



# Progress Notes

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## In this issue



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# Transformative Communication

**Sahar Barayan, MD**
Chief of Staff

In 2010, Watson Wyatt Worldwide, a global consulting firm, released a comprehensive study covering 328 organizations, representing 5 million employees. The study showed that companies with effective communications had 47 percent higher total returns to shareholders over the previous five years than firms considered to have the least effective communications.

No doubt medicine is a "team sport." Teams are most effective when communication is effective. The good news is that strong communication results in improved patient care, recovery rate and satisfaction. In addition, and equally as important, strong communication results in self-satisfaction, reduction in malpractice risk and improvement of overall team performance. The bad news is that there are too many communication gaps that lead to less-than-optimal outcomes of care.

A lot of emphasis is placed nowadays on patient satisfaction. Nearly 70 percent of variance in satisfaction scores is attributed to the physician's communication style, nonverbal cues, attitude, information gathering and style of decision making. The root cause analysis of nearly 66 percent of all reported sentinel events can be traced back to ineffective team communication.

Communication is the most common procedure a physician performs in his/her career life. Clinicians conduct more than 160,000 interviews with patients and countless interactions with staff and colleagues, and yet, it is the least learned skill. Mastering of the skill takes practice and experience.

The Accreditation Council for Graduate Medical Education (ACGME) and most recently the American Board of Medical Specialties (ABMS) are listing effective interpersonal skills and communication as a core competency. Many medical schools are now introducing training courses to promote communication and collaboration skills. In every leadership meeting I've attended, there is at least one session devoted to the importance of effective communication to improve quality outcomes. We have made big strides in electronic medical record and medical documentation, but verbal communication among the different medical team members is irreplaceable and should still occur daily.

Our nursing partners have been adopting the SBAR communication tool for several years. SBAR – Situation, Background, Assessment, Recommendation – is a technique used for prompt and appropriate communication in healthcare organizations. It is particularly useful for reporting changes in a patient's status between healthcare services or shift. It is time for physicians to develop similar communication tools to use in communicating with other physicians, members of the medical team and patients.

To carry out our vision to become the nation's best children's hospital, we need to adopt major transformational steps. Better communication will surely put us on the right path. The leadership team is working on improved communication methods and greatly appreciates your support in this endeavor.

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# Importance of Communication

Over the past year, our Medical Staff Services (MSS) office has worked diligently to ensure the department is structured to support our medical staff's needs. The MSS team refined their internal processes to provide the traditional support, namely documenting committee minutes, scheduling time with department chairs to review files, and ensuring we remain Joint Commission and Centers for Medicaid and Medicare Services (CMS) compliant. A new focus that transcends the conventional role includes providing high-quality customer service our physicians should expect from their support team.

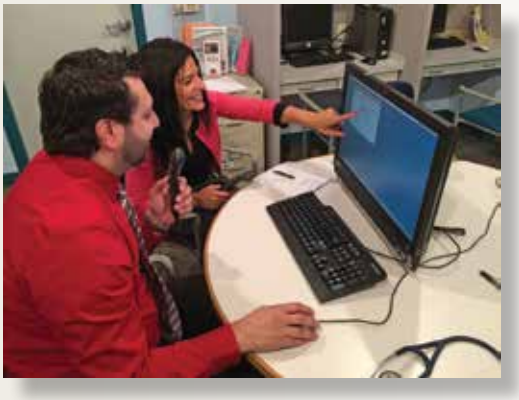
Key elements most medical staffs put at the top of their list are quality, communication, physician involvement and collaboration. Our MSS staff has embraced this vision to make your Children's medical staff office your "one-stop shop" for everything medical staff related. Our partnership continues to evolve, with our physicians' needs based on the best patient care.

As we reach out to our physician partners to discuss quality initiatives, trends in healthcare documentation, and the constant changing electronic health record environment, the need for a team of training professionals dedicated to our physicians became imperative. As a result, the Physician Leadership and Development (PLaD) team was created. The PLaD team supports the physicians' continuing medical education process, including our Distinguished Lecture Series, and plays a more active role in process change education.

