

COHORT FOUR

Teaming to Improve Care

Baylor Scott & White Health

Christiana Care Health Services

Guthrie Robert Packer Hospital (2 projects)

Aurora Health Care – Internal Medicine Team

Baylor Scott & White Health





NI VII Meeting Three/Storyboard

Incorporating Teaming for Long-Term Sustainment of a Communication Program

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Background & Aim

- It is reported that
 - > Dysfunctional team dynamics lead to ~70% of medical errors
 - > Patients whose surgeons had higher numbers of coworker reports about unprofessional behavior had more surgical and medical complications
 - > Rudeness experienced by healthcare team members was associated with decreased hand hygiene
- Improving experiences for our patients and for the healthcare environment is important to our institution and aligns with several initiatives currently underway to improve our overall culture. Our project will focus on the avoidable suffering realm of Press Ganey's Compassionate Connected CareModel™ by focusing strategies on miscommunication, lack of empathy and lack of patient engagement.
- The Academy of Communication in Healthcare (ACH) is an interprofessional organization committed to improving communication and relationships in healthcare. We have partnered with ACH to offer an evidence-based approach for both effective and efficient communication. An Art of Communication (Ask, Respond, Tell) workshop that focuses on evidence for relationship-centered communication (RCC) and builds communication skill sets and practice for effective relationship-centered care was developed to achieve this goal. The 8-hour workshop has been completed by Internal Medicine residents and faculty; however, reinforcement of this education is important to ensure sustainability and further achievement.
- Aim: Expand Art of Communication to rounding team composed of diverse healthcare workers to sustain educational impact and improve communication of the entire team

Methods: Audience, Interventions, Measures

- Art of Communication trainers will reinforce PEARLS (Partnership, Emotion, Apology/Appreciation, Respect, Legitimization, Support) during morning report sessions for residents and huddles and staff meetings for nurses on one internal medicine hospitalist unit primarily staffed by residents compared to a non-resident driven unit
- We will collect unit specific institutional People Survey AHRQ questions pre and post communication reinforcement to provide staff perspectives on communication
- Units will receive monthly provider communication HCAHPS data. Since this data is captured and reported slowly, we will look at six months pre-intervention and six months post-intervention to determine improvement
- Qualitative data will also be collected from participants to learn if they find success with the taught communication approach and capture its practical usefulness and limitations. This will help with adapting sustainability plans and moving to additional units.

Results (to Date)

- We are currently working with our data team to set up the pre-intervention data extraction

- The below questions will be collected pre and post intervention
 - > I feel free to speak my mind without fear of negative consequences
 - > I trust my Direct Supervisor
 - > Where I work, people are willing to confront and solve problems
 - > There is a spirit of cooperation and teamwork within my unit
 - > Where I work, we are treated with respect
 - > Where I work, we have a working environment in which different views and perspectives are valued
 - > I work in an environment that is free from harassment and discrimination
 - > Offensive behavior (i.e., sexual harassment, insensitive remarks, etc.) is not tolerated in my department
 - > Staff will freely speak up if they see something that may negatively affect patient care.
 - > Staff are afraid to ask questions when something does not seem right. [R]
 - > Staff feel like their mistakes are held against them. [R]
 - > I am confident if I submit a compliance concern that it will be investigated or addressed
 - > We feel comfortable asking questions when something doesn't seem right
 - > When we see staff doing something unsafe for patients, we speak up
 - > Staff feel like they are treated fairly when they make patient safety errors

Discussion: Barriers & Next Steps

- Currently working to complete QI vs Research Determination Form to determine if IRB oversight will be required. Next steps are to create and submit a research protocol if IRB oversight is deemed necessary
- Art of Communication organizational capacity – although there are many trainers, we are currently working with them and the unit leaders to schedule implementation of communication interventions
- Because our unit of focus is primarily resident-staffed, scheduling acrobatics may be needed to ensure all team members are provided the intervention
- We anticipate results will be indicative of improved communication of unit teams and can then describe our approach to adjusting the standard Art of Communication workshop to increase sustainability and improvements in care teams
- For this project to reach maximum capacity, we will need to expand to other providers in the care team and to other units. We look for this project to lay the foundation and provide learned lessons for project expansion

