National Initiative VII: Meeting Three Storyboards

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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

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 multidiscip teams

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

- Chronic obstructive pulmonary disease (COPD) has significant patient morbidity and mortality

- This leads to high health care resource utilization and cost

- Many health professionals do not feel comfortable or have the time to address proper inhaler administration with patients

- The COPD Multidisciplinary Clinic offers comprehensive care for patients with COPD
  - Sponsored by the Advocate Medical Group, ALGH and Advocate Physician Partners
  - Team includes physicians, pharmacists, social workers, respiratory therapists and LPNs who provide holistic care
  - The goals of our program are to reduce symptoms, improve exercise tolerance, educate patients about their disease so that they can lead fuller and better lives, prevent future complications, and educate residents and other team members in the team model.

- The AIM of this pilot multidisciplinary clinic is to
  - 1- improve our patients' understanding of COPD
  - 2- improve patient compliance with recommendations.
  - 3- decrease emergency room visits and hospital admission by 50% over the next three years (2019-2022)

Methods: Audience, Interventions, Measures
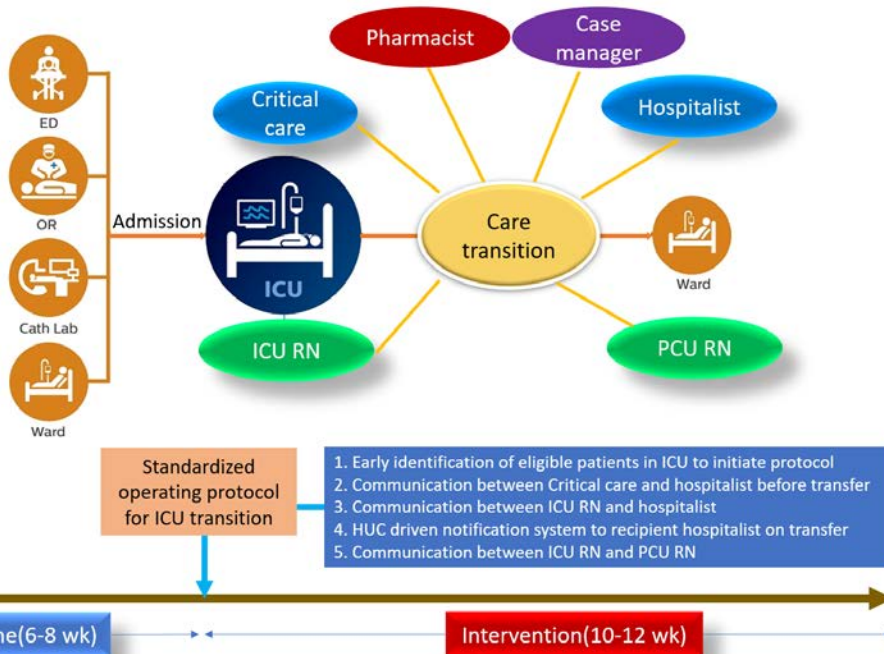
Outcome measurements:

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)

The effect of ICU admission time and site on assigned hospitalist/consult
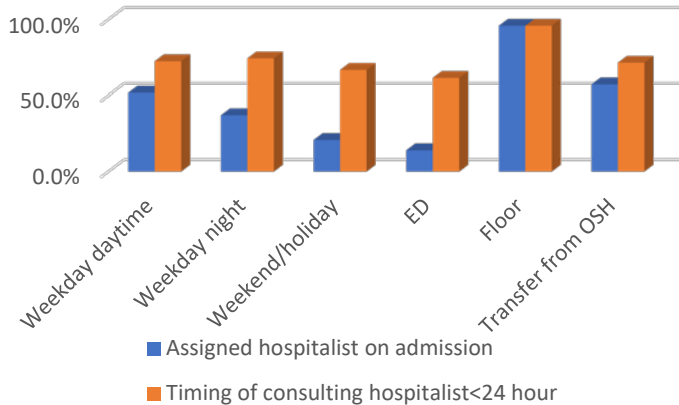
Less than 15% patients directly admitted from ED had assigned hospitalist and less than 60% of them will have an IM consult within 24 hours.

Communication between CCM and Hospitalist (n=88)

- Verbal communication, 12
- Phone or text, 55
- Others, 21

■ Verbal communication ■ Phone or text ■ Others
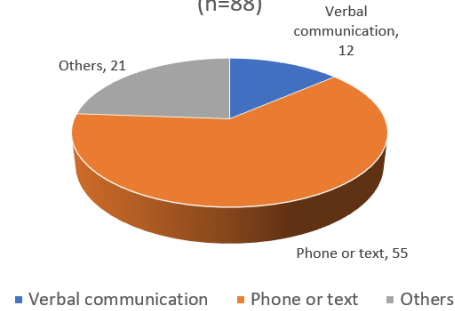
Did ICU RN identify receiving hospitalist prior to handover to PCU RN

- 19
- 69

■ Yes ■ No
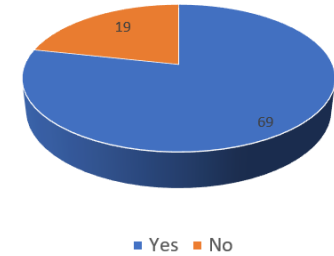
Did ICU RN contact hospitalist prior to handover to PCU RN

- 30
- 58

■ Yes ■ No
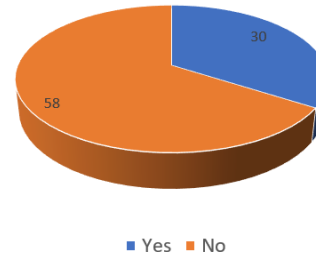
Interval between consult order and first notes by hospitalist

- 9
- 79
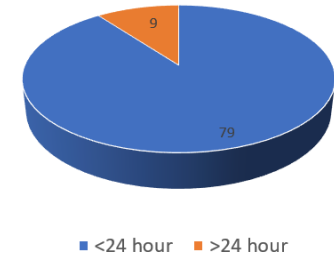
■ <24 hour ■ >24 hour

- 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

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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

Next step

Implementation of standardized protocol for ICU transfer

IM ▽ CCM

RN leaders in ICU/Stepdown unit

Data collection

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

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

Expanding the role of the PCP in Hospital Medicine

Patrick Piper, MD

Judith Gravdal, MD

Franklin Chang, MD

Introduction & Aim

▪ Our original project aimed to increase the percentage of advanced directives completed and filed in appropriate patient charts. Rapid turnover in key stakeholders and the COVID-19 pandemic shifted institutional priorities and project placed on hold.   The springtime surge of COVID-19 infected patients created an earlier adaptation of available technology for patient care. Nurses, house staff and other team members were able to interact with and treat patients with different communication modalities. Our new project is focused on utilizing technology to enhance team-based care in a broader sense. Our hypothesis is that incorporating the PCP virtually in hospital-based care will lead to not only improved end-of-life care goal discussions but will also increase patient satisfaction and decrease readmissions. Our hospital is currently below our target in all 3 of these measures. We plan to initiate the option of a virtual PCP consult on targeted patients to improve these measures. Specifically, we plan to:

-Increase patient satisfaction scores and move 50% closer to our stated target

-Decrease our readmission ratio and meet our target on identified patient cohorts

Methods: Audience, Interventions, Measures

- **AUDIENCE**
  - > Broader audience includes hospitalists, primary care physicians, nursing staff, hospital leadership and accountable care organization (APP)
- **INTERVENTIONS**
  - > Utilization of virtual primary care consult on selected patient groups.
- MEASURES
  - > Outcome
    - "Provider Pulse" date on HCAHPS and 30-day readmissions
  - > Process
    - Percentage of consults obtained on targeted patients
  - > Balancing
    - Hospitalist, PCP and nursing satisfaction scores, including questions of teaming

Results (to Date)

- Initial buy in on new project from hospital leadership, APP (accountable care organization) and hospitalist groups

- Trial run of technology on selected volunteer inpatients successful and elicited positive feedback from patients

- Results on patient satisfaction scores and readmission ratios remain below target for prior 9 months

Discussion: Barriers & Next Steps

- **Barrier:** Larger project scope will require buy-in from multiple newly identified key stakeholders
  - > Capitalize on buy-in from nursing and hospitalist leadership
  - > Continue to work with hospitalist groups and accountable care organizations to identify primary care physicians

- **Barrier:** Unclear compensation model for participating PCPs
  - > Focus on "full risk" patient groups where revenue is generated by meeting targeted quality measures rather than E&M codes

- **Barrier:** Outpatient primary care availability
  - > Allow flexibility on timing of consult and train nursing to provide technology at off hours

- **Barrier:** Larger project scope will require longer project timeline
  - > Focus on quality data that is fully aligned with key hospital and ACO goals

An approach in teamwork - COPD Multidisciplinary Clinic

Farah Chaus, MD

Judith Gravdal, MD

Erica Zak, MD

Methods: Audience, Interventions, Measures

- IRB ID: 6687, Quality Improvement Project Around Education of COPD Disease and Medications
  - Once a month clinic
  - Clinic model staffing
    - PSR, MA/LPN, Patient Advocate. Pharm D, Social Worker or Care Manager, Respiratory Therapist, and physician
  - Session Structure: Rotating individual appointment with physician, respiratory therapist, and patient advocate
    - Initial Intake: 30 mins per individual appointment
    - Follow ups: 15 mins per individual appointment
- Patient Demographics
  - Looking at high risk utilizers of ED and high risk for hospital readmissions across APP

Results (to Date)

- Effectiveness of the clinic
  - > Patient Surveys
  - > Look at metrics of decreasing ED visits and readmission risks
- Effectiveness of teaming
  - > Team survey
  - > Chinook Model
  - > Evaluation of effective communication within team
- Data has been limited due to COVID pandemic

Discussion: Barriers & Next Steps

- **Barrier: Patient enrollment**
  - > Next Steps:
    - Automatic Referrals through inpatient into clinic in EMR to improve patient enrollment
    - *Meeting scheduled with care management team to improve referral rate*

- **Barrier: New inpatient EMR implementation on February 9, 2020.**
  - > Next Steps:
    - Improve and standardize care management engagement/communication across inpatient and outpatient setting
    - Invited transition care team to be part of the discussion
    - Create system wide protocols for standardization of paperwork on discharge in inpatient and outpatient setting

- **Barrier: Need for a project manager to identify and review readmission data**
  - > Next Steps:
    - Continued engagement with leaders of organization to ensure commitment and support for the project
    - Active participation in Hospital ACO committee to voice concerns and ask for help

- **Barrier: Education of residents rotating through the clinic by working with the pharmacist for didactic lectures**
  - > Next Steps:
    - Difficulty with in person didactics, looking at scheduling webinars or pre recorded videos

- **Barrier: Need tool(s) for measuring team effectiveness**
  - > Next Steps:
    - Continued engagement in workshops and meeting with AiAMC for guidance

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

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 quarantine 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

INTERPROFESSIONAL COMMUNICATION IN THE CARDIAC CATHETERIZATION LABORATORY

Matthew McDiarmid DO, Charnai Sherry PA-C, Jodi Zilinksi MD, Deborah Simpson PhD, Tonga Nfor MD, Renuka Jain MD
Cardiology, Electrophysiology, and Interventional Cardiology Fellowship Programs

Aurora Health Care – Milwaukee, Wisconsin @AAH_StLukesCV

INTRODUCTION & AIM

- Continued growth in procedural volume & innovative technology in the Cardiac Catheterization Laboratory (CCL) → increased complexity of CCL fellowship training
- **Improve communication/feedback between fellows ↔ faculty**
- **Improve the effectiveness and efficiency of the CCL**

METHODS:

- **Targeting Faculty, Fellows, & Friends (...techs/RNs)**
- **Explicitly defined fellow's role in the CCL based on PGY status**
  - Delineated levels of supervision x whom (attending, IC fellow)
  - Feedback frequency, formality, timing (pre-post procedure)
- **Workflow:**
  - Earlier procedural case assignment to the fellows
  - Fellow confirmation of procedure and access site
  - Promote in office procedural consent - goal >70% outpatient

METRICS

- **CCL data regarding volume, transition, and delays**
- **ACGME annual fellows survey & Aurora Evaluations**
- **Clinical Learning Environment Quick Survey (CLEQ)**
- **Mayo Well-Being Index**

CARDIAC CATH LAB PGY Year and Rotation/Semester → Objectives w Levels of Supervision ↓	1st Yr PGY4/Fel1 No formal lab rot	2nd Year PGY5/Fel2 1st & 2nd Blk	3rd & 4th Blk	5th & 6th Blk	3rd Year PGY6/Fel 3	Interv PGY7 1st Sem	2nd Sem
Level of Supervision*		A	B	C	D	E	F
Communication/feedback*		A	B	C	D	E	E
MEDICAL KNOWLEDGE: ASSUMES PRIOR LEVEL KNOWLEDGE UNLESS OTHERWISE NOTED							
1. Coronary anatomy as pertaining to LV function and wall motion	1						
2. Coronary anatomy and role with patients presenting with Acute Coronary Syndrome	1						
3. Indications for invasive diagnostics	1						
4. Basic understanding Coronary Angiogram films and views ○ Identification of view and projection ○ Identification of coronary anatomy ○ Identification of basic angiographic abnormalities	1						
5. Procedural H&P, sedation note, AUC, consent			1				
5.1. Procedural H&P, sedation note, AUC		1					
6. Pertinent patient information; including prior surgical		1					
7. Review of prior angiogram results and/or images independently					1		
7.1. Review of prior angiogram results and/or images with IC fellow/attending		1					
8. Understanding of fluoroscopy and radiation safety		1					
PROCEDURAL SKILLS:							
20. Develop understanding in the setup, use, and interpretation of advanced equipment (ie, Atherectomy, Impella)						1	
20.1. Proficiency in appropriate coronary equipment selection						1	
20.2. Complete competency in setting up patient and equipment for procedure			1				
21. Proficiency in sterile scrub technique and procedural draping		1					
21.1. Setting up procedural area: drape, manifold connections, zoll, etc		1					
22. Development of proficiency in peripheral vascular equipment selection						1	
23. Independent conscious sedation administration			1				

* Level of supervision: A = Close, immediate oversight by the attending; B= Close, immediate oversight by the IC fellow and/or attending; C= Limited; D = Diagnostic studies= independent & Advanced/interventional procedures= Direct; E= Diagnostic studies= independent & Advanced/interventional procedures= Direct; F = limited → independent for diagnostic and advanced/interventional procedures
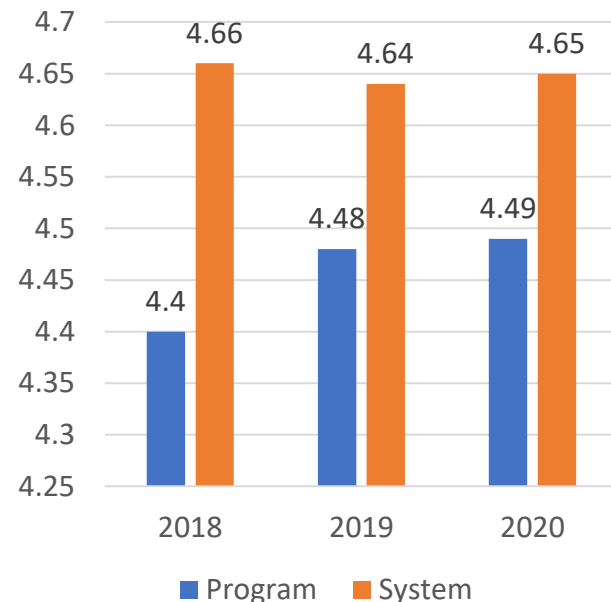
* Communication/feedback: A = verbal, before and after case. Write post op report with attending; B= verbal. Write post op report with attending/IC fellow; C = verbal, pre and post op brief with attending. Independently write post op report; D = verbal, in person, two-way assessment; E= verbal, in person, Pre-Post PCI brief;

RESULTS (TO DATE)

CLEQS ITEM SCALE: 1 = Strongly Disagree to 5 = Strongly Agree	Baseline Mean (SD)	Mid Point Mean (SD)
I feel supported by team/unit members in my/team's everyday on-going learning	3.9 (0.85)	**3.8 (1.15)**
Team members' (and my) roles and expectations are clear.	4.1 (0.75)	**4.3 (0.75)**
My direct supervisor/ attending provides sufficient supervision/ feedback and treats me with respect in support of my personal growth.	4.2 (0.93)	**3.3 (0.74)**

PROVIDED HELPFUL TIMELY FEEDBACK (CV)
Scale 1=Strongly DISAgree to 5 Strongly Agree

Bar chart:
- 2018: Program 4.4, System 4.66
- 2019: Program 4.48, System 4.64
- 2020: Program 4.49, System 4.65

Legend: ■ Program ■ System

DISCUSSION: BARRIERS & NEXT STEPS

- This cycle saw an increase in responses as well as increased diversity of responders (staff type)

- Overall, the CCL still has a positive image, but Communication still seems to be a major concern

- Identified Barriers were CCL volume, pace, & provider schedule

- Fellows trended to more negative responses; could be reflection that some have not independently choose this career area

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Improving Hypertension in Young Adults within Two Family Medicine Clinics

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Aurora Family Medicine Residency, Milwaukee, WI – Our Program Website

Introduction & Aims

- **Early data review revealed age-related disparity in hypertension control at our FM residency clinics**

- **Aims**
  - Increase patient awareness of hypertension-related sequelae
  - Standardize clinician response to elevated BP during clinic visits
  - Improve BP control in younger hypertensive patients to reduce the age disparity
  - Develop creative solutions to push toward achieving these aims despite pandemic disruptions

METHODS: AUDIENCE, INTERVENTIONS, MEASURES

- **Clinic Approaches**
  - ☐ Resident lecture and desk reference on HTN management
  - ☐ Patient education cards given to patients with elevated BP; team-based workflow (MAs, RNs, physicians)

- **Virtual Approaches**
  - ☐ EPIC Reporting to define at risk population within individual providers' panels
  - ☐ MyAdvocateAurora scripted-and-personalized patient messaging to offer virtual or (as able) in person visits for at risk patients
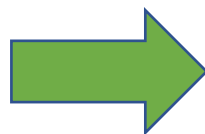
RESULTS (TO DATE)

Overall, improvement in disparity gap at each clinic and across combined population

ALL CLINICS	AUGUST 2020				JANUARY 2020			
	Control	Uncontrolled	% Control	Disparity Gap	Control	Uncontrolled	% Control	Disparity Gap
Age 18-49	194	74	72.4%	**6.3%**	206	89	69.8%	**10.8%**
Age 50+	891	241	78.7%		951	229	80.6%	

January 2020 Disparity Gap

☐ Clinic A: 7.6%

☐ Clinic B: 11.8%

August 2020 Disparity Gap

☐ Clinic A: 7.2%

☐ Clinic B: 5.1%

DISCUSSION: BARRIERS & NEXT STEPS

- **Address Setbacks**
  - Clinic B and both clinics overall with apparent decrease in BP control for *older* patients, this requires further parsing/review
  - Reduced in person visits challenges BP re-measurement and med management follow ups
    - Recent approval to use home BP measurements toward quality scores!

