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MP10-17 RESIDENTS USE LEAN DAILY MANAGEMENT SYSTEM TO ENHANCE CARE EXPERIENCE AT A SAFETY NET HOSPITAL

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Peer reviewed



	Motivational	Ability
Personal	Make smoking undesirable	Give skills needed to not smoke
Social	Peer pressure to not smoke	Strength in numbers
Structural	Design rewards	Changing the environment to encourage non-smoking

Source of Funding: None

**MP10-15
ANALYSIS OF PRESCRIBING PATTERNS AFTER IMPLEMENTATION OF EVIDENCE-BASED OPIOID PRESCRIBING GUIDELINES FOR THE POSTOPERATIVE UROLOGIC SURGERY PATIENT**

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INTRODUCTION AND OBJECTIVES: The United States faces an opioid epidemic, and surgeons must take action. However, a one-size fits all approach to opioid prescribing is sub-optimal. Here, we sought to evaluate changes in prescribing patterns after implementing a urologic-surgery specific postoperative opioid prescribing guideline at three tertiary care facilities.

METHODS: We convened a urologic surgery opioid task force. Historical prescribing data for all adult patients without a history of chronic opioid use undergoing 21 urologic procedures at three tertiary care centers from 2015-2016 were used to derive an evidence-based, four-tiered guideline for postoperative opioid prescribing. The guideline was implemented into clinical practice on January 1, 2018, and prescribing patterns including quantity of opioids prescribed (oral morphine equivalents = OME) and refill rates were compared for a cohort of patients undergoing surgery prior to (January 1–April 30, 2017; n=1,732) and after (January 1–April 30, 2018; n=1376) implementation. The primary outcome was change in median OME prescribed after guideline implementation. Secondary outcomes include changes in refill rates and guideline adherence. Univariable analysis was performed using Wilcoxon Rank-Sum tests for continuous variables and Chi-squared tests for categorical variables.

RESULTS: After guideline implementation, the median OME (IQR) prescribed was significantly lower for 2018 compared with 2017 [100 (0;175) versus 150 (60;225); p<.0001]. The median OME also significantly decreased for procedures in all guideline tiers with the exception of tier 0 where the median was stable at 0. The median prescribed OME decreased in 14/21 procedures (67%). The refill rates did not significantly change. Guideline adherence rates within the first four months after implementation, based on individual procedures, ranged from 33-95%.

CONCLUSIONS: Fewer opioids were prescribed after implementing the first iteration of our evidence-based prescribing guideline without a significant increase in prescription refills. However, further work is necessary including provider education and assessment of patient utilization of prescribed opioids.

Source of Funding: No external funding

**MP10-16
HIGHER PROPORTION OF FEMALE UROLOGY APPLICANTS MATCH TO RESIDENCY PROGRAMS WITH HIGHER FEMALE FACULTY AND RESIDENT REPRESENTATION**

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INTRODUCTION AND OBJECTIVES: There is a significant gender disparity in the urology workforce, with females comprising just 8.5% of practicing urologists in 2016. However, there is a trend towards improvement in this gender gap, with the average percentage of women in urology residency programs rising from 1.9% in 1978 to 23.1% in 2013. Limited data exists regarding factors that influence females pursuing urology. We sought to determine if faculty and resident gender plays a role in match rates of female urology applicants.

METHODS: We utilized results from the 2018 AUA match encompassing all US accredited urology programs. The number of female and male core faculty and residents at each institution were identified. Programs with incomplete data availability and military-affiliated programs were excluded. Correlations between the number and proportion of female core faculty and residents at each program and number and proportion of matched female applicants to that program were calculated. Match results were further stratified by AUA section and analyzed.