As our electronic heath records evolve, new workflows are created that impact bedside care. The "business" of healthcare has taken on new initiatives driven by the Meaningful Use criteria, which may include patients accessing information through portals, exchange of real-time documentation requests by our referring physician partners, and eventually physician portals that allow access into several electronic health record systems.

The need for physician-focused, educational support becomes understandable given the change to documentation requirements with the eventual ICD-10 implementation, voice recognition dictation, and newly created physician workflow due to the electronic health record.

Our PLaD team has a representative "at the table" with every new project to identify a physician-related change that should be communicated and/or requires training. The team also focuses on bringing that training outside the Hospital walls to ensure our referring providers can navigate the electronic health record when necessary.



So as we introduce the physician support teams, be confident we will continue to evolve as our physician partners' needs change. We'll continue to find better ways to communicate, and evaluate new systems or processes yearly that help support the vision of quality, communication, physician involvement and collaboration.

**Joel Brownell, MD**
Chief Medical
Information Officer

# Capitalizing on System Improvements

## Ready to get enhanced again?

We have become fairly experienced with undergoing significant Meditech upgrades every couple years. Along the way, one or two things don't go quite as planned. As a result, I have started hearing people say things like, "My computer got enhanced last night and now it doesn't work!" Sometimes it's a little more straightforward, just a sad look and the statement, "I have been enhanced."

We are approaching two years since our last Meditech upgrade so we'll go through the process again in June.

A lot is being done now to identify how best to take advantage of the many enhancements available this round. The majority of system changes are due to Meaningful Use-related requirements. This will likely work in our favor in that improved functionality is mandated at the national level and therefore there's a push for consistent system design for all EMR vendors.

The upcoming enhancements truly seem to benefit us, including the following:

- Multiple small changes related to Meditech's **click reduction** initiative.
- Improvements to the **problem list** tool that is better integrated with CPOE and PDoc.
- Improved workflow for **cosigning notes** created by residents and midlevel providers.
- Improved **medication reconciliation** panel and process.
- Major rework of the **discharge** process to make it more interdisciplinary and consistent with the team approach of preparing a family to go home.
- Improved **nursing surveillance** tools to better monitor in real time for pressure ulcers and other potential hospital-acquired conditions.

In addition to enhancements directly associated with the Meditech upgrade, there are a number of other Hospital-wide initiatives occurring in a similar timeframe.

One is a transition away from paper superbills. Instead, we will use PDoc to document information for professional services. This allows a more streamlined process for the provider to document the information and later track and act upon that information.

Our Hospitalist group has successfully piloted this effort, which will be implemented more broadly in the coming months. When ICD 10 goes live Oct. 1, 2014, paper superbills will likely become unmanageable due to the ballooning number of diagnoses. Our goal is for everyone to transition successfully prior to that time.

Another ongoing major initiative relates to implementing patient portals. The athena outpatient portal will go live soon. Meditech's inpatient portal is intended to launch during the summer.

Both tools should allow families easier access to various important information about themselves and their family members. Medication lists, test results and appointments will become readily available to families in the near future. We will always need to balance confidentiality with ease of access, but overall this is expected to be a big win for our families.

All in all, when the Meditech upgrade goes live soon I have high hopes that the term "enhanced" will be seen again as a good thing.

## New practitioners who recently joined the Medical Staff include:

**Pediatric Cardiology**
**Scott Ceresnak, MD**
Dr. Ceresnak practices as a pediatric cardiologist/electrophysiologist at Lucile Packard Children's Hospital.

Education & Training: Robert Wood Johnson Medical School in New Jersey

Residency: Weill Medical College of Cornell University

Dr. Ceresank completed fellowships at Columbia University College of Physicians and Surgeons in pediatric cardiology, as well as a fellowship at Lucille Packard Children's Hospital in electrophysiology.

**Pediatric Emergency Medicine**
**Christy Walter, DO**
Dr. Walter is a new member of Emergency Medicine Physicians practicing as a pediatric emergency room physician.

