Our Field Was Always About Change

The Case for Change

- "It is not the strongest of the species that survive, nor the most intelligent, but the one most responsive to change." – Charles Darwin
- "You never change things by fighting the existing reality. To change something, build a new model that makes the existing model obsolete." – Buckminster Fuller
- "In times of rapid change, experience could be your worst enemy." – J. Paul Getty
- "When you’re finished changing, you’re finished." – Benjamin Franklin
- "Company cultures are like country cultures. Never try to change one. Try, instead, to work with what you’ve got." – Peter Drucker
- "I put a dollar in one of those change machines. Nothing changed." – George Carlin
Our Goals for this Session

• Describe some hospitalist program innovations that worked
• Describe at least one hospitalist program innovation that didn’t work
• Draw general lessons from both
• Stimulate all of us to think about the need for innovation in hospital medicine, and the ingredients for success

At Your Hospital, Do You Have...

1. A hospitalist-led ED throughput/active bed mgmt initiative
2. A surgical co-management program
3. A robust program to promote discharges earlier in the day
4. A robust program to improve pt satisfaction
5. 2-3 of the above
6. All four of the above

Which of the Four Do You Think Failed?

1. A hospitalist-led ED throughput/active bed mgmt initiative
2. A surgical co-management program
3. A robust program to promote discharges earlier in the day
4. A robust program to improve pt satisfaction
Prerequisites for Successful Innovations

- Is it **IMPORTANT**?
- Is it **EASY** to measure?
- Can someone actually **DO SOMETHING** about it?

Hospitalist Interest
Institutional Need

QI sweet spot

Examples of Successful Innovations

And one failure

Hopkins Bayview Hospitalist QI

**SUCCESSFUL**
- LOS reduction
- Ambio diversion
- ED throughput
- ABX utilization
- Discharge process
- Housestaff duty hour reduction
- New unit opened
- Patient satisfaction
- Hospitalist satisfaction

**NOT SUCCESSFUL**
- Early in the Day DC
Reducing ED crowding through Active Bed Management

Or

How to have hospitalists increase ED throughput, decrease ambulance diversion and still have friends

ED Crowding is a BIG DEAL

- IOM: EDs “in crisis” with 91% crowded
- ED crowding is dangerous:
  - Increases death (ambulance diversion)
  - Increases morbidity (ABX time for CAP, pain)
  - Poor care for pain patients.
  - ICU patients at risk (ICU mortality & LOS)
- ED crowding costs a fortune

The History @ JHBMC

- In FY06 “red alert” diversion* at 2026hrs
  - Bayview #1 in Red Alert!
- Solutions failed year after year
- New proposals to fix infrastructure cost millions (focused on increased academic-based intensivists)

*In Maryland Red Alert is ambulance diversion due to lack of monitored ICU beds
Hospitalists had an Idea:
Active Bed Management (ABM)

- Use hospitalists to increase efficiency of existing physical inpatient space
- Triage to all of DoM (patient "goes up" when hospitalist says so)
- Proactively manage ICU beds
- Appoint a Bed Czar (Eric Howell)

Red Alert by FY

- Goal 1200 by FY
- Red Alert (hours)

Effect of ABM on ED Admit LOS

- Goal 360 minutes
ED Volume Control and Intervention

<table>
<thead>
<tr>
<th>Control</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>15000</td>
<td>15500</td>
</tr>
<tr>
<td>16000</td>
<td>16500</td>
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<tr>
<td>18000</td>
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Hospitalist Active Bed Management

- ED problems often are not under ED control
- Boarding is a significant contributor to crowding
- Hospitalists can have positive impact on EDs:
  - Ambulance diversion
  - ED LOS
  - Other important services (angioplasty) have gone up

Why Did This Project Work?

- ED Crowding IMPORTANT!
- Ambulance diversion EASY to measure: state does it
- It was advanced QI, but hospitalists could DO SOMETHING
AND WE DIDN'T STOP THERE:
E-TRIAGE

Hospitalists iteratively improving the admissions process
Hospitalists and Patient Satisfaction

Or
How to make the hospital, the patient and hospitalists happy!

MD Composite Questions (5)
>439 surveys

Composite MD

Goal 70th %

Time spent
Concerned MD
Kept informed
Friendly MD
Skill of MD

Composite MD by Unit

Goal 70th %

Bridgeview
Med A
Med B
My name is Alejandro Mendez, M.D., and I am a hospitalist physician with the Collaborative System Medicine Service (CSMS) at Johns Hopkins Hospital. I will be caring for you during your stay.

To contact me while you are in the hospital, please ask your nurse to page your health care provider.

After you are discharged from the hospital, you should direct any questions to your primary care provider. However, if you need to reach a member of the hospitalist team, please call the CSMS administrative office at 410-550-0030. The CSMS staff is available to answer calls Monday through Friday, 9 a.m. to 5 p.m. After hours, someone will return your call as soon as possible.

If you are experiencing a medical emergency after you are discharged, please call 911.

Patient Satisfaction Results

You received this message on 11/09/2011 5:19 PM.