- **Maintain Momentum & Weather the Storm**
  - Intern resident class, new clinic staff since starting the project
  - As flu/COVID season approaches, anticipate that clinic access may fluctuate as more restrictive safety measures are re-implemented

Crisis Response Mock Drills

Jacob Bidwell MD, Nicole Eull PsyD, Dawn Faucett, Tricia La Fratta MBA,
Esmeralda Santana C-TAGME, Deborah Simpson PhD,
Keyonna Taylor-Coleman MD
Graduate Medical Education, Milwaukee, Wisconsin

INTRODUCTION

- Approximately 300 to 400 practicing physicians die by suicide each year [1]
- Residents are at high risk (depressive disorders, depressed mood, burnout, and suicidal ideation)[2-4]
- Extensive prevention interventions
  - Prepare faculty for appropriate response in a time of crisis
- Adapted ACGME endorsed toolkit:[5]
  - Conduct "Mock Drills" to assess PDs, APDs, Coordinators, and Chiefs for preparedness
  - Provide education + feedback on response

AIM

- To ensure knowledge of the Crisis Communication Plan and Mental Health Support Plan, individual responsibilities and roles, nuances and exceptions to ensure smooth use of plan in time of emergency
  - POLICY KNOWLEDGE = 25%
    - ☑ Ability to access GMEC crisis plan and Program Specific Plan ("no call, no show") what resources are relevant to your situation, who must be informed)
  - ACTIONABLE KNOWLEDGE = 75%
    - ☑ How proceed (e.g., call resident 2-3 times, Loss prevention notification is situation specific)

1. Center C, Davis M, Detre T, et al. Confronting depression and suicide in physicians: A consensus statement. JAMA. 2003;289:31613166. Mata DA, Ramos MA, Bansal N, et al. Prevalence of depression and depressive symptoms among resident physicians: A systematic review and meta-analysis. JAMA. 2015;314:23732383.
2. Mata DA, Ramos MA, Bansal N, et al. Prevalence of depression and depressive symptoms among resident physicians: A systematic review and meta-analysis. JAMA. 2015;314:23732383.
3. Bellini LM, Baime M, Shea JA. Variation of mood and empathy during internship. JAMA. 2002;287:31433146.
4. Dyrbye LN, West CP, Satele D, et al. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. Acad Med. 2014;89:443451.
5. After Suicide a Suicide: A Toolkit for Physician Residency/Fellowship Programs (American Foundation for Suicide Prevention - AFSP) http://www.acgme.org/Portals/0/PDFs/13287_AFSP_After_Suicide_Clinician_Toolkit_Final_2.pdf

METHODS: AUDIENCE, INTERVENTIONS, MEASURES

- Adapted ACGME endorsed toolkit:[5]
  - Known as the "Crisis Communication Plan"
  - Approved by and is a partnership of GME, GMEC, Legal, HR, PR, EAP and Security

- Conduct "Mock Drills" to assess PDs, APDs, Coordinators, and Chiefs for preparedness
  - Conducted within each individual residency program
  - Each drill = 3 scenarios
  - 2 assessors complete assessment of competency
  - Provide education + feedback on response

MOCK DRILL RESPONSE/SCORING SHEET
- Designed by team consensus
- Approved by GME leadership and HR
- Sheet includes detailed ratings of:
  1. Awareness and use of policy
  2. Actions to be taken x when x who
  3. Confidentiality considerations
  4. Special considerations

- Each of 3 mock scenarios has a specific Mock Drill Response Sheet

RESULTS (TO DATE)

- **Mock drills completed for all of our residency and fellowship programs**

- **Compiled data to compare across programs**
  - Reviewing & reconciling scoring inconsistencies
  - Identifying areas that need more teaching

- **We have used feedback and common questions during drills to guide improvements to the process**

DISCUSSION: BARRIERS & NEXT STEPS

- **Scheduling 2 raters plus PD, APD, and Chiefs - daunting task requiring several schedule changes**

- **Conducting mock drills with one program at a time, gave us the opportunity to debrief and provide specific feedback relevant to the nuances of each program**

- **We will continue to reinforce the use of the plans and follow through (eg, incident cards for unexcused absences)**

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Advancing Advanced Directive Documentation in the Internal Medicine Clinic

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Aurora Internal Medicine Residency Program Milwaukee, Wisconsin

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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 $\geq$65 yo to ensure pts receiving appropriate goals of care counseling
  - □ Implemented 1 residency clinic, other control
  - □ Educ academic ½ days + noon conferences to teach residents strategies and interactively engage pts in AD discussions (role plays)
- Clinic Workflow modified II° pandemic - virtual video visits

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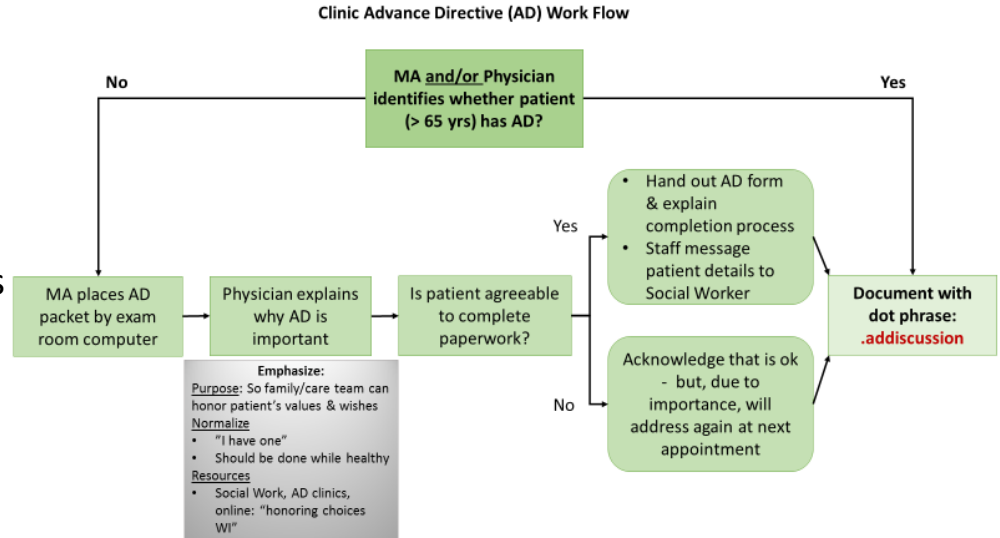
Metrics:
- Clinic AD % completion and CGCAHPS compare with control + overall clinic QI scores
- Clinical Learning Environment Quick Survey (CLEQS) used as balancing measures

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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!

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
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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:

PHASE 1: SETTING THE STAGE
- ☐ Collect baseline data
- ☐ Intervention: record/distribute scenarios

TeamSTEPPS

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
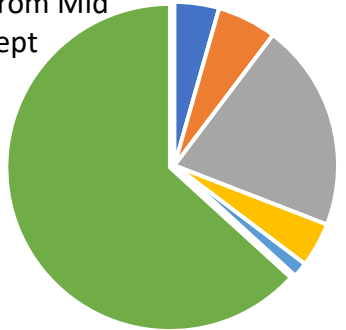- ☐ Complete phase 1&2 in postpartum

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

■ Medical Student ■ Nursing Student ■ Resident
■ OB Faculty ■ OB Hospitalist ■ Nurse

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**

45

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

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, Departments of Radiology[1] and Speech Pathology[2], Milwaukee, WI

Purpose and Introduction

- **Purpose**
  - Retrospectively establish a fluoroscopic radiation exposure baseline
  - Monitor prospective reduction techniques
- **Introduction**
  - Swallow study evaluation: a procedure where a patient drinks contrast under real-time X-ray to evaluate laryngeal penetration or aspiration
  - Long-term exposure to ionizing radiation from fluoroscopic procedures can lead to side effects

METHODS

- **Data**
  - □ Retrospective analysis of radiation exposure to the resident over the course of a 4-week rotation
  - □ Absorbed dose: ionizing radiation absorbed per unit mass, measured in Grays (Gy)

- **Implementations**
  - □ Replaced/provided personal protective equipment per Occupational Safety and Health Administration guidelines
  - □ Developed standardized evaluation flowchart

RESULTS

- **Patient Radiation Exposure Data**

	Time (minutes)	Radiation (mGy)	Runs
Average	1.9	7.9	13.5
Median	1.8	7.2	13
Range	0.3 – 4.3	1.5 – 24.3	1 – 26

- **Resident Exposure Data prior to Implementations**

	Time (minutes)	Radiation (mGy)
Estimated Exposure/Rotation	367.7	23.9

- **Residents performed 100 swallow studies (3.1 hours of radiation exposure) per 4-week rotation**

DISCUSSION

- **Healthcare providers are at the greatest risk of developing cataracts if radiation safety glasses are not utilized**

  - In the setting of COVID precautions that include wearing a face shield and N95 mask for all swallow study evaluations, fluoroscopy technologists and speech pathologists had significantly low safety glasses utilization rates

  - Placing safety glasses on workstations in the room and direct encouragement did not increase utilization rates

- **Critical Next Steps**

  - Develop laminated sign with emphasis on radiation safety and potential consequences

  - Calculate comparative exposure data following implementations

Utilizing a Multidisciplinary Team to Improve Communication with Patients in the Hospital, as Measured by HCHAPS scores

Russell Moore, M.D., Daphne Monie, PhD, Suzanne Olson, Julie Hall, RN, Omid Shah, MBBS, Kristin Baker, MD, Anjeela Kadel, MBBS, Lintha Shah, MBBS, Phoebe Weiler, Stacy Wicks, RPh, James Dalton, M.D.

Utilizing a Multidisciplinary Team to Improve Communication with Patients in the Hospital, as Measured by HCHAPS scores
Background & Aim

- The reason for undertaking this project is the recognition that our communication with hospitalized patients is below the standard that we desire and our patient satisfaction scores around communication are lower than we believe they should be.

- The National Initiative VII project for Bassett aims to develop a team rounding system on the inpatient hospital Internal Medicine service. The goal is to improve communication among different disciplines on the healthcare team and, more importantly, to improve communication (including consistency in the communication) with our patients.

Utilizing a Multidisciplinary Team to Improve Communication with Patients in the Hospital, as Measured by HCHAPS scores
Methods

- One of the inpatient Internal Medicine teaching teams (Silver team) will change its daily (M-F) rounding schedule. After an hour "table rounds", the physicians (faculty, senior resident and interns) will join with the case manager, primary nurse, and team pharmacist to conduct bedside rounds on all patients in the geographic care area assigned to the Silver team. The role of each team member during the bedside rounds was loosely scripted.

- The Tan team is identical in make up and will serve as the "control", performing rounds separately.

- Prior to initiation of the project, physicians, nurses and case managers will complete a survey assessing attitudes regarding relationships with each of the other groups. These surveys will be repeated on an every 3-4 month basis.

- An internal survey regarding communication will be administered to patients at the time of discharge, with particular attention to how they perceive communication between their caregivers and themselves and between their caregivers among one another.

- HCAPHS scores are determined regularly, administered through Press Ganey.

- All survey results (internal and HCAPHS) will be compared before and during the project within the Silver team and between the Silver and Tan teams.

Utilizing a Multidisciplinary Team to Improve Communication with Patients in the Hospital, as Measured by HCHAPS scores
Results

- Baseline data was collected for all the participating faculty, residents, nurses and case managers between January and March 2020

- The rounding project was started in mid January, 2020

- HCAPHS surveys were conducted via Press Ganey as per their schedule.

- Internal patient surveys were tested and modified.

- Subjective response from all the employee participants was very positive.

- In mid-March the Covid pandemic required a massive restructuring of the inpatient service and precluded "teams" of people gathering in patient rooms. The project was put on hold.

- In mid-September the project was resumed with modifications – the pharmacist and the case manager would consult with the team each morning, but would not participate in the bedside component of rounds; "table rounds were no longer conducted; the scripting was modified; and there was a concurrent change in patient flow to develop better geographic care locating of patients.

Utilizing a Multidisciplinary Team to Improve Communication with Patients in the Hospital, as Measured by HCHAPS scores
Discussion: Barriers & Next Steps

- The coronavirus put a hard stop on this project mid-March. Many limitations are still in place

- Changes regarding personal distancing still preclude the kind of team rounding we first envisioned. Unclear whether that is temporary or "the new normal". We are still considering what to continue and what to abandon.

- Though we received exemption from the IRB, the changes that we have made will likely require that we show it to them again.

- The initial employee satisfaction (particularly on the part of the nurses) make us eager to proceed with some kind of variation of the plan

- Patient satisfaction took a modest hit during the height of the pandemic, not surprisingly (no visitors, no visible faces of care providers, decreased time in the rooms, etc.). There are so many variables as to make any effort at scientific interpretation all but impossible.

- We will persevere

Incorporating Teaming for Long-Term Sustainment of a Communication Program

Megan Newman, MD; Martha Howell, PhD; Wendy Hegefeld, PhD;

Shannon Johnson, MSN, RN NEA-BC

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^{TM} 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 an 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

Teaching Teaming, Leadership, and Conflict Resolution skills
to improve the culture and attitudes of OB case review

Donald Kirton, Ryan Quarles, Audrey Psaltis, Amrita Roy, Michelle George

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

- In our labor and delivery unit residents, faculty, nurses and midwives work together in patient care but do not train or learn together. We have Obstetric case reviews every other week that are meant to foster shared mental models, systems-based practice and teamwork, but they are poorly attended. Furthermore, some attendees have reported that these reviews can lead to tension and conflict amongst disciplines.

- The purpose of this project is several fold:
  - To improve attendance and attitudes towards obstetric case review by adding education components
  - To compare existing hospital survey data pre and post-intervention about the culture of labor and delivery.
  - To compare pre- and post-intervention surveys about labor and delivery culture, as well as comfort of teaming, conflict resolution and leadership skills.

Methods: Audience, Interventions, Measures

- A survey was created that will be sent to all faculty, midwives, residents and nurses who work in labor and delivery asking about overall culture, attitudes towards OB Case review, and personal comfort with teaming, conflict resolution and teaming skills. Deemed "not research" by our IRB.

- Our group is developing a teaming curriculum during OB case reviews. Materials will be made available for all staff who cannot attend. Highlights and Teaching points will be placed on break/meeting room bulletin boards in our labor and delivery units where all disciplines would have a chance to view the materials.

- Data from questions in the Press Ganey annual hospital surveys that pertain to labor and delivery unit culture will be compared pre and post-intervention.

- A post-intervention survey will be compared to our initial survey to see if there is improvement in any of the content areas, overall culture and morale.

- COVID Changes: Unfortunately, safety precautions were put in place due to the pandemic. OB case reviews were not held over the summer. They are starting back up at this time, so our initial survey has been sent and we plan to roll out our project at the end of fall.

