Fostering Effective Communication Among Health Care Providers

Louis Brusco, MD — Moderator
Chief Medical Officer and Senior Vice President
Mount Sinai St. Luke’s Roosevelt
Enhancing Physician–Nurse Communication in a Co-Management Project

Alan Briones, MD
Shalom Simmons, RN, MSN, BSN, BBA
Mount Sinai Hospital
Enhancing MD–RN Communication
Enhancing MD–RN Communication

BUILDS teamwork

RESOLVES conflicts

IMPROVES patient care

DEVELOPS alliance

GAINS respect for each other

EMPOWERS nurses’ decision making

SATISFIES work roles
Thoracic Vascular Surgery Step Down

• 34-Bed Telemetry Unit with 10 Intermediate Care Beds
• 48 Specialty Trained Nursing Staff

  – Thoracic Surgery
    • Self-contained service
    • Physician assistants (do not rotate)
    • Resident rotates annually
  – Vascular Surgery
    • Interns/residents rotate monthly
    • Surgeons are in the OR all day
    • One NP for the service on days, five days per week.
    • One PA focus on for the service on days, five days per week.
    • Night PAs rotate through General Surgery
The Vascular Surgery–Hospitalist Co-Management Program is an initiative to promote safety and improve quality of care of high-risk surgical patients. Several studies have shown that co-management decreases postoperative complications and improves provider satisfaction. This program aims to:

1. Improve patient satisfaction
2. Decrease cost and length of hospital stay
3. Decrease morbidity, including postoperative complications
4. Decrease readmissions
5. Enhance MD–RN communication
• **Getting to Know One Another**
  – Pre-implementation nursing survey, unit huddles, meetings with nursing leadership and interdisciplinary staff

• **Find Time and Place to Meet and Discuss Issues**
  – Nurse manager facilitates monthly interdisciplinary meetings that include the vascular physician champion, Hospitalist director and nurses, to review quality scores and metrics

• **Hospitalist Attend Interdisciplinary Daily Rounds**
  – Rounds streamlined with Hospitalist input; forum allows for expressing clear ideas, active listening
The Co-Management Program Benefits to the Nursing Staff include:

- **Hospitalists Are Visible on the Unit**
  - Nurses questions are answered quickly
  - Nurses trust the Hospitalist’s decisions and feel included in the decision-making process

- **Experts in DM Management**
  - Endocrine consults continue to decline
  - Decisions to adjust DM medications are made in “real time”

- **Patient Emergencies**
  - Hospitalist assists interns/residents in making decisions to decrease morbidity/mortality
  - Decreases nurse frustration
Enhancing MD–RN Communication

Strategies

• Get to know one another
• Define roles and expectations (esp. during patient emergencies)
• Express ideas in clear language
• Find time and place to meet and discuss issues
• Contain negative behaviors and promote positive ones
• STOP blaming people! Admit mistakes or oversight
• Negotiate respectfully and manage conflict wisely
• Use electronic communication thoughtfully and appropriately
• Respect authority and hierarchy
• Actively listen to what people have to say
Enhancing Surgeon–Hospitalist Communication in a Co-Management Project

Michael Leitman, MD
Dahlia Rizk, DO
Mount Sinai Beth Israel
Why Do Co-Management?

Who’s in charge?
What are the rules?
Do we have the resources to staff and fund this?
What are we hoping to achieve?
Defining Roles

- Surgical Resident
- Surgery Attending
- Hospitalist Attending
- Does nursing staff know who to call?
- Patient experience in an already complex environment?

