AiAMC
Alliance of Independent Academic Medical Centers

NI VII Meeting Three/Storyboard

COHORT ONE
Transitions of Care

AdventHealth Orlando
Arrowhead Regional Medical Center
HonorHealth
OhioHealth Riverside Methodist Hospital
St. Luke's University Health Network
Aurora Health Care – OB-GYN Team

National Initiative

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AiAMC Alliance of Independent Academic Medical Centers

NI VII Meeting Three/Storyboard

Improving the transition of care from ICU to step-down unit

Dwayne Gordon MD, Jian Guan MD, Luis Isea MD, Xuan Guan MD, Sumayyah Shah MD

National Initiative

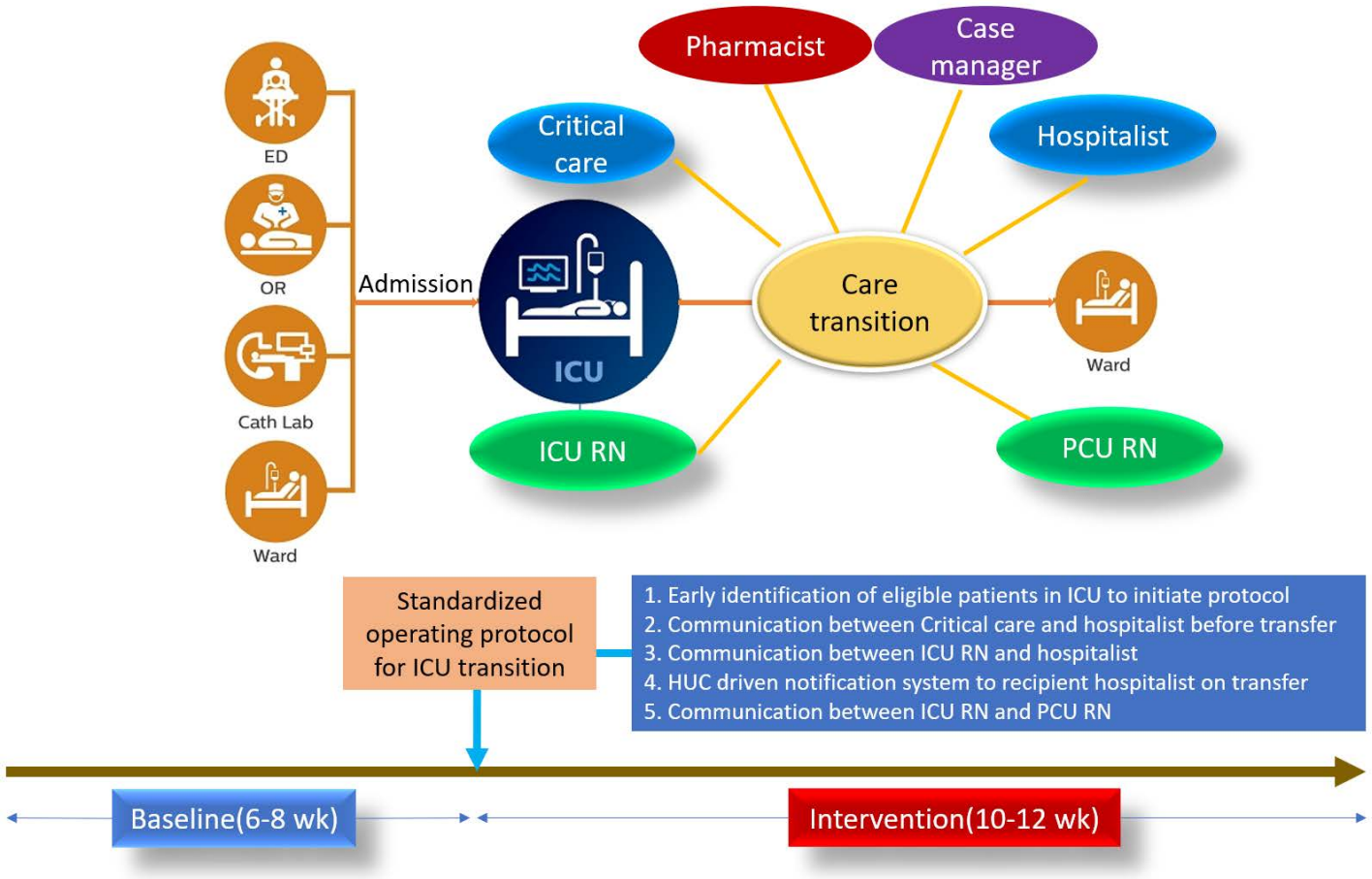
Introduction [or Background] & Aim [or Purpose/Objectives]

Introduction:

- Timely transitioning patients from costly ICU environments to step-down units (PCU) is a promising domain for cost-effectiveness improvement.
- An optimal flow is critical to ensure high-quality care. Engaging healthcare professionals across different clinical settings is vital to successful implementation of this strategy.
- Handover is the most error-prone step. We hypothesize improving the handover process from ICU to step-down unit will lead to enhanced patient safety, reduced ICU and hospital LOS and decrease ICU readmissions.