Results (to Date)

- We identified 8 questions in the Press Ganey survey that pertain to trust within the Labor and Delivery unit, patient safety, and interdisciplinary teamwork.

  > Trust in the work unit was 79% favorable

  > Questions about patient safety were 94% and 88% favorable

  > Overall working together within a unit was 87% favorable (5% unfavorable), but between units was only 49% favorable (6% unfavorable)

  > Teamwork between nurses and physicians was 56% favorable (12% unfavorable), and effective communication questions showed 56 % (between units) and 48% (between physicians nurses nad other medical professionals) favorability (7% and 15% unfavorable).

Results (to Date)

- The survey was sent to 198 faculty, midwives, nurses and residents.

- We have a 20% response rate in the first few days, with a fairly equal representation from each group so far.

Q4 Are you familiar with the concepts of "teaming"?
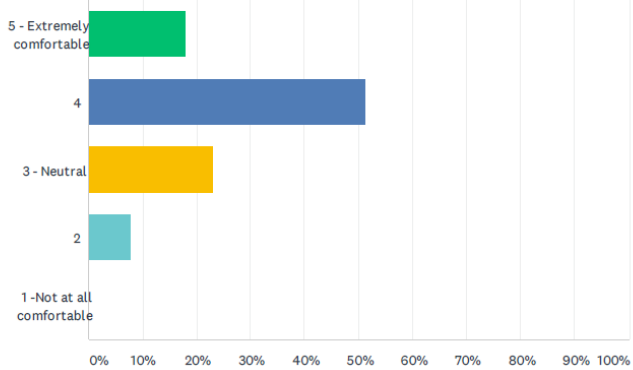
Answered: 39   Skipped: 0

Yes	
No	
Somewhat	

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
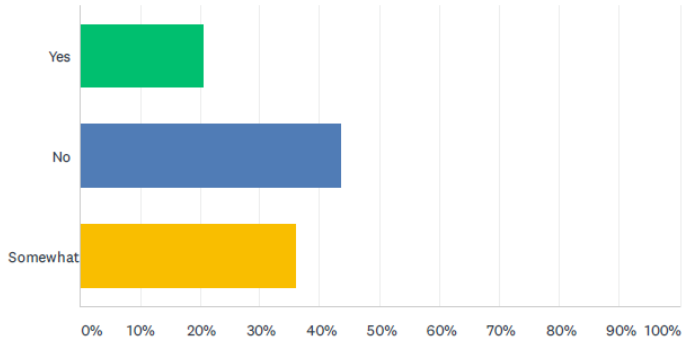
Q2 How often have you attended OB case review in the past (pre-COVID)?

Answered: 39   Skipped: 0

Every week	
Once per month	
Less than monthly	
Never	

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
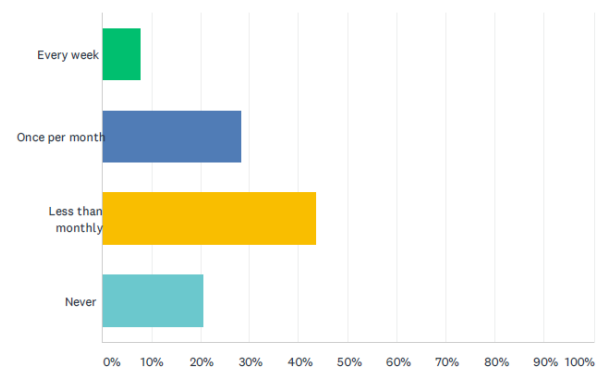
Q5 How comfortable are you with working in a team with new people?
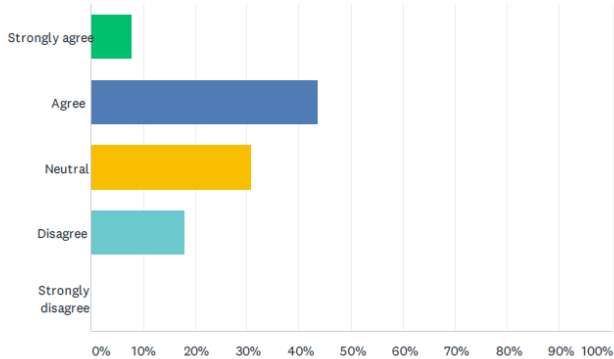
Answered: 39   Skipped: 0

Q8 The culture and morale on LDRP is positive.

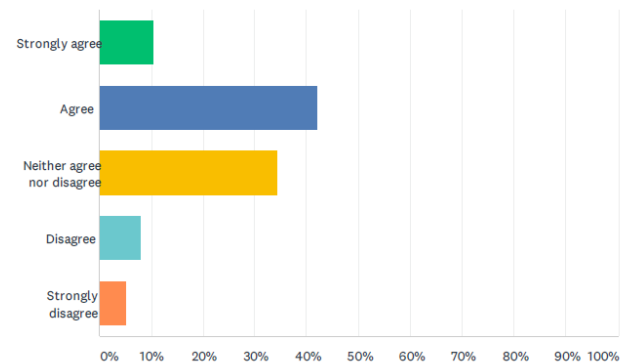Answered: 39   Skipped: 0
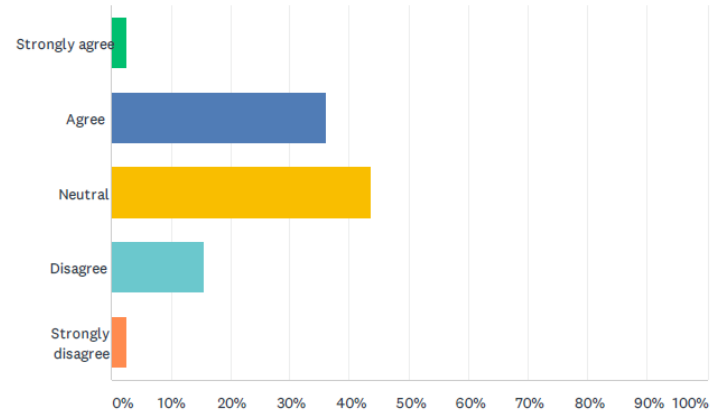
Q9 People come together easily towards a common goal on LDRP.

Answered: 39   Skipped: 0

Q13 The culture of OB Case Review is positive.

Answered: 38   Skipped: 1

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Results – How well do the disciplines work together? (%)

	Poor	Fair	Good	Very Good	Excellent
Overall	0	5	59	26	10
Nurse – Midwife	0	3	32	54	11
Attending – Midwife	0	5	37	42	16
Resident – Midwife	0	13	34	32	21
Resident – Nurse	5	26	44	23	3
Attending – Resident	0	5	43	38	14
Attending - Nurse	0	11	42	37	11
Among Resident	0	8	24	37	32
Among Nurses	0	11	29	47	13
Among Midwives	0	3	22	47	28
Among Attendings	0	8	37	37	18

Discussion: Barriers

- COVID delayed our project. We brainstormed many alternative ideas but were quite restricted in possibilities because of limitations of gathering and time (we had a very busy summer compounded by organizational changes that pushed this project to the background for a while).

- Successes:
  - > We achieved IRB exempt status and our survey was recently sent out.
  - > OB Case reviews are being held virtually. While we did not measure this before COVID struck for pre-data, In the first 2 conferences, there seems to be an uptick in participation.
    - Virtual meetings makes it easier to attend. In fact, we are likely to hold all future conferences in person AND virtual in the future to allow for more participation.
    - Participants are contributing more because the chat can be used instead of public speaking, and participants can send comments and questions directly to presenters (semi-anonymous).
  - > In the ramp up to restarting the OB Case review, it was noted that email invitations sent to anyone involved in the case used phrases such as "your case has been flagged" to be presented, which was to be triggering terminology which may contribute to some negative perceptions of these conferer This has been modified to say "your case has been selected to present at OB Case Review".

Next steps

- Continue to collect our pre-intervention survey data.

- Incorporating our teaming curriculum into the OB Case reviews and post this information
after each session

- Completion of our post-survey and the data from this years' Press Ganey survey.

Exploring experiences of interprofessional teaming in the clinical learning environment before, during, and 'after' COVID

Ashley Dennis, PhD; James Jackson, MD; Virginia Mohl, MD, PhD; Sarah Mete DO; Tya Campbell, MD; Alexis Robinson, PharmD; Candice Wells, RN, MSN, MBA; Jen Potts, OT

Introduction & Aim

Before: Pilot two resident-led patient safety interventions at the micro level in the inpatient medical unit and IMR residency using the theory of relational coordination to measure improved relationships in the interprofessional teams as a measure of "Teaming"

COVID-19

After: This qualitative study aims to explore the impact of COVID-19 on interprofessional participants' experiences of interprofessional teaming in the clinical learning environment.

Introduction & Aim

Research Questions:

- What are healthcare professionals' experiences of interprofessional teaming before, during, and 'after' COVID-19 and how has this influenced their views towards interprofessional teaming?

- What are the similarities and differences in experiences and understandings across different types of participant (e.g. pharmacist versus physician) and settings (e.g. hospital versus general practice)?

- What are participants suggestions for continuing to enhance interprofessional teaming?

Methods: Audience, Interventions, Measures

Participants:

- Two focus groups per target interprofessional group (nursing, medicine (resident, faculty), pharmacy) = Eight focus groups
- Four people per focus group = Approximately 32 people

Focus Groups:

- Participants will be asked to tell their stories about interprofessional teaming before, during, and 'after' COVID-19 using narrative interviewing techniques.

- Once the narratives have been exhausted, we will ask any outstanding questions about participants' opinions interprofessional teaming and how it could be enhanced

Methods: Audience, Interventions, Measures

Qualitative Analysis:

- Focus groups will be digitally audio-recorded and transcribed anonymously.

- Thematic Framework Analysis
    - Data familiarization
    - Thematic framework identification
    - Indexing
    - Charting
    - Mapping and interpretation

Results (to Date)

Plan:

- Thematic framework analysis will enable us to illustrate key themes in our data around participants' views and experiences of interprofessional teaming.

- Qualitative data analysis software (i.e. Atlas-Ti) will enable us to explore patterns across our data such as similarities and differences in views and experiences between participant groups.

Discussion: Barriers & Next Steps

- Covid has created significant barriers for us as a team

  - Our original projects were not feasible considering the current context

  - Many of our team are directly involved in our institution's COVID response

  - Moving forward, our biggest challenge will be re-grouping in a still stressful and busy time for our team

  - Our plan with this project is that it will be something that we can scale up or down so that we can flexibly respond to the environment as it changes over the next 6 months

Integrating Residents into an Interdisciplinary Collaborative: The MD/RN Collaborative

Lili Shek, MD, MHDS; Bryna Harwood, MD, MS; Betsy McGaughey, EdD, MS;

Peachy Hain, RN, MSN

Cedars-Sinai Mission
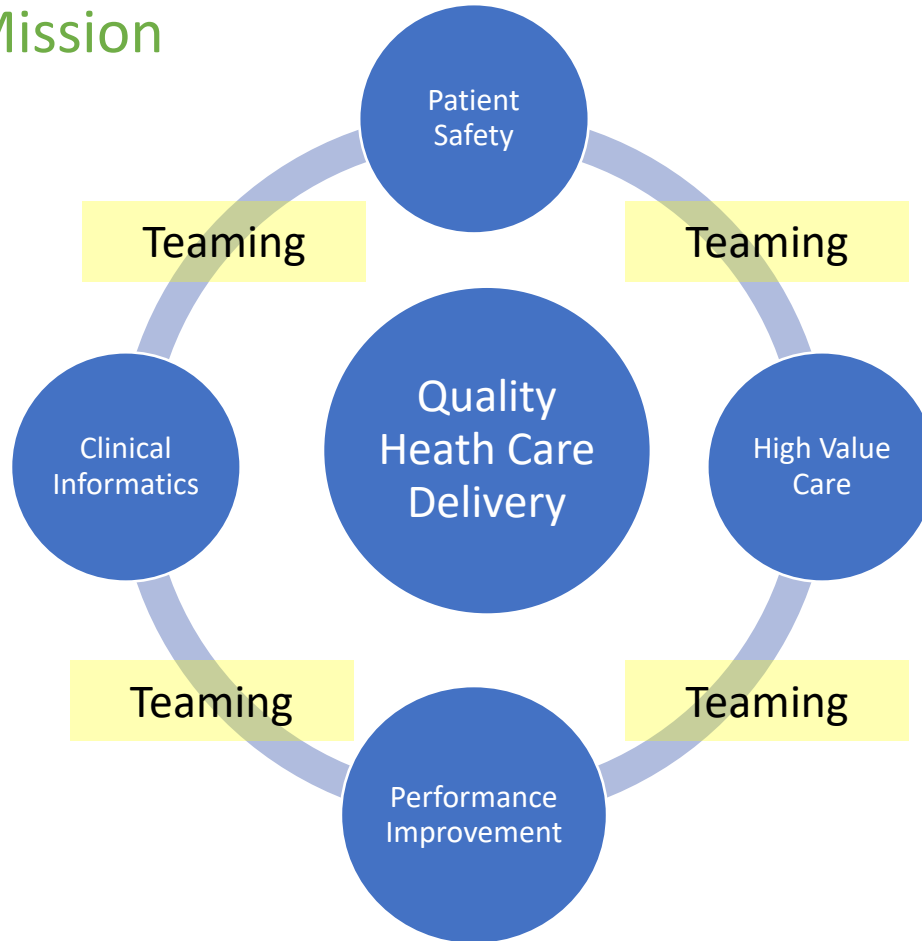
Cedars-Sinai MD/RN Collaborative Committee: Teaming in Practice

- Established in 1998

- Physician-nurse partnership → interdisciplinary unit-based teams
  - > Social workers
  - > Case managers
  - > Pharmacists
  - > Physical Therapists
  - > Occupational Therapists

Lacking Resident Involvement
Lacking Teaming Implementation

Aim

- Engage residents in the MD/RN Collaborative committees and projects

- Provide training on teaming concepts to MD/RN collaborative committees

- Increase satisfaction of MD/RN Collaborative members

- Increase in timely and effective solutions for inpatient care

Methods:

| Align resident interests with MD/RN initiatives | Assess needs for training on teaming | Provide appropriate training on teaming using real-time situations | Assess satisfaction of resident participation and teaming strategies |

Challenges

- Delay in start of project due to COVID-19 prioritization efforts and new social distancing standards

- Transition period of incoming housestaff June-August

Next Steps

- Selection of collaboratives/projects with which to integrate new resident members
- Assignment of residents to MD/RN committees
- Teaming education and training with real-time scenarios

Nurse Mentoring Program for Internal Medicine Interns

R. Powers MD, K. Snyder RN, A. Ababneh MD,
D. Mayes RN, J. Gorecki RN, C. Goliath PhD, N. Haller PhD,
A. Diwakar MD, T. Sheers MD

Background

- There is a need to improve resident physician – nurse teaming for the purpose of improving patient care.

- Currently, our institution does not have an onboarding program to address this need.

- A review of the literature yielded reports of institutions that incorporate inter-professional mentorship programs in the resident onboarding process (Tilden et al, 2016).

Purpose

- To improve patient care and safety through increased communication and teaming following a nurse-Internal Medicine intern mentorship program.

Objectives

- To develop a nurse mentorship-based onboarding program for Internal Medicine Interns.

- To assess feasibility and desirability of the mentoring program concept and content.

Methods: Audience, Interventions, Measures

- A mentoring program will be piloted with Internal Medicine interns.
- 12 interns will be paired with self-selected nurse mentors on a 1:1 basis.
- There will be four sessions:
  - Session 1 (1 hour): Dyad Pairing and Icebreaker Luncheon.
  - Session 2 (4 hours): Nurse mentor shadows intern.
  - Session 3 (4 hours): Intern shadows nurse mentor.
  - Session 4 (1 hour): Debrief of shadowing experience – identify challenges and role misperceptions, and discuss teaming for patient care topics (patient safety and communication).
- This project received a Quality Improvement designation from the CCAG IRRB.
- There will be two pilot sessions of the program:
  - Pilot 1: Jan 2020-Jun 2020 (established interns)
  - Pilot 2: Jul 2020-Dec 2020 (new interns)
- Program feasibility and desirability was assessed upon completion of the the first cohort.
- Objective measure of the program's success will occur through pre/post-program administration of a relational coordination survey.
  - The RC Survey 2.0 is a validated measure of teamwork in healthcare.

Results (to Date)

- Relational Coordination tool completed for pre/post-program Cohort 1.
  - > Preliminary results were obtained, but definitive comparisons cannot be made due to low post-program completion rate.
  - > Between group comparisons will be made upon completion of RC tool by Cohort 2.
- Adjustments were made to overall structure of the program in light of COVID work-stream demands and restrictions.
- Changes made to scheduling of sessions for Cohort 2.
- Cohort 2 participants (nurse mentors and interns) have been identified.
- Pairing of mentors and interns is underway.

Discussion: Barriers & Next Steps

- Intern schedules
- Nurse mentor schedules
- Identifying meeting times that work for the entire group.
- Participation rate for RC survey.
- COVID, COVID, COVID!

