IMPROVING THE QUALITY AND IMPACT OF INTERDISCIPLINARY ROUNDS AT TULANE MEDICAL CENTER

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Context
- Interdisciplinary rounds (IDR) foster collaboration between provider types and establish a forum for patient care coordination.1
- The Centers for Medicare and Medicaid Services require hospitals to make a good-faith effort to conduct IDR on the majority of patients, and that records are kept of the care coordination occurring through IDR.
- Tulane Medical Center (TMC) began weekday IDR in 2012.
- The majority of medical-surgical patients are discussed at morning IDR sessions; other units conduct similar care coordination rounds at different times of day.
- In 2015, TMC sought to streamline IDR as part of a hospital-wide throughput initiative.

Aim
- Primary: Improve the quality of communication in interdisciplinary rounds.
- Secondary: Expand the IDR process house-wide at Tulane Medical Center.

Intervention
- In March 2015 we standardized the content, schedule, and participants in IDR on two TMC medical-surgical units (5 Center and 5 East).
- We qualitatively and quantitatively tracked the content of IDR by “IDR saves” before and after the changes.
- We define an “IDR save” as a discordant communication corrected.
- IDR saves:
  1. Occur during IDR.
  2. Correct a potential error in management of a patient, or clarify the best available plan of care.
  3. Avoid errors typically related to transition of care, as opposed to medical care.
  4. May coordinate outside resources, e.g. hospice discussions.
- We compared the saves-to-patients discussed ratio before and after March 2015.
- In Fall 2015, we conducted a participant satisfaction survey to assess staff perceptions of IDR and to solicit suggestions for further improvement as a house-wide expansion begins.

Results
- We found a large, statistically significant increase in the IDR saves-to-patients discussed ratio after the March 2015 process changes:2
  - Save Ratio Pre-March 2015: 6.8/100 Patients
  - Save Ratio Post-March 2015: 35.1/100 Patients
  - p=2.2X10^-4
- Fall 2015 survey data showed staff agrees that:
  - IDR facilitates safe inpatient care (19/20)
  - IDR facilitates safe discharges (16/20)
  - IDR facilitates timely discharges (10/20)

Content
- We patterned the original IDR checklist after procedure checklists.
- We modified this concept into a daily script for IDR, focusing on standardized communication, so teams address all topics.

Schedule
- We introduced specific timeslots for rounding teams and the location of medical-surgical IDR was divided by unit.

Participants
- Many of the same departments participated in IDR before March 2015 as currently participate; however, the overall number of participants decreased. We introduced a seating chart and a moderator to control the flow of conversation.

Conclusions
- The process changes significantly increased the saves-to-patients discussed ratio, which demonstrates the value of focused care coordination such as the IDR process.
- We cannot identify specific drivers of this increase because of small numbers of save types; however, conversations are clearly more focused, efficient, and productive.
- IDR participants agree that our IDR process achieves certain goals, but the survey highlights areas for improvement.

Next Steps
- We plan to continue tracking the content of IDR with particular attention to fidelity to the script.
- Care teams will highlight target patients—those anticipated to have a greater number of care coordination needs—before daily IDR to triage patient panels and further improve discussion efficiency.
- We will expand IDR to units that do not currently have a procedure for daily care coordination rounds (SICU, 6 West).

Assessment Methods

Figure 1: Checklist of topics to be addressed in IDR.

Figure 2: Current physician script for IDR.

Figure 3: Old, loose schedule.

Figure 4: Current daily IDR schedule.

Figure 5: Survey assessing attitudes of IDR participants.