RESULTS: A total of 314 urology vacancies were initially filled in the 2018 AUA match, with 79 matched female applicants. Our analysis included 108 programs with complete publicly available data of faculty and residents. Only 8 programs (7.4%) had 50% or greater female resident representation. 16 programs (14.8%) had no female faculty members at all. 28 programs (25.9%) had only 1 female core faculty member vs. 64 programs (59.2%) with 1 or more female core faculty members. There was a positive correlation between matched female applicants with proportion of female faculty (r=0.22, p=0.02). Additionally, there was a positive correlation between matched female applicants and female resident representation (r=0.23, p=0.01). When stratified by AUA section, there was no significant difference in the proportion of females matched between AUA sections (p=0.61).

CONCLUSIONS: The number of female applicants to urology continues to rise with a concomitant narrowing gender gap amongst urology residency programs. In the 2018 AUA match, the proportion of matched female applicants correlates positively with the proportion of female faculty and residents in that program, regardless of location. The reason for this correlation is unclear but may be due to a sense of common gender identity, opportunity for female academic mentorship, or fewer barriers to females attaining leadership positions at these institutions. Future research in this area is needed.

Source of Funding: none

**MP10-17
RESIDENTS USE LEAN DAILY MANAGEMENT SYSTEM TO ENHANCE CARE EXPERIENCE AT A SAFETY NET HOSPITAL**

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INTRODUCTION AND OBJECTIVES: Lean is a continuous process improvement strategy designed to increase efficiency, safety and competitiveness. Zuckerberg San Francisco General (ZSFG) is a community safety-net and trauma hospital that serves as a major teaching site for the University of California San Francisco. We developed a urology service specific Lean Daily Management System driven by our resident and fellow physicians to improve efficiency, safety and the overall patient experience. Using a formal problem solving tool, residents are empowered to propose target statements, identify barriers, countermeasures and analyze their positive impact on patient care. Our objective is to assess the effectiveness of this approach.

METHODS: We examined our Lean activities from July 2016 to October 2018. Our weekly huddle serves to surface logistic, safety or equipment concerns, generate and mark progress on improvement ideas amongst stakeholders. On operating room (OR) days, we conduct a 5 minute huddle prior to case start to review cases, anesthetic approach, positioning and equipment needs.

RESULTS: Over a 2 year period 34 projects were developed by the resident team to improve work flow and patient experience. Projects most often impacted the outpatient setting (65%), followed by inpatient (21%) and the overall service (14%). Most projects related to the quality (n=13), workforce development (n=7), care experience (n=5), equity (n=5), safety (n=2), and financial stewardship (n=2). UroLean was used to improve next available outpatient clinic appointment wait from 168 to 21 days. BCG treatment times reduced from 180 to 105 minutes by identifying clinic flow changes such as ordering BCG the evening before, sending reminders to patients and prompt insertion of catheter. The urology on-time OR average start-time was better than the overall OR mean (71% v 61%, respectively) (Fig 1). Common barriers to on-time start identified via this process included: patient related factors (25.93%), anesthesia (17.59%), housekeeping (17.54%) and surgeons (12.9%).

CONCLUSIONS: Residents were successful in applying LEAN in a safety-net hospital. Our department improved communication within our team and across service lines. Lean provides structure and can be an effective tool to improve resident engagement in quality and safety endeavors.

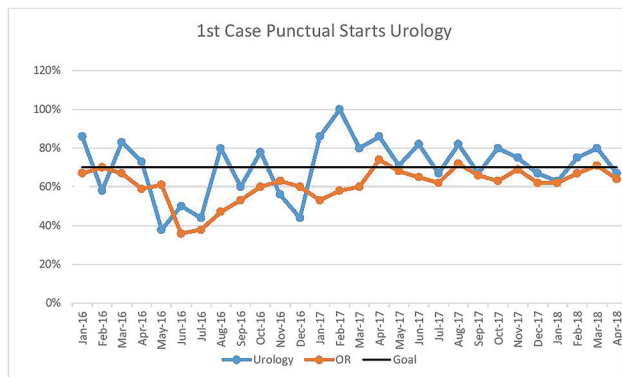


Figure 1: Percentage of punctual urology OR on-time starts vs. the overall OR mean (2016-2018).