- Currently administering the pre-program Relational Coordination survey for Cohort 2.
- Next steps include:
  - Scheduling the shadowing sessions.
  - Scheduling the debrief session.
  - Administering the post-program RC survey Cohort 2.
  - Comparison of survey results pre/post program between and within Cohort 1 and 2.

BOOST

Bridging **O**perative **O**bstacles by **S**trengthening **T**rust

C. Foshee PhD, L. Baszynski MSN, L. Gardner MSN, J. Lipman MD,
R. Romano MBA, L. Simko MS, L. Smith MBA, E.I. Traboulsi, MD, MEd

Introduction & Objectives

This program is designed to overcome inherent assumptions and biases that lead to a lack of trust and mutual respect between OR nurses and PGY1 surgical residents.

- Trust has been shown to be an essential component of effective teams. Trust fuels mutual respect, collaboration, and engenders a psychologically safe environment where team members are able to act on a shared vision and shared goals.

- The curriculum is framed by transformational learning theory to addresses identified gaps within a general surgery setting. Content is tailored to the needs of this group and engages participants in social learning activities, open discussions, and practice opportunities.
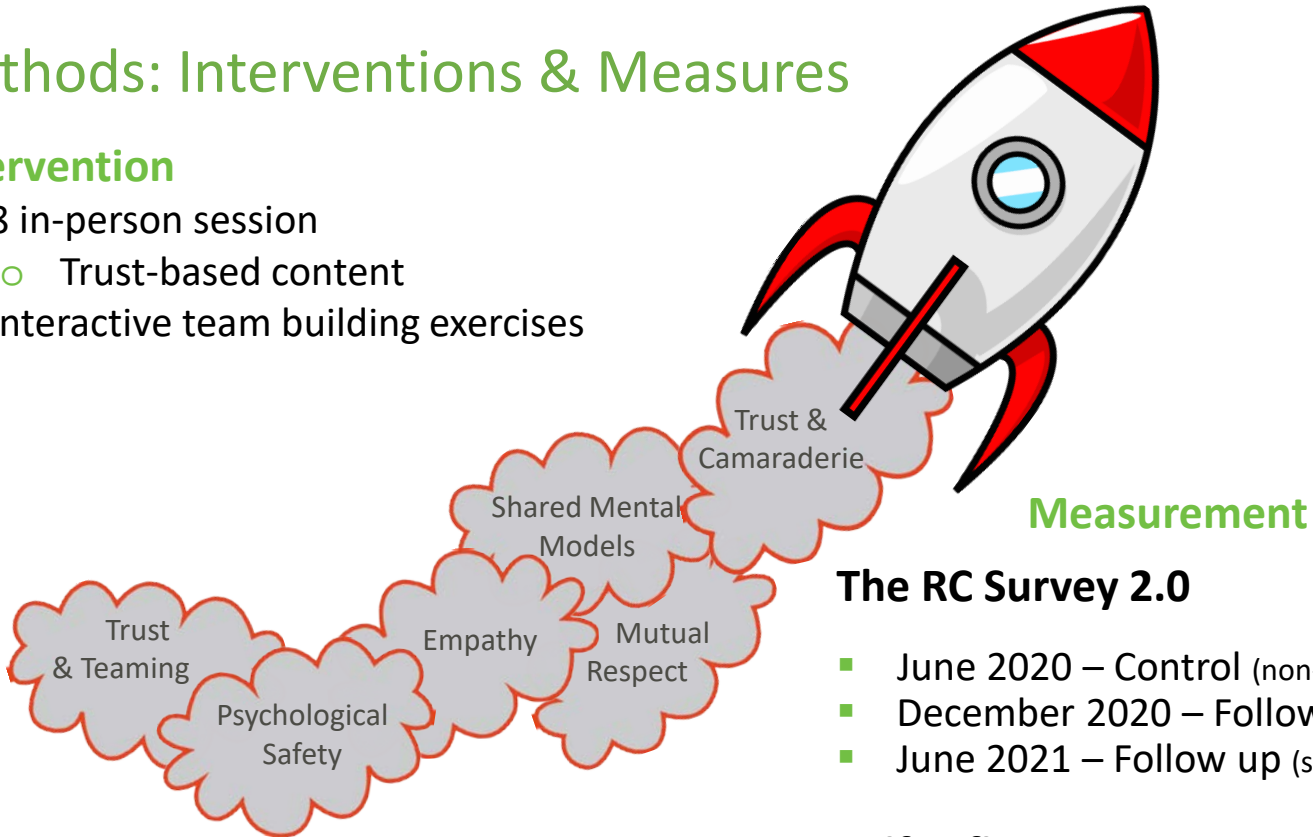
Program Objectives

- Discuss the role of trust and mutual respect on teamwork and patient outcomes

- Explain the implications of role understanding on patient care

- Demonstrate ability to maintain a climate of respect through effective communication

- Apply concepts of emotional intelligence and empathy to minimize assumptions and biases in daily professional interactions

# Methods: Interventions & Measures

Intervention

- 8 in-person session
  - Trust-based content
- Interactive team building exercises

Trust & Camaraderie

Shared Mental Models

Trust & Teaming

Empathy

Mutual Respect

Psychological Safety

Measurement

The RC Survey 2.0

- June 2020 – Control (non-concurrent)
- December 2020 – Follow up (survey)
- June 2021 – Follow up (survey)

Self-reflections
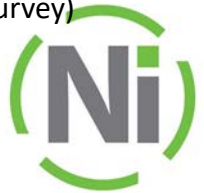
Results

WORKGROUPS AND THE 7 DIMENSIONS OF RELATIONAL COORDINATION

	CCN1	CCP2	AttPh	RN Mgr	Cs Mgr	Tech	OTHR
RC INDEX							
Frequent Communication							
Timely Communication							
Accurate Communication							
Problem-Solving Communication							
Shared Goals							
Shared Knowledge							
Mutual Respect							

Ratings

Nurses:
- Timely communication &
- Frequent communication

High

Residents:
- Timely communication &
- Frequent communication

Moderate

Nurses & Residents:
- Shared knowledge &
- Problem solving communication

Low

92

Discussion: Barriers & Next Steps

Barriers:

- Building trusting teams during COVID
- Overcoming resistance or assumptions about intent of program
- Allocating sufficient time to successfully develop and implement program

Next Steps:

- Finalize development of curriculum
- Curate educational resources to supplement program
- Solidify program evaluation plan

Providing a Framework to Improve Understanding and Call to Action for Teams to Address Disparities in Healthcare

Areef S. Kassam, MD, MPA, Kasey Windnagel, PhD, Kim Jones, LCSW, Holly Wheeler, DO, Laura Ruekert, PharmD, Peter Karalis, MD, Crystal Neal, Allison Woody, Kathy Zoppi, PhD, MPH

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

In 2020, the American Medical Association reported, despite improvements in health and healthcare in many parts of the country, racial, ethnic, and other under-represented people experience a lower quality of care and suffer higher morbidity and mortality. Recent national events have charged healthcare organizations to face the personal, professional, and systemic factors which discriminate against marginalized groups of patients.

This important call to action has galvanized organizations, however, there is a significant lack of collated resources and paths to help guide them. The mission of Community Health Network's AIAMC initiative is to provide a framework for interdisciplinary teams to better understand systemic factors which create disparities with patients, providers, systems, and in research.

This framework will provide the structural support for residency programs to enact meaningful change within their team in addressing diversity, equity, and inclusivity

Methods: Audience, Interventions, Measures

We created four workshops to help our residency teams recognize gaps and in their understanding which includes:

1) Social Determinants of Care and Health Care Disparities

2) Implicit Bias

3) Microaggression

4) Cultural Humility.

At the end of the four workshop series, residency programs will be empowered with a new set of tools and understanding to create interdisciplinary initiatives aimed to tackle disparities evident within their team. In order to track success, the AIAMC collaborating team will measure ACGME Diversity survey results for 2020, pre-initiative, and 2021, post-initiative.

Results (to Date)

Workshop #1 on Social Determinants of Care and Healthcare Disparities was an overwhelming success with positive response from faculty, staff, and residents. Programs have began to think about where there are gaps in education, clinical care, and teaming as it relates to underrepresented minorities and other disparities.

Three more workshops are planning for Winter and Spring with completion set for March 2021. Results from ACGME Diversity Survey will be available in Summer 2021.

Discussion: Barriers & Next Steps

- Barriers
  - > Working on being "in-line" with other Network/Program initiatives
  - > Education/Training for large groups for dedicated time and different baselines
  - > Limited internal data/infrastructure set-up thus far
  - > Navigating personal, professional, and systematic biases
- Next Steps
  - > Complete workshop series on GME level
  - > Programs have a call to action to begin brainstorming on initiative to address program disparity (patient care, employment, teamwork, etc)
  - > ACGME Diversity subsection survey in Spring 2021 (2020 used as benchmark)

The Effect of Teaming on Opiate Prescribing and Usage in a GME Naïve Education Consortium

Dr. Christopher Neely, MD

Dr. Margaret Beliveau, MD, FACP

Dr. Robert Ficalora, MD, FACP

Dr. Adrian Singson, MD

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

- 2017: 1,176 reported opioid-involved deaths in Indiana; rate of 18.8 deaths/100,000 persons (national rate is 14.6 deaths/100,000 persons).

- 2017: 649 reported synthetic opioid cases; 20-fold increase from 2013.

- 160 to 327 heroin-related deaths.

- 2017: Indiana providers prescribed 74.2 opioid prescriptions for every 100 persons (US national average rate is 58.7 prescriptions); only 9 states have a higher prescribing rate than Indiana.

- Currently, no information on effect of inter-professional teaming on opiate prescribing and usage.

- This project is a dual opportunity to impact the opioid epidemic and build both relationship and infrastructure in a new program.

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

- AIM: We plan to investigate and construct teaming as we build our medical education infrastructure in our 4-hospital GME naive medical education consortium.

- This will also include medical consultation and hospital medicine at a surgical specialty hospital. The internal medicine and psychiatry residencies share many resources and facilities.

- We also plan to integrate nursing and pharmacy, and our established nurse and pharmacy residency programs, into the effort.

- This combination of disciplines will be well suited to focusing on opioid prescribing across the consortium, and thus we will have one project that spans several environments.

Methods: Audience, Interventions, Measures

- Trying to change how to treat pain in-house post-operatively.

- Educate patients in clinic prior to surgery.

- Equip patients with mantra/tools for appropriate opiate use.

- Going away from trying to "stay ahead" of pain; educate and modify patient behaviors to being able to cope with pain and direct patients toward a therapeutic activity goal.

Methods: Audience, Interventions, Measures

- Arms nursing staff to move away from "staying ahead" of pain and focusing on therapeutic activity goals.

- Monitoring pill counts post-operatively.

- Many arthroplasties now only requiring 1-2 day stay.

Results (to Date)

- Much momentum lost in orthopedic arm due to COVID 19.

- Orthopedic arm deployed individualized discharge opioid pill counts from multidisciplinary team involving RN, PT, pharmacy, and physicians.

- Assessed various factors to determine pill count including INSPECT, 24-hour opioid use in the hospital, and interviews with patients to assess if they are meeting their therapeutic activity goal.

- Pill counts are customized based on combining the surgery-specific maximum opioid pill count recommendations from Michigan OPEN data with a multiplier based on 24-hour use. Also involved non-narcotic analgesia.

- Patients also discharged with a carbon-based disposal bag to assist in safe destruction of unused opioid pills after treatment course. Data from orthopedic arm lines up with national data that estimates 40% of prescribed opioids are unused.

Discussion: Barriers & Next Steps

- Momentum lost due to COVID.

- Volume has been a barrier.

- Project started prior to SWINRES IM residents arriving.

- SWINRES IM residents will need to have rotation w/ Dr. Neely.

- Engaging pharmacy residents.

- Will recruit SWINRES IM residents to the project as well.

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 resident providers by June 2021
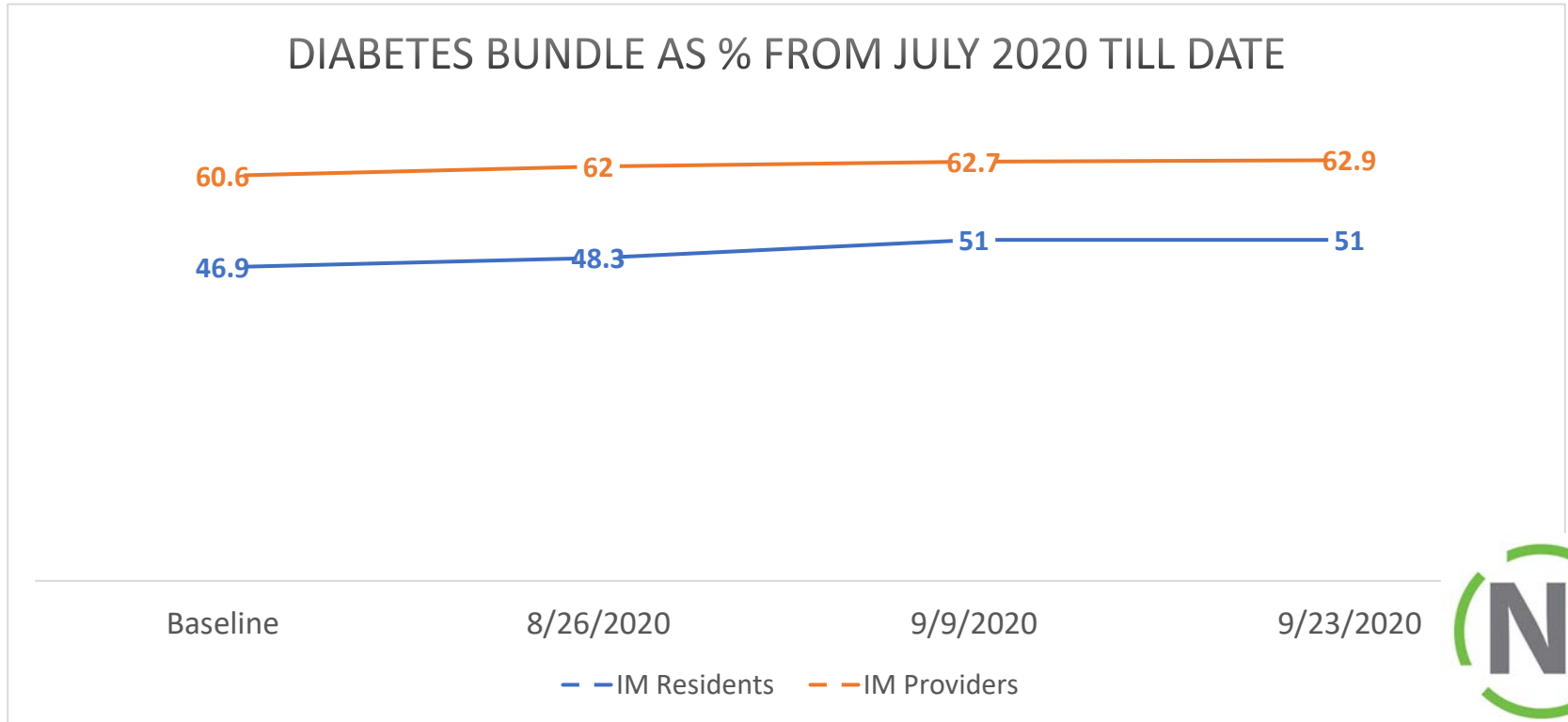
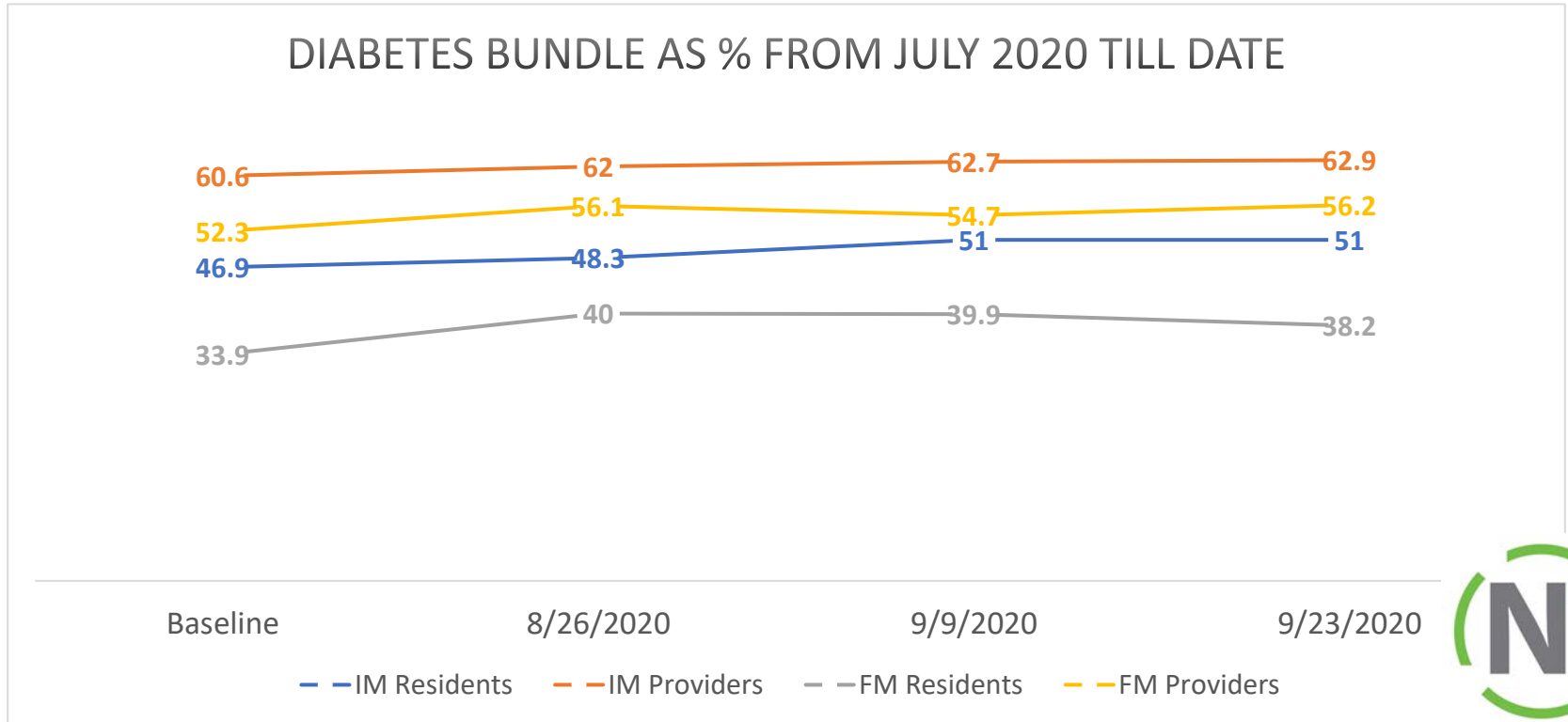# Methods: Audience, Interventions, Measures

