AIAMC National Initiative VII
Capstone Presentations
Cohort One

Transitions of Care

March 26th (1:30-3:00 ET)

Cohort One teams

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

National Initiative

Capstone Questions

1. What did you hope to accomplish?

2. What were you able to accomplish?

3. Knowing what you know now, what might you do differently?

4. What surprised you and why?

5. Success Factors:
   The most successful part of our work was…
   We were inspired by…

National Initiative

AdventHealth | Graduate Medical Education

AiAMC Alliance of Independent Academic Medical Centers

NI VII Meeting Four – Capstone Presentation
Cohort One: Transitions of Care

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, Mengni Guo MD

National Initiative

Q1. What did you hope to accomplish?

- We hoped to improve the handover process from ICU to step-down unit via implementation of a standard operational protocol to enhance communication among team members, to ensure patient safety and reduce ICU and hospital LOS

Q2. What were you able to accomplish?

- We were able to identify and qualify the significant communication gap between intensivists and hospitalists, as well as between critical care RNs to step-down units RNs, which leads to delayed care during the transition.

- We were able to implement a systematic standard transition care protocol with the teamwork of MDs, RNs and coordinator staffs

- We were able to demonstrate that improving patient handover process effectively closed the communication gap

Q3. Knowing what you know now, what might you do differently?

- Would like to start the project a little bit earlier since there was significant RN turnover in ICU, which affects the accuracy of RN questionnaire

- Would probably include step-down unit RN in the protocol design to get feedbacks and suggestions

Q4. What surprised you and why?

- *1) Communication gaps*
- *- Most of the ICU RN failed to contact the hospitalist when patient was transferred out of ICU. It was difficult for the ICU RN to figure out the exact hospitalist who will be seeing the patient in the PCU step-down unit due to a different call schedule.*
-
- *2) Resistance from ICU team in terms of consulting hospitalist when patients were admitted to ICU*
- *-They worried about inappropriate/unnecessary orders placed by the hospitalist*
-
- *3) More than 50% RN were worried about patient's safety during transition of care or[illegible] initial survey*

Q5. Cohort One – Success Factors

- *The most successful part of our work was improved communication and teamwork*

ICU residents/Intensivist

ICU RN

ICU coordinator

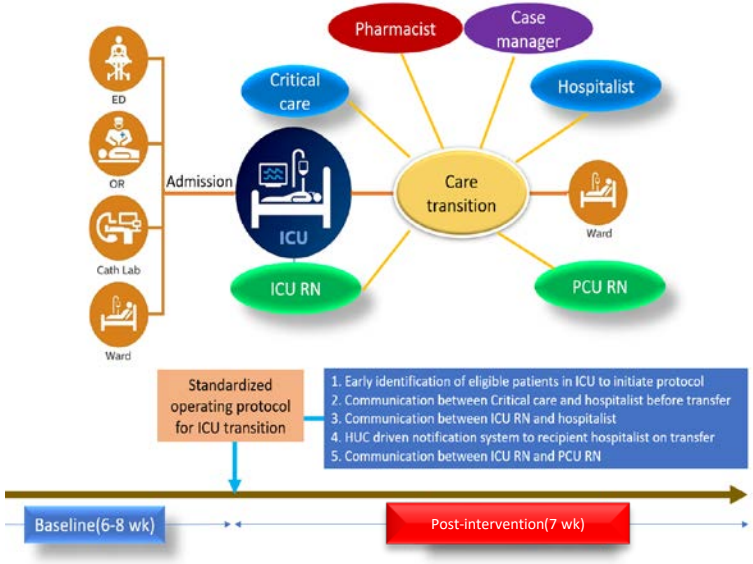
PCU RN

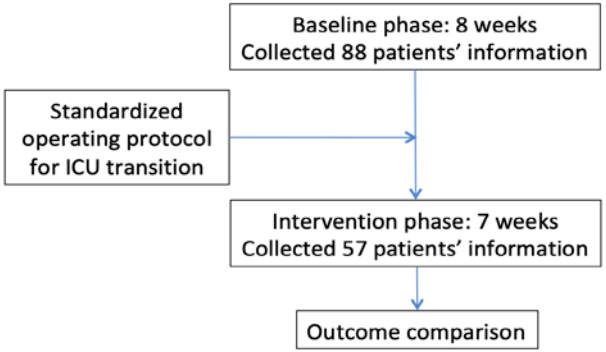
Hospitalist

Research team

- *We were inspired by the fact that everyone in this project were sharing the same MISSION: To enhance the patient safety during the transition of care from ICU to PCU step down units. All of them were willing to take the initiatives and embrace the changes.*

Optional – Graph, table picture, etc., to aid in telling your story





Outcome measurements		Baseline	Post-intervention
Communication between ICU and hospitalist	Verbal communication	12 (14%)	20 (35%)
	Phone or text	55 (62%)	34 (60%)
	Others	21 (24%)	3 (5%)
ICU RN contacted hospitalist prior to handover to PCU RN	Yes	30 (34%)	53 (93%)
	No	58 (66%)	4 (7%)
ICU RN identified hospitalist prior to handover to PCU RN	Yes	69 (78%)	54 (95%)
	No	19 (22%)	3 (5%)
Interval between consult order and first hospitalist note	<24 hours	79 (90%)	53 (93%)
	>24 hours	9 (10%)	4 (7%)

QUESTIONS

National Initiative

ARROWHEAD REGIONAL MEDICAL CENTER

AiAMC Alliance of Independent Academic Medical Centers

NI VII Meeting Four – Capstone Presentation
Cohort One: Transitions of Care

Teaming Perspectives from the COVID-19 Global Pandemic

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

National Initiative

Q1. What did you hope to accomplish?