Christiana Care Health Services Place Holder



Guthrie Robert Packer Hospital Project 1





NI VII Meeting Three/Storyboard

Improving Ambulatory Quality Metrics in a Resident and Faculty Internal Medicine clinic

Victor Kolade, Sheela Prabhu, John Pamula, Tejaswini Maganti, Shobha Mandal



Background & Aims

- Our health system chooses quality metrics for Primary Care and sets goals for each, typically seeking a 5% improvement over baseline – by office and overall - every year, to be pursued from July-June
- Metrics for 2020-21 include ‘diabetes bundle’, diabetes eye exams, colorectal cancer (CRC) screening, hypertension control, depression screening, and fall screening in patients over 65
- July 2020 marked the first time resident data would count towards the overall system goal
- Primary Aims:
 - > To improve the ‘diabetes bundle’ compliance to 62% across patients in Sayre Internal Medicine being cared for by non-resident providers (faculty, non-faculty doctors, and advanced practice providers) by June 2021
 - > To improve the ‘diabetes bundle’ compliance to 54.6% across all patients in Sayre Internal Medicine being cared for by resident providers by June 2021
- Secondary Aims:
 - > To see or maintain a colorectal cancer screening rate of 70% or more among patients in Sayre Internal Medicine being cared for by non-resident providers by June 2021
 - > To see a colorectal cancer screening rate of 65.2% or more among patients in Sayre IM being cared for by resident providers by June 2021

