AIAMC National Initiative VII
Capstone Presentations
Cohort Five

Program/Education

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

Cohort Five teams

- HealthPartners
- Main Line Health
- Monmouth Medical Center
- Ochsner Health System
- Our Lady of the Lake Regional Medical Center
- Aurora Health Care – GME
- Aurora Health Care - Radiology

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. Sustainability and Next Steps:
   What does your CEO need to know to help keep your work sustainable?

National Initiative

HealthPartners Institute

AiAMC
Alliance of Independent Academic Medical Centers

NI VII Meeting Four – Capstone Presentation
Cohort Five: Program/Education

Designing a Teaming Framework to Align Training to Patient Care Outcomes

Michelle Noltimier, Kelly Frisch, Hannah Van Lith, Ankit Mehta, Scott Faust, Felix Ankel, Rachel Dahms, Julie Maust, Cecily Spencer, Anabel De Juan Gomez, Rochelle Johnson, Meredith Wold, Emily Mishek Brennan, Kathryn Sandgren, Mackenzie Moore

National Initiative

Initial Goals

- **Gather an inventory** of current work in interprofessional collaborative practice (IPCP) across the HealthPartners system
- Identify **the training methods** used for new hires or trainees
- Determine if any **evaluation methods** are used to determine effectiveness on patient care
- **Design and administer medical improv** training to address the essential elements needed for effective communication in IPCP

HealthPartners Teaming Framework

Teaming is defined as the dynamic flow of a trusted group of diverse and courageous people coming together to collaborate in achieving a well-defined goal. There is mutual respect, adaptability and sharing of knowledge quickly as members are called to action at the right time in service to a shared purpose.

Essential Teaming Skills Tru- CLASSIC

Trust

Courageous Communication

Leadership

Adaptability

Shared Vision

Self Awareness

Insynch- whole person

Communal

Lessons Learned

Don’t be afraid to create something that has significant impact for your organization

Scoping the project is key

Engaging the team required a balance between:

- the need for the team to have a defined project from the beginning
- allowing time for discovery and flexibility

Things That Amazed/Surprised Us

- A 15 minute interview can give you rich information
- People’s raw honesty and feedback in discussion constructed a safe place to share and create
- Team stayed engaged because the work was meaningful
- Practical examples of teaming behaviors defined approach
- Virtual meetings worked well

Sustainability and Next Steps

Share internally and externally

Develop as curricula/toolkit for interdisciplinary team learning

Incorporate into existing curricula and practices

Test and measure when incorporated into existing practices

As a call to action people can promote this work by becoming a:

Champion

Liaison

Consensus Builder

Toolkit Designer

Curriculum Designer

Researcher

Teaming Faculty

QUESTIONS

National Initiative

Main Line Health
Well ahead.
Jefferson
Thomas Jefferson University
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

AiAMC
Alliance of Independent Academic Medical Centers

NI VII Meeting Four – Capstone Presentation
Cohort Five: Program/Education

Nurturing Collaborative Skills in the Clinical Learning Environment

Sandra Ross, LSW, Elena Umland, PharmD, FNAP, Katherine Pang, DO,
Drew Kopicki, DO, Joanna Dixon, MSN, RN, CEN, Salma Mami,
Eleanora Yeiser, DO, Barry D. Mann, MD

National Initiative

Q1. What did you hope to accomplish?

- Create a sustainable model of bringing students together to learn about, from and with each other

- Determine if an interprofessional conference in the early phase of clinical learning results in improved self-efficacy and improved ability to function in a team

- Assess the replicability of the interprofessional case conference with our academic affiliate, Jefferson Health

- Instill a sense of confidence and competency in students of multiple disciplines while working as part of an interprofessional team

Q2. What were you able to accomplish?

- Provided 5 discussion-based case conferences involving multiple facets of patient care, both in person and virtually
- Students from different disciplines came together to discuss their approaches
- Data showed that participation in these conferences improved Interprofessional Competency Attainment
- We replicated the model at Jefferson Center City, suggesting the model can be scaled and applied in multiple clinical settings

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

- Equal representation and input from multiple disciplines
- Increased and more intentional team engagement with our off-site partners
- More diverse steering team to ensure consistent participation from multiple disciplines

Q4. What surprised you and why?