- We originally hoped to do a project on teaming surrounding the discharge planning process at our hospital.
- We eventually had to abandon the project due to the COVID-19 pandemic and the restrictions on meetings at our institution.
- Our last best hope was to chronical the perspectives of some of our key doctors and administrators regarding teaming in a global pandemic.

Q2. What were you able to accomplish?

- We were able to gather a series of perspectives from the resident, program director, department chair, and CEO levels.
- We asked four questions which were:
  - What surprised you or made you realize 2020 was going to be different?
  - What did your organization or program do to respond to the challenges of COVID-19?
  - What did you/your team do during this pandemic that previously you would have never imagined?
  - What are your hopes for the future as we move beyond 2020 and what would you do if you knew you could not fail?

Q3. Knowing what you know now, what might you do differently?

- Don’t try and do a group project in a global pandemic.
  - Original project involved discharge planning meeting with 15 physician in-patient teams and all the case managers and social workers in the hospital. (we had upwards of 50 people at a time in one large meeting room)
- Have a backup plan in case of natural/man-made disasters.

Q4. What surprised you and why?

- How much all of our lives have changed since the initiative started.
- How much we have as a healthcare team been able to accomplish for our patients. Everyone from the environment services staff all the way to the CEO worked together in new ways we never would have imagined. The hospital converted who patient units into negative pressure rooms for the pandemic in a matter of days. FEMA built a tent city in one our parking lots to help expand our capacity. The U.S. Military deployed doctors and nurses to our hospital during our darkest hours. Through it all we worked, as a team, to rapidly address issues and needs so we could respond as best as possible to this unprecedented situation.

Q5. Cohort One – Success Factors

- *The most successful part of our work was…*
- Pivoting project multiple times as waves of COVID patients forced our plan to be scrapped.

- *We were inspired by…*
- Our collaboration and teamwork through all the hardships.

Teaming Perspectives from the COVID-19 Global Pandemic

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

ARROWHEAD REGIONAL MEDICAL CENTER

National Initiative

NI VII Meeting #4

INTRODUCTION: Background

In 2019, Arrowhead Regional Medical Center (ARMC) embarked on the AIAMC National Initiative with a project originally focused on patient discharge planning. However, as the team prepared for the implementation of the project in the winter of 2020, the medical center and the world began to experience the COVID-19 global pandemic. Due to restrictions and responses to surging COVID numbers, the team had to abandon the planned project. The team worked toward a revised project over the summer but also had to be scrapped due to a larger surge in the Fall of 2020. As a result, the team decided to adopt a perspectives approach to the initiative due to lack of time to salvage a regular project. The team worked with the AIAMC and developed a set of four questions and asked key stakeholders at different levels for their perspectives on the crisis and for the future.

Question One

What surprised you or made you realize 2020 was going to be different?

In January 2020, when we learned that a plane was landing in the Inland Empire with American citizens who might be infected with a novel coronavirus. This was the first tip-off that 2020 would not be a typical year. From that point on we moved quickly into the grip of the pandemic. Thanks to our excellent leadership team and physicians Arrowhead was able to pivot quickly to meet all challenges thrown at us during COVID-19.

– William Gilbert, ARMC CEO

The realization that we were going to have to deal with a pandemic that would affect all of society, not just the US, but throughout the world. In the past, most disease outbreaks or significant scope tend to be limited to other parts of the world and have not directly affected the US as much. This time, however, it was not just the US that was affected, but each and every one of our own individual worlds and communities.

– David Lanum, MD, ARMC Family Medicine Department Chair

The severity of cases at Arrowhead, the news surrounding the world-wide shutdowns, the sheer number of unfortunate deaths…in combination this culminated in my realization that 202 was going to be [very] different.

– Ali Darwish, MD, ARMC Internal Medicine Resident and House Staff President

Once we started hearing about how COVID-19 was impacting New York and Italy, we knew it was only a matter of time before we would be impacted. As the true front-line providers, Emergency Medicine residents and faculty knew that they would be in the thick of things. Heavy media coverage of front-line providers in New York dying of COVID-19 only fueled their anxiety and concerns for safety, but every one of the providers stepped up and saw it as their duty to serve those in need. We also experienced many "side effects" of COVID-19 that we in our department. One was a sudden and almost precipitous drop in our ED patient volume; some of this was due to the strict shutdown mandated by the government and some were due to patients' fear of being in ED. ED visits normally caused by injuries and accidents suddenly dropped off. We saw very few patients presenting with "minor" complaints, such as minor wounds, minor aches, etc. Those presenting were most often critical ill, so they really had no choice but to visit ED. The end result was that we had higher acuity patients in our ED but our overall volume was less than in the past. Another surprise was that because of the wide impact COVID-19 had on the medical community in general in terms of patient volume, our graduating residents had a very difficult time finding jobs (hardly anyone was hiring). I find this very ironic as the "frontline heroes" were not only affected by the safety concerns/conditions, but also were faced with financial and professional challenges by the pandemic.

– Carol Lee, MD, ARMC Emergency Medicine Program Director

Question Two

What did your organization or program do to respond to the challenges of COVID-19?

Pivoted to using telehealth for the first time ever within 33 hours. Institute rigorous PPE training programs and adherence protocols. Ensure that enhanced communication tools were used across the Department to try to make up for the fact that we could no longer meet in person, and information that needed to be disseminated was changing rapidly, sometimes by the hour. Thus, setting up secure messaging systems to allow for information being sent by text and e-mail up to several times daily, including chat and question forums to allow best practices and information to be shared. We also looped the Infectious Disease and Pulmonary Critical Care specialists into these chains. Faculty began holding weekly 1 hour Zoom meetings to ensure that not only medical issues could be communicated, but physician well-being issues could also be addressed. The Department brought in a private professional Coaching and Support service to allow all faculty 24/7 access to support and tangible resources for themselves and family members.

