Percent of Patients Receiving Family Centered Rounds

Abstract 28 Figure 2 Percent of patients receiving family centered rounds (FCR). Patients receiving FCR increased from 93 (59%) to 136 (93.6%), achieving the project's aim. Thirty percent more patients received FCR following PDSA Cycle 4 compared to baseline (95% CI 19, 40). *Data was not collected for PDSA Cycle 3

Occurrence of Trio Rounds

Abstract 28 Figure 3 Percent of patients receiving trio rounds. The second outcome measure involved improving physician-nursing communication utilizing trio (physician, nurse, caregiver) rounds. There was a 22% increase in trio rounds since implementing geographic-based teams and increasing daily FCR, thus far. *Data was not collected for PDSA Cycle 3. Data for PDSA Cycle 4 is currently being collected and results will be available at time of post presentation

Percent of Rounds Exceeding Allotted Time

Abstract 28 Figure 4 Percent of rounds exceeding allotted time. This balancing measure looked at the time it took to conduct rounds. The percentage of rounds exceeding the allotted time remained relatively stable from a baseline of 36% (N=5) to 31% (N=5) as of PDSA Cycle 4. *Data was not collected for PDSA Cycle 3. Unit-based teams potentially allowed for more efficient rounding as more patients received FCR without increasing the duration of rounds

Objectives This project's aim was to increase the percentage of patients receiving FCR from 59% to 90% in 6 months.

Methods The Model for Improvement and sequential PDSA cycles were utilized. The process of assigning patients to physician teams was delineated, teams were restructured, and FCR was standardized. The percentage of patients on their geographic team-based unit (process measure) was collected daily. Convenience sampling was used to obtain the frequency of FCR, care team communication measured via 'trio rounding' between physician, nurse, and caregiver (outcome measures), and duration of rounds (balancing measure).

Results The percentage of patients geographically assigned improved from a median of 40% (25th, 75th percentiles 38, 41) to 96% (25th, 75th percentiles 95, 100), figure 1. Patients receiving FCR increased from 93 (59%) to 136 (93.6%), figure 2, achieving the project's aim. Trio rounding frequency is improving (33, 35% to 38, 45%), figure 3, with data for the current PDSA cycle being collected. Rounds exceeding the allotted time remained stable (5, 36% to 5, 31%), figure 4.

Conclusions By increasing the percentage of patients on unit-based teams, 30% more patients received FCR (95% CI 19, 40) without prolonging rounding time. Results may be generalizable to similarly sized hospitals and residency programs. Future interventions will focus on improving FCR effectiveness.

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ACHIEVING MEANINGFUL HEART FAILURE READMISSION REDUCTIONS IN A SAFETY NET HOSPITAL

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Background Heart Failure (HF) the most frequent MS-DRG resulting in 30 day readmission is a major focus of readmission reduction initiatives. Achieving meaningful and sustained reductions in HF readmissions in a Safety Net Hospital is particularly challenging. Boston Medical Center achieved this goal through designing a robust slate of multidisciplinary interventions tapping existing institutional resources in new ways.

Objectives Design a slate of multidisciplinary interventions that lower BMC's average 30 day Medicare HF readmission to less than 19% by May 2019.

Methods Using PDSA methodology a multidisciplinary team implemented interventions addressing care processes, co-morbidities and social determinants of health. Effectiveness was monitored through automated performance dashboards. Interventions included (1) Inpatient HF Consult Criteria patients not on Cardiology teams; (2) Standardized RN Teach Back and EPIC smart phrases discharge documentation; (3) VNA support HF home discharges, preferential respite admission when homelessness; (4) HF Clinic Nurse Practitioner follow up appointments within 7-14 days discharge ;(5) Scripted call day prior Cardiology appointment to mitigate barriers to arrival;(6) Concurrent Renal consultation CKD IV or V patients not on hemodialysis.

Abstract 29 Figure 1

% HF Consult on Non Cardiology Teams

HF % Home Discharges with VNA Services

Abstract 29 Figure 2

Abstract 29 Figure 3

Results In the six month prior to QI initiative, BMC's Medicare 30 day HF readmission rate averaged 26.85% which decreased to 15.2% (12/1/18–6/30/19) as the slate of interventions fully activated. Total HF readmissions showed similar decrease from 23.9% to 17.2%.

Conclusions BMC demonstrates that meaningful Heart Failure readmission reductions can be achieved Safety Net Hospitals by tapping into existing institutional resources in new ways. Planning permanent accountable team, automated dashboards and robust feedback loops insure reductions seen are sustained.

30 REDUCING IATROGENIC LOW BLOOD GLUCOSE EPISODES DURING HOSPITAL MANAGEMENT OF PEDIATRIC DIABETIC KETOACIDOSIS

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Background IV insulin therapy, the treatment for pediatric diabetic ketoacidosis (DKA), may lead to iatrogenic low blood glucose episodes (BG <100 mg/dL). At our institution, 53% of DKA patients on IV insulin experienced BG <100 mg/dL episode resulting in premature discontinuation of insulin and delays in therapy.

Objectives We aimed to decrease the percent of DKA patients experiencing BG <100 mg/dL episodes while on IV insulin from 53% to 43% over 24 months.

Methods Multiple interventions linked to key drivers were tested using plan-do-study-act cycles including a standardized DKA guideline incorporating the two-bag fluid system, order panels, frequent blood glucose monitoring, and provider and nursing education. The primary outcome was the percent of DKA patients experiencing a BG <100 mg/dL episode while on IV insulin. Order panel utilization rate was the process measure. Balancing measures included length of stay, time to correction of acidosis (time to HCO₃ >17), and admission