- No significant variance of efficacy with interdisciplinary learning between virtual and in-person presentations
  - > More equitable participation on the virtual platform
- Students from all disciplines reported improved confidence in their ability to collaborate interprofessionally post-conference

Table 3. In person

	n	mean	sd
Before	75	3.83	0.79
After	75	4.42	0.55

Table 4. Virtual

	n	mean	sd
Before	26	4.08	0.89
After	26	4.64	0.56

Table 7. Medicine

	n	mean	sd
Before	16	3.90	0.79
After	16	4.21	0.59

Table 8. Nursing

	n	mean	sd
Before	20	3.77	0.82
After	20	4.54	0.47

Table 9. Respiratory Therapy

	n	mean	sd
Before	35	3.92	0.91
After	35	4.55	0.63

Table 10. Other Discipline

	n	mean	sd
Before	30	3.96	0.75
After	30	4.50	0.49

Q5. Cohort Five – Sustainability and next steps

- Financial/resource perspective
- Designated resident to assume responsibility for sessions
- Advance project to clinical learning environment
  - > Hospitalized patients
  - > Interdisciplinary rounds
- Continue as a virtual model?
- Reengage partners at Jefferson Center City to better incorporate interdisciplinary case conferences into their clinical curriculum

QUESTIONS

National Initiative

Monmouth Medical Center | RWJBarnabas HEALTH

AiAMC Alliance of Independent Academic Medical Centers

NI VII Meeting Four – Capstone Presentation
Cohort Five: Program/Education

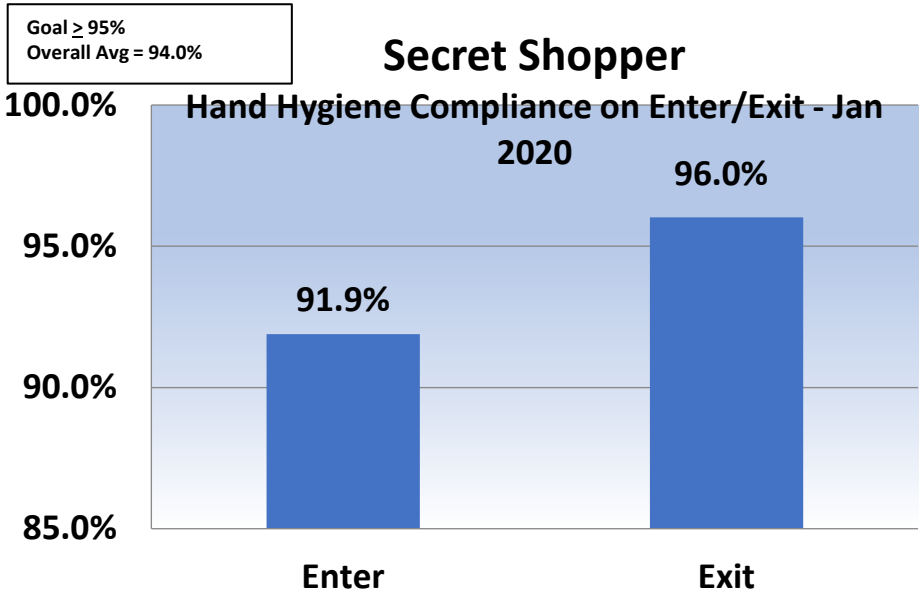
Interprofessional Teaming to Address Hand Hygiene

