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

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

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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 increasing 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

- 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.

References

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