To view your responses, please visit our online response system at

Patient: Jane Doe, January, 2011; 12:13 PM

Hospital: Duke University Hospital

[Patient satisfaction scores and comments are shown here, indicating areas for improvement or commendation.]

Great company, we have improved in every single category compared to the previous data period. Now it is time to help improve.

Number of QDIs on the acute unit and total QDIs are defined.

[Responses to specific questions are listed below.]

Advised.

Overall physical score (0-100)

[Bar chart showing patient satisfaction scores for various aspects of the hospital experience, with a legend indicating the scale and specific categories rated.]
What helped?

• Bridgeview
  – Team based really works
  – Faculty know staff and staff know faculty
• Passionate Leader (Alejandro Necochea)
  – He is smart & dedicated to the cause
  – Patient centeredness exudes from him
  – Knock, touch and tell
  – Patient friendly cards
  – Specific Individual feedback

Why was this Successful?

- IMPORTANT
  - To hospital
  - To hospitalists
- Easy to Measure
  - PG tracked quarterly
  - Source trusted by both hospital & hospitalists
- Hospitalists can DO SOMETHING (change workflow)

The UCSF Neurosurgery/Hospitalist Co-management Service (CNS)

• Pre-2007, ADC 55 pts, managed by 1 PGY2
  – Tremendous clinical need, concerns about safety
• Began 7/1/07: selected hospitalists do 6-12 wks
  – Support comes from med center
  – “Worth” about 50% more than a ward month
• Triage rules: ADC 12-15 patients, there for rest
• Rules of engagement: No burr holes, collegiality, responsiveness
Hospitalist-Neurosurgery Co-Management:
Neurosurgery MDs,NPs Attitudes

<table>
<thead>
<tr>
<th>Variable or statement</th>
<th>Average rating before CNS</th>
<th>Average rating after CNS</th>
<th>P value for change†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, neurosurgery patients receive high quality care for their medical problems:</td>
<td>3.3</td>
<td>&gt; 4.6</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Patient's medical problems are promptly recognized and appropriately addressed.</td>
<td>3.9</td>
<td>4.0</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Medical problems are adequately addressed when patients are discharged.</td>
<td>2.7</td>
<td>4.4</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>The presence of a hospitalist improves care for neurosurgery patients:</td>
<td>N/A</td>
<td>4.9</td>
<td>N/A</td>
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Hospitalist-Neurosurgery Co-Management:
Neurosurgery Nurses Attitudes

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</thead>
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<td>I can easily and promptly reach a provider when I have concerns or questions about a patient’s medical problems:</td>
<td>3.1</td>
<td>4.2</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>I understand the care plan for my patient’s medical problems:</td>
<td>3.4</td>
<td>4.1</td>
<td>0.0004</td>
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<td>Overall, neurosurgery patients receive high quality care for their medical problems:</td>
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<tr>
<td>The presence of a hospitalist improves care for neurosurgery patients:</td>
<td>N/A</td>
<td>5.0</td>
<td>N/A</td>
</tr>
<tr>
<td>The presence of a hospitalist makes it easier for me to do my job:</td>
<td>N/A</td>
<td>4.8</td>
<td>N/A</td>
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Outcomes of Co-Management

- No change in mortality, readmissions
- 6% decrease in hospital costs (p=0.05)*
  - Equivalent to $1439/hospitalization
  - Annualized on neurosurgery, savings would be $3.5 million/year
  - Cost of CNS intervention: ~$500,000
  - Thus, ROI of ~7:1
- Then came the really surprising stuff...

* Auerbach, Arch Intern Med 2010
Quinny Cheng, Winner, UCSF Departmental Teaching Award

...For the Department of Neurological Surgery!

Cat Lau, Director of Quality and Safety...

...For the Department of Neurological Surgery!

Why Was This Successful?

- **IMPORTANT**
  - To hospital and key dept.
  - To hospitalists
  - Positive results were obvious
  - Both improved pt. care and increased satisfaction
  - Role was manageable, well supported, reasonable rules of engagement
  - Hospitalists enjoyed the work and felt good about making a difference
  - Relationships led to amazing spin-off benefits
And finally
ONE FAILED PROJECT

Early in the Day DC

- Discharges occur late in the day
- Admissions wait for occupied beds
- Backs up ED
- Causes a tsunami of admissions when beds open
- Docs and nurses get overwhelmed
- Patients complain

Attempts to Fix since 2004

- ID "get better dx" → FAILED
- Case manager rounds → FAILED
- ID LOS on Admit → FAILED
- Schedule "discharge time" → FAILED
Why Did this QI Project Fail?

- IMPORTANT
  - To institution
  - +/- hospitalists
- X Not easy to measure
  - No one could measure:
    - Order
    - Order after POE
    - Small, not trusted
- X Hospitalists unable to do something
  - Could not change pharmacy for filling meds
  - Unable to change transport issues to NH/SNF
  - Patient expectations not addressed

To this day Hopkins Bayview struggles with this issue

Thank You!

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