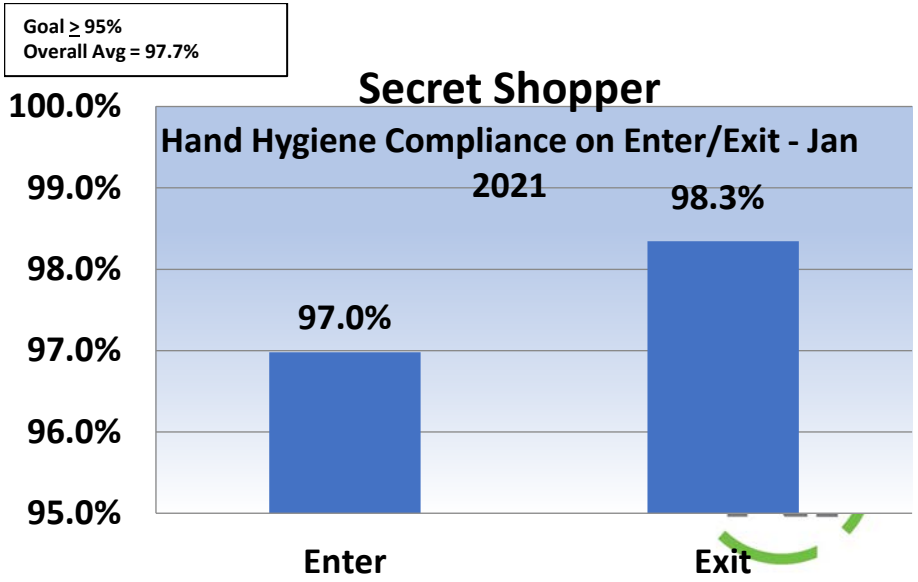
Dr. Joseph Jaeger, Pranoy Mohaptra, MHA, Christine Steinberger, Priya Fernicola, MPAH, David Hanos, Jason Montero, Raymond Duarte, Deb Peterson, RN, Julie Villa, RN, Laura Fleming, RN, Yasmin Ahmed, MPH, Laura Taddeo, Brian Baker, Carolyn Korotky, Traci Foccarino, MBA, Dr. Nikita Tripathi

National Initiative

Q1. What did you hope to accomplish?

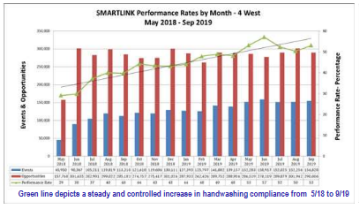
Our goal was to first implement a system that accurately measures handwashing compliance rates during each opportunity and then achieving 95% compliance through intervention and continual feedback and peer to peer support



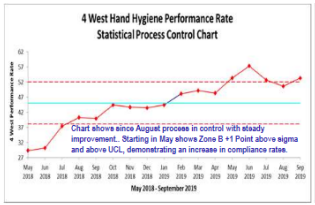


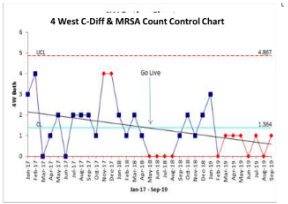
Q2. What were you able to accomplish?

- Creation of interdisciplinary Hand Hygiene work group
- Agreement to pilot solution in pediatric unit
- Proposal for studies, potential tracking solutions, as well as interventions based on successful implementation at another system hospital



Green line depicts a steady and controlled increase in handwashing compliance from 5/18 to 9/19





BMTU: 49% to 77% = 28% ↑ **4N: 32% to 52% = 20% ↑** **4W: 28% to 53% = 25% ↑**

Successful results were demonstrated during the Pilot Program as Hand Hygiene Compliance rates increased 20% or greater over baseline on all 3 units. BMTU saw the greatest increase and currently has the highest current goal of 70%. This is attributed to both an increase in events and a decrease in opportunities. 4N saw an initial jump and then remained constant and stable until seeing an increase these past few months. 4W continued small and steady incremental increase throughout the pilot program.

C-Diff	Year	BMTU	4 N	4 W
Pre-Intervention	2017	22	11	20
Intervention	2018	12	10	12
Post Intervention	Annualized thru Sept 2019	16	7	11