Education & Training: Des Moines University of Osteopathic Medicine

Residency: McClaren Oakland Medical Center

**Neonatology**
**David Aguilar, MD**
Dr. Aguilar is a member of Perinatal Medical Group practicing as a neonatologist.

Education & Training: Chicago Medical School University of Health Sciences

Residency: UCSF-Fresno Medical Education Program

Dr. Aguilar also completed a fellowship in neonatology at UC Davis Medical Center.

**Ana Lia Graciano, MD**
Co-chair, Medical Education Committee
Pediatric Intensivist

# The Art of Medicine

Medicine combines science and scientific methods with the art of being a physician. The art of medicine requires mastery and expertise, not just experience. It requires wisdom, knowledge, creative thinking, and, most importantly, humility.

One essential component of the art of medicine is humanism. Medical schools now evaluate prospective candidates based on high marks for humanism as well as science. Humanism emphasizes understanding the patient as a person. Humanism is best taught by example at the bedside in our daily interactions with patients, colleagues and staff. Humanism requires that we imagine what it is like to be our patients or their parents and offer the competence, kindness, and devotion we would want in that situation.

As a medical student I had the opportunity to participate in an amazing experience that impacted me tremendously as a physician. "The pediatric train" was a mini hospital built on a train that traveled to the most remote areas of the country. I grew up in a big city with all the comforts of city life, and while poverty and poor healthcare access was a reality for many of our patients, it was never totally real to me until I participated in the pediatric train.

Although I learned how to perform a physical exam in medical school, we knew additional tests, X-rays or labs were easily available. The pediatric train was different as resources were limited; we had to maximize our clinical skills.

I remember learning from my attending to maximize the findings on the physical exam. I'd close my eyes and listen carefully to the different breath sounds, or put my hands on a child's chest and feel the breathing pattern or feel the skin temperature. My attending was a very skillful man, calm and empathetic. He had a PhD in physiology and taught me about respiration patterns and cardiac sounds. He knew Guyton's experiments from beginning to end and described them with a contagious passion.

I became more creative learning to communicate with the families in a way I never imagined. Some of them spoke only dialects. I drew smiley suns and moons for AM and PM medications and sketched "early warning signs" like mother's hands on the baby's forehead to check for fever. This experience helped me to approach my daily practice in a different way.

The pediatric train experience is far behind me but the art and science of medicine learned then will never be forgotten. Every day in our amazing Hospital I have a tangible sense of the art and science of medicine, fortunately with all the resources to care for the ones in need. We have the best technology; we successfully treat the most complex diseases; our expert teams contribute every day to the wellbeing of our patients not only because of knowledge and wisdom but also because of communication, empathy and understanding the patient as a whole.

The art of medicine is that quality cherished by those we serve. We should practice this art every day and transmit it to the younger generation of healthcare providers.