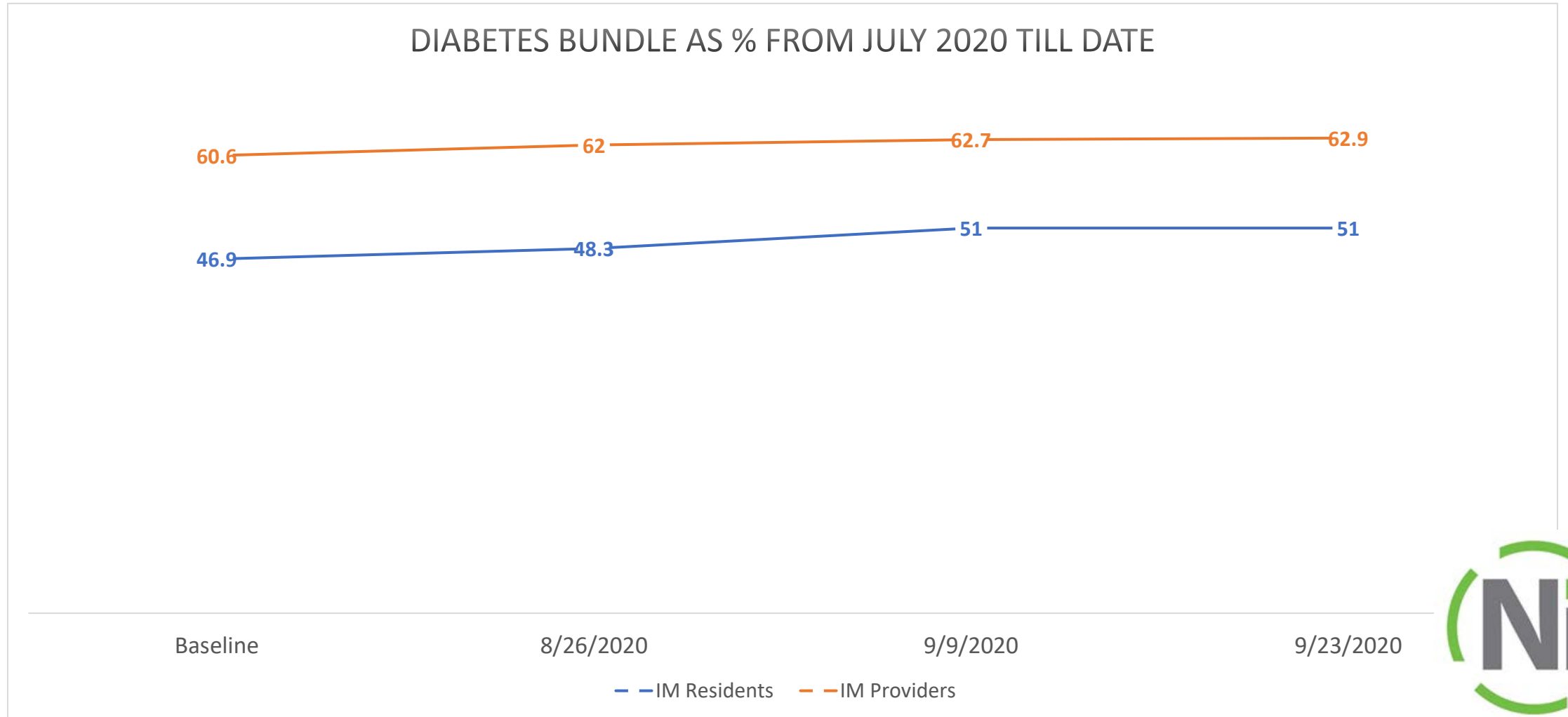


Methods: Audience, Interventions, Measures

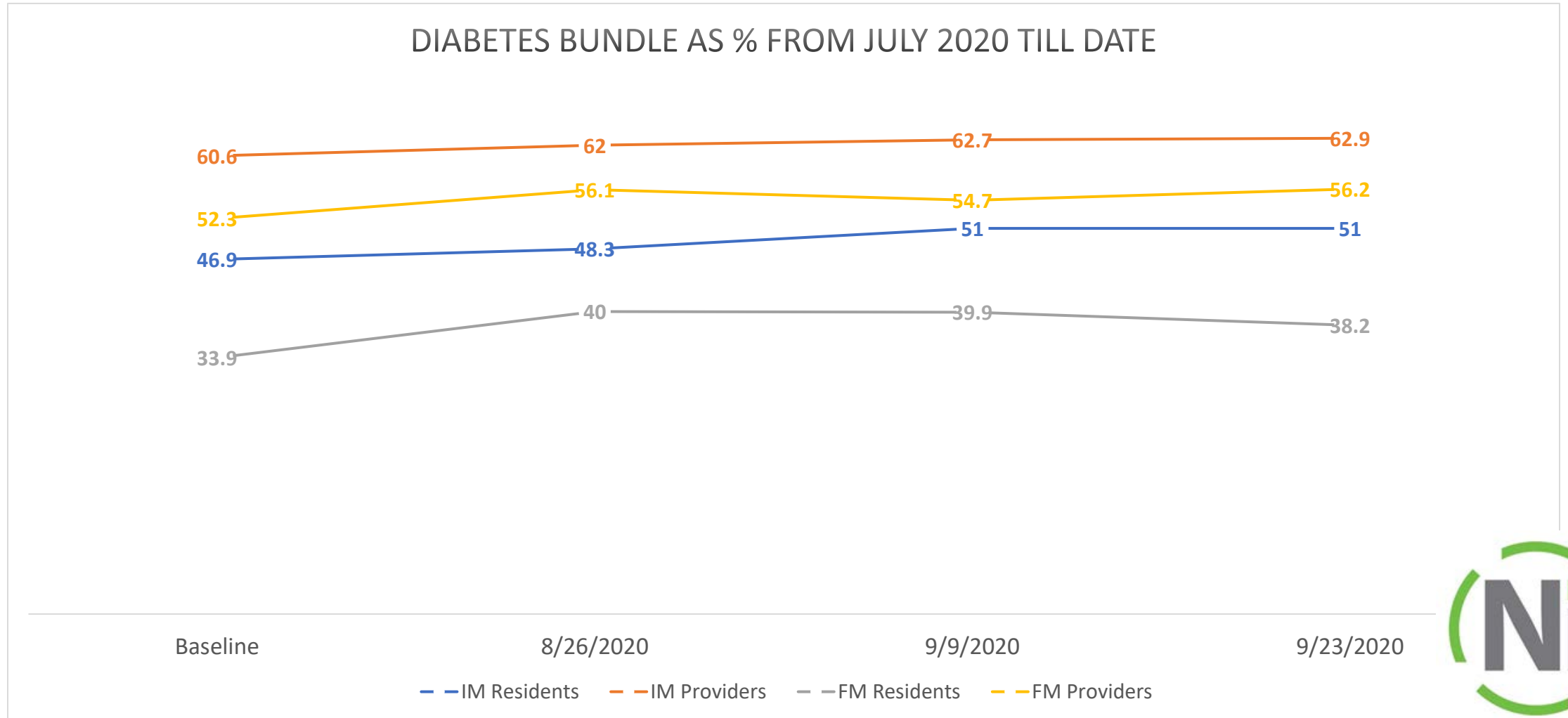
- We sought to leverage daily office huddles to achieve these aims
- Huddles occur from 8:40-9 am and include the office director, care coordinator, providers, residents, nurses, patient service specialists and nurse practitioner/physician assistant/medical students
- The care coordinator reviews provider schedules and provides printed copies to the nurses/providers identifying patients out of compliance with the diabetes bundle – most recent hemoglobin A1c <8 in the last 6 months, microalbumin checked in the last 1 year, LDL <70 (or patient is on a statin) in patients aged 40-75 – and CRC screening status
- Data is reviewed by providers and in huddle every 1-2 weeks
- Data is provided by administration and includes information on other primary care practices
 - > These data files include information on both residency programs in primary care, our IM program and the family medicine (FM) program – which is not a part of this project
 - > Data is also available on the non-resident providers in the FM clinic that hosts the residency