– David Lanum, MD, ARMC Family Medicine Department Chair

We held weekly meetings, cancelled physical didactics and moved to online learning/communication. The department heads supported the residents throughout especially in ensuring proper PPE – this was paramount and appreciated by all the residents and fellows.

– Ali Darwish, MD, ARMC Internal Medicine Resident and House Staff President

Lots of education of safety precautions, efforts to secure additional PPE (our department on our own bought masks, collected donations from friends and family), daily communication/updates regarding everything COVID, restructuring ED workflow to keep staff and patients safe. We also developed elaborate back up/call systems to accommodate quarantining and isolating residents and attendings. Our residency program did a weekly "check in sessions" to not only address concerns and provide communication but to address wellness/burnout issues. The institution declared ACGME Emergency Declaration, so we did have less providers in the ED at one time (IM residents were pulled off for example).

– Carol Lee, MD, ARMC Emergency Medicine Program Director

Arrowhead responded quickly and decisively by conducting daily meetings, collaborating with other county agencies, community stakeholders, hospitals, and the state. Arrowhead initiated its incident command system, which is still currently in place. Team members worked 24/7 to meet each challenge, whether it was retrofitting patient rooms to be negative pressure rooms; searching worldwide for PPE supplies; organizing and standing up an alternative care site on the hospital campus; providing COVID-19 testing to staff and the community and extending the ER with tents and temporary buildings to handle the winter surge.

– William Gilbert, ARMC CEO

Question Three

What did you/your team do during this pandemic that previously you would have never imagined?

Lots of people refused to go home because of concerns for family. Some slept in call rooms, some in hotels, some in donated RV's. Our department/hospital provided extra call rooms, resources for free or reduced rate hotel rooms, etc. We also pulled all non-essential people from the department, including medical students, shadowing students, visitors, etc. We had dying patients whose families were unable to be with them. Many providers had to notify family members of patient's death via telephone because family members could not visit. We faced many challenges as we attempted to identify and "isolate" potential COVID patients or COVID confirmed patients. The triaging of these patients proved challenging at times as we did not have enough capacities for negative pressure rooms.

– Carol Lee, MD, ARMC Emergency Medicine Program Director

Telephone visits. I had never done telephone visits prior to the pandemic. I do think that some clinics are running more efficiently with phone calls rather than face to face visits.

- Carlyn Estrella, MD, ARMC Family Medicine Resident

Care for patients with a communicable disease for a protracted period of time (now approaching one year), for which at the time no known cure or good treatment was known. It was also one of the first times that almost everyone on the care team shared the same level of experience and expertise, as so little was actually known about Covid-19. As such, it was good team-building as whether you were the attending, resident or medical student – all had something to contribute and all were learning alongside each other.

– David Lanum, MD, ARMC Family Medicine Department Chair

We broke down silos between county agencies and worked together as a team to get through the pandemic. This included working and collaborating with other hospitals. ARMC took a leadership position in the County's acute care hospital system response by facilitating and supporting the development of a communications platform that included all key major stakeholders. This platform encouraged real time information sharing across the County and with the hospital association and state partners. It provided forums to discuss proposed response actions delineated above, many of which were implemented with the support of the group. Through the holiday surge it provided a real time forum to hear urgent hospital resource needs so that resources (staff and PPE) could be sourced and secured.

– William Gilbert, ARMC

Question Four

What are your hopes for the future as we move beyond 2020 and what would you do if you knew you could not fail?

Hoping the vaccine works and that we can go back to normal.

- Carlyn Estrella, MD, ARMC Family Medicine Resident

That society would use any future pandemics to demonstrate care and concern for the most vulnerable, follow evidence and science, and resist the urge to make such issues political in nature. We should all be less concerned about ourselves as individuals, and more about our fellow human beings as a whole.

– David Lanum, MD, ARMC Family Medicine Department Chair

Hopes for the future include continuing the successful relationships and collaborations with other hospitals and health agencies. In addition, our COVID-19 response set a solid ground of preparation for any disaster/incident that may come our way in the future. We now have a template to build off for future incident planning. We learned that strong relationships in the community are essential and working together rather than in silos is the key.

– William Gilbert, ARMC CEO

Widely available Vaccination and herd immunity; resumption of normal activities including educational activities and social events, etc. We are looking forward to scheduling our graduation, retreats, journal clubs, traveling for academic events, etc., really soon.

– Carol Lee, MD, ARMC Emergency Medicine Program Director

QUESTIONS

National Initiative

HONORHEALTH

AiAMC
Alliance of Independent Academic Medical Centers

NI VII Meeting Four – Capstone Presentation
Cohort One: Transitions of Care

Teaming to Create a Culture of Inclusivity and Health Equity

Alethea Turner DO, FAAFP; Cynthia Kegowicz MD; Darlene Moyer MD, FAAFP;
Ashley Dyer-Giaquinto MD, FM PGY3; Yiwen Richard Liang MD, FM PGY3

National Initiative

Q1. What did you hope to accomplish?