Aim: To provide a systematic method to transition patients from the ICU to the step unit, by bridging gaps in communication between the ICU and step down multidisci teams

Methods: Audience, Interventions, Measures



Outcome measurements:

1 Timing of consulting hospitalist (less than 24 hour of ICU admission)

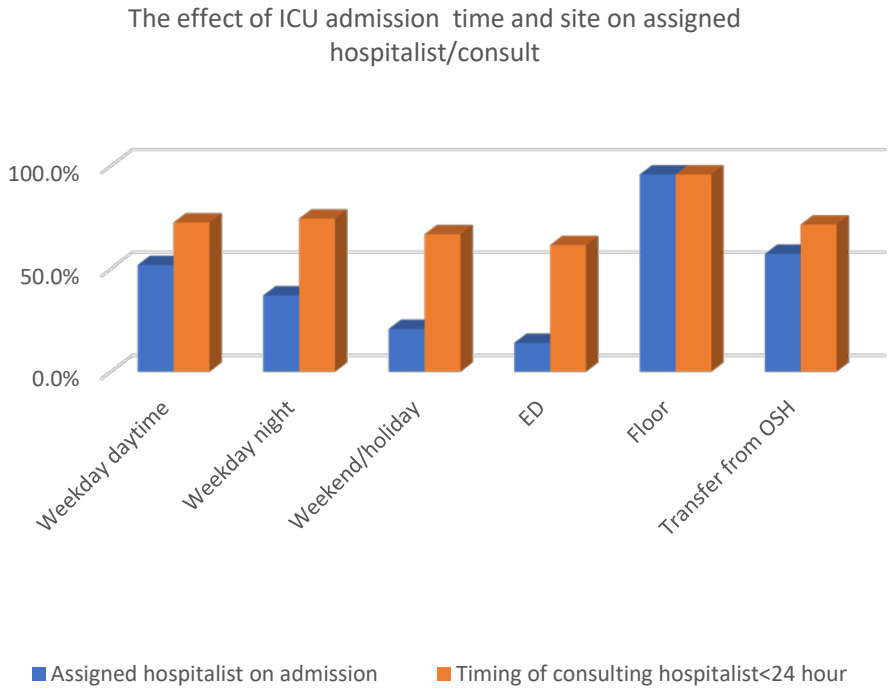
2 Communication between CCM and hospitalist (In person vs. Phone/text vs. others)

3 Standardized ICU nurse to PCU sign off protocol (Nurse leader input, key components including receiving hospitalist group and HUC driven notification system)

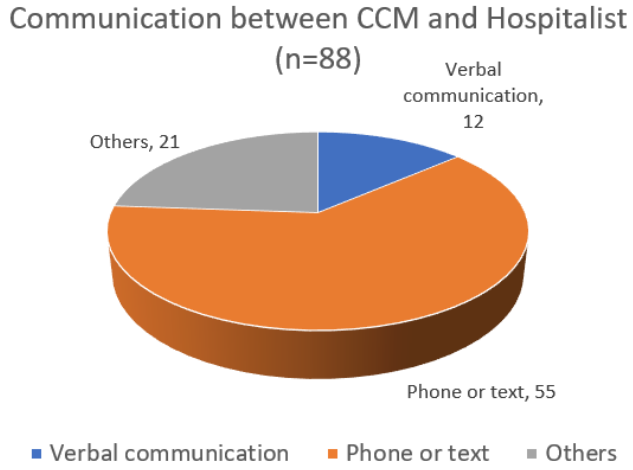
4 ICU RN to identify and communicate with receiving hospitalist on the day of PCU transfer

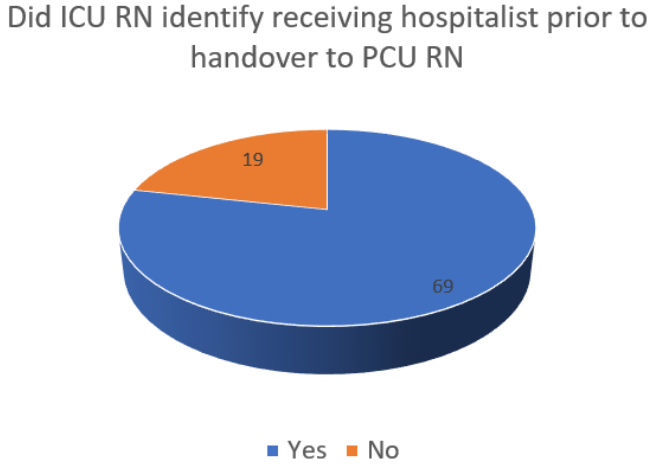
5 Questionnaire to assess ICU RN's perception on current ICU to PCU care transition

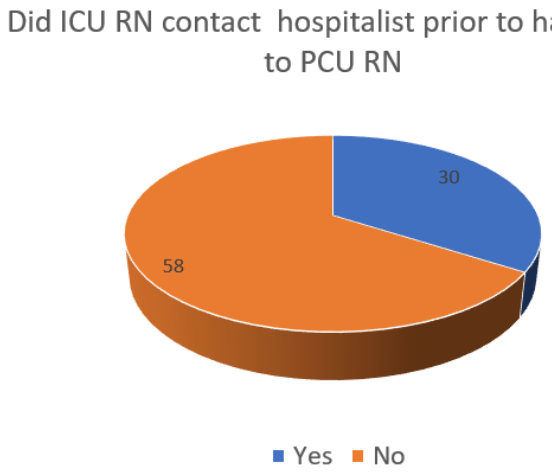
Results (to Date)

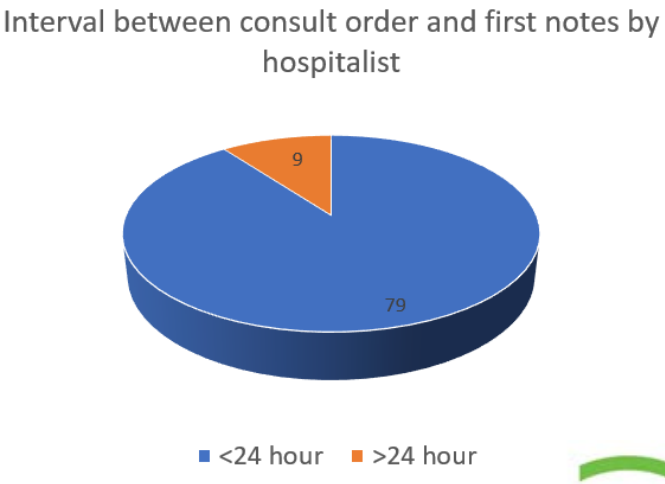


Less than 15% patients directly admitted from ED had assigned hospitalist and less than 60% of them will have an IM consult within 24 hours.





