Quality Improvement conference

"Hybrid Wards Rotation"

Dr Rahul Gill MD
Hospitalist/Sound physicians
Associate program director
THD Presbyterian hospital
Dallas, TX

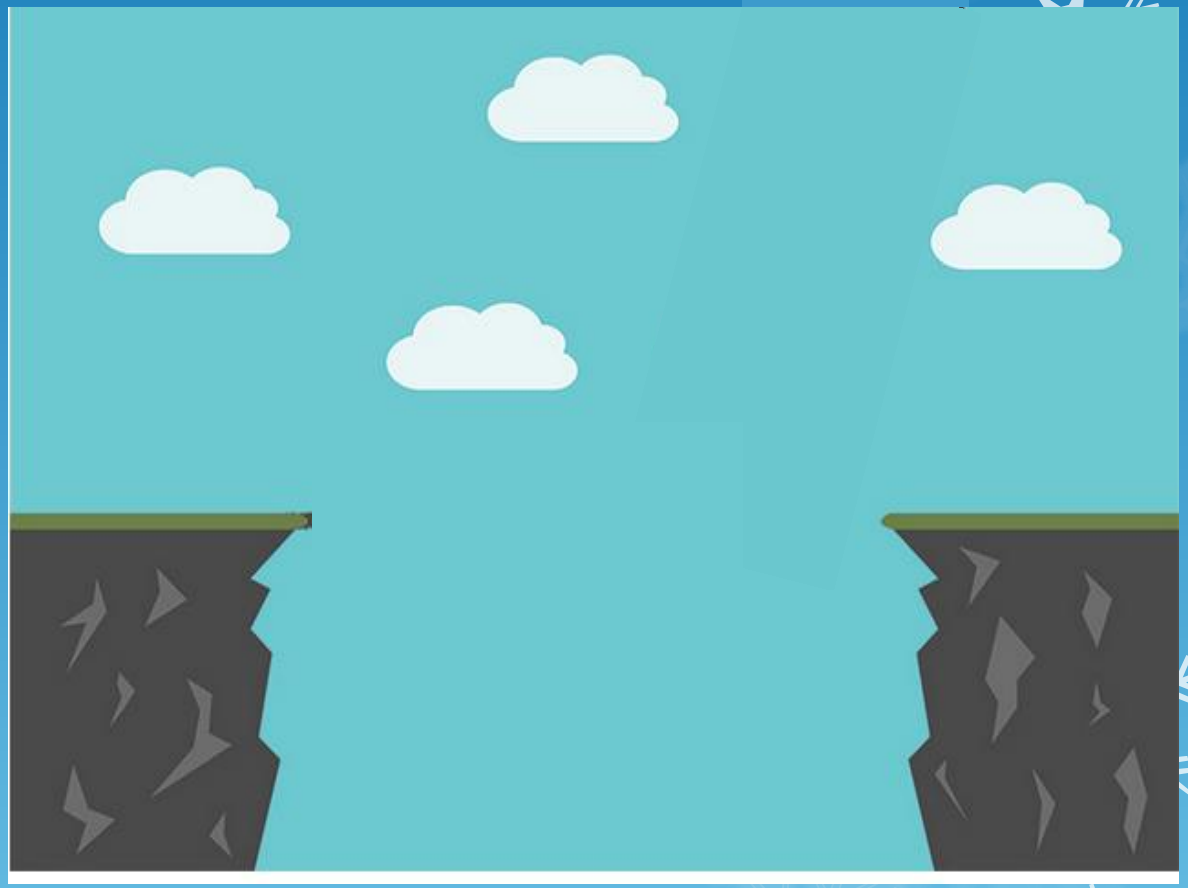
https://www.ranker.com/list/half-human-anime-characters/anna-lindwasser