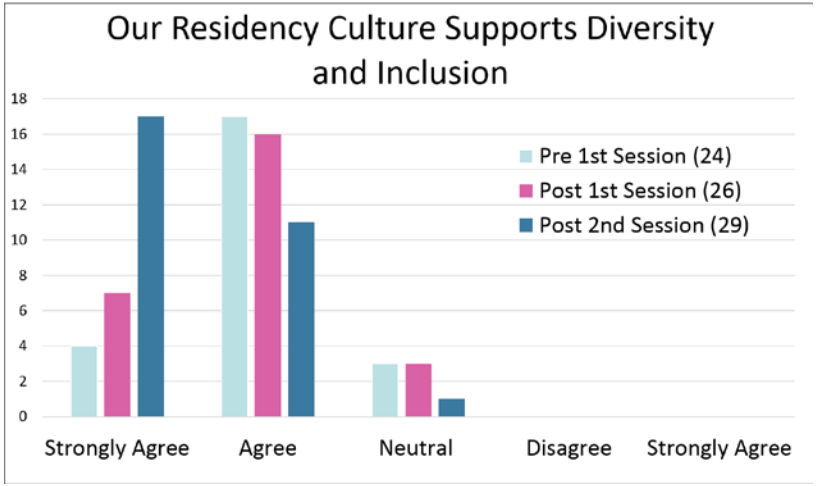
- Initial project – Readmission Roundabout
  - > Aim
    - Standardize transitional care management from the inpatient to the outpatient setting for residency patients who are deemed high risk for hospital readmission
  - > Objectives
    - Increase outpatient follow-up within 14 days of hospital discharge for patients who are at >20% risk for readmission
    - Reduce readmission rates in this cohort of patients
    - Identify patient barriers for effective transitional care
- COVID-19 halted our progress 

Q2. What were you able to accomplish?

- Project Revision
  - New Aim
    - By June 2021, we will develop and implement a longitudinal curriculum that increases resident and faculty understanding of topics related to health equity, and strengthens our program's culture of diversity and inclusivity
  - Objectives
    - Learn and disseminate facts
    - Create a safe space for dialogue
    - Strengthen our culture of diversity and inclusivity

- So what did we do?
  - Resident and Faculty Committee
  - Resident Equity, Diversity and Inclusivity (EDI) Champions
  - Quarterly Sessions
  - Longitudinal Curriculum

Q2. What were you able to accomplish?



- After the 1st session, the median score improved significantly compared to baseline, p=0.042
- The median score improved even more after the 2nd session, p=0.006

Session #1 - Implicit Bias

- "I understand the concept of implicit bias and the role it plays in medicine"
- The median score significantly improved after the 1st session, p=0.002

Session #2 - Equity, Equality & Privilege

- "I understand the concept of equity and privilege, and the role they play in medicine"
- The median score significantly improved after the 2nd session as well, p<0.001

Q3. Knowing what you know now, what might you do differently?

- Develop the curriculum and initiate the conversation sooner
- Realize that you do not have to be an expert to facilitate a discussion
- Vulnerability, honesty and genuine curiosity can go a long way

Q4. What surprised you and why?

- Level of engagement and enthusiasm
- Willingness to learn and discuss traditionally sensitive topics
- Downstream effect

Q5. Cohort One – Success Factors

- *The most successful part of our work was…*
  - Teaming
  - Creating safe and open space for dialogue
  - Introducing topics not previously discussed

- *We were inspired by…*
  - Social injustice and health inequity among minorities
  - Sense of unease among many faculty, residents and patients

QUESTIONS

National Initiative

OhioHealth
Riverside Methodist Hospital

AiAMC
Alliance of Independent Academic Medical Centers

NI VII Meeting Four – Capstone Presentation
Cohort One: Transitions of Care

Improving the Care of Women with Opioid Use Disorder

Valerie Busick, MD; Susan Catlett, RN; Karen D'Angelo, MD;
Susan Davy, MD; Allison Gase, DO; Emily Gorman, DO; Michelle Hoffman, DO;
Melissa Nine, CNP; Kathy Sharkis, MSW; Brittany Williams, RN

National Initiative

Q1. What did you hope to accomplish?

- To increase the rate of initiation and continuation of breastfeeding.
- To increase rate of linkage with PCPs for long-term management of other co-morbid medical problems.
- To increase patient experience satisfaction across the continuum of their care.
- To increase provider comfort and satisfaction when dealing with this complex population.

Q2. What were you able to accomplish?

- A standardized script and workflow to help support breast feeding
- Establishing a standard method to refer patients from the obstetric opioid addiction clinic to the family medicine clinic for both primary care and medication assisted therapy (MAT) needs as well as the pediatric needs of the newborn.
- Have monthly transition of care conferences for the obstetric residents so that everyone was familiar with the current panel of patients.

Q3. Knowing what you know now, what might you do differently?

- Had there not been a pandemic…
  - > Added an out-patient lactation consult to our protocol sooner
  - > Had more patients involved in our clinic
  - > Done more patient and provider surveys as we would have had more consistency

- Since there was a pandemic, we feel we did the best we could under the circumstances and adjusted to the curve balls thrown at us.

Q4. What surprised you and why?

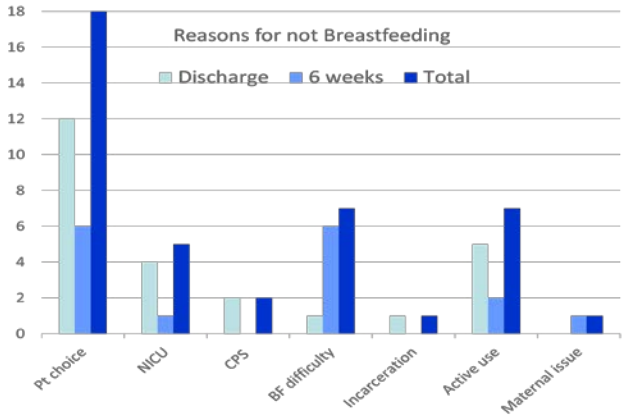
- Clearly, the pandemic caught us off guard.
- It is also surprising that we haven't had more patients enroll in our clinic as the pandemic also brought an increase in opioid use in our community. The city of Columbus and state of Ohio saw a significant increase in the number of overdoses that occurred in 2020, so opioid use continues to remain a significant health problem.
- As a primary care physician, it was also surprising how many patients (14/18 or 78%) did not have a primary care physician despite having chronic medical conditions (mood disorders, hepatitis C, asthma, etc).