MRSA	Year	BMTU	4 N	4 W

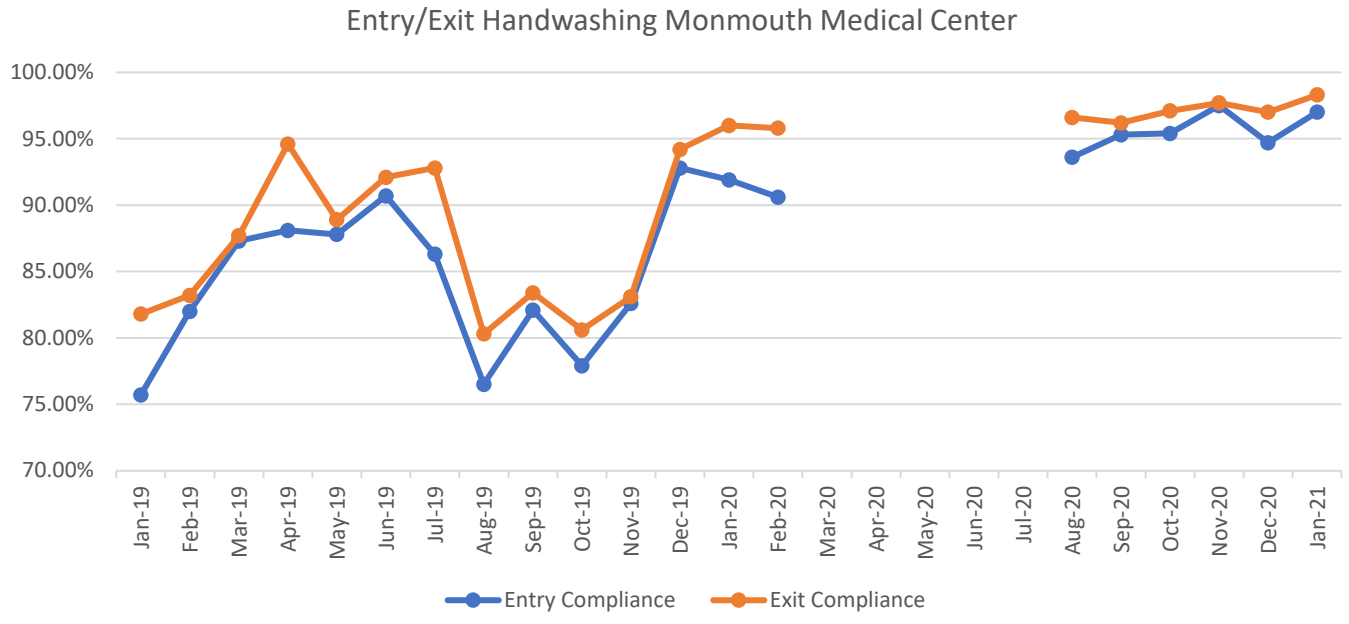
SMARTLINK DEVICE COUNTS					
Building	ACs	Modules	Repeaters	Gateways	Total
1958	64	404	26	9	**503**
Acute	34	191	6	6	**237**
Administration	0	21	0	5	**26**
Ambulatory	0	107	4	5	**116**
Children's Hosp.	68	547	28	11	**654**
Core	59	312	15	8	**394**
East Tower	1	164	5	5	**175**

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

- Consider the bias introduced in “Secret Shopper Observation” via the Halo effect
- Plan for scale, learn from others’ experiences (positive and negative)
  - > Consider sense of security other PPE offers, and what effect that has on handwashing compliance
- Ensure all professionals (including nonclinical) feel comfortable and empowered to voice their thoughts

Q4. What surprised you and why?

- Handwashing compliance increased significantly and has remained stable post pandemic. This shows the value and impact of emphasizing and prioritizing proper sanitary awareness.



Q5. Cohort Five – Sustainability and next steps

- *What does your CEO need to know to help keep your work sustainable?*

Hand Hygiene initiatives show a demonstrable decrease in communicable disease and must become a serious part of hospital culture- especially after this past year and updated Leapfrog requirements. It is clear that when emphasized, hand washing rates can be meaningfully impacted.

QUESTIONS

National Initiative

Ochsner Health

AiAMC Alliance of Independent Academic Medical Centers

NI VII Meeting Four – Capstone Presentation
Cohort Five: Program/Education

Teaming on Labor and Delivery – Ochsner Baptist

Rajiv B Gala, MD – Project Lead

Lauren Bergeron, MD – OB Hospitalist

Joseph Biggio, MD – Ochsner OB System Lead / MFM

Tabitha Duvernay – OB Nursing Leadership

Jessica Grote, MD – Ob/Gyn Resident (PGY3)

Roneisha McLendon, MD – OB Anesthesia

Barry Starr, MD – Pediatric Hospitalist

Anna White, MD – Ob/Gyn Residency Program Director

National Initiative

Q1. What did you hope to accomplish?

