

Abstract IHI ID 10 Table 1 Pearson correlations of SEP-1 bundle compliance versus hospital complications and quality, controlling for number of staffed beds

Control Variables	Variables	Hospital Sep-1 Bundle Score	
		Coefficient	P-Value
None	Composite Complication Rate	-0.103	<0.001
	Staffed Beds	-0.114	<0.001
	Average Length of Stay	-0.118	<0.001
	Readmission Rate	-0.013	0.480
Staffed Beds	Composite Complication Rate	-0.093	<0.001
	Average Length of Stay	-0.058	0.002

Records missing SEP-1, complications, and discharge data were excluded. Pearson correlation, controlling for staffed beds, and an independent t-test were used for analysis.

Results A total of 2796 hospitals met inclusion criteria. An increased SEP-1 score was negatively associated with PSI-90 ($r=-0.103$, $p<0.001$), staffed bed number ($r=-0.114$, $p<0.001$), and ALOS ($r=-0.118$, $p<0.001$). There was no association with 30 day readmission rate ($p=0.480$). PSI-90 and ALOS remained significantly correlated with SEP-1 while adjusting for staffed beds. Figures 1 to 4 show independent t-test results relating SEP-1 scores to higher – and lower-performing hospitals on each of the indicated quality measures.

Conclusions Higher performance on SEP-1 compliance is associated with lower composite complication rate and shorter length of stay. The inverse relationship between SEP-1 compliance and hospital size may reflect the challenges associated with implementation of new protocols in large, complex hospitals. While this study does not establish a

causal relationship, the ability of hospitals to successfully implement SEP-1 may suggest a higher level of overall operational excellence.

IHI ID 11 INTERPROFESSIONAL TEAM HUDDLE TO OPTIMIZE CARE DELIVERY TO PEDIATRIC INTENSIVE CARE UNIT (PICU) FAMILIES WITH COMPLEX PSYCHOSOCIAL STRESSORS

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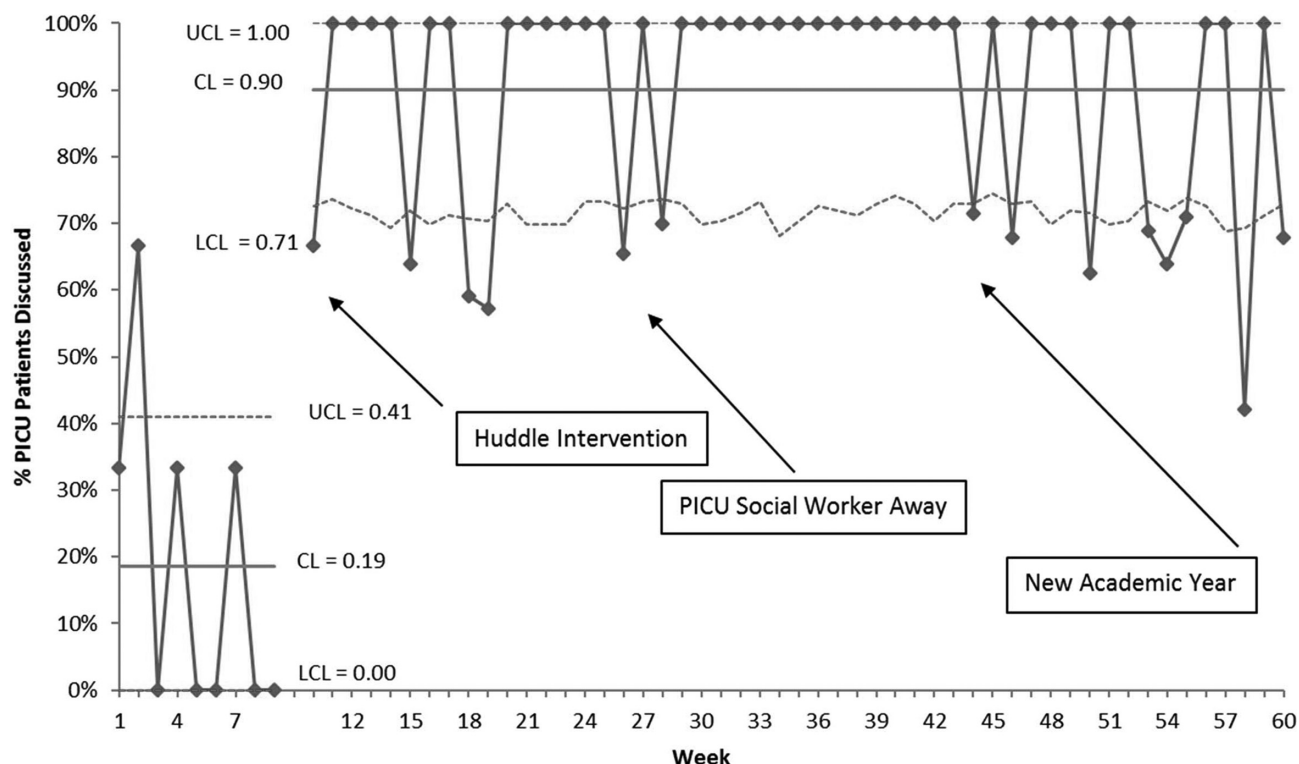
10.1136/ihisciabs.11