- 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
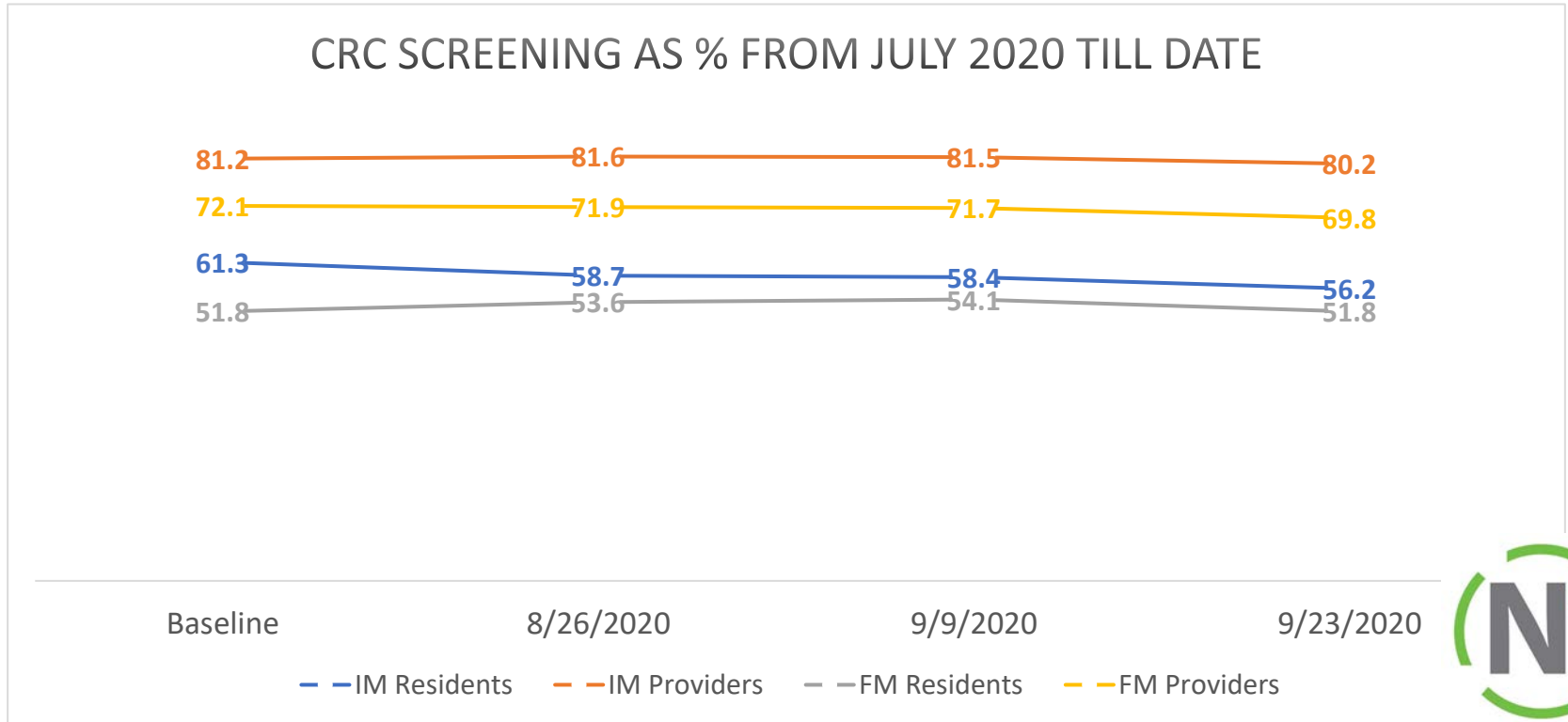 - Data is also available on the non-resident providers in the FM clinic that hosts the FM residency

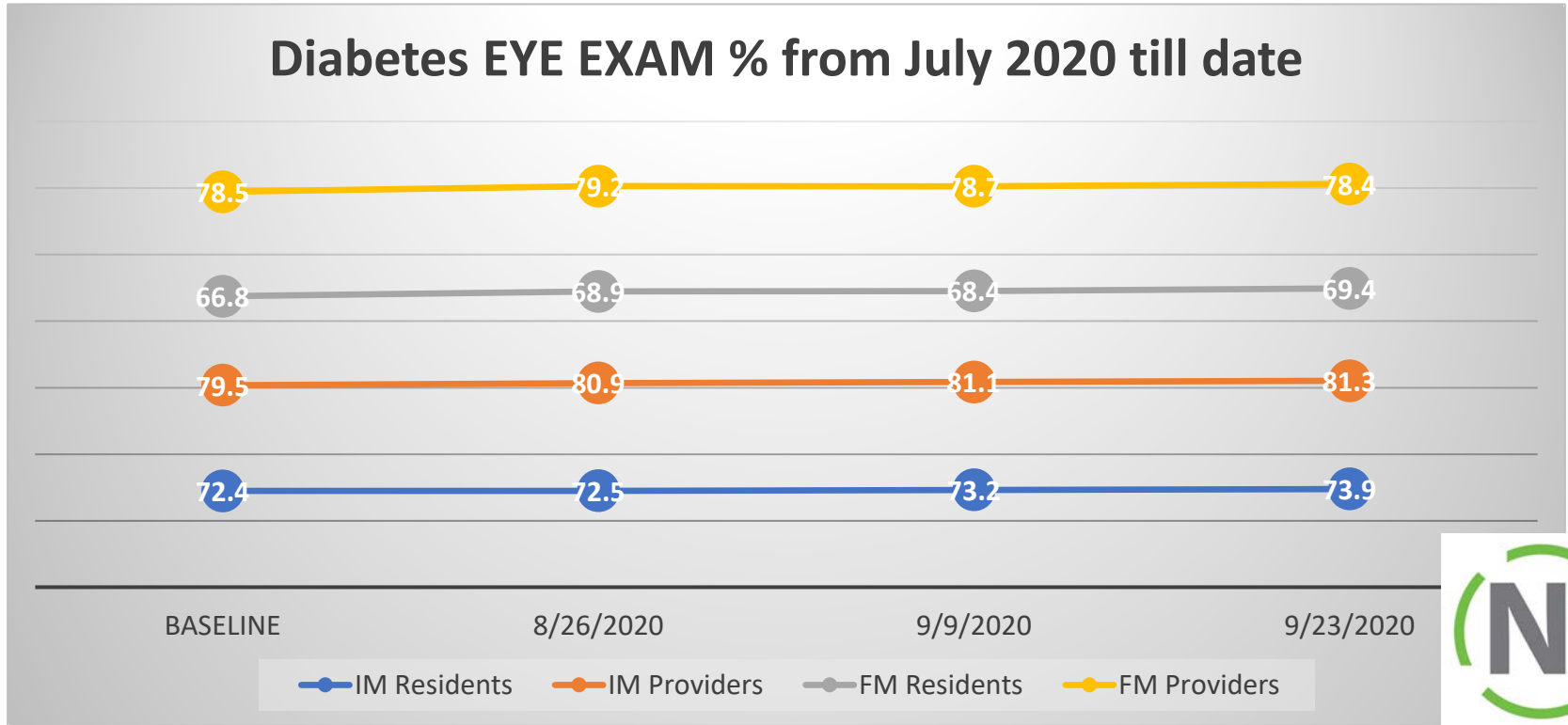# Results – diabetes bundle (upward trend)

DIABETES BUNDLE AS % FROM JULY 2020 TILL DATE

IM Residents: 46.9, 48.3, 51, 51
IM Providers: 60.6, 62, 62.7, 62.9

Baseline 8/26/2020 9/9/2020 9/23/2020

– – IM Residents   — IM Providers

Results compared to non-participating practices

DIABETES BUNDLE AS % FROM JULY 2020 TILL DATE

	Baseline	8/26/2020	9/9/2020	9/23/2020
IM Residents	46.9	48.3	51	51
IM Providers	60.6	62	62.7	62.9
FM Residents	33.9	40	39.9	38.2
FM Providers	52.3	56.1	54.7	56.2

– – IM Residents   – – IM Providers   – – FM Residents   – – FM Providers

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Results – CRC screening, with comparisons

CRC SCREENING AS % FROM JULY 2020 TILL DATE

	Baseline	8/26/2020	9/9/2020	9/23/2020
IM Providers	81.2	81.6	81.5	80.2
FM Providers	72.1	71.9	71.7	69.8
IM Residents	61.3	58.7	58.4	56.2
FM Residents	51.8	53.6	54.1	51.8

– – IM Residents   – –IM Providers   – –FM Residents   – –FM Providers

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

Diabetes EYE EXAM % from July 2020 till date

	BASELINE	8/26/2020	9/9/2020	9/23/2020
FM Providers	78.5	79.2	78.7	78.4
FM Residents	66.8	68.9	68.4	69.4
IM Providers	79.5	80.9	81.1	81.3
IM Residents	72.4	72.5	73.2	73.9

IM Residents   IM Providers   FM Residents   FM Providers

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

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
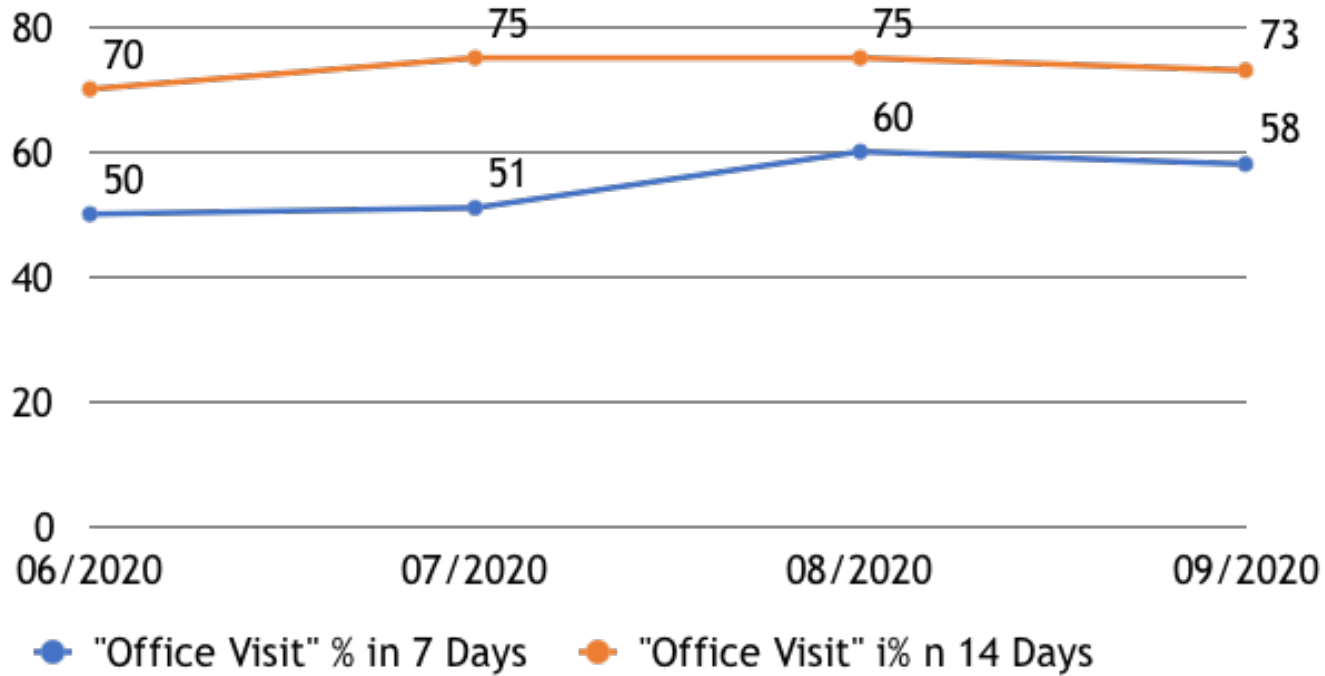
Discussion: Barriers & Next Steps

▪ 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 we have taken.

▪ There is a slight improvement in the TCM rate so far; we continue our interventions in pursuit of our goal.

Aligning Health Professions Education and Organizational Strategy to Create a Teaming Framework for Training Health Professional Learners

Michelle Noltimier RN BSN MBA

Director for Physician Assistant and Nurse Practitioner Graduate Education

HealthPartners Institute

Office of Health Professional Education

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Background

As an organization, HealthPartners has a mission to provide the best quality and value for patients and members by designing and implementing models of care that provide convenient, effective care for patients. We have many successful models of teaming already established and have various initiatives that link teaming behaviors to desired patient care outcomes.

Our objective is to learn about existing teaming efforts across our large health system, identify essential elements of teaming and create a shared vision around teaming. With our experience responding to the COVID 19 pandemic, we will incorporate learnings from both the clinical setting and our educational structure as we plan for future training.

Objective

Create a framework from which health professional learners are trained in teaming skills that will improve patient care outcomes.

Methods: Audience, Interventions, Measures

Through the support and guidance of the AIAMC National Initiative VII, a team of educators, leaders, clinicians and learners at HealthPartners will collaborate to:

> Curate content related to teaming as a resource for our organization.

> Develop an inventory of HealthPartners initiatives/efforts that includes teaming as a method to achieve better patient care outcomes.

> Identify the essential teaming skills identified across HealthPartners initiatives.

> Collect valuable learnings from the effects of the COVID 19 pandemic as it relates to how teams were effective in caring for patients.

> Compare learnings from the COVID pandemic with the initial list of essential teaming skills to distill the core skills that will be incorporated into new teaming framework.

Methods: Audience, Interventions, Measures

Future Work After March of 2021

> Incorporate teaming skills into the design of a new curriculum framework,

> Implement and measure the outcome of this curriculum on learners perceived confidence and competence related to their ability to "team on the fly" to improve patient care outcomes.

> Share future recommendations with HealthPartners leaders, educators and clinicians.

Results (to Date)

Developed an inventory of HealthPartners initiatives/efforts that includes teaming as a method to achieve better patient care outcomes.