Interdisciplinary Communication Is Key!!
General / Vascular Surgery and Hospitalist Co-Management
Beth Israel Medical Center
SERVICE AGREEMENT

A. Background and Purpose:
The General / Vascular Surgery - Hospitalist Co-management Program is one of the HIC/FOJP’s Perioperative SWAT initiatives to promote safety and improve the quality of care of high-risk surgical patients. Several studies have shown that co-management decreases postoperative complications and improves provider and patient satisfaction. This program aims to:
1. Improve patient satisfaction
2. Decrease cost and hospital length of stay
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This service agreement defines this co-management relationship as "a shared responsibility for the hospitalized surgical patient." This relationship involves collaborative and multidisciplinary care and active participation in medical decision making; this is in contrast to the model of care of traditional medical consultation where the primary patient care responsibility resides with only the surgical team and recommendations are given on an as needed basis.

The purpose of this agreement is to delineate and outline the roles and responsibilities for the participating providers to provide seamless care and avoid overlap of functions; describe a workflow of the participating providers; and describe the mechanism on how to resolve conflict should issues arise.

This co-management program will commence on March 18, 2013 for a period of one year. Extension of the program will be determined through discussions with HIC/FOJP.

Outcomes will be reviewed and this service agreement will be revisited every 6 months and as needed and will be revised accordingly to ensure timeliness, relevance and appropriateness of protocols.
D. Post-discharge patient issues

E. Conflicts and disagreements

F. Program evaluation
   I. Baseline measures and metrics
   II. Provider/staff satisfaction
   III. NSQIP data

**Scope of practice/clinical roles and responsibilities - Hospitalists:**
- Hospitalists will actively participate in the medical care of the patient, providing guidance and support to the surgical team.
- All medical issues are addressed by the Hospitalist, including management of chronic diseases (e.g., DM, CAD, CKD, COPD, and AFIB) and acute medical complications (e.g., AKI, acute respiratory failure, sepsis, delirium, etc).
- Hospitalists will communicate with house staff and other surgery providers the recommendations for plan of action and treatment of the patient.
- Hospitalists may write orders for medicines and diagnostics tests during emergency basis; routine orders are written by surgery team.

**Scope of practice/clinical roles and responsibilities - General / Vascular Surgical team:**
- There will be no change in the usual schedule of the surgical providers, including workflow and rounding.
- Surgical representatives will participate in multidisciplinary rounds.
- Surgical issues are addressed by the surgical team.
- Surgery House staff and surgical non-physician providers will continue to use computerized physician ordering and documentation.
- Surgery team will take first call from the Nursing staff regarding any patient issues. The surgery team may contact the medicine team if the matter falls within medicine’s scope.
Successes and Challenges

Successes

• Team building and interdisciplinary collaboration

• Medical management of complex surgical patients

• Treatment of hypertension, diabetes, etc. not typically taught in surgical curriculum – Hospitalists can teach surgical house staff this skill set

• Easier transition to outpatient management with support from Hospitalists
Successes and Challenges

Challenges

• Breaking or streamlining prior referral patterns
• Geography ideal but not always achievable
• Creating time and place for the face-to-face interaction among staff
• Creating a true purpose for the consultant with information that is integrated to achieve goals
• Defining appropriate population so as not to overburden consultants with lower-acuity cases
Physician Satisfaction

Overall, surgical patients receive high-quality care for their medical problems

I am satisfied with the level of communication and collegiality with the Hospitalist/Internist

Mar 2013

- Poor: 15%
- Fair: 20%
- Good: 35%
- Very Good: 36%
- Excellent: 14%

Sep 2013

- Poor: 10%
- Fair: 20%
- Good: 40%
- Very Good: 39%
- Excellent: 22%
Nursing Satisfaction

The presence of a hospitalist/internist improves care for surgery patients

Nurses’ satisfaction with level of communication and collegiality between surgical teams

My patients’ medical problems are promptly recognized and addressed appropriately and timely

Medical problems are adequately addressed when patients are discharged
Active Interdisciplinary Communication to Improve Patient Safety and Time-Out Process

Carol Kidney, RN
Mark Kronenfeld, MD
Sameh Samy, MBBCh, MSA, CPHQ
Maimonides Medical Center
• **Wrong Site/Side Procedures**
  – Actual/sentinel events
  – Near misses (make us even more nervous!)