- Improve efficiency of Labor and Delivery
- Strengthen the team's situational awareness by improving communication

Q2. What were you able to accomplish?

- Improved admission to induction start times
- Developed checklists to assist with crisis management for common emergencies
- Introduce post-procedure debriefs to allow us to continue performing PDSA cycles for sustained performance
- Better incorporated the mother-baby unit (Peds, nursing) in the greater team

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

- Advocated for technical resources earlier
- Sought more feedback from patients after delivery to get an objective sense of their satisfaction with the care delivered.
  - One of the biggest barriers has been overcoming faculty assumptions that their patients would not be satisfied if they were not present for delivery.

Q4. What surprised you and why?

- The team performed **better** in times of crisis
  - > We spend a lot of time doing drills and debriefing after emergencies
  - > We focus on being efficient during catastrophic events.
  - > Routine / low acuity care review (which accounts for the majority of what is done) didn't happen as regularly

- Leaders are actively looking for early signs of burnout and trying to be more proactive with management strategies
  - > COVID has highlighted the critical role wellness plays on overall team performance

Q5. Cohort Five – Sustainability and next steps

- *What does your CEO need to know to help keep your work sustainable?*

- *1) A major source of burnout is managing the complexity of trying to communicate with the entire team. It is a system of work-arounds that is time consuming. We need to invest in technology that can streamline this process.*

QUESTIONS

National Initiative

NI VII Meeting Four – Capstone Presentation
Cohort Five: Program/Education

Incorporating Lessons Learned to Increase Participation and Engagement in Interdisciplinary Huddles within Surgical Units

Meridith Bergeron, EdD; Sophia Solomon, MSN, RN; Rebekah Warner, BSN; Michelle Nelson, DNP-FNP; Emily Stevens, MBA, MSW, LCSW-BACS; Rich Vath, MAEd; Phillip Allen, MD, MBA; Brent Allain Jr., MD, FASMBS

Q1. What did you hope to accomplish?

- National focus on Interprofessional (IP) rounds.
  - Institute of Medicine advocates rounding involving IP teams to support patient care and improve patient safety.[1]
- Research demonstrates improved efficiencies and diminished cost and length of stay when collaborative IP practice occurs.[2,3,4]
- Healthcare providers participating on IP teams report greater job satisfaction[5] and there is increased workforce retention.[6]
- Overarching Aim
  - Implement a Quality Improvement (QI) Project to advance the use of interprofessional rounds and patient safety discussions including events that need to be reported on OLOL's SUR 2 unit, which involves the LSU Surgery Residency Program and the LPG Surgeon's Group.
- Priorities and Goals
  - Increase IP participation and engagement
  - Decrease Average Length of Stay
  - Decrease patient harm
  - Improve patient experience

Q2. What were you able to accomplish?

- Increase IP participation and engagement
  - Baseline data indicated 7 to 8 attendees for each IP round, mainly comprised of nurses, case management, and social work.
  - This increased to 15 to 18 attendees for each IP round.
- Decrease Average Length of Stay
  - Overall decrease in ALOS for FY 21
  - ALOS for FY 21 is 4.60
  - ALOS for FY 20 was 4.33
    - *Increase year-over-year may be due to an increase in non-cohorted medicine patients.*
- Improve patient experience
  - Greatest Increases according to Press Ganey
    - Degree all staff showed compassion (19.32% increase)
    - Extent felt ready for discharge (5.26% increase)
    - Staff addressed emotional needs (3.14% increase
- IDT Governance Council Findings and Observations
  - Improved yearly baseline performance on IDT Scorecard by 17%.

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

- Don’t try to boil the ocean
- Plan for uncertainty

Q4. What surprised you and why?