**Samuel Lehman, MD**
Medical Director, Patient Safety
Pediatric Intensivist

# Resuscitating Septic Children Faster

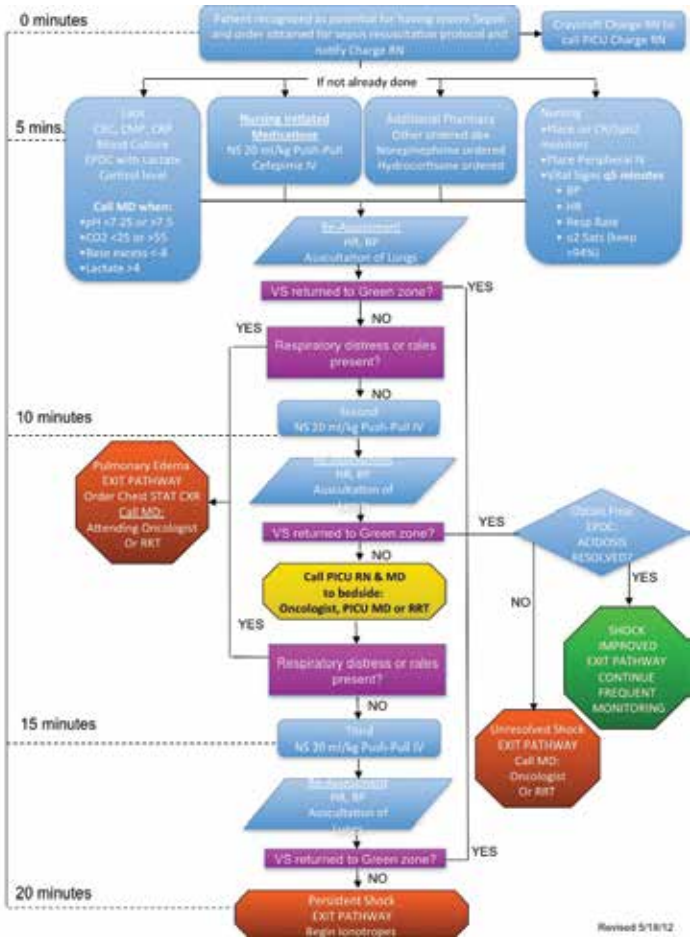
Each year over 4,000 children die of severe sepsis. The American College of Critical Care Medicine published clinical guidelines for hemodynamic support of neonates and children with septic shock in 2002 and updated in 2007. There's evidence that early intervention of hemodynamic support has significantly reduced mortality from severe sepsis nationwide. These severe sepsis guidelines are quite rigorous and call for administering up to 60 ml/kg of intravenous crystalloid within the first 15 minutes of the resuscitation and for inotropes to be started if needed within 20 minutes.

At Children's Hospital, we have oncology patients with implanted central venous lines and immune-compromised from chemotherapy who are particularly vulnerable to severe sepsis. Many of our patients with fever and neutropenia who had early signs of septic shock were receiving small doses of fluids over long periods and then if inotropes or pressors were required, the patients had to wait until the pharmacy could make them.

In October 2011, we implemented a project to improve the rapid resuscitation of our children with neutropenia and severe sepsis. A multidisciplinary team including oncologists, intensivists, intensive care nurses, and oncology nurses created a nurse-driven protocol used under physician direction to rapidly resuscitate these septic children. The protocol featured things such as bringing the resources to the bedside, rapid fluid administration systems, and ordering norepinephrine to the bedside in advance in case the child needs it.

We built the protocol, created a flow diagram (Figure 1), developed vital sign guidelines, built a resource cart, practiced in simulation, educated our oncology nurses to perform blood gasses, and performed rapid cycle improvement implementation. Simultaneously, we started a research project to better identify fever and neutropenia patients with severe sepsis by developing a sepsis scoring system. While we spend most of our efforts preventing these children from obtaining sepsis, we developed a system that ensures if they become septic, they will receive state-of-the art, evidence-based resuscitation for the best outcome.

**Figure 1**



**Craig Costi,** RN, Critical Care

# Providing Lifesaving Transport

For over 40 years Children's Hospital medical transport services have been providing families and children across the region with lifesaving critical care and transport. At any time, our transport services may receive a request to stabilize and transport a patient to our facility. These services are provided 24/7, 365 days a year. Last year our two neonatal and one pediatric critical care transport teams transported over 1,300 children from outlying hospitals. The scope of operation covers the entire Central Valley – a 45,000-square-mile area extending from Modesto to Bakersfield and from the Central Coast to Bishop.

Calls range from noncritical to life-threatening diagnoses. Extreme prematurity, persistent pulmonary hypertension, surgical emergencies of the newborn, congenital heart defects, hyperbilirubenimia, ingestions, seizure disorders, asthma , RSV and pediatric traumas exemplify just some types of transport that take place very day.

The transport teams that facilitate these critical care transports include a registered nurse and a respiratory care practitioner. Both team members have many years of ICU experience and advanced practice skills. They also receive extensive training to provide specialized care in any environment.

Experienced neonatologists and intensivists from Children's neonatal intensive care unit and pediatric intensive care unit oversee every aspect of the transport process but do not actually travel with these teams to referring hospitals. These transports are completed utilizing two ambulances specifically designed by American Ambulance and the transport department.  Med-Trans Corporation provides all of our rotary wing flight operations and is based here at Children's Hospital. Occasionally transport teams will even use fixed-wing aircraft to facilitate long-distance transports or in cases when adverse weather limits the use of our helicopter.