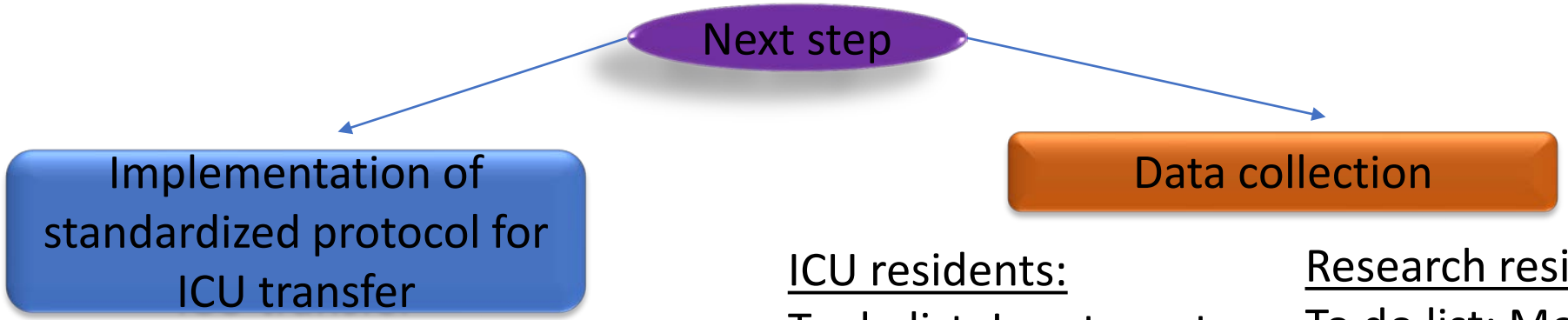




- 25% of patients transferred out of ICU without any communication between CCM and Hospitalist
- Most ICU RN won't contact or notify receiving hospitalist about PCU transfer
- Greater than 10% hospitalist did not see the ICU patient within 24 hour after consult orders placed

Discussion: Barriers & Next Steps

- Significant communication gap between CCM and Hospitalist on the patients transferred out of ICU
- Most ICU RN won't contact or notify receiving hospitalist about PCU transfer
- Delayed care of receiving hospitalist is common in patients transferred out of ICU



IM CCM

RN leaders in ICU/Stepdown unit

<u>ICU residents:</u>
To do list: Input most of data (highlighted with yellow)
Method: Google sheet vs. paper sheet

<u>Research residents:</u>
To do list: Monitor ICU transfer; Send reminder; input data(highlighted with green), transfer data from paper to Google sheet if applicable

Arrowhead Regional Medical Center

National Initiative

ARROWHEAD REGIONAL MEDICAL CENTER

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NI VII Meeting Three/Storyboard

Physician Perspectives and Assessments of Teaming through a Major Pandemic Response at an Academic Medical Center*

Curtis Converse, DO; Kiran Matharu, MD; Monique Lopez, MD; Vivian Ngo, MD; Niren Raval, DO; Teresa Smith, MBA; and Greg Young, MBA, PMP

National Initiative

Introduction: Background & Context

In March 2020, Arrowhead Regional Medical Center began an unprecedented mobilization as part of the County of San Bernardino's COVID-19 mobilization efforts to prepare for a looming wave of infected individuals in Southern California. As the County run hospital for the largest county in the United States, Arrowhead Regional Medical Center was at the heart of the County's efforts to respond to the global pandemic. Attending physicians, fellows, and residents were involved throughout the County's response including efforts to quarantined the first US Nationals evacuated from Wuhan province in China in the early days of the outbreak. The County also setup an Alternate Care Site dubbed "ACS Village" in one of the hospital's parking lots to help allow for surge capacity as well as covert several of our regular medical units into negative pressure isolation wards for COVID patients. Within the hospital there were numerous levels of teaming happening between representatives from multiple departments and roles. Some examples included: daily COVID zoom calls with all the department heads in the hospital to address COVID related issues; daily patient management calls with all the inpatient attending physicians; and daily email communications to all hospital staff members. While our region only experienced a moderate wave of cases, the efforts among team members across roles to help prepare and manage the cases we did get proved to be an interesting example of teaming in the healthcare environment.

Methods: Audience, Interventions, Measures

- Methods are in development for an assessment of the hospital's teaming efforts.
- The Team is considering conducting focus groups with both residents and faculty to assess satisfaction and effectiveness with the teaming that occurred during the last 6 months.
- The Team will be discussing teaming efforts with hospital leadership and key stakeholders to identify the different levels which comprised the overall hospital response.
- The Team will then focus on the effort of 2 to 3 of these layers and design a series of questions to be used for the focus groups.

