD Explains in way patient understands" (6 out of 12 months)	77%	79%	In process
#MedRec Achieve ≥90% of patients who have had all medications reconciled before discharge (4 out of 12 months)	88%	87%	89%
#POLST Achieve ≥ 60% of patients (not full code) with POLST completion (8 out of 12 months)	55%	61%	67%