Advocate Lutheran General Hospital, Park Ridge, IL
Defining and Committing to Physician Professionalism

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Background: Problems with professionalism are well documented in the literature and are a concern of hospital and GME leadership. Lapses in professional behavior in medical school have been associated with increased rates of malpractice actions during practice. Physician professionalism is essential to achieving safety, quality, and service for every patient every time. Concerns about resident and attending professionalism have been raised at Advocate Lutheran General Hospital (ALGH) but are inconsistently identified and managed, and little has been done to identify exemplars. Our goal was to investigate the literature and to develop an objective definition of physician professionalism for the ALGH clinical learning environment.

Methods: We conducted a literature review to define physician professionalism and used a fishbone diagram to help identify problems. As a result, we created the ALGH Physician Commitment to Professionalism, a document that attending physicians, residents, and fellows sign at application, reappointment, or annual contract.

Results: The literature on this subject is extensive but not always applicable. The Physician Commitment to Professionalism has been well accepted but has not been in place long enough to evaluate its impact.

Conclusions: Defining explicit expectations for physician professionalism is challenging and ongoing work that can and should be undertaken.

Advocate Lutheran General Hospital, Park Ridge, IL
Physician Professionalism: Feed in and Feedback

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Background: Physician professionalism is of utmost importance, but measuring professionalism and providing feedback to both problematic and exemplary practitioners have been challenging. Our goal was to develop tools and processes for documenting and providing feedback to physicians about reported behavioral lapses, drifts, and exemplars.

Methods: We created a physician feedback process map that identified the current process and the ideal process. We also developed and piloted 5 feedback letters: 1 for exemplars and 4 for concerns (timeliness of response, documentation, medication error, other).

Results: We discovered that processes existed that could be used for documenting physician professionalism. Understanding and using existing quality management tools were essential to project success. Several education sessions were held, and the feedback letters were piloted in family medicine and internal medicine. With few exceptions, physicians were receptive to the feedback letters.

Conclusions: We have greater clarity about what we mean by "physician professionalism," as well as an expectation that all physicians are expected to meet standards of professionalism that align with the ALGH Behaviors of Excellence. Physician and department chair education about the feedback process must be ongoing, and the support of the elected medical staff throughout the process is important.

FINAL WORK PLAN – Advocate Lutheran General Hospital

Team Charter/Objectives	Our goal was to investigate and improve how the ALGH clinical learning environment promotes and measures professionalism. Lapses and drifts in physician professionalism lead to deficiencies in safety, quality, associate satisfaction, and patient satisfaction. In our institution, concerns about resident and attending professionalism have been raised but have been managed inconsistently. We needed a clear and consistent approach to dealing with professional concerns as well as a way to share stories of exemplars in professionalism.

Project Description	A review of the literature pointed to (1) definitions of professionalism; (2) observable and measurable behaviors; and (3) measurement tools that have been used. We used process mapping to investigate our current reporting systems and data repositories to identify how we could report and track physician professionalism concerns and praises.
Vision Statement	By March 2015, our team had clearly operationalized components of physician professionalism for residents, fellows, and attending physicians. Partners and existing tools were identified and tweaked. The Physician Commitment to Professionalism was rolled out. We now have the capability to investigate and improve how our ALGH learning environment promotes and measures physician professionalism at the medical staff level.
Success Factors	The most successful component of our work was collaboration with multiple partners in Quality, Safety, and Patient Experience as well as medical staff leadership and GME leadership.
Barriers	The largest barrier we encountered was the inconsistent and insufficient reporting by and about physicians (both attending and residents) at our hospital. Education and reporting exemplary behavior should improve the volume and variety of reports. A telephone hotline was initiated for physicians and residents/fellows to encourage and facilitate reporting. We have not yet identified a tracking mechanism for residents/fellows that is standardized across programs.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Schedule regular (weekly or biweekly) meetings. Keep an open mind about who needs to be at the table and who has the necessary expertise. Make assignments and collaborate to keep them on track. Follow the monthly assignments. Focus on the end goal.

Akron General Medical Center, Akron, OH

Floor-to-Unit Transfers Within 24 Hours of Admission from the ED

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Background: We are a community hospital with approximately 500 beds, 25,000 annual admissions, and 103,000 ED visits at 4 ED sites. The perception among residents was that a high number of patients were being admitted to a medicine floor from the ED but required transfer to a critical care unit within 24 hours of admission. We investigated this transition-of-care question and attempted to answer whether a change occurred in patient status, whether the status change could have been anticipated, and whether the initial admission unit was appropriate.

Methods: We performed a medical record audit of 5,302 admissions from January 1, 2014 through March 31, 2014 to identify patients who were transferred to an ICU within 24 hours of admission. Twenty-two patients met the criteria. We manually reviewed these medical records to determine admitting diagnosis, reason for transfer, time to transfer, and final patient disposition. Based on this data and our review of the record, we determined whether the initial placement was appropriate and whether any status change could have been anticipated.

Results: No patients died while in the hospital, and 50% were discharged home. The average time to transfer was 11:46 hours. Approximately 27% of transfers were felt to be due to questionable initial placement; however, no clear pattern of cause was identified. Fifty percent of the transfers were due to respiratory decompensation.

Conclusions: Reports from residents of unnecessary transfers within 24 hours from admission seemed to be a somewhat pervasive problem, but our study found the opposite: the number of transfers was much lower than expected. Although 50% of transfers were due to respiratory decompensation, without data on the total number of patients admitted for respiratory diagnoses, it is impossible to quantify the risk. In the future, we would like to explore standardized handoffs such as I-PASS to help admitting teams anticipate possible status changes.