Lurie Children’s Hospital ABP MOC Portfolio

ABMS meeting
May 14, 2015
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Chair, Department of Pediatrics Quality Improvement TEam

Patient-focused. Purpose driven.
History of Lurie Children’s portfolio

• Planning started in 2010; approved in 2011 after ABP site visit; reapproved in 2013
  • Projects included hospital initiatives and division/program/community-based initiatives
• Overseen by Department of Pediatrics Quality Improvement Team
  – Multidisciplinary team: physicians, nurses, administrators, staff from the Center of Excellence
  – “Volunteer army”, open membership
    • All project leaders invited to be members
    • Representatives from LCH Center of Excellence
  – Initially had dedicated data analytic and staff support
  – New staff support model since summer 2014: Medical Staff Office
    • Sharepoint maintenance
    • Communication and tracking
    • MOCinfo email address
Physician attestations 2013-2014

• 2013: ~ 200 (> 50% community based MDs)
• 2014: ~ 125

• Examples
  – Safety: Recognition and Early Treatment of Sepsis
  – Effectiveness: Bronchiolitis Care Guideline
  – Patient-centered: Family-centered rounding
  – Efficiency: Timely and Efficient Asthma Care in the Emergency Department
Family Centered Rounds: Improving Efficiency and Increasing Family Satisfaction

Project Lead & Team Members: Susanna McColley, MD, Cynthia Castiglioni, MD

Project Start Date: 1/1/2013
Project End Date: 12/31/2014

**Problem Statement:** Family-Centered Rounding (FCR) is consistent with the Institute of Medicine goal of patient-centeredness and has been shown to increase efficiency, safety and both family and staff satisfaction. Participation in FCR is not currently tracked on the General Medicine Service at our partner hospitals. The Department of Pediatrics has included full implementation of FCR as a departmental goal for this academic year at all sites. This proposal will lead to full implementation of FCR on the hospitalist services at several of our outreach hospitals.

**Aim Statement:** Achieve participation in FCR of 90% of hospitalized patients/families and parent satisfaction of “satisfied” or “highly satisfied” with family centered rounds of 90% or above by Q4 2013.

**Project Defined**

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**Implementation**

**Measurement/Analysis**

- **What outcomes are being measured?**
  - Family/Patient Participation
  - Family/Patient Satisfaction regarding concerns heard, time spent with physicians, and communication between healthcare providers.

- **What process metrics are being measured?**
  - Family Notification/Education
  - Nurse Participation
  - Discharge Criteria/Planning Reviewed

- **Project Update**
  - Walk rounds were performed at multiple community sites with no indication of how often parents and nursing were present and involved in patient decision making.
  - There is no baseline data at these sites of patient satisfaction with the rounding process.

- **Explanation of Key Drivers:**
  - Family Centered Rounding has been shown to increase patient and family satisfaction. In order to be effective, families need to understand what is FCR, how they can participate, and when rounding will occur. Nursing participation has been shown to be a key factor in successful implementation of FCR and improving patient satisfaction. Finally, increased efficiency in obtaining tests and facilitating discharges can be improved with bedside ordering during rounds and ensuring that everyone understands the goals of treatment and the criteria for discharge.

- **How many patients have been affected or how much data has been collected?**
  - Patients admitted onto the inpatient pediatric hospitalist service at several community hospitals who contract with the Ann & Robert H Lurie Children’s Hospital of Chicago. Patient census varies by site. Start dates for each site also varied.

- **Did participants submit data reliably?**
  - Data collection regarding parent and nursing participation was collected by physicians at each site. Family surveys were provided at time of discharge or daily based on site census or preference.

- **How many participants submitted data at least 80% of the time? 100%**
  - What is the level of data quality (the rate of errors in the data) and explain how this is determined.
  - Physicians completed the data collection sheets at different times (during rounds vs by recollection after rounds).

- **Explain the basis for the score:**
  - Three out of 4 hospitals had greater than 90% participation among families and nurses. Family satisfaction scores were positive overall, although all sites report low survey return.
  - At 3 sites, obtaining consistent nursing participation has been the greatest area of difficulty.

- **What changes have been effective for achieving improvements in care?**
  - This is an initial period of data collection, no changes yet initiated.

- **Select the QI project’s current score on the Improvement Progress Scale from the table above.**
  - 1.5 - Measurement began on 4 new sites with no baseline data to this point.

- **Results**
  - Northwest Community Hospital
  - Presence Mercy
  - Vista East

- **Results (cont.)**

- **Lessons Learned & Conclusions**
  - What have been the biggest barriers you have encountered?
    - Physicians completing consistent nursing participation has been the greatest area of difficulty.

- **Do you plan any major changes to the project in the coming year?**
  - There are no major changes proposed, although each site is working independently to encourage FCR participation.

- **Do you plan to spread this project or share what you have learned?**
  - Data from all 4 sites will be shared amongst each other and there is opportunity for each to share their experiences.

- **Is the project renewing for another two years?**
  - This project will be up for renewal the December 2013.

**References**

## SWOT analysis

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<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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<tr>
<td>• Portfolio driven by physicians: focused on discrete needs of our patients</td>
<td>• No time allocation for participants; leads to delays and fewer applications</td>
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<td>• Many physicians with advanced QI training</td>
<td>• QI training for MDs has been basic and project-specific</td>
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<td>• Center of Excellence QI projects can be included as a “carrot” for MD participation</td>
<td>• Lags in data and quarterly reporting</td>
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<td>• Multidisciplinary “self propelled” team</td>
<td>• Slow “start up” to tests of change</td>
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<tr>
<td>• Opportunity to link to OPPE</td>
<td>• OPPE not formally linked</td>
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<tr>
<th>Opportunities</th>
<th>Threats</th>
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<tr>
<td>• Improve QI education/ centralize</td>
<td>• Multiple competing commitments for team members</td>
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<tr>
<td>• Engage training program</td>
<td>• Value of large impact to small population can get lost</td>
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<td>• Engage patients and families in QI efforts</td>
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<td>• Offer administrative time offsets to physicians</td>
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<td>• Publish QI projects: positive impact on reputation, faculty promotion</td>
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Questions, Comments?

QUALITY

The Race for Quality has no finish line—so technically, it’s more like a Death March.