BRIDGING THE GAP

Hospitalist

vs

Teaching attending



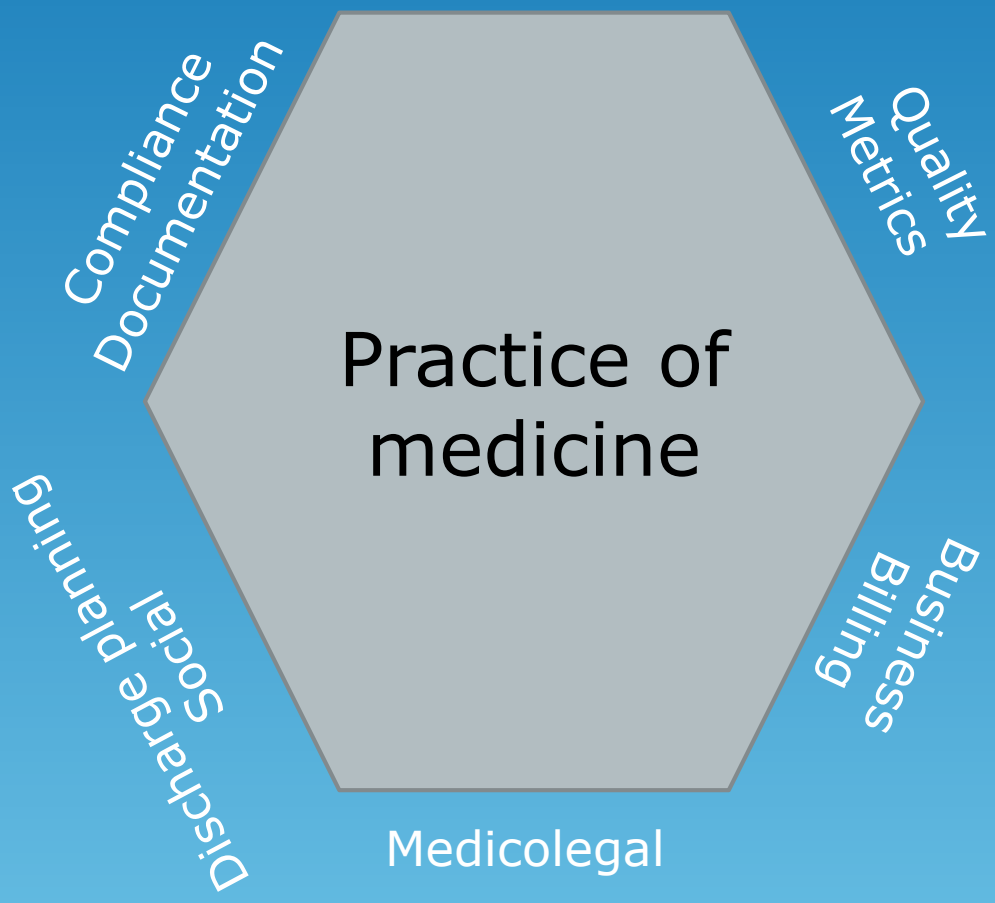
https://www.research.umich.edu/news-issues/michigan-research/bridging-gap