Inventory of System Wide Initiatives: Teaming Skills

- **Accountability**
- **Communication**
- **Awareness and improvement mindset: anticipation; monitoring; identify barriers**
- **Empathy**
- **Interpersonal connection**
- **Adaptive change**
- **Collaboration**
- **Innovate within restraints**
- **Ability to find/use resources/guidelines/standards-checklist**
- **Resiliency**
- **Leadership-give direction**
- **Global perspective**
- **Timely action**
- **Composure**

- **Morale**
- **Prioritization**
- **Expand abilities within team members**
- **Flexibility**
- **Commitment to team**
- **Deep listening**
- **Building trust**
- **Deal with uncertainty**
- **Awareness of team**
- **Inclusion**
- **Compassion**
- **Seek to understand**
- **Know each other's work**

Inventory of System Wide Initiatives: Goals

- **Patient satisfaction-fits lifestyle**
- **Provider satisfaction**
- **Efficiency/streamline**
- **Communication**
- **Empathy for clinician**
- **Resiliency for clinician**
- **Quality of patient care (decrease infections)**

- **Safety/ decreased risk for patient care**
- **Accountability of team**
- **Present error**
- **Faster care**
- **Decrease length of stay**
- **Culture- small town**
- **Affordable**

Inventory of System Wide Initiatives: Measurement

- **Time/throughput- length of stay**
- **Observation by outside evaluators**
- **Data-pages**
- **Application**
- **Patient quality**
- **Risk management**
- **Survey of providers- validated scale**
- **Patient experience/perception-real time feedback**
- **Direct feedback**

- **Completion of training**
- **Peer review assessments**
- **Needs assessment**
- **Total cost of care**
- **Intolerance to uncertainty (scale)**
- **Perceived stress scale**
- **Plans are successful or not**
- **HCAPS**
- **Team member stories**

Inventory of System Wide Initiatives: Training Approach

- **Focus on early adaptors**
- **Awareness email**
- **Presentations**
- **Simulation**
- **1:1 communications**
- **Focus on stakeholder input**
- **Scenarios**
- **Pilot activity**
- **Participants selected based on scenario**
- **Classes**
- **Drills**
- **Work off normal practices**
- **Course**

- **Voluntary**
- **Telling the story**
- **2-day training event**
- **Regular meetings with leaders (30 min) and frontline workers (30 min)**
- **15 min orientation all caregivers**
- **Huddles**
- **BR briefs**
- **Experiential learning (10 hour medical improv)**
- **Debrief and reflection**
- **UPC task force**
- **Peer learning**

Discussion: Barriers & Next Steps

Phase three: August 2020 - October 2020
> Identify teaming skills that emerged as essential from the COVID 19 pandemic

> Compare COVID 19 teaming skills with larger HealthPartners teaming initiative goals and distill a core list to incorporate into a curriculum framework.

Phase four: October - December 2020
> Create recommendations for future approach to training for HealthPartners

Phase four: December 2020 – March 2021
> Disseminate findings through a paper and poster summary

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

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

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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 social determinates of health negatively impacting a patients ability
  - ✓ 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 formal curriculum that that will serve as a foundation for cultivating a culture of Equity, Diversity and Inclusivity

Vallejo Mobile Health: Teaming For an End to Homelessness

Emily Fisher, MD; Ted O'Connell, MD; Kat Dang, MS, MAS; Siddharth Selvakumar;
Jung Kim, PhD, MPH; Joelle Lee, MPH; Vanessa Franco, MD;
Theresa Azevedo-Rousso, DIO; Angela Jenkins; Michelle Loaiza

Introduction and Aim

- **Solano County:** ~1200 people living without homes
- **Top Needs:** Aid with employment, rent, alcohol/drug counselling, and mental health services
- **Vallejo Mobile Health**(VMH) is a street outreach team seeking to reduce the burden of disease and improve wellness of Vallejo's people without homes through a multi-disciplinary, community-based approach
- **VMH findings:** lack of trust in healthcare system is common

- ***Mission*:** We strive for wellness and the long term goal of facilitating housing stability for people without homes through the culturally-informed provision of supportive services including, but not restricted to, medical services, mental health, housing assistance, and case management.

Pre COVID-19 Plan:
- Integrate medical care with mobile outreach and improve referral workflow process
- Track a) patient utilization with referrals,
        b)ED and primary care visit
        c) the patient experience.

Post COVID-19 Plan:
- Integrate medical care with Project RoomKey, formalize partnerships, integrate social services, expand to additional transitional housing sites
- Track a)patient utilization and referrals
        b)ED and primary care visits
        c)the patient experience.

Methods:

Audience

- Previously homeless patient housed at Project RoomKey
- Research indicates this population:
  - Shows high utilization of emergency services and low utilization of primary and specialty care
  - Reports transportation, insurance enrollment, and economic barriers to access care
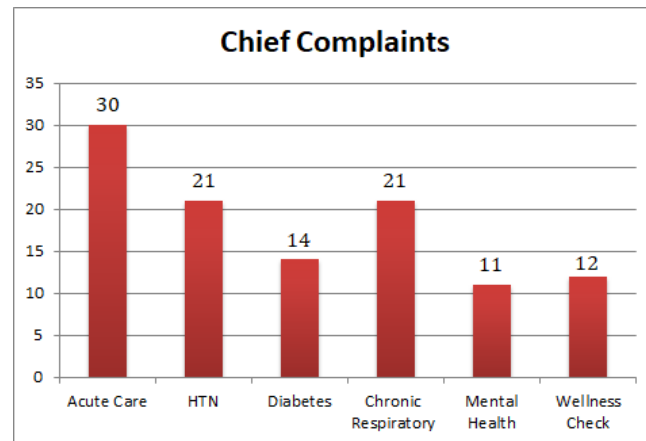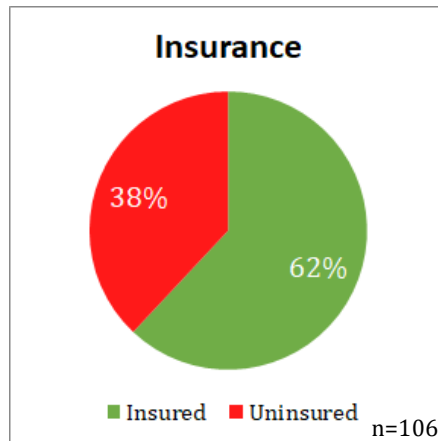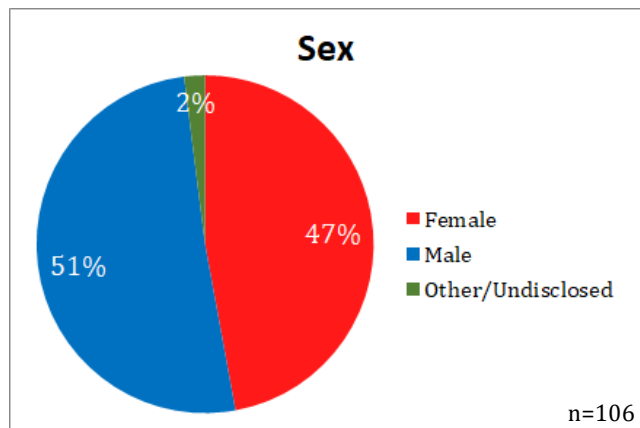
Interventions

- VMH services to PRK patients include:
  - Health Screenings and Primary Care Services
  - Aid in PCP connection

Measures

- **Demographic:** Age, Sex, Insurance, Utilization Behavior, Common Diagnoses and Chief Complaints, and Social History (length of time without stable housing, drug use, employment)
- **Process Measures:** # patients seen, periods of high activity, patients enrolled in PRK over time
- **Outcome Measures:** # appts with PCP, ER incident reports

Results (to Date)

Sex

- Female — 47%
- Male — 51%
- Other/Undisclosed — 2%

n=106

Insurance

- Insured — 62%
- Uninsured — 38%

n=106

Chief Complaints

Acute Care	HTN	Diabetes	Chronic Respiratory	Mental Health	Wellness Check
30	21	14	21	11	12

Age

Over 60	46-60	36-45	18-35
30	57	21	13

n=106

Do You Have a PCP?

- Yes — 57%
- No — 43%

n=106

Enrolled Patients and Visits Over Time

	May	June	July
Total Patients	49	121	121
Visits	40	71	34

137
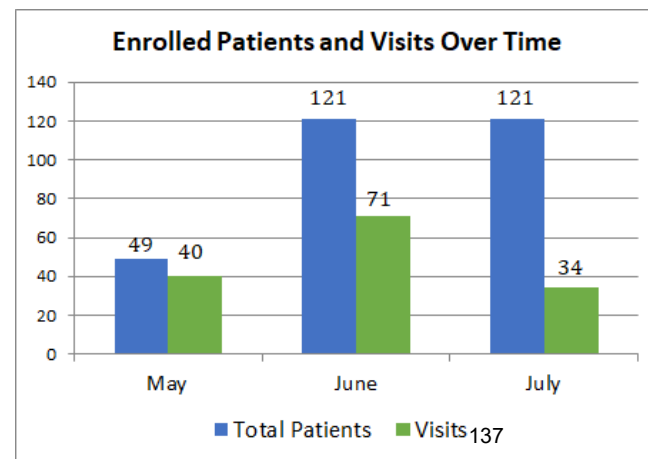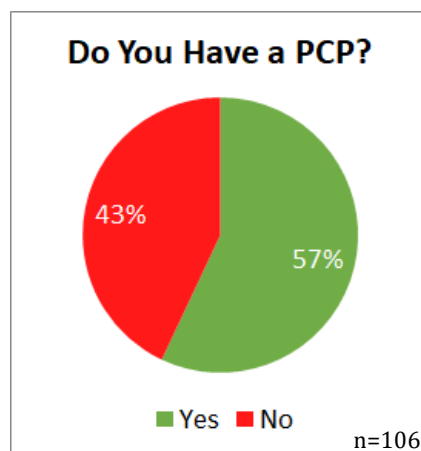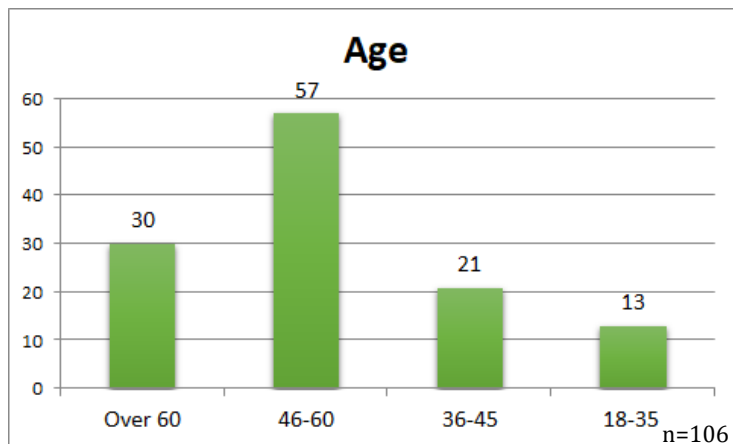
Discussion: Barriers & Next Steps

Barriers
Getting involvement of patient population in the team

Medical Student and Resident involvement continues to be an issue working with faculty

COVID prevents number of team members and volunteers on site for organization and data collection

Telemedicine barriers

Recent lack of on-site coordination and case management due to organization and city communication barriers
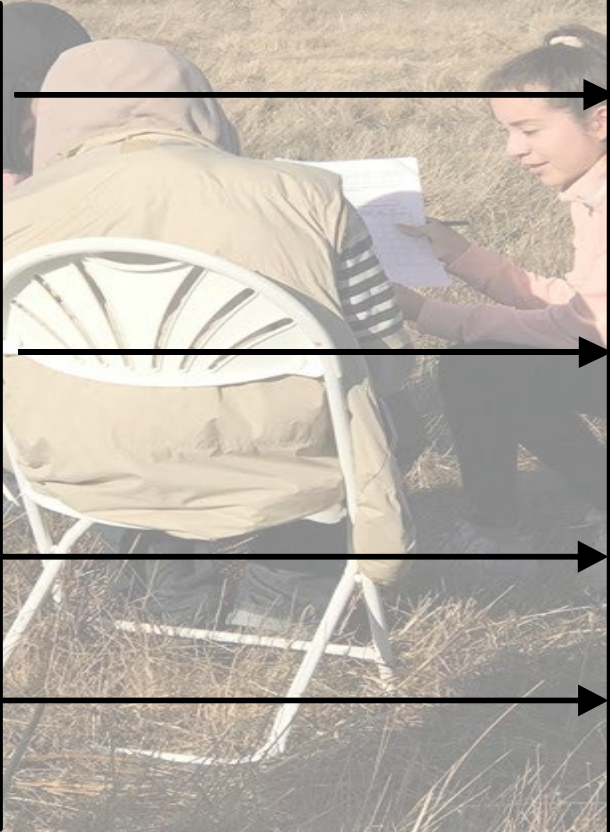
Next Steps
Identify leaders in the patient population for inclusion in team

Include residents on Community Medicine Rotations, reach out to neighboring residency programs,establish Street Medicine elective with Medical School

Scheduling PCP appointments for patients with on site medical staff present

New case management team to start this week; Creating clear scopes of practice and onboarding documents

Nurturing Collaborative Skills in the Clinical Learning Environment

Sandra Ross, LSW, Elena Umland, PharmD, FNAP, Katherine Pang, DO,
Joanna Dixon, MSN, RN, CEN, Michael Danielewicz, MD, Eleanora Yeiser, DO,
Sarah Hirsh, MD, Salma Mami, Chinwe Onyekere, MPH, Barry D. Mann, MD

Introduction & Aim

Training for healthcare providers is often siloed with limited opportunity for interaction with other disciplines prior to graduation. Main Line Health and Jefferson are clinical rotation sites for multiple disciplines, and recognized an opportunity to incorporate interprofessional training during clinical rotations. Our goal is to increase appreciation for interprofessional collaboration among students from various disciplines through monthly case conferences and patient encounters.

We strive to create a sustainable model of bringing students together to learn about, from, and with each other. The ultimate goal is for students to value professional teaming to improve patient outcomes and incorporate a sense of confidence working with an interprofessional team to improve patient care. We aim to determine if an interprofessional conference in the early phase of learning results in improved self-efficacy and improved ability to function in a team in the clinical setting, through assessing interventional methods impact and determine replicability of the project with our academic affiliate, Jefferson.

Methods: Audience, Interventions, Measures

- A series of 5 case conferences involving student participants from multiple disciplines were created to be delivered via zoom
- Disciplines involved: medicine, nursing, physical therapy, occupational therapy, respiratory therapy, social work, pharmacy, medical assistants
- Students are split into interprofessional teams to discuss cases with a focus on identifying the value of each member of the team in addressing various elements of the case
- Small groups respond to discussion questions in zoom breakout rooms throughout the case conference and then report out to the larger group
- The conferences are co-facilitated by family medicine residents and advanced nursing candidates

Measurement:

- IRB approval obtained at Main Line Health and Jefferson
- Interprofessional Collaborative Competency Attainment Scale (ICCAS): a 21-item self-assessment tool that evaluates participants' perception of ability to demonstrate behaviors related to collaborative care
- Jefferson Teamwork Observation Guide®(JTOG®): a 15-item survey designed to identify the level of performance in collaborative practice behavior in groups
- ICCAS is distributed at the conclusion of case conferences and JTOG is administered after interprofessional patient encounter and debrief
- JTOG outcomes will be evaluated relative to ICCAS findings

Discussion: Barriers & Next Steps

- Scheduling conferences and patient encounters at a time that is conducive to participation from all disciplines without overwhelming patients
- Knowledge gaps between different disciplines dependent upon level of training and prior clinical experience
- We have minimized barriers with consistent communication and early scheduling so disciplines have time to make adjustments to their schedules
- Interprofessional teams of students established during the monthly case conferences will assess and develop a plan for a hospitalized patient. Students will convene at a predetermined time in the afternoon to discuss their assessment and plan with members of their interprofessional team. This will be followed by a feedback and debriefing session. Students will complete the JTOG®to identify the level of collaborative practice behaviors observed in their interprofessional team.

Areas for Guidance/Input:
- How do we engage students with varying schedules in patient care/assessment without overwhelming the patient?
- Strategies to get preceptors on the same page regarding the purpose of the patient encounter activity and the guidance they provide for an interprofessional team
- How do we replicate the amount of engagement in in-person sessions over zoom

Hand Hygiene Compliance Protocol

Joseph Jaeger, DrPH

Pranoy Mohapatra, MHA

Priya Fernicola, MPH, MS,

Christine Steinberger

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

- To establish a reliable and non-biased method of tracking and improving hand hygiene

- Current hand hygiene data is gathered through secret shopper manual observations

- This leads to small sample sizes and a potential "halo effect"

- We aim to establish a system that captures more thorough and accurate baseline data and subsequently improving behavior and culture as related to hand hygeiene

Methods: Audience, Interventions, Measures

- Pilot study to take place on pediatric floor due to closed/easily observed environment, multiple types of members of care team, strong leadership support, and lower financial impact

- Plan to install electronic monitoring systems (GoJo, SmartLink, Vitalacy etc) to capture realtime hand hygiene data to establish accurate baseline data

- Implement interdisciplinary learning initiatives and/or automated reminders after 3 months

Results (to Date)

- Project has been paused due to Coronavirus- hope to resume work shortly

Discussion: Barriers & Next Steps

Utilizing Inter-professional Teaming
To Reduce Inpatient Length of Stay

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Introduction & Aim

- **Introduction**:
  - > Reducing length of stay (LOS) is a network wide initiative, and Hackensack Meridian Ocean Medical Center is committed to achieving the goal of reduction of LOS by 1 day. CMI-Adjusted Length of Stay (LOS) Goal for 2020 is 2.5 days for Hackensack Meridian Ocean Medical Center. Our goal is to utilize inter-professional teaming to reduce length of stay through collaboration.