Q5. Cohort One – Success Factors

- *The most successful part of our work was…*

- Having any patient be able to successfully breastfeed past the six-week mark. While we were hoping to make a bigger impact, we were thrilled with any win.
- Our ability to link our patients with primary care physicians was extraordinary, clearing showing how we are able to work together as a collaborative team.

- *We were inspired by…*
- The women we serve and all that they have endured and struggle with on a daily basis. Having them trust in us to care for them gives us the motivation to come to work and provide outstanding care. We were also inspired by the dedication the patients have to their health and the health of their children.



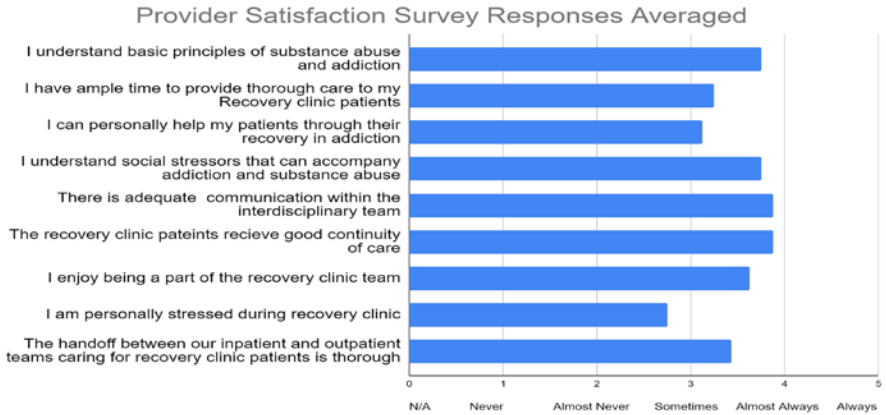
RESULTS

- 18 total patients were a part of the data collection, 4 patients had a primary care physician, so they were excluded from the sample.
- Of the 14 patients without a primary care provider, 8 (57%) established with RFPC.

Table 1. Patient characteristics, n=14

Characteristic	Established with RFPC (n=8)	Not established with RFPC (n=6)
Medical history		
Mood disorders, n (%)	5 (62.5)	5 (83.3)
Hepatitis C	3 (37.5)	2 (33.3)
Asthma	3 (37.5)	0 (0)
Number of children, mean ± sd	2 .0 ± 1.8	3.17 (2.3)
Number of pts with newborn visits	5 (71.4)*	2 (33.3)
Number of patients with missed appointments	6 (85.7)*	1 (16.7)**

*denominator is 7 as one patient's EDD is still impending
**newborn visit missed



QUESTIONS

National Initiative

St Luke's UNIVERSITY HEALTH NETWORK

AiAMC Alliance of Independent Academic Medical Centers

NI VII Meeting Four – Capstone Presentation
Cohort One: Transitions of Care

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

Project Leader: Parampreet Kaur MD

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

National Initiative

Introduction & Aim

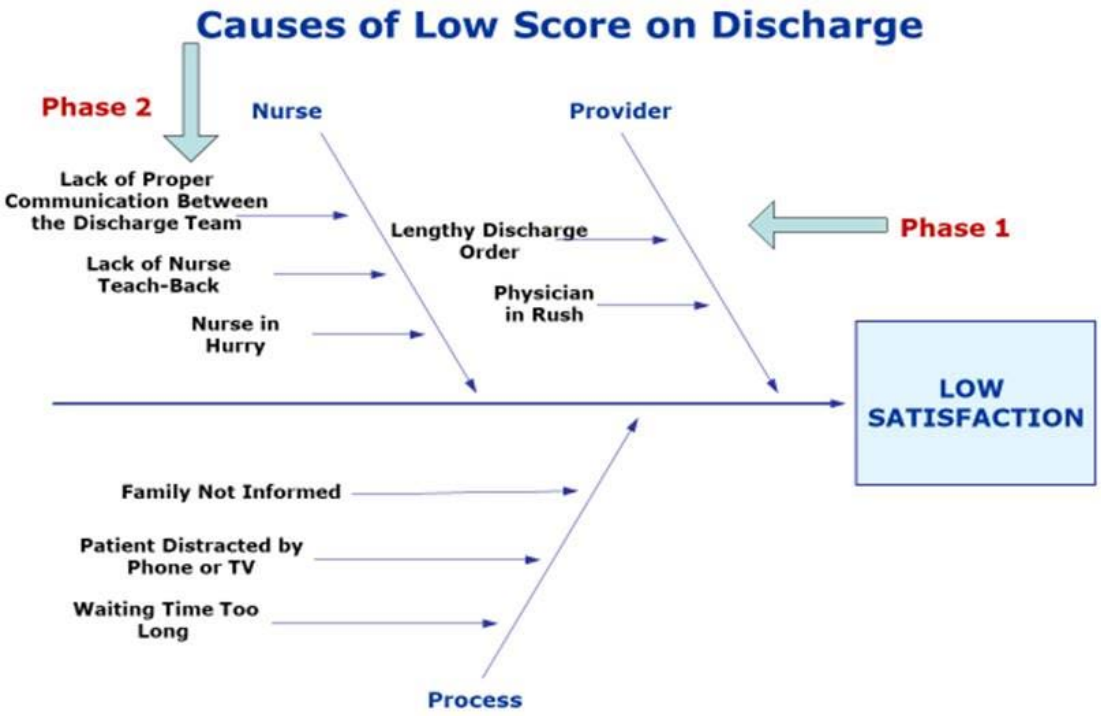
Introduction:

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) - Scoring system is used to measure and compare the standard of care in healthcare facilities.

Overall HCAHPS scores at St. Luke's University Health Network Anderson Campus (SLRA) have been in the positive percentile, but the "**discharge domain**" of HCAHPS have been historically been low.

Objective:

To ***improve patient satisfaction*** *by* ***increasing HCAHPS scores*** in the ***overall discharge domain*** to twice the baseline percentage within six months for phase 1 and then 10% incremental increase at every next phase.