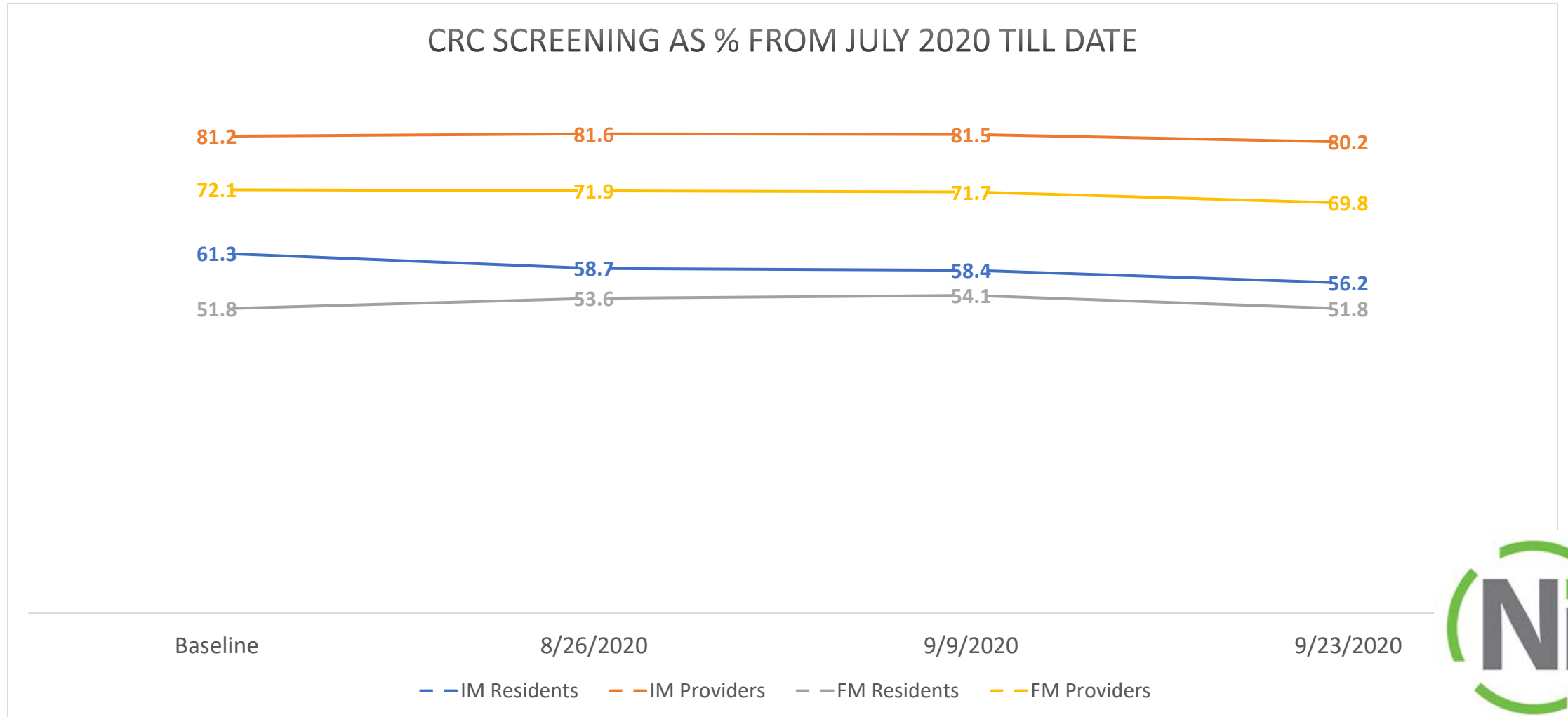
Results – diabetes bundle (upward trend)