Results (to Date)

- TBD

Discussion: Barriers & Next Steps

Barriers:

- Starting fresh – Previous project had to be abandoned due to social distancing requirements
- Still service impacted
- Limited remaining timeline for NI VII
- Ban on in-person meetings – Everything is going to have to be done virtually

Next Steps:

- Finalize our assessment of the layers of teaming response
- Select and focus on 2 to 3 layers of the teaming response
- Develop focus group questions
- Conduct focus group sessions with residents and attendings
- Review results and present findings in the final poster in March

HonorHealth

National Initiative

HONORHEALTH

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NI VII Meeting Three/Storyboard

Readmission Roundabout

Alethea Turner DO, FAAFP; Cynthia Kegowicz MD; Darlene Moyer MD, FAAFP; Ashley Dyer-Giaquinto MD, FM PGY2; Yiwen Richard Liang MD, FM PGY2

National Initiative

Introduction & Aim

- Transitioning care from the hospital to the ambulatory setting is often complex and challenging for both patients and the healthcare team
- We AIM to standardize transitional care management (TCM) from the inpatient to the outpatient setting for patients within our residency program who are at the highest risk for hospital readmission
- Objectives:
  - ✓ Increase outpatient follow-up within 14 days of hospital discharge for patients who are at >20% risk for readmission
  - ✓ Reduce readmission rates in this cohort of patients
  - ✓ Identify patient barriers for effective transitional care

Methods: Audience, Interventions, Measures

- Focus efforts on patients at the HonorHealth Scottsdale Osborn Hospital, who are also on the family medicine residency inpatient service and who will be following up at the NOAH HFMC
- Assess existing transitional care processes within our institution and partner with other departments to improve, consolidate and standardize efforts
- Measures:
  - ✓ Ambulatory follow up rates within 14 days of hospital discharge for patients at >20% risk for readmission
  - ✓ Readmission rates within 30 days of hospital discharge for this cohort of patients back into the HonorHealth system
  - ✓ Identification of barriers preventing effective transitional care; such a social determinates of health negatively impacting a patients ability t
  - ✓ Follow up on the telephone and/or in the office

Results (to Date)

- No results to report as our efforts were greatly impacted by COVID-19
- Residency program – ACGME Pandemic Emergency Status declaration

Discussion: Barriers & Next Steps

- Barriers :
  - ✓ Reallocation of resources and time in response to pandemic

- Next Steps:
  - ✓ Change focus of our project
  - ✓ Propelled by the social injustice and racial inequality highlighted this year, tremendous teaming occurred to provide education, safety and stimulate conversation
  - ✓ New aim and objectives are being refined, but ultimate goal is to create a formal curriculum that that will serve as a foundation for cultivating a culture of Equity, Diversity and Inclusivity

OhioHealth Riverside Methodist Hospital

National Initiative

NI VII Meeting Three/Storyboard

Improving the Care of Women Using MAT for Opioid Disorder Use in Pregnancy and Beyond

Karen D'Angelo, MD; Susan Davy, MD; Valerie Busick, MD; Michelle Hoffman, DO; Emily Gorman, DO; Allison Gase, DO; Melissa Nines, CNP; Susan Catlett, RN; Brittany Williams, RN; Nicole O'Donnell, RN; Kathy Davidson-Sharkis, LSW, MSW

Introduction [or Background] & Aim [or Purpose/Objectives]

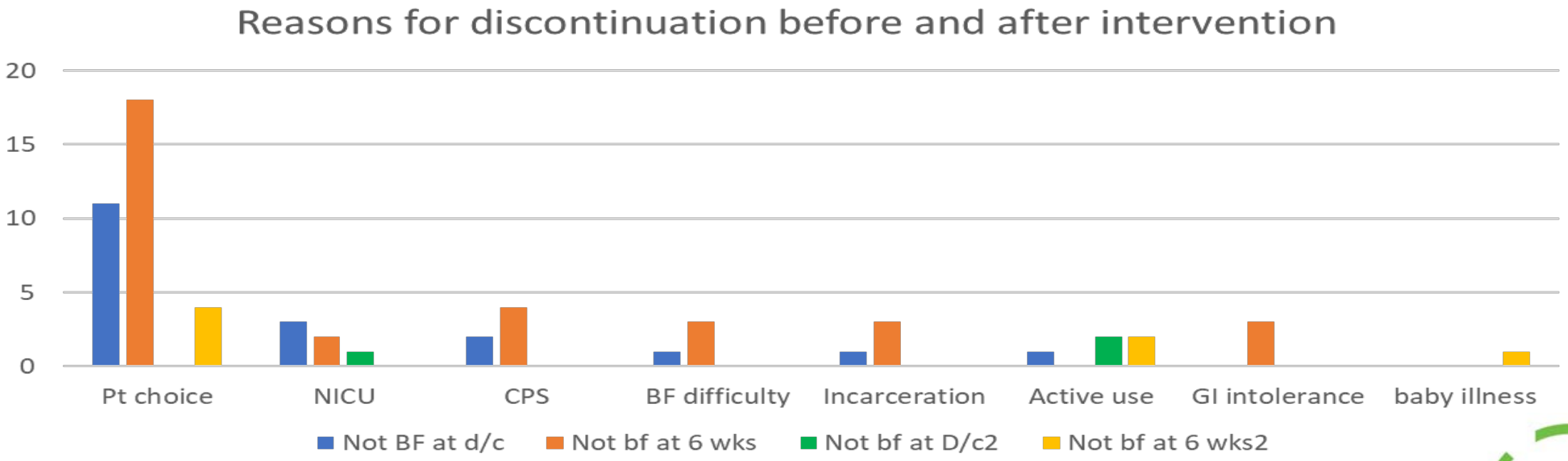
- Pregnancy and the postpartum time period can be challenging for any woman. These challenges are magnified for women dealing with an addiction to opioids. Several medical organizations endorse and support breastfeeding exclusively through the first six months of life. Many women on medication-assisted therapy question whether or not they can breastfeed and often lack the social support to be successful with it. For this particular group of patients, there are multiple benefits, such as decreased neonatal abstinence syndrome, better bonding with baby and decreased incidence of postpartum depression. The postpartum period also can have a higher rate of relapse. Having a continued MAT care plan and a unified team approach are crucial to preventing this. Patient and provider satisfaction are also key to the success of these programs. If patients feel they are truly cared for by providers and providers find joy in their work, it leads to more successful outcomes for all.
- Through careful scripting, providing a breast pump prescription, and encouragement throughout the pregnancy, the goal is to have 75% of the patients breastfeeding when they leave the hospital and a continuation rate of 50% at six weeks postpartum.
- In order to provide seamless care, through a partnership between OB-GYN and Family Medicine, the goal will be to have 50% of patients who want to follow up with Family Medicine(FM) schedule and attend at least one visit with the FM clinic.
- There will be transition of care meetings in both the in-patient and out-patient settings as well as additional education for providers in order to improve the care given to patients in the MAT program. This will hopefully lead to improved patient and provider satisfaction scores.