- Embracing change during COVID-19 pandemic
- Changing course

Q5. Cohort Five – Sustainability and next steps

- *What does your CEO need to know to help keep your work sustainable?*
  - This work leads to improved team member engagement, improved patient outcomes and patient experience
  - Reengage additional teams
  - Support additional collaborations

References

1. Kohn LT, Corrigan JM, Donaldson MS (eds). *To Err is Human: Building a Safer Health System*. Washington, DC: National Academic Press. 2000.
2. Reeves S, Goldman J, Burton A, Sawatzky-Girling B. Synthesis of systematic review evidence of interprofessional education. *J Allied Health*. 2010;39:198-203.
3. Curley C, McEachern JE, Speroff T. A firm trial of interdisciplinary rounds on the inpatient medical wards: an intervention designed using continuous quality improvement. *Med Care*. 1998;36:AS4-AS12.
4. Smyrnios NA, Connolly A, Wilson MM, Curley FJ, French CT, Heard SO, Irwin RS. Effects of a multifaceted, multidisciplinary, hospital-wide quality improvement program on weaning from mechanical ventilation. Critical Care Medicine. 2002;30:1224–1230. doi: 10.1097/00003246.
5. Körner M. Interprofessional teamwork in medical rehabilitation: A comparison of multidisciplinary and interdisciplinary team approach. Clin Rehabil. 2010 Aug; 24(8):745-55.
6. Xyrichis A, Ream E. Teamwork: A concept analysis. J Adv Nurs. 2008;61:232–241. doi: 10.1111/j 2648.2007.04496.x.

QUESTIONS

National Initiative

Aurora Health Care

We are AdvocateAuroraHealth

AiAMC Alliance of Independent Academic Medical Centers

NI VII Meeting Four – Capstone Presentation
Cohort Five: Program/Education

Using Crisis Response Mock Drills to Prepare Leaders and Enhance Policies

Presenter: Keyonna Taylor-Coleman, MD

Nicole Eull PsyD,* Jacob Bidwell MD,* Dawn Faucett, Tricia La Fratta MBA, Esmeralda Santana TAGME, Payal Sharma MD, Deborah Simpson PhD

Graduate Medical Education Council, Milwaukee, Wisconsin

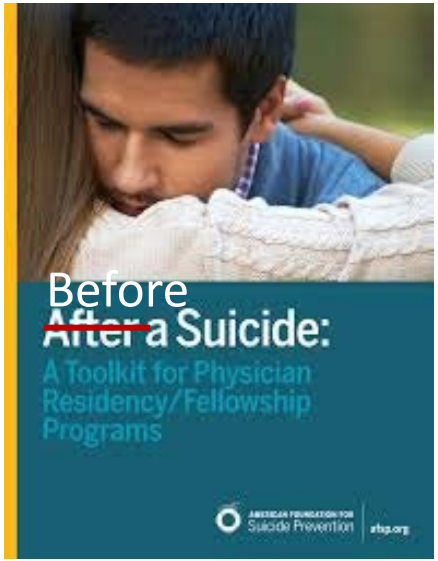
National Initiative

* Project Leaders

Q1. What did you hope to accomplish?

- Engage GME program leaders in how to appropriately respond if an untimely death, absence, or a suicide occurs

- Refine our standardize process and policies for early recognition and response to concerns based on mock drills experience



Q2. What were you able to accomplish?

- **All GME program leaders completed 3 mock drills** (PDs/APs, Coord, Chiefs)
  - An unexplained absence, an attempted suicide, a completed suicide
  - Separate scoring rubric x scenario
    1) Awareness and use of the policy
    2) Actions taken
    3) Confidentiality considerations
    4) Case specific special considerations
- **Identified/refined gaps** in current policies + New unexplained absence policy
- **Internal Spread:**
  - Mock drill approach adopted by our medical student leaders
  - UME adapting crisis communication plan/policies
  - Initiated drills w Advocate GME Programs with DIO support