Causes of Low Score on Discharge
Phase 2
Nurse
Provider
Lack of Proper Communication Between the Discharge Team
Lack of Nurse Teach-Back
Nurse in Hurry
Lengthy Discharge Order
Physician in Rush
Phase 1
LOW SATISFACTION
Family Not Informed
Patient Distracted by Phone or TV
Waiting Time Too Long
Process

Methods: Audience, Interventions, Measures

Audience:

- Acute Care Patient Population (includes 4 separate units; SMS-2, SMS-3, SMS4 and WMS-4) These units have a total of 126 beds. The data excludes the OB unit.

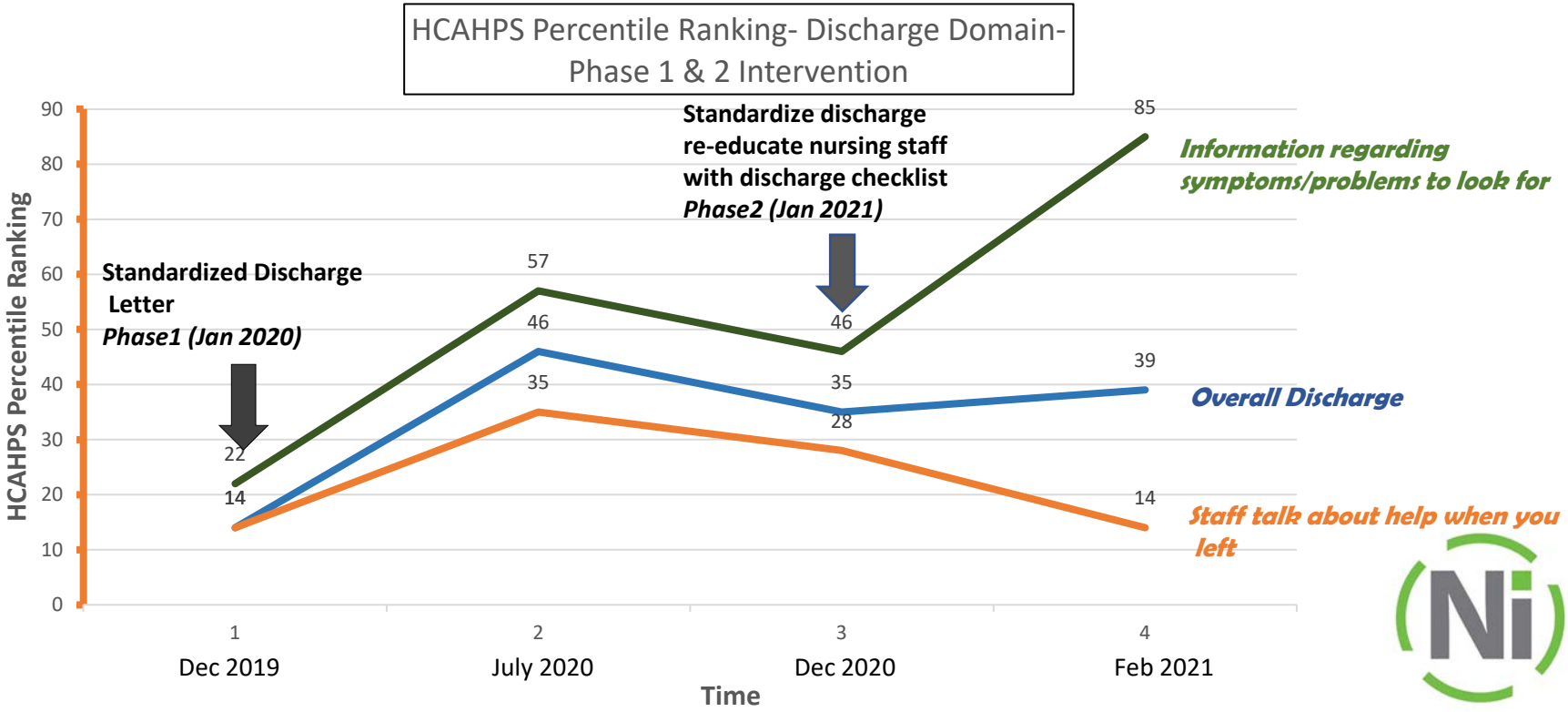
Interventions:

- Phase 1 – Implement a Standardized Discharge Letter
- Phase 2- Re-educate Nurses on Discharge checklist and teach back to patients
  - 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
- Number of Nurses attending Re-education Discharge Checklist.

Results


HCAHPS Percentile Ranking- Discharge Domain- Phase 1 & 2 Intervention
HCAHPS Percentile Ranking
90
80
70
60
50
40
30
20
10
0
Standardized Discharge Letter
Phase1 (Jan 2020)
Standardize discharge re-educate nursing staff with discharge checklist
Phase2 (Jan 2021)
57
46
46
85
39
35
35
28
22
14
14
Information regarding symptoms/problems to look for
Overall Discharge
Staff talk about help when you left
1
2
3
4
Dec 2019
July 2020
Dec 2020
Feb 2021
Time

Limitations/What might we do differently

- We will have another personnel in-charge of each task, as a **backup**, instead of a single person, so that the proper timeline can be followed as scheduled.
- Better education (ex. **Add to on-boarding process**) for new providers (Attendings/PA's/NP's/new incoming Residents) during the new academic year.

What surprised us and why

- Covid-19 Pandemic

- During Covid surges, the utilization rate of discharge template decreased and it became difficult to remind providers coming from other campuses to Anderson, new hires, and new residents to use the discharge template.