Background Families with children admitted to the PICU experience complex emotional, psychological and financial stressors. Even though interprofessional teams can miss need identification or have duplicative efforts, compromising family-centered, high-quality care. In 2016, the interprofessional care team formally reviewed psychosocial stressors in 19% of PICU patients.

Objectives To increase PICU patients formally reviewed for psychosocial stressors by 30% over 12 months.

Methods The interprofessional team met to identify barriers to psychosocial care. Interventions included a time-limited, thrice-weekly interprofessional huddle guided by a checklist. Process measures included frequency of huddles and member participation. Balance measures monitored time spent waiting for huddle. Performance over time was tracked with statistical process control (SPC) methodology. New interventions were introduced through PDSA cycles based on drivers of special cause variation.

Results PICU patients formally discussed by the interprofessional team increased from 19% to 90%. Huddle frequency



Abstract IHI ID 11 Figure 1 PICU psychosocial discussions by interprofessional team (p chart, 3 sigma, n=1,511)

increased from 18% to 89%. Delayed start time averaged 6 min. Huddle broke down when the social worker was absent. Education beyond the primary team and a system to identify a back-up team leader were developed.

Conclusions With sustained focus on outcome of all patients having psychosocial needs addressed, there was significant and sustained change. Use of SPC informed subsequent PDSA cycles. When huddle convened there was sufficient time to discuss the entire census. Addition of the question, Would you be surprised if this patient were to die in the next 6 months? appears to be a powerful trigger for early palliative care consultation. Further data collection will determine if change is sustainable.