Results compared to non-participating practices

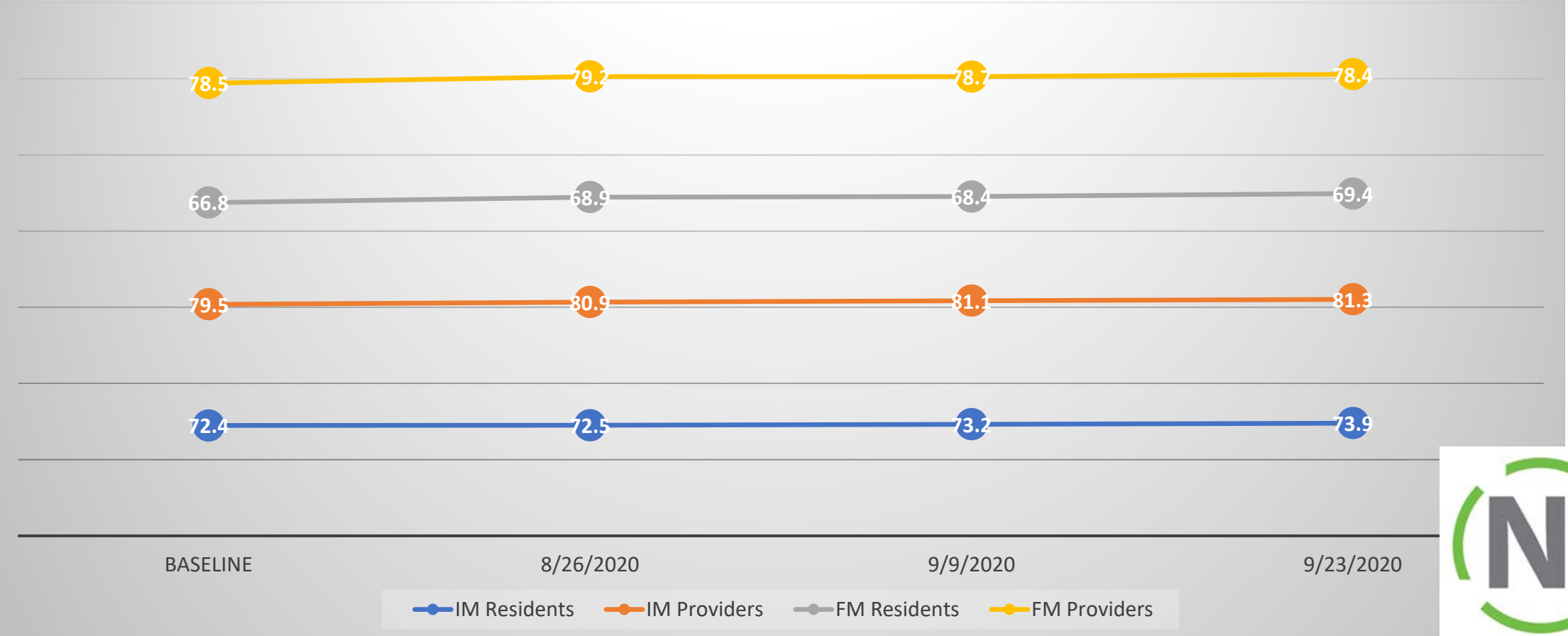


Results – CRC screening, with comparisons



Results – diabetes eye exams, compared to non-participating practices

Diabetes EYE EXAM % from July 2020 till date



Discussion: Barriers & Next Steps

- The COVID-19 pandemic has prevented some patients from coming for office visits or lab draws
- However, we have re-instituted daily huddles since mid-July 2020 while wearing masks
- We have also expanded our huddle-based initiative from its initial focus on the diabetes bundle alone to tackle a larger disparity in CRC screening rates between resident and non-resident providers
 - > Availability of Fecal Immunochemical Test (FIT) kits (currently on back order) may have affected screening rates
 - > Some colonoscopies were cancelled during the pandemic and have not been rescheduled
- Additionally, we are looking at the rates of completion of eye examinations in patients with diabetes
- A quality improvement project on completion of Transitional Care Management (TCM) visits within 7 days of hospital discharge started running within the daily IM clinic huddles in August 2020
- A separate quality improvement project on ACE inhibitor/ARB use in patients with chronic kidney disease was launched in the IM clinic on 9/28/20 and may increase diabetes bundle completion



