Impact of Huddles on Provider’s Knowledge of Medically Complex Patients

Irina G. Trifonova  
Children's Mercy Hospital, igtrifonova@cmh.edu

Troy E. Richardson  
Troy.Richardson@childrenshospitals.org

Jessica L. Bettenhausen  
Children's Mercy Hospital, jlbettenhausen@cmh.edu

Matthew B. Johnson  
Children's Mercy Hospital, mbjohnson@cmh.edu

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Impact of Huddles on Provider’s Knowledge of Medically Complex Patients

Irina G Trifonova, MD, Troy E Richardson, MS, MPH, PHD, Jessica L. Bettenhausen, MD, Matthew B. Johnson, MD

Background

• The increasing complexity of pediatric inpatients requires that all providers have a complete understanding of a child’s medical and social needs.
• A survey administered to Children’s Mercy Hospital providers identified gaps in knowledge regarding coordination of care and discharge planning needs among Complex Chronic Care (CCC) patients.
• Multidisciplinary rounds (MDRs) create a shared decision model among team members to ensure that all patients’ needs are met.

Objective

• To improve care coordination and provider knowledge on discharge planning needs for CCC from 40% to 75% by implementation of MDRs.

Design

• Inclusion criteria: CCC patients (defined by ICD-10 code diagnosis) admitted to the Hospitalist service.
• Exclusion criteria: CCC patients admitted to the resident teaching service.
• MDR team included a hospitalist, nurse, care manager, social worker, pharmacist and nutritionist.

Interventions

• Providers were notified of qualified CCC patients for MDRs.
• The MDR team members discuss the medical plan, medication changes, nutritional status, and social and discharge needs.
• Pre-round huddles were implemented in May 2017 to facilitate discussion of CCC patients among team members unable to attend bedside rounds (Figure 1).
• Statistical process control charts were used to assess the impact of pre-round huddles on percent provider attendance at MDRs.

Measures

• Primary Outcome: Increase in provider’s understanding of all aspects of the plan of care from 40% to 75%.
• Process: Frequency of provider’s attendance at the MDRs.
• Balancing: Time spent rounding per patient.

Results

• MDRs were implemented in August 2016. Attendance remained unchanged until the introduction of pre-round huddles in June 2017, which significantly improved provider attendance.
• Provider knowledge of the plan of care for CCC patients changed from 40% to 49% (Figure 2; P=0.400).
• Mean rounding time per patient remained similar: 26.1 minutes pre-intervention and 25.2 minutes post-intervention (Figure 3).

Implementation of the pre-round huddles had the most impact on providers’ attendance at MDRs, without increase the rounding time per patient.

While providers reported some improvement in understanding of care for CCC patients, the impact of provider attendance at MDRs or pre-round huddles on readmission rate of CCC patients remains to be determined.

Conclusion

References