Success Factors

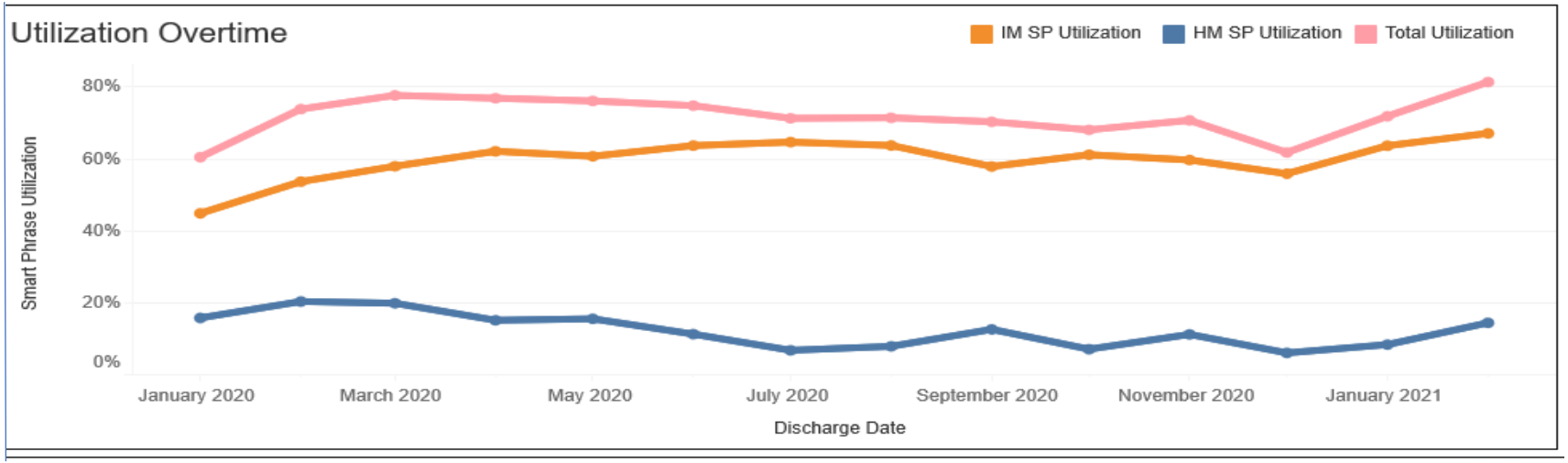
The most successful part of our work was…

- Multidisciplinary team
- Monthly meetings and sharing takeaways for each meeting with the whole team
- Following utilization rates of standardized discharge letter each week
- Appointing the lead resident for the project
- Support from leadership

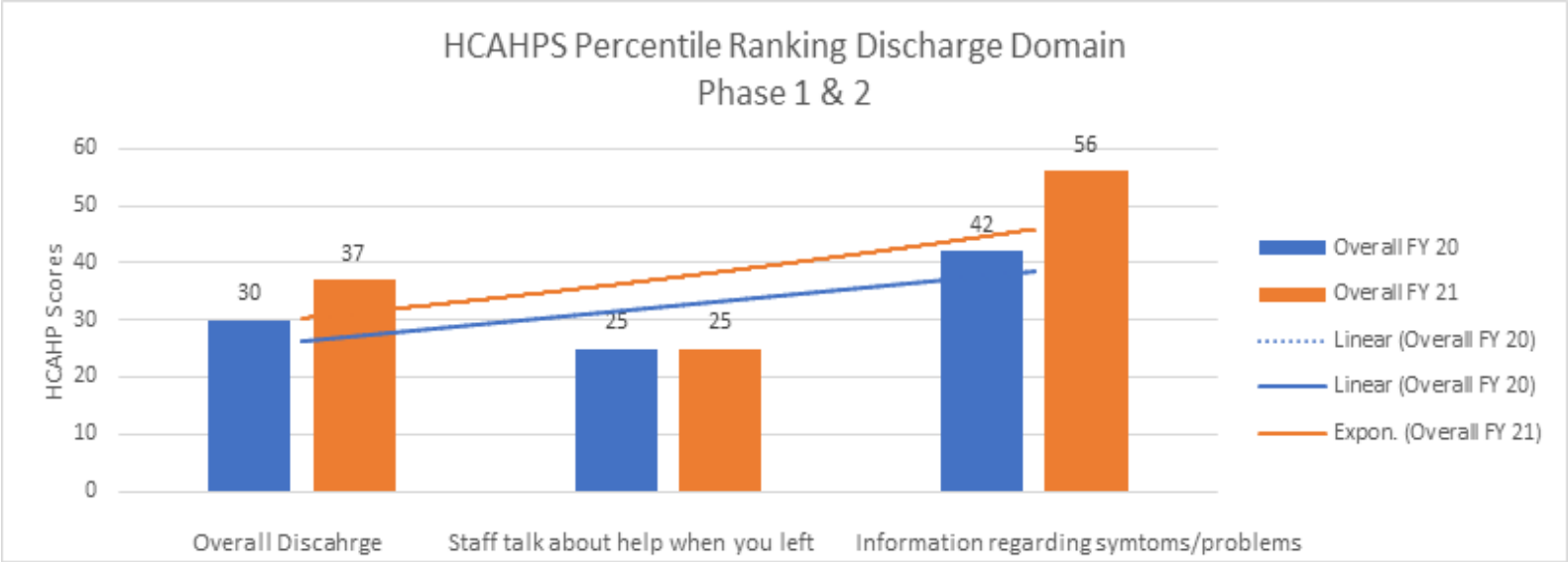
We were inspired by…

- Consistently adapting to any new findings that we encountered along the way in order to tailor our inventions, as well as informing stakeholders along the way of our progress.
- Pulling the project through COVID surge and vaccination clinics

Sustainability and Trends



Overall Trends



QUESTIONS

National Initiative

Aurora Health Care

We are AdvocateAuroraHealth

AiAMC
Alliance of Independent Academic Medical Centers

NI VII Meeting Four – Capstone Presentation
Cohort One: Transitions of Care

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

Shant Adamian, DO, Callie Cox Bauer, DO, Nicole Salvo, MD, Deborah Simpson, PhD, Jennifer Vollstedt, RN, Cynthia Wick, RN
Ob/Gyn Residency Program, Milwaukee, Wisconsin

National Initiative

Q1. What did you hope to accomplish?