Methods: Audience, Interventions, Measures

- For our breastfeeding portion of this project, we discussed with our caregivers the importance of breast feeding in this population as well as its safety. We have written a consistent script to be used during prenatal care with these patients. We are providing them with prescriptions for breast pumps at their 36 week visits, as these are a covered benefit of most insurances. We are then looking at the data to see how many patients are breastfeeding upon discharge from the hospital and again at 6 weeks postpartum. We are comparing these rates before and after our interventions.
- For the linkage with primary care providers (PCP) in our family medicine program for MAT after the postpartum time, a running list of our patient panel has been created. An effort is being made to schedule an initial visit for these patients while they are still pregnant. At this appointment, MAT transfer of care and the rules of that particular clinic will be discussed. Ideally, the patient will be encouraged to bring her infant for care with family medicine as well so that the whole family unit will be holistically cared for. Rates of linkage and success in scheduling and attendance of appointments will monitored and compared to those prior to interventions and COVID-19.
- Due to COVID-19, the IRB approval for a QI project was put on hold as the group was unable to meet. Recently, that team met and approved our project. We are now able to start delivering the surveys to both providers and patients. The goal will be to see if our interventions lead to improved satisfaction in both groups.

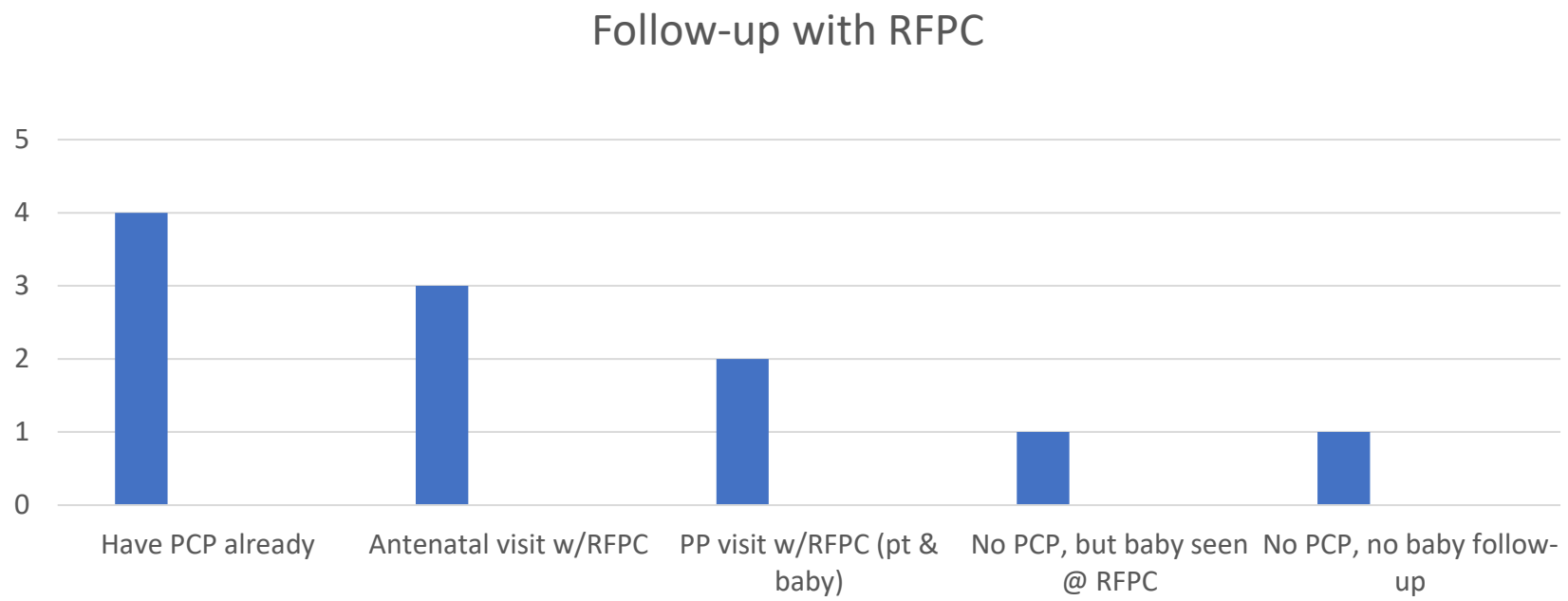
Results to date, continued

- After initial interventions, rates of breastfeeding at discharge went from 50% to 67%. The rates of breastfeeding continuation at 6 weeks, however, fell from 22.5% to 12.5%. Our next intervention will focus on out-patient lactation consults to support continued breastfeeding after discharge.