The Access Center is the command center for all of our medical transport services. Dispatchers receive calls from referring physicians about children requiring possible emergency stabilization and transport to Children's. A consult is quickly arranged with one of our on-call neonatologists or intensivists.

Once the physician activates the transport team, team members are notified by pager or phone and are in our facility within 30 minutes. The average time it takes to have the transport teams out the door and on their way to the referring hospitals is 45 minutes.

The expertise, quick response times and highly trained medical transport team members are what make Children's neonatal and pediatric transport teams the premier transport provider in the Central Valley and one of the best in the state. Children's Hospital can be proud of the amazing care this department gives to the families of our community.

**Tim Curley,**
Director of Community and Government Relations,
Children's Hospital Central California

# Targeting Childhood Obesity

As part of Children's Hospital's commitment to improving the health and wellbeing of children in Central California, the Hospital is participating in a pilot project to help address weight issues in children in Fresno and Madera counties.

The purpose of the pilot is to test a new model for delivering and financing weight management services in the primary care physician office, with the goal of reducing the body mass index (BMI) percentage of participating children by at least 1 percent. The pilot will run for 12 months.

Other organizations participating in the pilot with Children's Hospital include the California Health Collaborative, Anthem Blue Cross, CalViva Health, and five separate primary care sites.

To be eligible to participate, children must have a BMI percentage of at least 85 percent, which is above the ideal body weight, and must be from 2 to 12 years of age. The children also must currently be enrolled in a Medi-Cal managed care plan, which for Fresno and Madera counties is Anthem Blue Cross and CalViva Health.

The five primary care provider sites include two federally qualified health centers and three private pediatrician practices. Across those five sites, seven physicians are participating, each of whom will enroll at least 20 children in the pilot, allowing for 140 patients to be served. Physicians began enrolling patients in September 2013.

The pilot includes the following key components. Over the 12-month period, participating patients will visit with their physician five times, including the initial visit, a two-week follow-up visit, and visits at three, six and 12 months. Both health plans agreed to pay for all five visits. In addition to the physician visits, each patient and his/her family will be assigned a community health worker (CHW), who will be responsible for helping to manage the patient's care in between the physician visits. The CHW's time is funded by a grant from Kaiser Permanente.

Lastly, each patient also will be connected with nutrition counseling services that will provide education and direction regarding diet and nutrition.

The pilot represents one of several community-based initiatives in which the Hospital is involved that seeks to promote a healthy lifestyle and healthy weight among children.

**For more information on the pilot or other community-based initiatives, contact Tim Curley at 559-353-8610 or tcurley@childrenscentralcal.org**

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# Dr. Graciano Receives Top Honor

Dr. Ana Lia Graciano, a pediatric intensivist, was inducted into the American College of Critical Care Medicine at the college convocation ceremony held in San Francisco on Jan. 11. This is the first time this honorary college has recognized a member of our organization.

As Dr. Graciano's notification award states, "The College applauds her dedication to clinical excellence, education and research and her contributions in fostering the ideals of critical care. We hope you continue to advance technical and cognitive aspects as well as continue to be a role model for younger critical care practitioners and researchers."

Originally from Argentina, Dr. Graciano completed her critical care studies at Massachusetts General Hospital (Harvard Medical School) and her pediatric critical care fellowship at Children's Medical Center of Dallas where she served as chief fellow. She joined Children's in 2003. In addition to her busy clinical work, she has developed an active clinical research program in the pediatric intensive care unit and beyond; published in various peer-reviewed journals; and presented her work at national and international meetings. Dr. Graciano has also contributed to book chapters and was recently invited to be editor-in-chief of a new pediatric critical care textbook.

"A collaborative model of critical care is an essential part of what we do every day while caring for critically ill children," said Dr. Graciano. "PICU care is a team sport and this award would not have been possible without the whole team."

## Medical Staff Services

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Children's Hospital Medical Staff Services solicits articles for Progress Notes several times a year. It's a great place to distribute news, share accomplishments, and communicate with all members of our medical staff. Contact us for information or to make a submission.