• **Challenges/Restraining Forces:**
  – Perfect on paper...but poor practice
  – Following standardized protocol versus autonomy
  – The concept of “hard-stop/pause” is not easily accepted by clinicians
  – Lack of ownership of process
  – Hierarchical/cultural challenges

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**Time Out Monitor – Team Engagement**
Observational Study (N = 58)
(January–March 2010)

- All team members available during the entire time-out process: 98.3%
- Actual stop/suspension of all team activities during the entire time-out process: 74.1%
- The team used the checklist: 86.2%
- Interactive participation of all members of the team: 82.8%
Call to Action!
Improvement Strategies (Road Map)

- Get the voice of the customers
- Training and education
- Process redesign
- Shared accountability
- Monitor the compliance
The Voice of the Customer

**OR Staff Survey**

<table>
<thead>
<tr>
<th>Barriers for Using the OR Checklist</th>
<th>Staff Perception</th>
<th>April–May 2012 (N = 93)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of engagement by all team members</td>
<td>43.0%</td>
<td></td>
</tr>
<tr>
<td>Lack of clarity as to who leads the process</td>
<td>21.5%</td>
<td></td>
</tr>
<tr>
<td>Time-consuming process for the OR staff</td>
<td>20.4%</td>
<td></td>
</tr>
<tr>
<td>Lack of adequate training for OR staff</td>
<td>9.7%</td>
<td></td>
</tr>
<tr>
<td>Process driven by regulatory forces, not by clinical evidence</td>
<td>5.4%</td>
<td></td>
</tr>
</tbody>
</table>

Some comments from end users:

- “Show me the data…. It’s not an evidenced based protocol.”
- “Checklist is too long.”
- “It’s redundant… too much paperwork.”
- “It won’t make a difference.”
- “We just do it because the state wants us to do it.”
- “Nurses should be the ones who remind us to do the time out.”
System/Process Redesign

• More Focused and Meaningful Checklist
• Active Participation
• Marking Process (confirmed by all team members)
  – Resolve any discrepancies or disagreements before proceeding with surgery

Pre-Procedure Time Out

• Team Member Introductions
  – Anesthesia → Proceduralist → Nursing → Others
• All team members confirm:
  – Patient Name: Patient ID band was verified in room
  – Proposed Procedure: Verified with signed unaltered consent
  – Position of Patient
  – Surgical Site Markings: Visible in prepped and draped surgical field
• Clinical dialogue:
  – Duration of procedure
  – Blood use: Projected loss; status of products; religious concerns
  – Paralysis: Needed or contraindicated intra or post-op
  – Allergies
  – Prophylactic Antibiotics: As per SCIP
  – Beta Blocker: Within the last 24 hours
  – Venous Thromboembolism Prophylaxis
  – Any Critical Anesthetic/Surgical Issues
• Equipment and Post-Operative Disposition Dialogue
  – Specialized Equipment or Prosthetics available
  – Essential Imaging displayed and confirmed by proceduralist
  – Pathology specimen management
  – Post-operative Disposition/Isolation communicated in PACU/ICU/Step-down
  – Is Ventilator needed and set up?
  – Other pertinent issues
• Reconfirm correct side and view markings
  – Does ANYONE have any objections to the proposed procedure?
Training and Education:

1. Traditional in-service and education

2. Team STEPPS Training
   - Staff are empowered to SPEAK UP if they have a question or concern
   - Staff can STOP the procedure if there is any discrepancy in information identified by any member of the team

3. Simulation

Accountability:

- The Just Culture concept
- Ongoing monitoring (observational studies)
- Sharing the data
Check the Results

Time-Out Observations (July–August 2013)  
(N = 98 Cases)

- All team members present: 98%
- All activities suspended: 89%
- All TM engaged: 91%
- Verified ID band: 99%
- Surgeon confirmed procedure: 99%
- Entire team observes and marks: 94%
Lessons Learned

• Early end-user feedback of a new process is necessary

• Senior leadership support is critical for implementing change

• Physician buy-in is essential for success

• Acknowledge and celebrate accomplishments!
Using Simulation to Enhance Provider-to-Provider Communication in an Obstetrical Setting

Dena Goffman, MD
Colleen Lee, MS, RN
Montefiore Medical Center
Why Multidisciplinary Simulation-based Team Training?