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

- Utilize SBAR to create practice scenarios for residents and nurses
  - > Allow individuals to provide an assessment and recommendation to ensure collaboration
- Shift live in-person SBAR practice scenarios to virtual mediums
  - > Short < 2-minute videos distributed via links to a YouTube channel
  - > Half-page written SBAR scenarios handouts placed in L&D team meeting room

Q2. What were you able to accomplish?

- **PRE-COVID:** created role play scenarios and enacted them live with resident/faculty and a nurse during am transitions
- **DURING COVID:** produced and disseminated SBAR videos and handouts both highlighting effective/ineffective uses of SBAR
- **RESULTS:** Increased interprofessional dialogue during transitions of care using SBAR
  - > Collaboration/teamwork with nurses in providing Assessment and Recommendation
  - > From Baseline (November 2019) to Present (February 2021) improvements were noted in all Clinical Learning Environment Quick Survey (CLEQs) items[1]

Survey Items	Overall (N=40)	Nurses (N=20)	Residents (N=9/12)	Faculty (N=6/9)
MY SBAR use has increased by ___%	**39%**	**58%**	**25%**	**17%**
OTHER's SBAR use has increased by ____%	**31%**	**57%**	**26%**	**17%**
Use of SBAR on L&D has ___ influenced achievement of project aim (collaborative learning environment) (1=Very Negatively to 5 = Very Positively)	**3.7 (.56)**	**3.9 (.50)**	**3.5 (.50)**	**3.3 (.45)**

1. Simpson D, McDiarmid M, La Fratta T, Salvo N, Bidwell JL, Moore L, Irby DM. Preliminary Evidence Supporting a Novel 10-Item Clinical Learning Environment Quick Survey (CLEQS) Submitting as Educational Innovation. Under Review J Grad Med Educ.

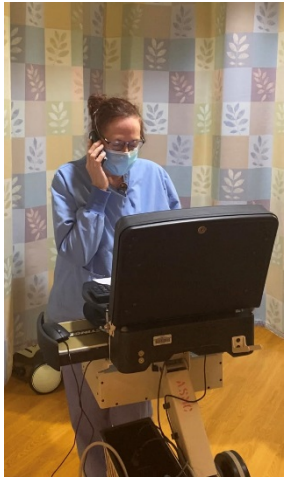
Q3. Knowing what you know now, what might you do differently?

- Be prepared for team member departures/changes:
  - Two of early nursing leads changed roles/left the organization, residency program director transitions/maternity leaves, etc.
- Actively Engage Team members:
  - Enlist more help and identify specific roles for each team member with accountabilities supported by their supervisors
- Attempt to ensure that the same team members are surveyed pre and post to have most accurate data

Q4. What surprised you and why?

- Difficulty of effecting change in communication without being able to complete interventions face to face
- Strong support of nurse educators for the project
- Nurses self-reported SBAR increased use and improvement was juxtaposed with residents still perceiving communication challenges.
- Adaptability of project during a pandemic that restricted interpersonal interactions
  - > Alternative mechanisms of dissemination of information

Q5. Cohort One – Success Factors

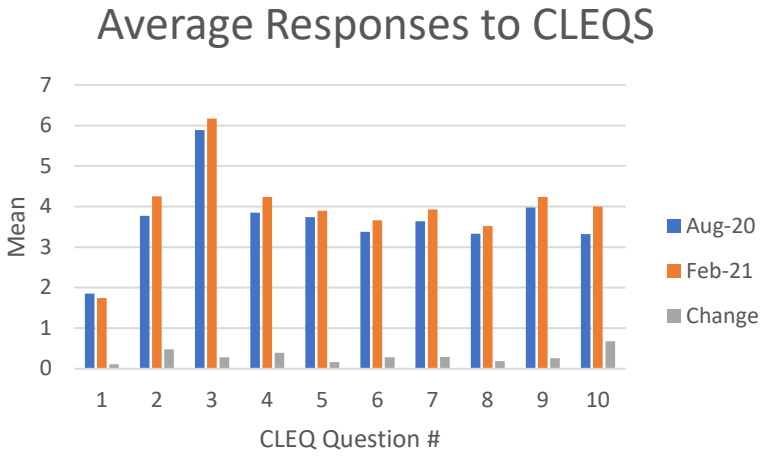


- *The most successful part of our work was…*
  - > Ability to adapt and pivot project with impacts of Covid-19 on no face-to-face meetings
    - *Result:* endurable resources (videos, handout)

- *We were inspired by…*
  - > Tenacity and resilience of resident project leader in continuing the project and willingness of others to participate in the face of multiple competing demands

Results: Clinical Learning Environment Quick Survey

ITEM	SCALE	Mean 08/20	Mean 02/21	Change
I feel supported by team/unit members in my/team's everyday on-going learning.	1 = Strongly Disagree 3 = Neither Agree nor Disagree 5 = Strongly Agree	**3.85**	**4.24**	**0.39**
People in this work area/unit treat each other with respect, trust each other and are inclusive.	1 = Strongly Disagree 3 = Neither Agree nor Disagree 5 = Strongly Agree	**3.74**	**3.90**	**0.16**
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 3 = Somewhat Effective 5 = Extremely Effective	**3.38**	**3.66**	**0.28**



Role	08/2020 (N)	02/2021 (N)
Resident	14	11
Attending	4	7
Nurse	43	24
Total	**61**	**42**

QUESTIONS

National Initiative