BRIDGING THE GAP

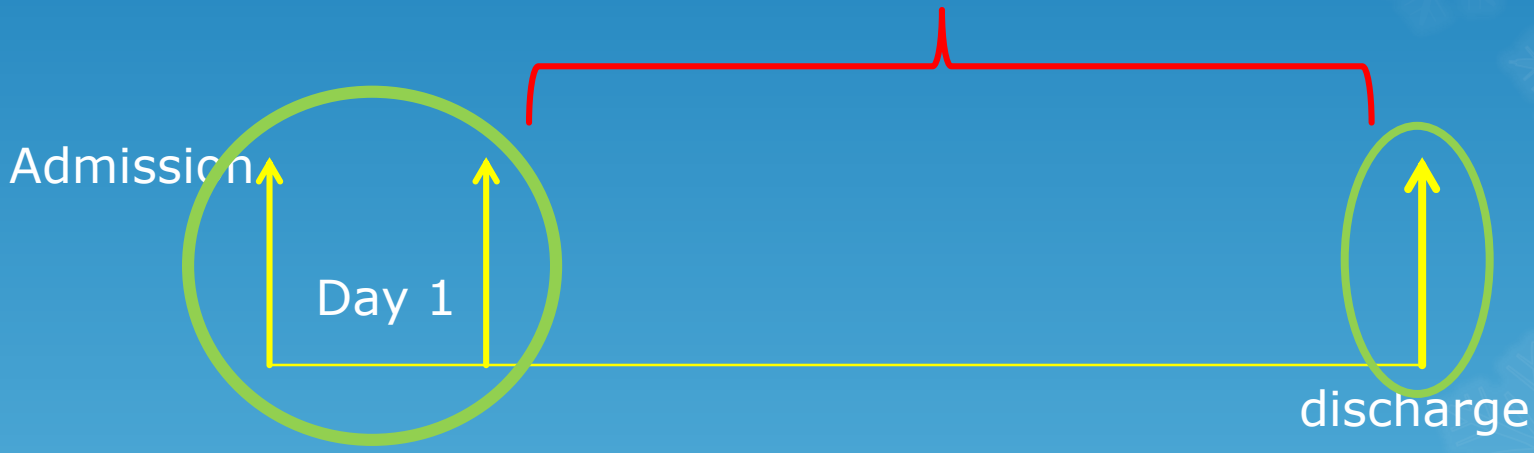
- Daily teaching based on care of admitted patients.
- Evaluation of residents Management plans/involvement in care
- Other practical aspects of daily decision making

https://www.research.umich.edu/news-issues/michigan-research/bridging-gap

Practice of medicine = **MDM**



Patient stay

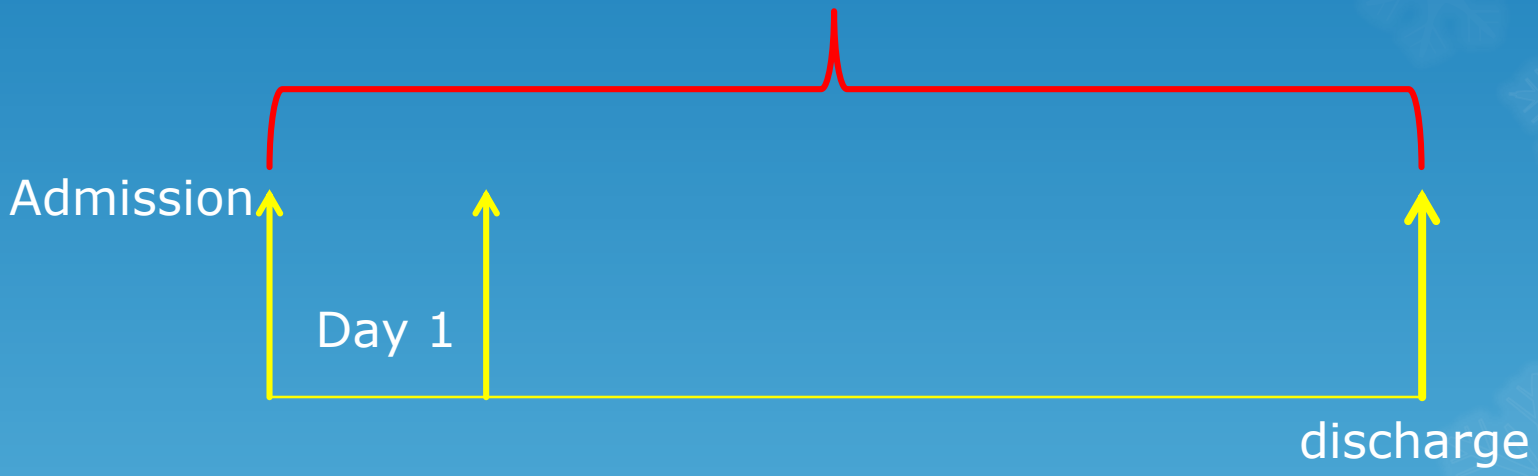


Patient stay

What we can do for the patient

vs

What we need to do for the patient during this admission



Patient stay

Obs vs inpt

Goals

- Education
- Improvement
- Preparation for real world practice

Learn as we take care of your patients

- Reading
- Planning
- Discussions

Provide quality patient care

"EVERYDAY"