Results to date, continued

- Currently, 23% of patients have a visit with Riverside Family Practice Center (RFPC) before they deliver. Of these patients, only 1 has continued to routinely seek care. One patient and her baby were lost to follow up completely. One patient has been to her appointment, but missed the baby's appointment. Both patients who established care after delivery have been compliant with both their appointments and the those for their babies.



Results to date, continued

- Due to COVID-19, we were only recently able to get approval for the patient and provider satisfaction surveys and have no data to report at this point.

Discussion: Barriers & Next Steps

- COVID-19 has had a huge impact on this project. Because many offices were closed or at limited capacity, the referral base for this clinic dramatically declined. New patient appointments in our family practice center were postponed as well. In-person meetings were prohibited for several months. Normal residency operations came to a halt as everyone was in crisis/survival mode.
- Slowly, things have returned to a new form of normalcy. Clinics are up and running in a more robust fashion and there have been several new patients added to the panel. Due to the educational nature of the provider meetings, these are able to be hosted in a hybrid fashion both in person and on-line via WebEx.
- Next steps include patient and provider satisfaction surveys. Continued patient education regarding breastfeeding as well as providing resources to support this will be on-going. Increased availability of out-patient appointments should aid in the scheduling and attendance of linkage visits for these patients.

St Luke’s University Health Network

National Initiative

NI VII Meeting Three/Storyboard

Teaming for Excellence: Improving the patient experience during hospital discharge through phased interventions at St. Luke's Anderson Campus

Project Leader: James Dalkiewicz MBA, MHA

Project Co-Authors: Eluwana Amaratunga, MD; Rebecca Markson, DO; Catherine Craven, MD; Kristal Khan, MD; Richard Snyder, DO; Richard Garwood, MD; Parampreet Kaur, MD; Daniel Martins, RN; Jenna Diasio, PA-C; Quynh Hicks MS, MSW, LSW; Jessica Lester, RN; James Orlando, Ed.D.; Sandi Yaich M.Ed.; Matthew Geary, BSN, RN

Introduction & Aim

Introduction:

- The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a scoring system used to measure and compare the standard of care in healthcare facilities.
- While the overall HCAHPS scores at St. Luke's University Health Network - Anderson Campus (SLRA) have been in the positive percentile, the "discharge domain" of HCAHPS has historically been low.
- This could have been due to unclear communication and instructions at discharge. Prior studies have demonstrated how implementation of specific initiatives can improve both the discharge process and patient experience.
- As both private and public insurers are beginning to reimburse more for value-based care, there is an additional financial incentive to enhance the patient experience in various hospitals.

Objective(Aim):

To improve patient satisfaction by increasing HCAHPS scores in the overall discharge domain to twice the baseline percentage within six months.

Methods: Audience, Interventions, Measures

Audience:

- Acute Care Patient Population (includes 4 separate units; MS-2, MS-3, MS4 and WW-4) These units have a total of 126 beds. The data excludes the OB unit.

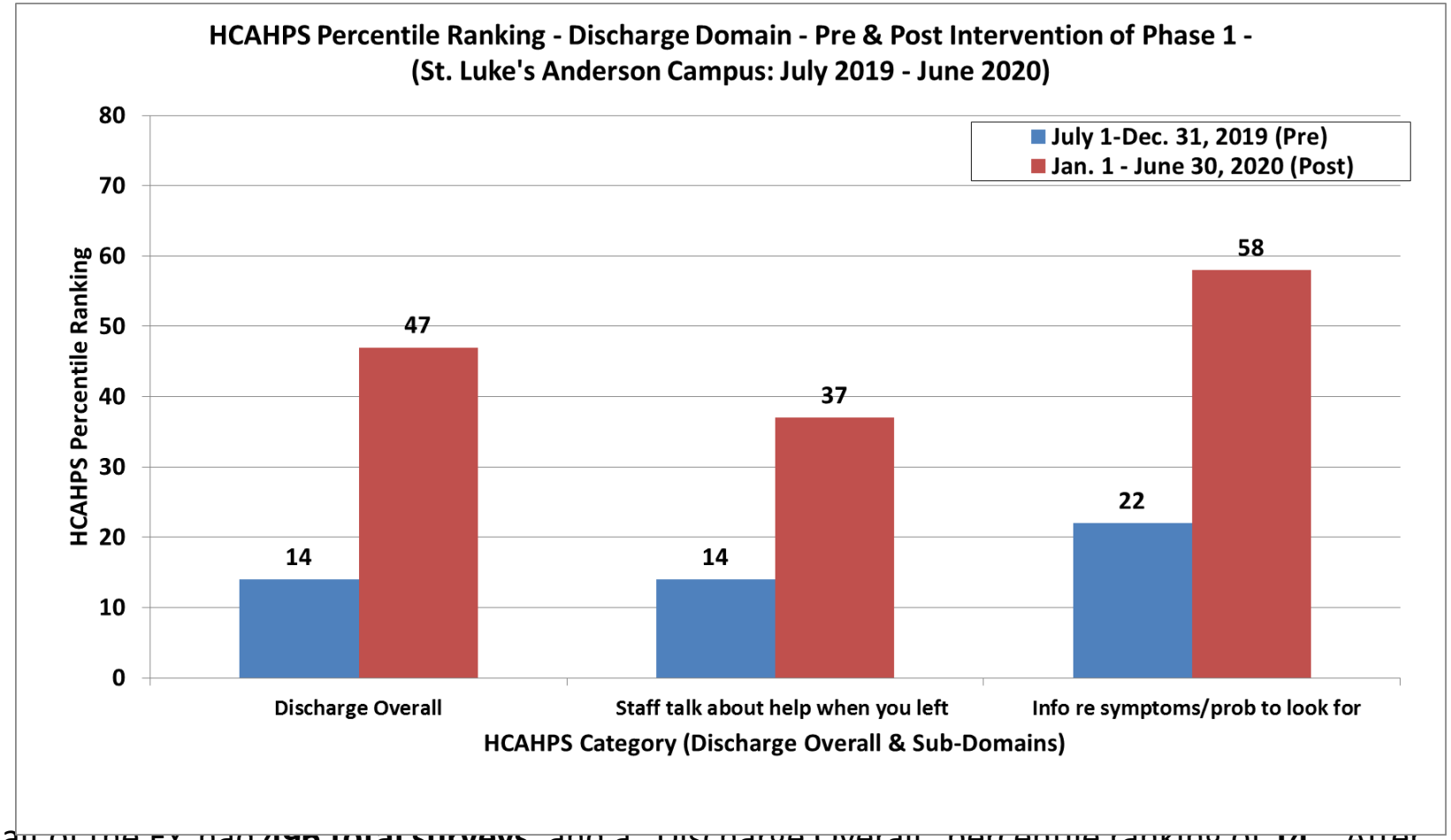
Interventions:

- Phase 1 – Implement a Standardized Discharge Letter
- Phase 2 – Observe Nurses during Discharge
  - ✓ Discharge for consistency
  - ✓ Survey Nurses for their perspectives
- Phase 3 – Hardwired Inpatient to Outpatient Communication – Physician to Physician
- Phase 4 – Managing Patient Expectations During Discharge

Measures:

- HCAHPS Scores (Discharge Domain)
- Utilization Rates of Standardized Discharge Letter

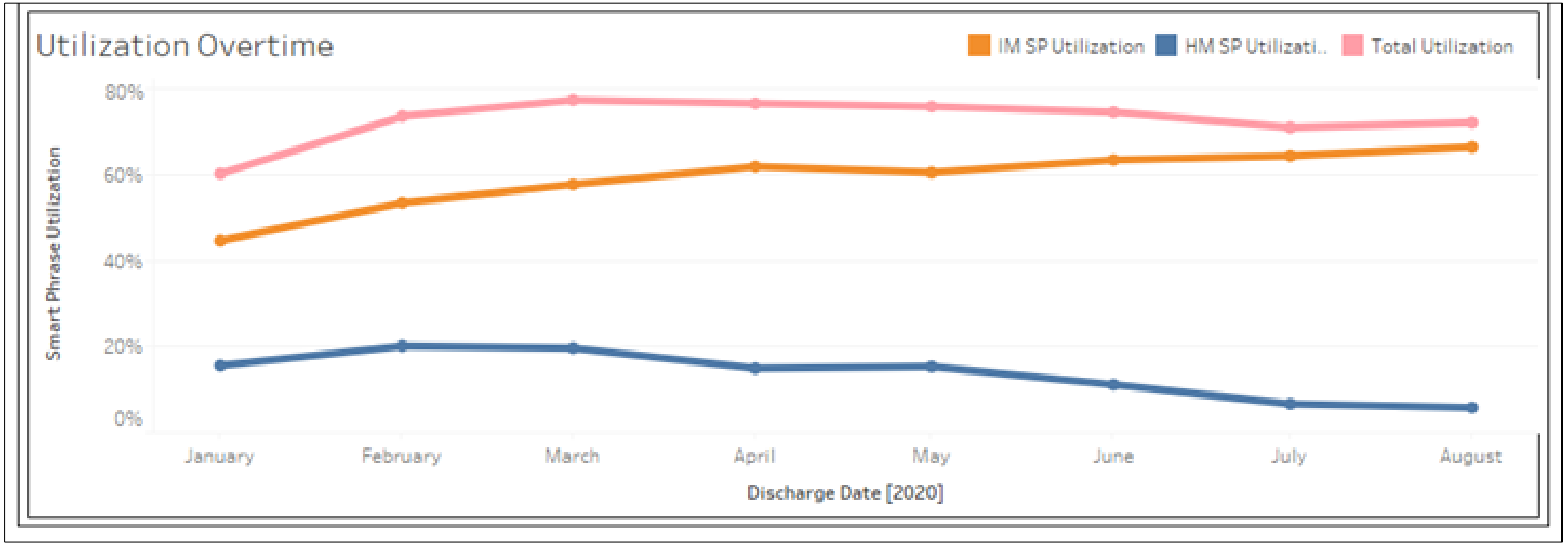
Results



- The first half of the FY, had **496 total surveys**, and a "Discharge Overall" percentile ranking of **14.** After implementation of intervention #1 (Discharge Letter), the second half of the FY had **539 total surveys**, and a "Discharge Overall" percentile ranking of **47**.
- The most significant improvement occurred in the HCAHPS sub-domain titled "**info regarding symptoms/problems to look for**", which improved from a **22** percentile for the first half of the FY, to **58** percentile in the second half.