Guthrie Robert Packer Hospital Project 2





NI VII Meeting Three/Storyboard

Improving Transitional Care Management Compliance in Ambulatory Clinic

Dr. Tejaswini Maganti, Dr. John Pamula, Dr. Victor Kolade, Dr. Sheela Prabhu



Introduction & Aim

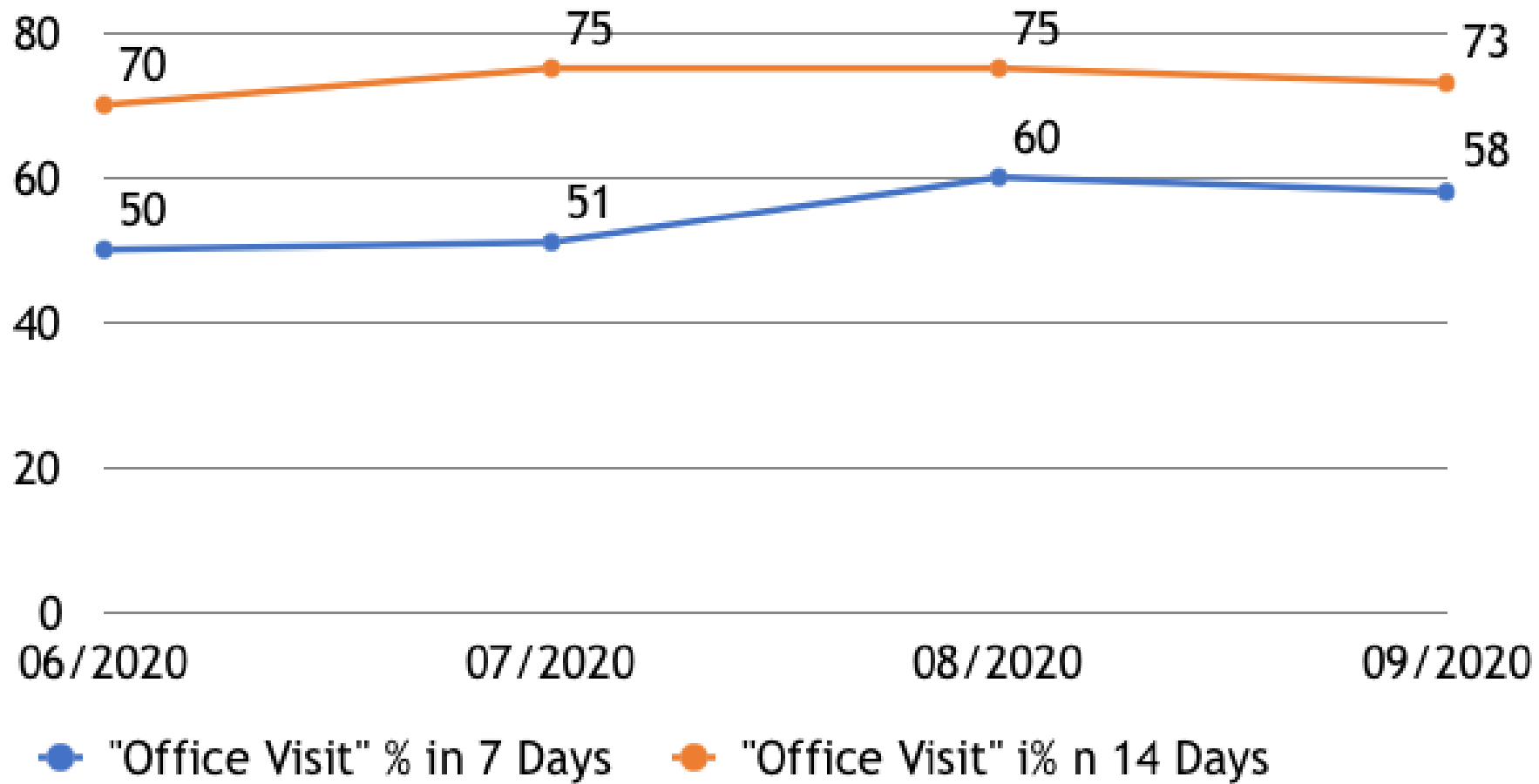
- Many studies have shown that transitional care services significantly impact reducing the number of hospital readmissions
- However, there are limitations for TCM appointments that decrease the rate of compliance with provision of this service, including
 - > lack of coordination among the inpatient and outpatient care teams,
 - > ineffective patient or family education,
 - > patient noncompliance,
 - > scheduling challenges
- Aim of our project: To improve the TCM compliance rate by improving the process of interdisciplinary morning huddles among the care team, by
 - > Educating resident physicians to complete discharge instructions and summary promptly, and
 - > Encouraging nurses to inform and educate patients about the TCM appointment while discharging them from the hospital
- Specifically, we aim to improve the TCM rate in the Internal medicine clinic by 10% from 6/2020 to 12/2020