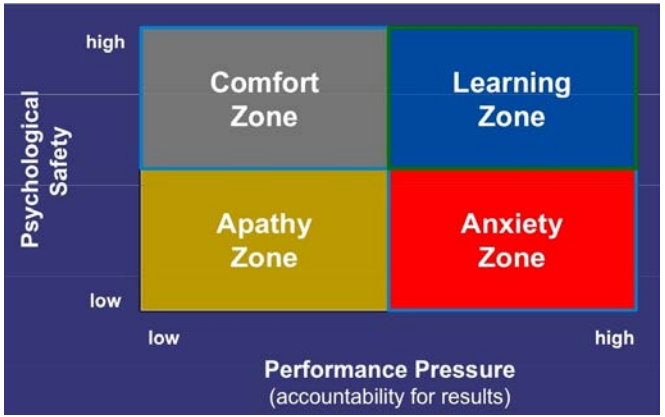
Q3. Knowing what you know now, what do differently?

Preparation

- Add pilots to “test run” policy to clarify policy prior implementation
- Initiate formal rater training for mock drills

Enhance Psychological Safety

- Orient participants using multiple communication channels re: purpose and approach
- Bring “hydration refreshments” or other approach



Q4. What surprised you and why?

- Hard to author drill scenarios + scoring guide
- Participants knew was a policy | where it was located but…
  - Didn't know where to find it
  - Action related steps within the policies
- How engaged and appreciative all participants in the mock drill.
  - 45-60 minutes doing the drills and getting feedback virtually
  - 1 PD perceived drill limited flexibility → dialogue re why policy-actions
- Substantive improvement in the policy clarity
- **ACTION FOR US**: Critical/important policies should be **"mock drilled"**

Q5. Cohort Five – Sustainability and next steps

Our CEO needs to know …

- Medicine is a high stress profession
- Residents (like all clinicians) are at high risk for suicide
- Vital anticipatory practice / feedback on how to enact the processes and procedures for unexpected events (suicide, unexpected no show)
- **Critical:** Your strong and visible support for GME - Innovation
  - Policies and practices

NI-7 GME Mock Drill Master Scoring Sheet

Program Name: **Date:** **Reviewer:**

DRILL #1: Resident 1 did not show up for impatient shift today. Supervising physician has called & paged R1. Chief resident has called and paged R1. Three hours have passed, & no one has heard from R1 who was assigned to a core clinical rotation.

DRILL #1 ITEMS	IDEAL ANSWER	RATING PASS= 1 /FAIL = 0	NOTES
POLICY Part A:			
1. Is there a formal plan for handling this situation?	Yes		They should access the Unexplained Absence Plan
2. What is the name of the Plan?	Unexplained Absence Plan – Must Show on Screen		The CCP does not apply at this stage.
3. Access the plan now from the location where residents, faculty can get to it.	Access policy (in MedHub)[1]		If they cannot access policy, help them find it.
ACTIONS TAKEN			
4. What's the 1st thing you would do in this scenario per the plan? If **a. Coordinator** **b. Chiefs** **c. PDs**	a. Coordinator: Call PD or if not available APD b. Chiefs call PD/Coordinator and determine coverage/advise/assist with contact up to 2-hour mark. c. PD will attempt to reach resident up to 3-hour mark		All or nothing. Everyone must answer correctly to get the point.
5. If unsuccessful in reaching the resident, who do you contact next and when?	a. PD/APD (or coordinator): Call Public Safety & GME Manager or DIO		If no contact within three hours, Assess Risk with Public Safety
6. Are there any additional people that may need to know about this issue?	Programs Leadership (PD, APD, Coordinator, Chief, Residents sharing rotation or called in for coverage.)		Chiefs need to be involved as need to attend to scheduling/communication. Each role should be informed based on what they need to know to proceed with patient care and duty coverage and ensuring safety of the missing trainee. Score: All roles must be identified to receive one point. If role missing = 0

QUESTIONS

National Initiative

Aurora Health Care

We are AdvocateAuroraHealth

AiAMC Alliance of Independent Academic Medical Centers

NI VII Meeting Four – Capstone Presentation
Cohort Five: Program/Education

Radiation Exposure, Reduction Techniques, and Standardization of Swallow Study Evaluations