- **Aim**:
  - > To decrease length of stay (LOS) by 1 day at Hackensack Meridian Ocean Medical Center by utilizing enhanced interprofessional communication. The project will continue until this goal is achieved.

Methods: Interventions

- **Methods**:
  - > Utilizing a newly developed Multi-Disciplinary Rounding Tool in EPIC, virtual multi-disciplinary rounding
  - > Monthly implementation team meetings to exchange best practices and areas for improvement

- **HCAHP discharge questions**
  - > During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
  - > During this hospital stay, did you get the information in writing about what symptoms or health problems to look out for after you left the hospital?

Methods: Measures

- **Data and Measurement:** Quarterly reporting of Length of Stay (LOS) Data, CMI Adjusted LOS and HCAHPS patient survey results.

- **IRB Submission:** IRB exempt

- **Patient/Family Engagement:** Utilize HCAHPS survey questions about transition of care, discharge information, and staff communication to incorporate patient and family feedback into the project

Methods: Implementation

- **Measure**: all payer Case Mix Index (CMI) adjusted Length of Stay (LOS) data

  > Baseline: 90 days prior to intervention (Feb 15th, 2020)

  > Follow up: 90 days after intervention (Feb 15th, 2020)

  > Ongoing: Every 90 days

- **Intervention Group**: Family Medicine Teaching Service

- **Control Group**: Internal Medicine Teaching Service

Results (to date)

ALOS - Family Practice vs. Internal Medicine Residency
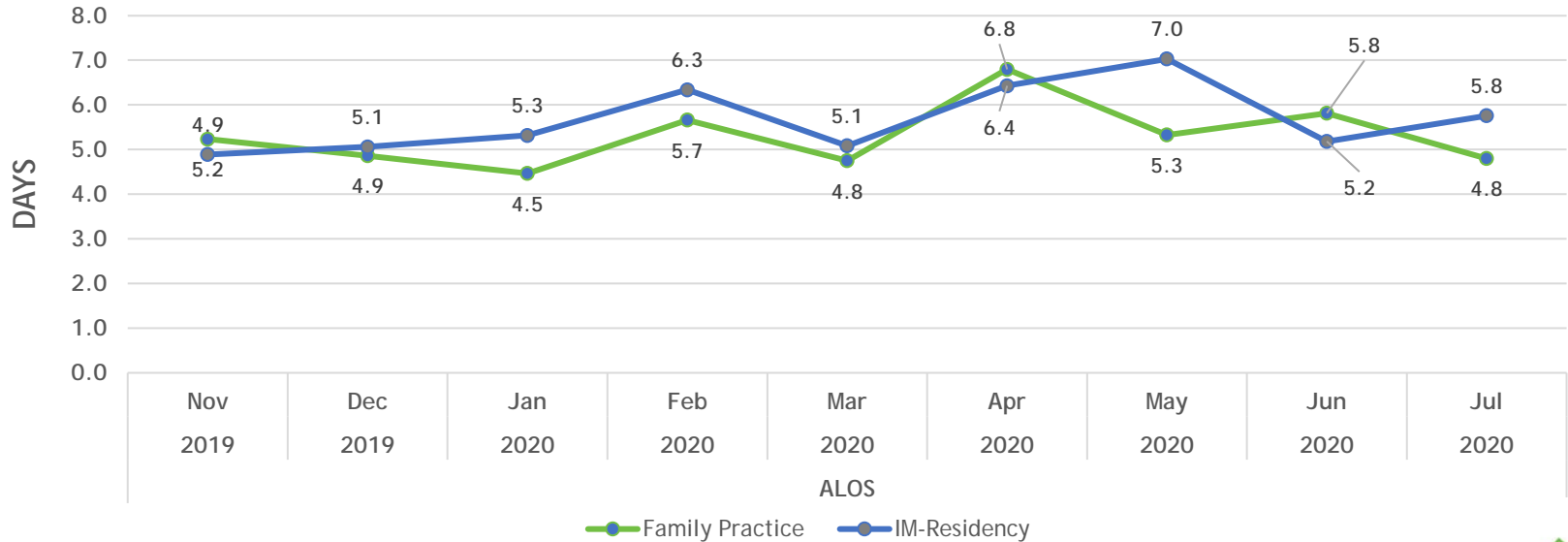
Results

CMI Adjusted LOS - Family Practice vs. Internal Medicine Residency
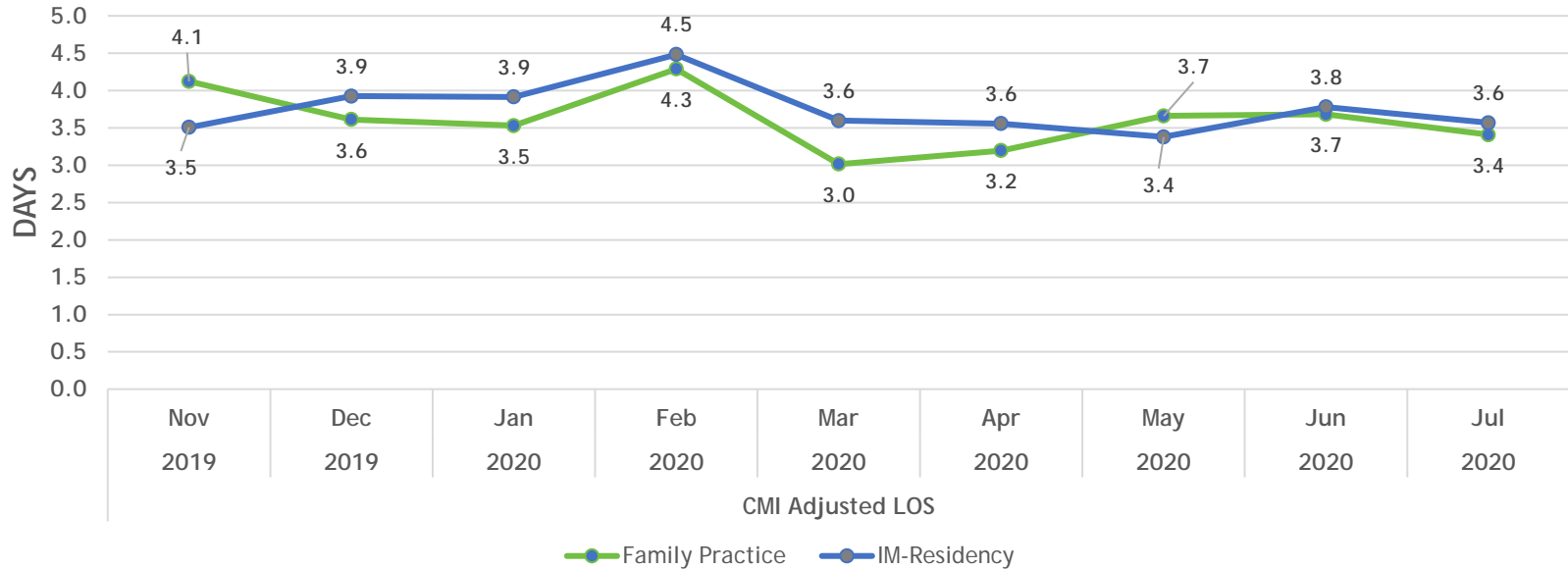
Results

Family Practice - HCAHP Discharge Information
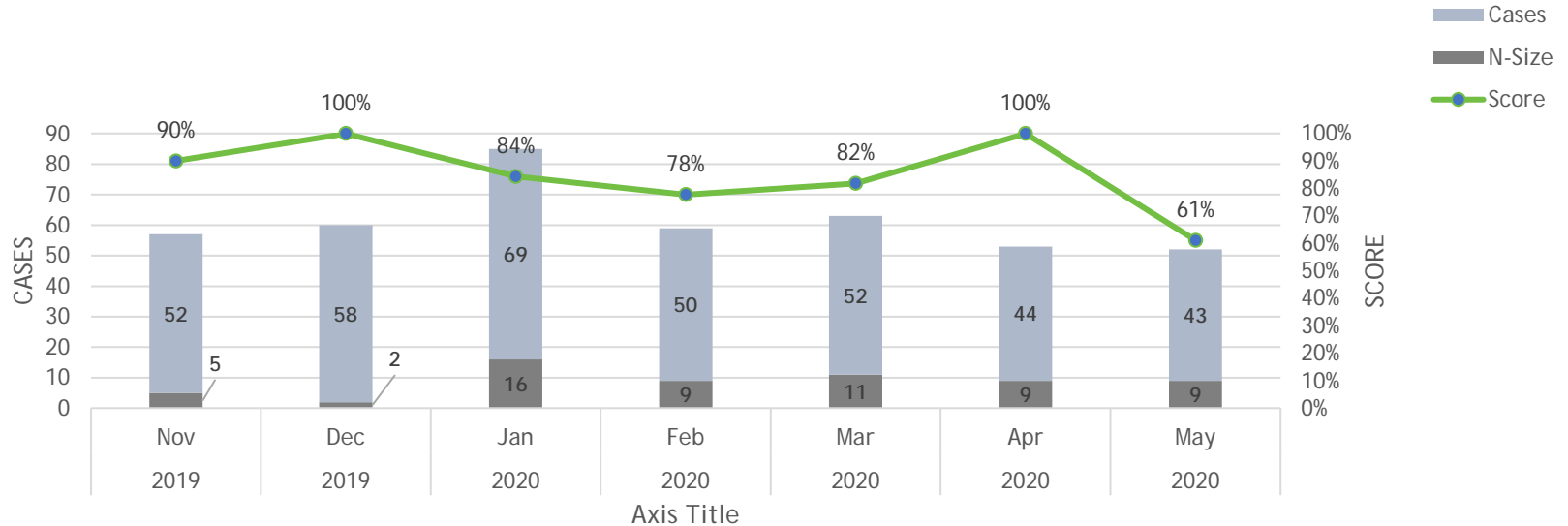
Project goal are scores >75%/month

Discussion: Barriers & Next Steps

- **Barriers:**
  - > Engagement- encouraging resident and physician engagement in the process by ensuring they find value in the process
  - > Re-education of the process with each changing patient care team
  - > COVID-19 pandemic impacted our patient mix, discharge rates, meetings, and time available to diligently apply interprofessional communication via EMR for each patient

- **Next Steps:**
  - > Residents have been scheduled to spend time with case management and with the physician advisor team to experience the steps in discharge
  - > Education sessions have been scheduled with the Patient Experience Office, Pharmacy, Clinical Documentation Specialists
  - > Pharmacists rounds with the inpatient team
  - > Standardized DME scripts provided from Case Management
  - > Creation of a Discharge Template for the team to use
  - > Bedside discharge rounds with the patient's primary nurse

Teaming on Labor and Delivery – Ochsner Baptist

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

<u>Introduction</u>

As we reflected on our current culture in Labor and Delivery and some of the potential barriers, the two that stood out were the medical hierarchy and impact of sudden changes in acuity/plans. While we have a "stop the line" culture, it doesn't always happen in practice because of fear or lack of situational awareness. As our unit gets busier, we need to find a way to promote and encourage psychological safety and clear communication in our environment. Questions in plans should not be limited because of fear or silo mentalities (intentional or otherwise)

<u>Aim</u>

Our vision is to deliver a world-class experience on Labor and Delivery that our patients recommend to their loved ones, our employees are proud to be a part of, and our learners carry with them to any future employer.

The mission of our group is to provide the highest level of maternity care in the Gulf South through our integrated, team-based approach.

Methods: Audience, Interventions, Measures

<u>Methods</u>

We have tried to create a three-pronged approach to improving Teaming on Labor and Delivery:

- We have re-structured the staffing coverage to provide greater continuity on the unit

- We are implementing a Safety Checklist

- We are hoping to offer educational sessions on communication and situational awareness, adapted from TEAMSTEPS

Audience:

- Obstetrics team on L&D – Generalist faculty, Hospitalists faculty, MFM faculty, Ob/Gyn residents

- Anesthesia team – OB Anesthesiologists, OB Anesthesiology fellows

- Nursing team – Day and Night nursing staff, Remote monitoring nurses (FHT Bunker)

- Pediatrics team – Pediatrics Hospitalists; NICU

Interventions:

- Self-paced TeamSTEPPS modules on Communication, Situational Monitoring, and Mutual Support

- Safe Surgery Checklist

Measures:

- Team performance observational tool after each case

- Teamwork Perceptions Questionnaire (T-TPQ)

- Teamwork Attitudes Questionnaire (T-TAQ)

Results (to Date)

Results

Pre-intervention observations:

- High performance during

acute events (107/115)

- Significantly lower performance

during "*routine care*" (46/115)

Discussion: Barriers & Next Steps

Discussion

It is well established that team-based health care is directly correlated with improved patient outcomes and clinician well-being. Effective teamwork hinges on the psychological safety of each member and the ability to learn and think together irrespective of one's status in the medical hierarchy. Our unit has undergone a total transition based on our experiences during COVID and our new team model is still trying to overcome historical norms.

Barriers

We have had 3 major barriers – resistance to change, increased pressures on productivity, and new leadership at all levels. While the new core leadership has brought a fresh perspective on clinician burnout and strategies to overcome it, the greater team still fears this change. Communication and constant, transparent reflection will continue to build trust among everyone.

Next Steps

We are continuing to measure the impact of the new Safe Surgery Checklist so we can expand this to all facets of care on labor and delivery. We also hope to provide more coaching on effective teaming on L&D.

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

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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.
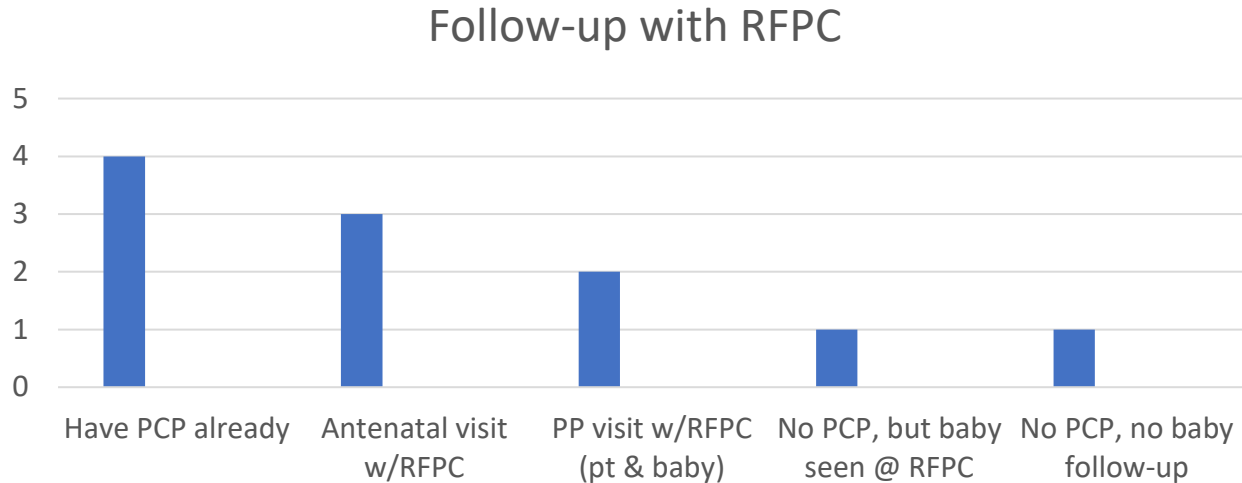
Results to date, continued

- 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.

Reasons for discontinuation before and after intervention
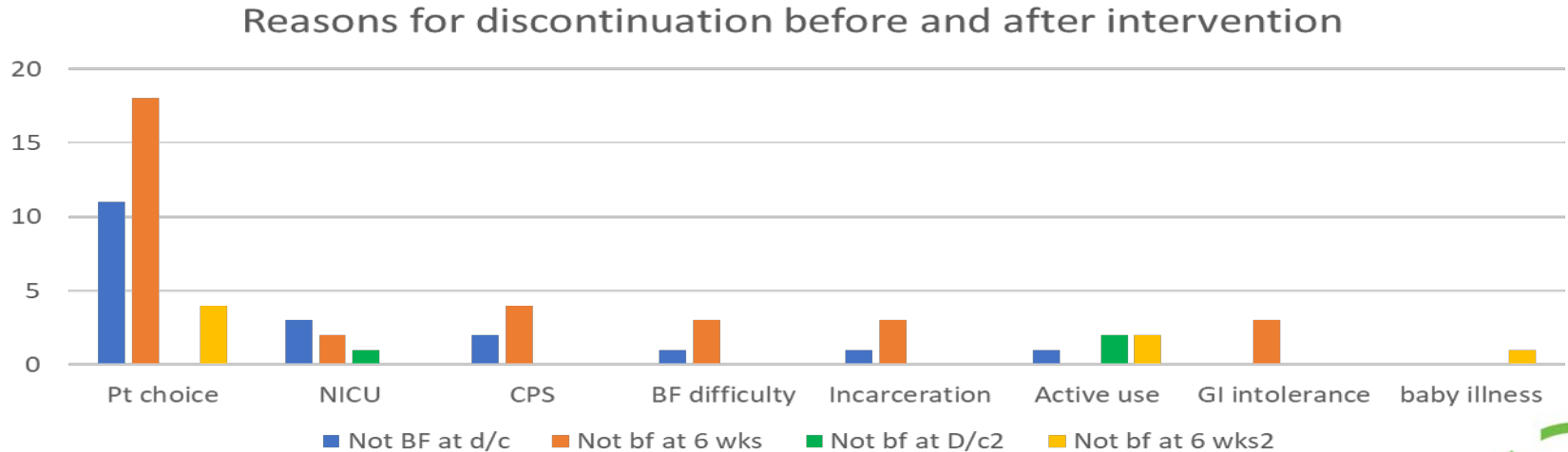
Results to date, continued

▪ 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.