Methods: Audience, Interventions, Measures

- Huddles occur in the morning in the IM clinic every day in a team-based approach
 - > They include the office director, care coordinator, providers, residents, nurses, patient service specialists, and nurse practitioner/physician assistant/medical students
 - > Where necessary, use of vacant slots for TCM appointments is discussed in the huddle
- Multi-disciplinary approach was implemented:
 - > A pair of Patient Service Specialists was mandated to call patients for appointment reminders
 - > The care coordinator called patients to perform medication reconciliation and address acute issues
- Physicians were urged to discuss the importance of TCM with patients while discharging them
- Inpatient unit clerks or nurses were to schedule TCM appointments prior to patient discharge
- Resident/physicians were asked to order TCM follow up appointments rather than generic follow up appointments with PCP in order to facilitate identifying TCM for scheduling and doing outreach calls
- We reviewed the data every week to assess challenges and educated physicians accordingly



Results - TCM rate in 7 and 14 days



Discussion: Barriers & Next Steps

- It is challenging to get TCM appointments within seven days rather than 14 days for every patient due to multiple reasons:
 - > patient unavailability when outreach calls are made
 - > Lack of provider appointment spots
 - > Due to the COVID Pandemic, fewer patients are willing to come for appointments
 - > Fewer staff are available to coordinate care in inpatient and outpatient settings due to employee cutbacks due to the COVID pandemic
- Virtual visits have become available in our clinic as a result of the COVID pandemic and can now be used for TCM visits.
- Educating/ training and Reassigning tasks to existing staff is one of the steps have taken.
- There is a slight improvement in the TCM rate so far; we continue our interventions in pursuit of our goal.



Aurora Health Care Internal Medicine





We are  AdvocateAuroraHealth



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NI VII Meeting Three/Storyboard

Advancing Advanced Directive Documentation in the Internal Medicine Clinic

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INTRODUCTION & OBJECTIVES

- Introduction

- The vast majority (89%) of patients prefer advance directive (AD) conversations to be initiated in the outpatient setting, ideally with their primary care doctor.
- Only 47% of patients > 65 years in resident clinic with significant health disparities have completed AD documentation on file.