Mason A. Brown, MD[1], Shelly Reimer, MD[1], Leah Presper[2], Theresa Ackerman[2], and William MacDonald, MD[1]
Aurora St. Luke's Medical Center, [1]Department of Radiology, [2]Department of Speech Pathology, Milwaukee, WI

National Initiative

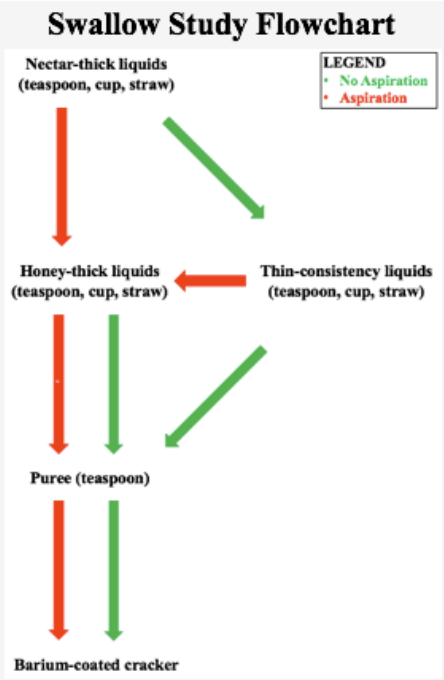
Q1. What did you hope to accomplish?

- Retrospectively establish a fluoroscopic radiation exposure baseline
  - > Analyze past swallow study procedures performed by a single resident as proxy measure for interprofessional team exposure rates
- Interventions
  - > Provide proper radiation safety equipment for all team members
  - > Implement a standardized swallow study evaluation flowchart to promote efficiency and organization
- Monitor prospective radiation exposure reduction techniques
  - > Analysis of swallow study procedures performed by that same resident after implementations
  - > Compare retrospective and prospective data in order to assess relative success of implementations

Q2. What were you able to accomplish?

- **Baseline:** Obtained and analyzed retrospective radiation exposure data
  - > Calculations for patient radiation exposure (time, dosage, # of imaging runs)
  - > Resident radiation exposure data over a 4-week rotation extrapolated (time, dosage)
- **Interventions:** Proper equipment provided to all team members
  - > Shared radiation safety glove for speech pathology
  - > Shared radiation safety goggles with cleaning supplies for fluoroscopic techs
- **Findings:**
  - > Protective equipment unused by interprofessional team members
  - > Identified safety issues with badge-dosimetry monitoring
    - Deficient collection/reporting by the physics department
    - Inconsistent usage
    - Incorrect monthly badge updates/turn-ins

Swallow Study Flowchart and Results



Patient Radiation Exposure

	Prior to Implementations: Time (minutes)	Radiation (mGy)	Runs	After Implementations: Time (minutes)	Radiation (mGy)	Runs
Average	1.9	7.9	13.5	1.8 ↓	8.3 ↑	14.1 ↑
Median	1.8	7.2	13	1.9 ↑	7.8 ↑	15.5 ↑
Range	0.3 – 4.3	1.5 – 24.3	1 – 26	0.4 – 3.3 ↓	1.9 – 21.8 ↓	4 – 27 ↑

Resident Radiation Exposure

	Prior to Implementations: Time (minutes)	Radiation (mGy)*	After Implementations: Time (minutes)	Radiation (mGy)*
Extrapolated Exposure per 4-week Rotation	183.7	21.2	174 ↓	22.3 ↑

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

- Interventions:
  - > Educate team re: repeated radiation exposure effects on their long term health (*just because do not immediately experience it…*)
  - > Periodic reinforcement essential
- Metrics
  - > Obtain proper badge-dosimetry data – it's standardized radiation exposure reporting system
  - > Compare baseline results with badge-dosimetry data

Q4. What surprised you and why?

- Assumed providing radiation safety goggles to fluoroscopic technologists and gloves for speech pathologists would result in their use
- Team members rarely if ever chose to wear them - “inconvenient”

Q5. Cohort Five – Sustainability and next steps

- *What does your CEO need to know to help keep your work sustainable?*
  - > Need to improve badge-dosimetry reporting/documentation
  - > Proper use of radiation safety equipment needs to be hospital priority

QUESTIONS

National Initiative