Follow-up with RFPC

Category	Count
Have PCP already	4
Antenatal visit w/RFPC	3
PP visit w/RFPC (pt & baby)	2
No PCP, but baby seen @ RFPC	1
No PCP, no baby follow-up	1

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.

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

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Introduction & Aim

- 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
  - Improve patient experience
  - Decrease patient harm
  - Decrease length of stay
  - Increase IP participation and engagement

Methods: Audience, Interventions, Measures

- IP rounds on SUR 2 that include patient care team held Monday through Friday at 2:00 p.m.

- The rounds are thirty minutes and involve a scripted rhythm, with a role for all professionals.

- Primarily focused on discharge planning.

- Additional focus added on safety, quality, value, and equity.

- Review of unit-level data.

- Promote discussion of additional focus areas with educational components tailored to the setting and patient population.
  - Five-minute discussion occurring at least once per week

- Measures
  - IP attendance
  - Harm scores
  - Readmission rates
  - HCAHPS
  - Team Member Engagement Surveys

Results

- Collection of baseline data
  - > IP round attendance
  - > Harm scores
  - > Readmission rates
  - > HCAHPS
  - > Team Member Engagement Surveys

Discussion: Barriers & Next Steps

- Barriers
  - > Launch postponed due to COVID-19 and hold on elective surgeries
  - > Time and availability
  - > Willingness to change
  - > Limited resources
  - > Unclear goals for discharge
- Next Steps
  - > Piloting project (October 2020)
  - > Launching (November 2020)
  - > PDSA cycles (occurring every eight weeks)

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6. Xyrichis A, Ream E. Teamwork: A concept analysis. J Adv Nurs. 2008;61:232–241. doi: 10.1111/j 2648.2007.04496.x.

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

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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:

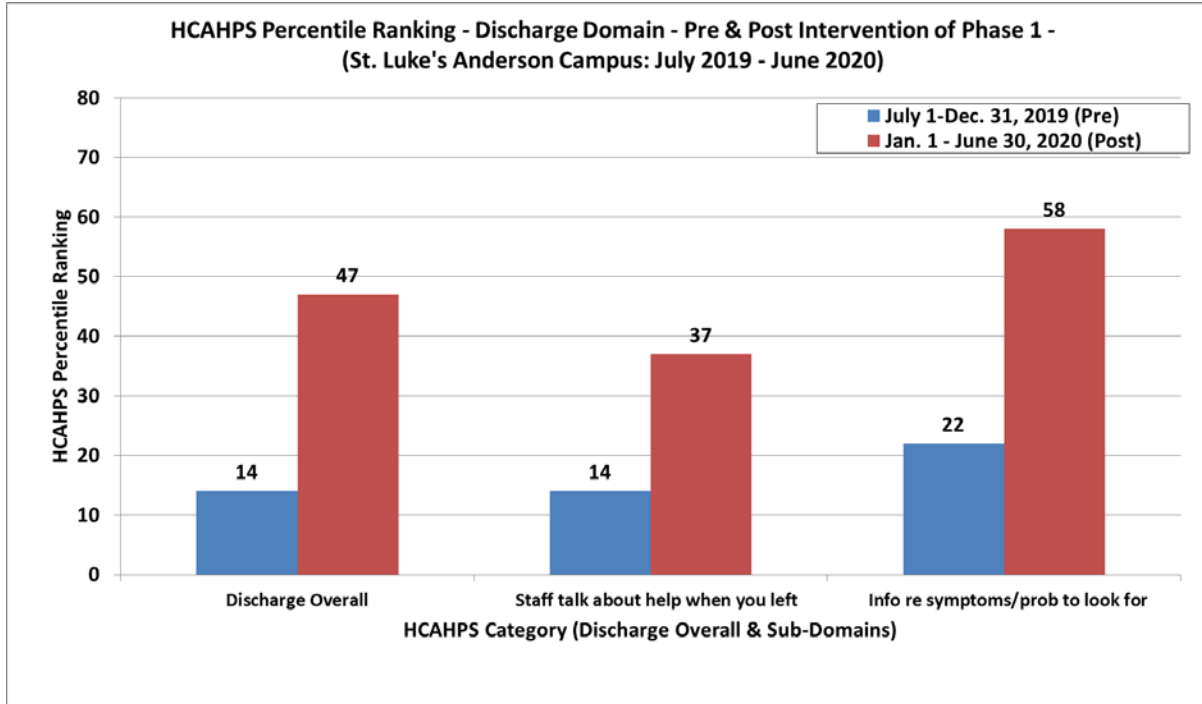- Phase 1 – Implement a Standardized Discharge Letter
- Phase 2 – Observe Nurses during Discharge
  - ✓ Discharge for consistency
  - ✓ Survey Nurses for their perspectives
- Phase 3 – Hardwired Inpatient to Outpatient Communication – Physician to Physician
- Phase 4 – Managing Patient Expectations During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

Measures:

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

Results

HCAHPS Percentile Ranking - Discharge Domain - Pre & Post Intervention of Phase 1 - (St. Luke's Anderson Campus: July 2019 - June 2020)

- 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.

178

Results

Phase 1: Standardized Discharge Letter (Compliance Average ~70.87% Total Utilization)
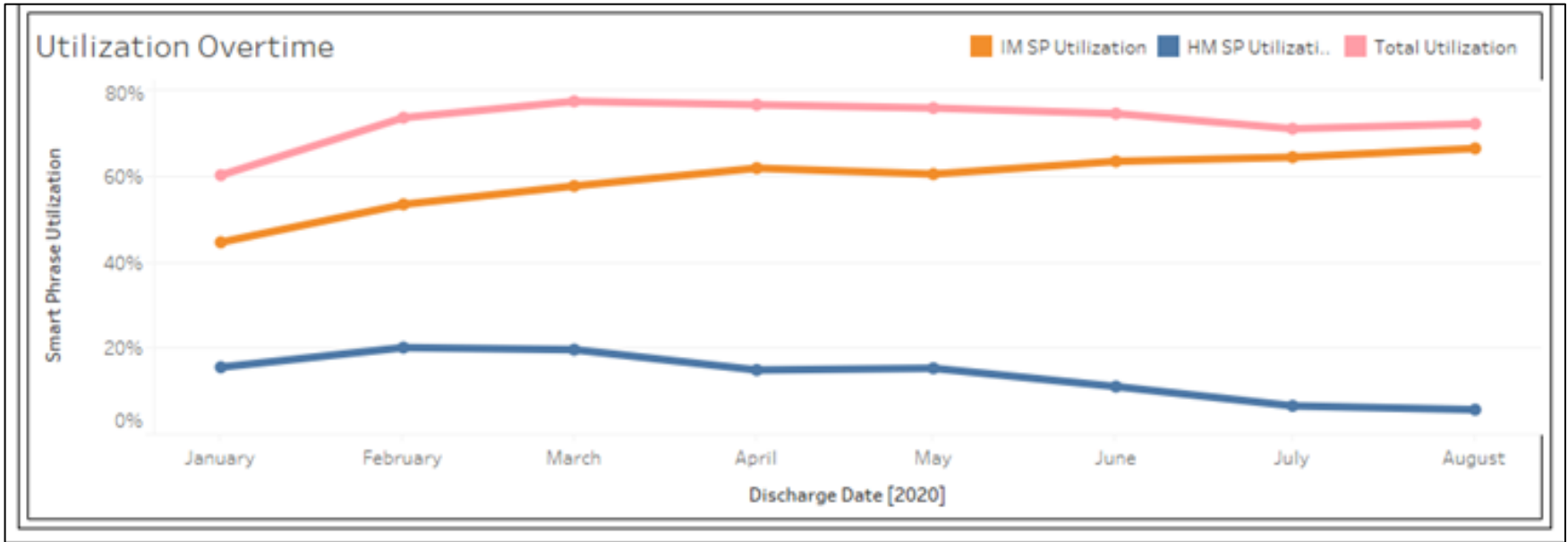
Discussion: Barriers & Next Steps

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

Interdisciplinary Teaming Across the GME Spectrum

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Introduction & Aim

- According to Joint Commission Perspectives article from August 2012, an estimated 80% of serious medical errors involve miscommunication between caregivers

- Resident physicians are the physicians with the most face-to face contact both with patients and with other clinical team members

- At the GME level, our project aim is to teach and validate the use of evidence based communication strategies

- Additionally, because the roles and composition of interdisciplinary clinical teams vary widely between clinical departments, each residency program is creating a department specific project to improve interdisciplinary teamwork utilizing these evidence based communication skills in their clinical settings
  - > Family Medicine/IM - Improving Hospital Discharges with Resident and Nurse Teamwork
  - > Surgery - Evaluation and Improvement of the Consultative Process at TriHealth
  - > OB/GYN - Centering and High Risk Pregnancies - ON HOLD due to COVID

Methods: Audience, Interventions, Measures

GME Project

Title: Improving Resident Communication Skills

Audience:

- Participants will be 120 male and female residents and fellows in TriHealth GME programs

Interventions:

- Educational sessions for all residents will be part of GME Grand Rounds to teach AIDET + the Promise, an evidence based patient communication strategy
- LEARN module for any residents unable to attend the live/video-conferenced session

Measures:

- Pre- and post- knowledge assessment from educational session
- Repeated measures of resident AIDET scores based on the AIDET validation rubric
- Track individual resident and post-graduate year (PGY) progress over time
- Track residency program progress over time
- Repeated measures of CGCAP & HCAHP scores

Methods: Audience, Interventions, Measures

OB/GYN Project

Title: Centering and High Risk Pregnancies

Audience:

- The study population will include all pregnant women, aged ≥ 18, diagnosed with gestational diabetes
- Participants will be identified based on a failed 3 hour glucose challenge test (using Carpenter-Coustan Criteria) or a 1 hour glucose challenge test result of > 200mg/dL
- They will be recruited during their prenatal office visits by residents and case managers
- Exclusion: Patients unable or unwilling to attend group sessions, with Pregestational Type 1 or Type 2 Diabetes, multi fetal gestations or patients with diagnosed fetal anomalies

Interventions:

- Participants will receive group prenatal care as opposed to traditional prenatal care
- There will be one pilot centering group, using rolling enrollment based on attrition and delivery
- Future centering groups will also consist of 10-15 patients

Measures:

- Mechanism of prenatal care provided
- Other dependent variables include pt satisfaction, delivery mode, shoulder dystocia, birth weight, NICU admission, and others

Methods: Audience, Interventions, Measures

General Surgery Project

Title: Evaluation of the Consultative Process at TriHealth

Audience:

- Any health care professional involved in placing consults to general surgery

Intervention:

- Creation of a specific surgical consult role in Voalte, a secure messaging system for hospital systems that allows creation of specific teams of care or roles within the app

Measures:

- A self-administered questionnaire will be provided to health care professionals to determine an association with satisfaction of the consultative process before and after the implementation of the hospital specific surgical consult Voalte role

- Compare survey data prior to the addition of the Voalte role with survey data 6 months post implementation

Results (to Date)

- Due to the COVID-19 delay in starting projects, results have not yet been collected

Discussion: Barriers & Next Steps

Barriers

1. COVID-19
   > Reduced staffing resources
   > Disrupted patient care services
   > Social distancing and PPE guidelines

2. Buy-in from Stakeholders
   > Inconsistent completion of communication skills validation
   > Staff turn over on patient units resulting in reconstruction of teams

Next Steps

- GME
  > Ensure that AIDET evaluations are being completed and reported by programs
  > Continue to collect data

- IM/FM

- Surgery
  > Collect data

- OB/Gyn
  > Deployment on hold due to no centering permitted yet

Quality Improvement and Antimicrobial Stewardship in the ICU

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Background & Aim

Background and Context

> A quality improvement initiative on anti-microbial stewardship revealed the rate of vancomycin use in our ICU patients was above national standards.

> A changed was instituted in our ICUs from using nasal cultures to PCR testing for MRSA screening to decrease vancomycin usage. After implementing this change, no impact on vancomycin usage was discernible even though screening results were now available w/in two hours.

> Also discovered was that patients were not being consistently screened for MRSA on ICU entry and vancomycin days of therapy was being improperly calculated.

Aim

> To decrease vancomycin days in the ICU at two UnityPoint facilities and to increase pharmacist engagement in appropriate vancomycin usage.
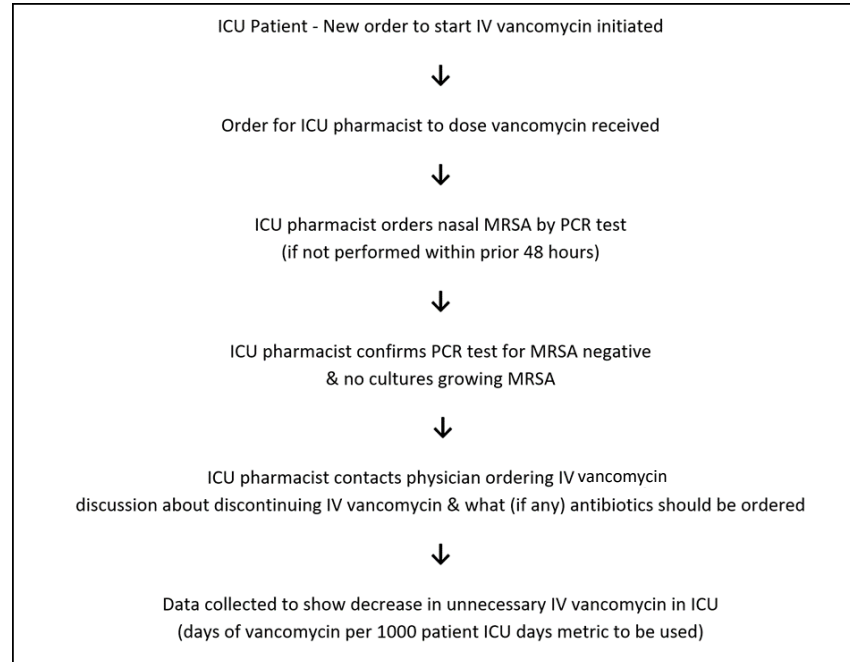
Methods: Intervention

Interventions

> Assemble an interdisciplinary team (i.e., education, nursing, medicine, pharmacy, infectious diseases, and IT data analysts).

> Acquire IRB approval for data abstraction and review

> Reveal processes for MRSA screening and vancomycin usage

> Engage pharmacists related to appropriate vancomycin usage

> Involve physicians working with clinical pharmacists to assure appropriate vancomycin usage

Methods: Measures

- Work with data analysts to properly measure vancomycin use per 1,000 patient days in ICU at each facility.

- Evaluate impact of initiative by comparing pre-intervention and post- intervention data for facilities.

ICU Patient - New order to start IV vancomycin initiated

↓

Order for ICU pharmacist to dose vancomycin received

↓

ICU pharmacist orders nasal MRSA by PCR test
(if not performed within prior 48 hours)

↓

ICU pharmacist confirms PCR test for MRSA negative
& no cultures growing MRSA

↓

ICU pharmacist contacts physician ordering IV vancomycin
discussion about discontinuing IV vancomycin & what (if any) antibiotics should be ordered

↓

Data collected to show decrease in unnecessary IV vancomycin in ICU
(days of vancomycin per 1000 patient ICU days metric to be used)

Discussion: Barriers & Next Steps

Barriers

> Communicate change in MRSA screening and availability of results to all providers (nurses, pharmacists, physicians, etc.) across the two campuses will be difficult.

> Quantify days of vancomycin therapy – metric calculated by data analytics.

Strategies

> Update pharmacists' ICU Clinical Practice Agreement and implement MRSA test ordering privileges in EHR.
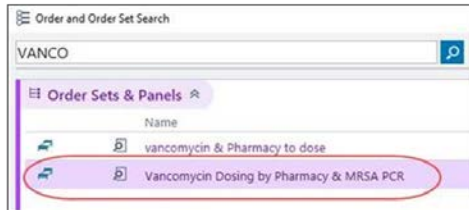
Next Steps

> How can we best hardwire changes?

> How is ICU prescribing and discontinuing vancomycin in possible MRSA infection patients managed at your facilities?