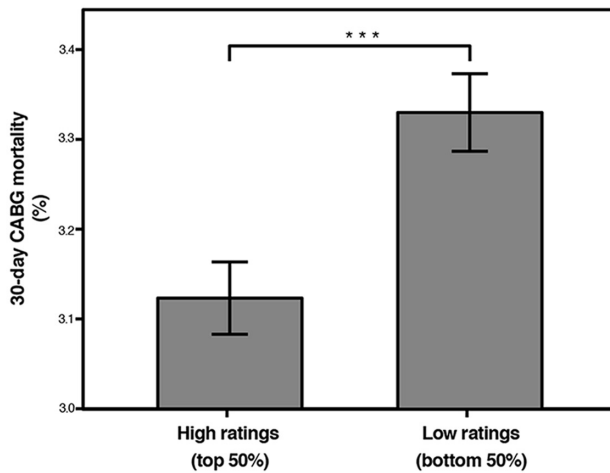
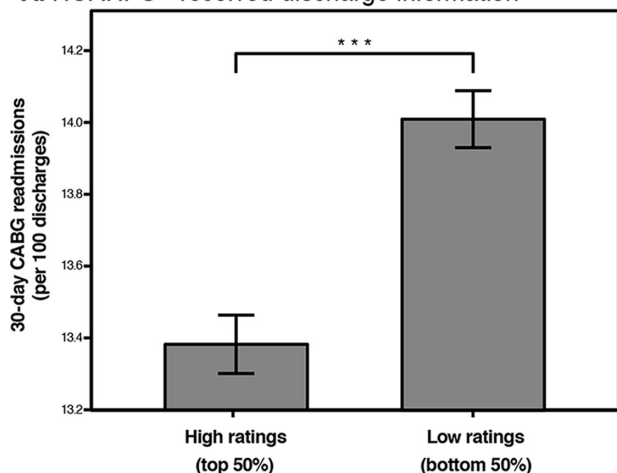
IHI ID 12 PATIENT RATINGS OF DISCHARGE INFORMATION AND CARE TRANSITION IN HCAHPS SURVEY PREDICT 30-DAY CABG MORTALITY AND READMISSIONS

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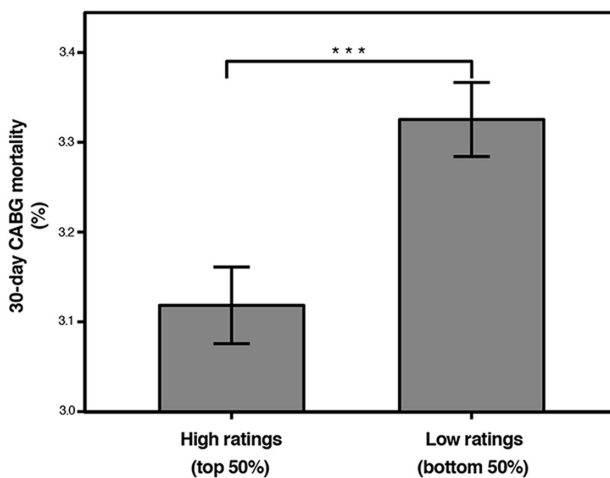
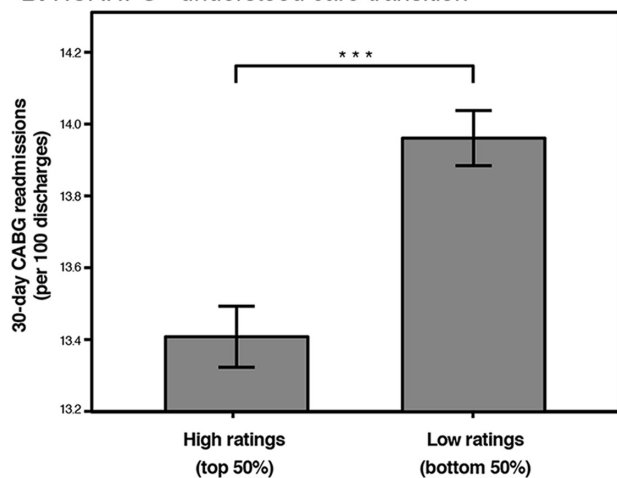
10.1136/ihisciabs.12

Background Improved discharge planning has been implicated in reducing post-operative complications. Readmissions and

A. HCAHPS - received discharge information



B. HCAHPS - understood care transition



Abstract IHI ID 12 Figure 1 30-day CABG readmissions and mortality rates by HCAHPS ratings of discharge planning (A) Readmissions and mortality rates (morbidity-adjusted) between hospitals scoring in the top half (n=474 and n=469, respectively) and bottom half (n=551 and n=548) on HCAHPS ratings of discharge information. (B) Readmissions and mortality rates between hospitals scoring in the top half (n=448 and n=446) and bottom half (n=577 and n=571) on HCAHPS ratings of care transition. Bars represent mean ±SEM, ***p<0.001, compared by two-tailed independent t-test