Results

Phase 1: Standardized Discharge Letter (Compliance Average



Discussion: Barriers & Next Steps

Barriers:

- COVID-19

Next Steps:

- **Phase 2** – Streamlined process for nurses during discharge
  - ✓ Observe nurses during discharge for consistency
  - ✓ Survey nurses for their perspectives
- **Phase 3** – Hardwired Inpatient to Outpatient Communication – Physician to Physician
- **Phase 4** – Managing Patient Expectations During Discharge

Aurora Health Care
OB-GYN Project

National Initiative

Aurora Health Care

We are AdvocateAuroraHealth

AiAMC Alliance of Independent Academic Medical Centers

NI VII Meeting Three/Storyboard

Building a Psychologically Safe and Collaborative Working Environment on L&D

Shant Adamian, DO, Nicole Salvo, MD, Corinne Droessler, MSN RNC-OB, Callie Cox Bauer, DO, Dara Markovic, BSN RN, Carla Kelly, DO MMM, Deborah Simpson, PhD

Aurora Ob/Gyn Residency Program & Aurora Sinai Medical Center, Milwaukee WI

National Initiative

BACKGROUND/AIM

- L&D is an intense, high stakes environment
- Interprofessional communication is critical for safety and well-being
- Improper communication = key contributor of negative sentinel events per JC [1]
- Use of simulations and practice scenarios allows individuals to develop a better understanding of others' goals[2]
- Creating a culture of safety under a common goal creates an environment of respect, curiosity, and accountability[2]

- **OB/GYN AIM: Create a collaborative, interdisciplinary learning environment where team members feel confident to speak up without fear of being put-down or retribution**

1. Lyndon, A., PHD, Rn, Johnson, M., CNM, MS, Bingham, D., PhD, Rn, Napolitano, P., MD, Joseph, G., MD, Maxfield, D., BA, O'Keeffe, D., MD. Transforming communication and safety culture in intrapartum care. Obstetrics & Gynecology. May 2015.
2. Lyndon, A., PhD, Rn, Zlatnik, M., MD, MMS, Wachter, R., MD Effective physician-nurse communication: a patient safety essential for labor and delivery. American Journal of Obstetrics and Gynecology. August 2011

METHODS: INTERVENTIONS/CHANGES

Using S-BAR & a 3-phase approach:

TeamSTEPPS

PHASE 1: SETTING THE STAGE

- Collect baseline data
- Intervention: record/distribute scenarios

PHASE 2: ACTIVE INTEGRATION

- Few team members enforcing SBA**R** (emphasize recommendations)
- Opening a dialogue

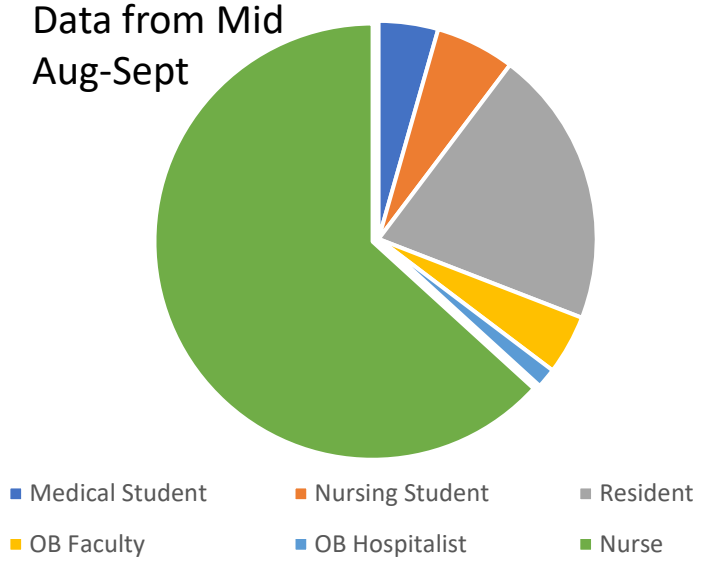
PHASE 3: EXPANSION

- Care-team huddles for individual patients
- Establishing group goals in patient care management
- Complete phase 1&2 in postpartum

Results: Clinical Learning Environment Quick Survey

Role	Responses
Medical Student	3
Nursing Student	4
Resident	14
OB Faculty	3
OB Hospitalist	1
Nurse	43
Total	**68**

Data from Mid Aug-Sept



ITEM	SCALE	Mean (SD)	Median
I feel supported by team/unit members in my/team's everyday on-going learning	1 = Strongly Disagree 2 = Somewhat Disagree 3 = Neither 4 = Somewhat Agree 5 = Strongly Agree	**3.8 (1.01)**	**4.0**
People in this work area/unit treat each other with respect, trust each other and are inclusive	1 = Strongly Disagree 2 = Somewhat Disagree 3 = Neither 4 = Somewhat Agree 5 = Strongly Agree	**3.3 (0.74)**	**3.0**
The inter-professional teams in this area/unit work together effectively using ongoing communication, collaborative decision making and coordinated team-based care	1 = Not at All Effective 2 = Slightly Effective 3 = Somewhat Effective 4 = Very Effective 5 = Extremely Effective	**3.3 (0.74)**	**3.0**

Discussion: Barriers & Next Steps

1. Busy Unit: Allocating time for reviewing/enacting scenarios
   - Strategy: Pre-recorded scenarios review individually + formal edu

2. Wide range of healthcare providers: Unique individuals each with their own philosophy
   - Strategy: Emphasizing common goals among team members
   - Strategy: Inclusion of interdisciplinary team members in more active roles in project design/deployment

3. Evolving Team Membership: Changing member availability
   - Strategy: Establishing back-up team members available in the setting of loss of a current team member

4. Next Steps: Implement Phases 2 & 3
   - Strategy: Educate, monitor data, expand to units & communication modes