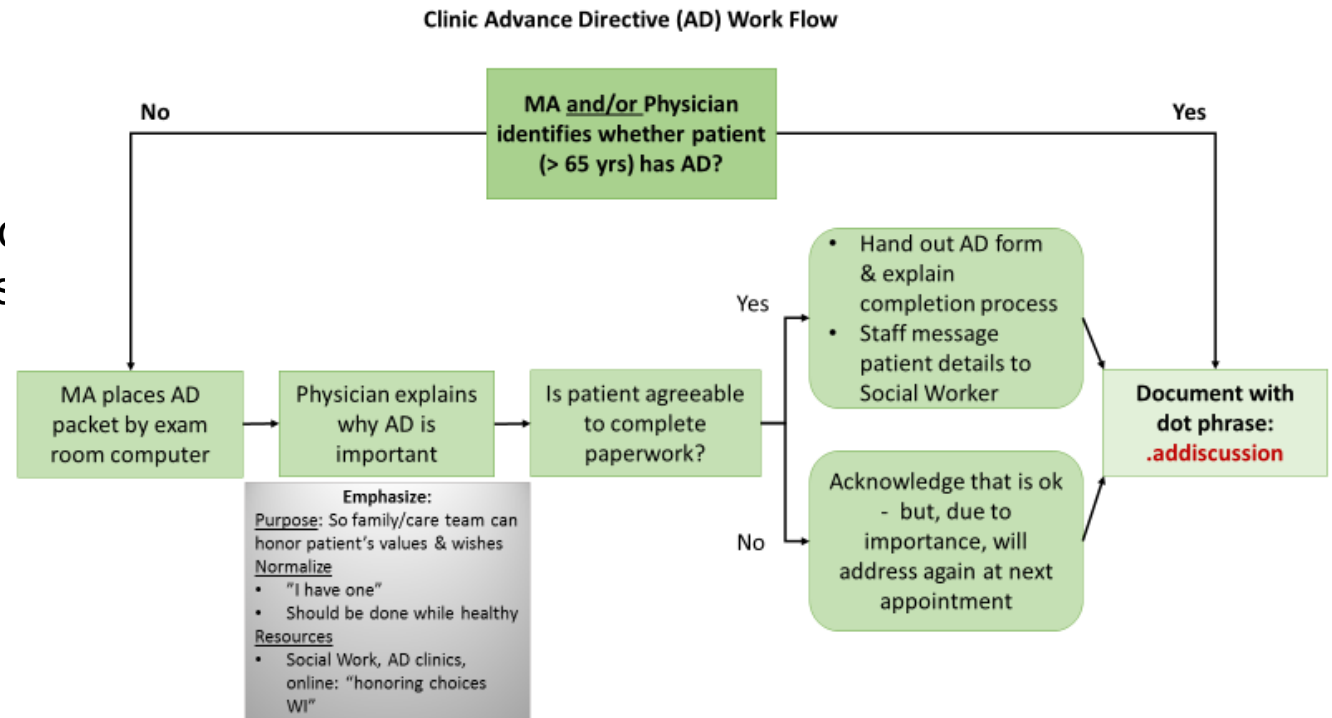
- Objective

- To increase our AD completion numbers for patients > 65 years in Internal Medicine Residency and Faculty Clinics to greater than 56% by project completion.



METHODS: AUDIENCE, INTERVENTIONS, MEASURES

- New standardized workflow for all clinic patients ≥ 65 yo to ensure pts receiving appropriate goals of care counseling
 - Implemented 1 residency clinic, other contr
 - Educ academic 1/2 days + noon conferences to teach residents strategies and interactively engage pts in AD discussions (role plays)
- Clinic Workflow modified II^o pandemic - virtual video visits



Metrics:

- Clinic AD % completion and CGCAHPS compare with control + overall clinic QI scores
- Clinical Learning Environment Quick Survey (CLEQS) used as balancing measures



RESULTS (TO DATE)

CLINICAL QUALITY:

- 7 project months including COVID altering clinical/education operations,
 - Intervention site AD scores ↑ by 1% despite pandemic related shifts
 - Control site no change
 - No unexpected change in other QI scores

CLEQS ITEM SCALE: 1 = Strongly Disagree to 5 = Strongly Agree	Baseline Mean N=49	Mid Point Mean N=33
Work I do is meaningful to me. SCALE: 1 = SD to 7 = SA	5.7	6.3
Interprofessional Teams in this unit work together effectively using ongoing communication, collaborative decision making, coordinated team-based care	3.7	3.9
Team members' (and my) roles and expectations are clear.	4.0	4.1



DISCUSSION: BARRIERS & NEXT STEPS

- The COVID-19 pandemic
- Improving provider comfort with and destigmatizing advance planning conversations is an essential step in promoting AD documentation completion.
 - Follow up with patients after the counseling visit to ensure they fill out the paperwork
 - Utilizing virtual platforms and increasing social work resources would help facilitate documentation completion in a timelier manner
- Intervention Clinic selected as *SYSTEM* pilot site for e-based Advance Directives beginning Jan 2020!