Source of Funding: None

MP10-18
THE DIFFICULT FOLEY: FACTORS PREDICTING APPROPRIATE UROLOGICAL CONSULTATION

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INTRODUCTION AND OBJECTIVES: Iatrogenic urethral injury due to unsuccessful Foley placement continues to be a serious, but preventable, problem. Urological Foley consultation, in select cases, is warranted but is not always the answer. The aim of our study was to detect differences between simple and difficult Foley consults in men and to identify areas for educational intervention.

METHODS: We retrospectively reviewed urological catheter consults in men from 7/2016 to 9/2017. Consultation variables included time of year and consulting service (surgery vs non-surgery). Patient variables included age, known genitourinary (GU) diagnosis and/or surgery. Type of Foley placed and any urological trauma was recorded. Each consult was classified as “simple” (straightforward regular/coude) or “difficult” (difficult coude/wire/cystoscopy/suprapubic tube). T-test and Chi-square/Fisher’s Exact analysis was performed.

RESULTS: We identified 276 men for which Foley consultation was placed. 216 patients (78.3%) were simple and 60 patients (21.7%) were difficult. The average age in both groups was 70 years old

(p=0.97). There was no difference in prior GU diagnosis (62.7% vs. 63.3%, p=0.47). When comparing individual diagnoses, there remained no difference between groups. More patients in the difficult group had prior GU surgery (26.7% vs. 16.7%, p=0.12). When comparing individual surgeries, transurethral resection of bladder tumor was higher in the simple group (11.1% vs 0%, p<0.001) and hypospadias/stricture repair was higher in the difficult group (25% vs 2.8%, p=0.009). There was no seasonal difference in simple vs difficult consults (p=0.88). Non-surgical teams placed more consults for simple catheters than surgical teams (80.6% vs 19.4%, p <0.001). Urethral trauma was higher in the difficult group (46.7% vs 27.8%, p=0.009).

CONCLUSIONS: A majority of Foley catheter consults are “simple,” however, urologic consultation for catheterization may be warranted in patients with previous hypospadias/stricture repair. Surgical teams more often consulted for truly difficult catheterizations, perhaps due to increased familiarity with Foley placement compared to non-surgical colleagues. More trauma was documented with “difficult” catheterization likely related to multiple attempts in the face of a true obstruction. Therefore, additional urethral catheterization training for surgical, but especially non-surgical services (nurses and residents), should be targeted to not only prevent unnecessary consultation but to improve patient care while reducing harm.

Source of Funding: None.

MP10-19
JUST A NUDDGE: APPLYING BEHAVIORAL INCENTIVES TO ENGAGE RESIDENTS IN QUALITY IMPROVEMENT EDUCATION

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INTRODUCTION AND OBJECTIVES: Health care researchers and policy-makers are increasingly applying behavioral incentives. Well-designed incentive structures can help individuals overcome barriers to engagement in a variety of activities, including education. Quality improvement (QI) education is required for urology residents, yet engagement may suffer from a perceived lack of learner interest. Our objective was to compare resident participation in a urology-specific QI curriculum with two difference behavioral incentives: team-based competition versus individual incentives.

METHODS: We conducted a multicenter cluster randomized trial of ACGME-accredited urology residency programs stratified by size. Programs were randomized to either a team-based competition or an individual incentive environment. In both, residents participated in an identical QI program on Qstream®, a web-based, mobile-device-compatible platform. Biweekly for 12 weeks, residents were emailed a link to the platform introducing 20 clinical-scenario-based questions. In the team-based competition environment, weekly leader boards displayed team standings. In the individual incentive arm, residents were eligible for a weekly loss-framed incentive that required the winner be current on attempted questions. Our primary outcome was percentage of questions attempted. Secondary outcomes included participation, defined as attempt of at least 1 question, and mastery, correctly answering a question twice-in-a-row.

RESULTS: We enrolled 453 residents from 36 accredited urology residency programs. Significantly more residents participated in the team-based competition than the individual-incentive environment (71% vs. 58%, p=0.005). Residents in the team-based competition not only attempted a greater percentage of questions than those in the individual incentive environment (60% vs. 44%, p<0.001), but