Appropriate documentation

Teaching models*

Traditional

"Teams C,D,E"

Hospitalist

And

Teaching attending

Hybrid

"Teams A, B"

Hospitalist

plus

Teaching attending

Teaching Model> Teams A/B

- Dr Gill and a Sound physician partner teaching attending every month> Alternate weeks

(Drs Baby, Troung, Quratul, Barua and Tawadrous)

- Most patients on sound list with teams A/B plus patients with other teams to make up for required census*

- Even distribution of residents/interns with teams A/B at the beginning of the year **

TEACHING METHODS- teams A/B

Teaching time > any time we meet/Talk

- Bedside rounding at 7.15-7.30 am on post call days +/- other days ***(currently on hold)***
- Admitting 2 patients every call day
- Classroom sessions- meet at 11am *(usually)* or 1pm (*if possible*) M/W/F when both teams are available ***(resuming next week virtually)***

Classroom sessions/didactic

- 4 small presentation (30-40 min max)> one per resident and interns
- 2-4 teaching sessions Dr Gill/partner> topics/MKSAP/NEJM interactive cases etc

case discussion
****DF****

Expectations > ALL TEAMS

Expectations

Both residents and interns

Diligence

- Patient care
- Education*> reading daily

Understanding patient care decisions

Attitude

- teachablilty/accepting feedback

Medical knowledge- Be responsible for your education

Expectations > interns

- Recognizing important aspects of patient care
  Abnormal vitals/labs, BP/BG Mx, Dispo, etc

- Competently execute plans

Reliable.

****Documentation****

Expectations > Upper level residents

OWN YOUR PATIENTS*

Effectively manage the team**

ALL decisions* > Interns> Attending**

Daily update

Patients and families

CNL/CTMs

Discharge Planning

Safety/ Follow ups

Medication regimen > stable and affordable

Communication

PMD app(PHI) or Regular text (NO PHI)

"Group text"

EARLY MORNING DISCHARGE PLANNING

2 checkouts per day *ALL TEAMS*

Morning checkout by interns "after 9 am"

Afternoon checkout by ***"ULR" ***DO NOT TEXT UPDATES****

DF- Daily follow up in afternoon > DO NOT TEXT UPDATES

MISC-

- Teaching by asking questions - RG
- Questions to read on your own

  > revisiting after reading up

- Communication w attendings after 7pm

Things that have worked well- Before COVID wrecked THEM

- Knowing the schedule in advance
- Post call day rounding
- Admitting on call days*
- Early discharges**
- Easy communication
- Class room teaching methods

Areas of improvement

Dr Gill **>** Lack of positive reinforcement

Other attendings

Curriculum

- Equitable distribution of months in teams A/B.
- Exposure to other attendings *
- Holding spots on admitting days –A/B vs other teams

Areas of improvement

UL RESIDENTS

- Initiative to reach out to Attending to discuss >
  Communication does not always have to be through interns

- Ensuring interns understanding of decision making rationale*

- Closing loop > Afternoon touch base
  Opportunity for dialogue

- Discharge planning*

Areas of improvement

INTERNS

"Keeping UL in the loop"

- Understanding of decision making rationale
- Discharges – timely and appropriate

Update attending when patient is ready to dc

Evaluations-

Teams A and B – Split between Dr Gill and Partner> decided at the end of month

Day float- Dr Gill

PATIENTS

GAME OF EVALUATIONS

Evaluations-

- Fair
- Unbiased
- Not based on mistakes

- **Teachability**> unnecessarily defensive
- **Patent care >** Know your patients
- **Learning >** read daily
- **Team work**> Actively involvement

ULRs- "***make sure your patients know you***"

Feedback vs evaluations

DOCUMENTATION

Templates
.IMRESIDENCYHP
.IMRESIDENCYPROGRESSNOTES
.IMRESIDENCYDCSUMMARY

WHEN U SEE A PATIENT DOCUMENT IT

ALL discussions w/ consultants/pts/family MUST be documented

Thank you

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