Several studies point to the evidence:

Draycott group:

BJOG, 2006:
- Before and after a required, annual, one-day course for all staff of emergency drills and FHR tracing interpretation:
- Rates of 5 minute Apgar ≤ 6, HIE, and moderate/severe HIE all decreased

OBGYN, 2008:
- Despite similar rates of shoulder dystocia, rates of newborn injury and brachial plexus injury significantly decreased after the same course

BJOG, 2009:
- 40% reduction in median DDI in cord prolapse

Phipps et al. AJOG, 2012:
- Post-implementation of a crew resource management (CRM) training course with medical simulation:
  - Correlation of clinically and statistically significant reductions in the obstetrical adverse outcomes index (AOI)
  - High rates of patient satisfaction maintained
  - Staff’s impression of the institution’s attitude toward patient safety improved

Unpublished US data
• Montefiore Medical Center: RPC with approximately 7,000 deliveries/year
• Patient population is generally high-risk with multiple comorbidities
• Need for improved communication and coordination of care amongst all disciplines on the labor floor for complex patients
• Started in 2010 with L&D personnel (OB attendings, MFM fellows, residents, PAs, CNMs, and RNs)
• 2011 – added Neonatology personnel
• 2012 – added Anesthesiology personnel
• 2013 – ongoing multiprofessional program
Comprehensive Obstetrical Simulation Course

Multidisciplinary simulation-based team training course

- **Monthly half-day course for providers who work in L&D**
  - Ob/gyn attendings and residents, MFM fellows, RNs, PAs, CNMs, Anesthesiology attendings and residents, Neonatology providers

- **Teams go through several obstetrical emergency simulations (topics are changed yearly)**
  - Shoulder dystocia, VAVD, PPH, emergency CD, maternal resuscitation, neonatal resuscitation

- **Goal of course is to focus on team training skills**
  - Team STEPPS concepts incorporated into scenarios
Scenarios (Technical skills reviewed in each)

• **Year 1**: PPH, SD (w/medicolegal component–mock deposition), VAVD, eclampsia
  – Team STEPPS skills: SBAR, closed-loop communication, call-out, check-back, handoff

• **Year 2**: Shoulder dystocia (w/breaking bad news component), cord prolapse/emergent CD
  – Team STEPPS skills: briefs, huddles, debriefs, also continued to work on previous year’s skills

• **Year 3**: maternal cardiac arrest, neonatal resuscitation, VAVD
  – Team STEPPS skills: two-challenge rule, CUS, continued to work on skills from previous 2 years

• **Year 4**: maternal resuscitation, shoulder dystocia, PPH
  – Team STEPPS skills: debriefing, role clarity
Attendance at Comprehensive Obstetrical Simulation Course by Discipline

- **Attending OB/MFM Fellows**: n = 98
- **Ob/Gyn Residents**: n = 46
- **PA**: n = 7
- **CNM**: n = 2
- **RN**: n = 85

Bar chart showing attendance percentages for each discipline across different years (2010-11, 2011-12, 2012-13).
Communication for Patient Safety
March 5, 2014
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Carol Kidney, RN
Sameh Samy, MBBCh, MSA, CPHQ
Maimonides Medical Center

Kathleen Bartholomew, RN
Author, International Speaker,
Hospital Culture Expert

Dena Goffman, MD
Colleen Lee, MS, RN
Montefiore Medical Center

Communication for Patient Safety
26th Health Care Risk Management Conference
sponsored by FOJP and Hospitals Insurance Company