Involving Patients and Families to Improve Care Transitions

Julius Yang, MD, PhD
Director of Inpatient Quality

Sarah Moravick, MBA
QI Project Manager
Overview of Today’s Discussion

1. BIDMC’s burning platform to reduce readmissions

2. Why patients and family members have been vital to our improvement efforts

3. Examples of projects we’ve worked with patients/family members on to improve care transitions

4. Challenges to effectively involving patients and family members

5. Measuring the impact
Publically Available Medicare Data:

Table 2: Your Hospital’s 30-Day Risk-Standardized Readmission Performance for AMI, HF, and PN
July 2007 through June 2010
BETH ISRAEL DEACONESS MEDICAL CENTER

<table>
<thead>
<tr>
<th>Measure</th>
<th>Your Hospital’s Comparative Performance</th>
<th>Number of Eligible Admissions at Your Hospital</th>
<th>Your Hospital’s RSRR (Lower Limit, Upper Limit of 95% Interval Estimate)</th>
<th>U.S. National Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI 30-day Readmission</td>
<td>Worse than U.S. National Rate</td>
<td>709</td>
<td>22.6% (20.0%, 25.1%)</td>
<td>19.8%</td>
</tr>
<tr>
<td>HF 30-day Readmission</td>
<td>Worse than U.S. National Rate</td>
<td>1,187</td>
<td>26.2% (26.0%, 30.3%)</td>
<td>24.8%</td>
</tr>
<tr>
<td>PN 30-day Readmission</td>
<td>Worse than U.S. National Rate</td>
<td>675</td>
<td>21.9% (19.4%, 24.4%)</td>
<td>18.4%</td>
</tr>
</tbody>
</table>
Why involve patients and families?

Current measures of care transitions do not seem to correlate with our readmission rates, and do not help us to identify actionable improvements.

Care Transition Measure (CTM-3)
From Care Transition Intervention (Coleman)

**Method:** Asked at the end of Care Connection’s follow-up calls to HCA Medicare Pts admitted for HF, AMI, PN, or COPD

**Timeframe & Responses:** End of April – Mid June; N= 29

<table>
<thead>
<tr>
<th>Question (On a scale of 1-5, where 5= Strongly Agree)</th>
<th>Average Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.</td>
<td>4.1</td>
</tr>
<tr>
<td>When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.</td>
<td>4.2</td>
</tr>
<tr>
<td>When I left the hospital, I clearly understood the purpose for taking each of my medications.</td>
<td>4.4</td>
</tr>
</tbody>
</table>

During this hospital stay...

- did hospital staff talk with you about whether you would have the help you needed when you left the hospital? (Q19)
- did you get information in writing about what symptoms or health problems to look out for after you left the hospital? (Q20)
Why involve patients and families?

Qualitative data in the form of patient feedback and stories can be more effective to inspire change...

Our patients’ needs are relatively simple... but hard to achieve

“OK, I have three requests...

1. Please tell me what you’re going to do before you do it to me. It’s kind of hard to deal with the surprises and if you could just make a plan with me, I can do a little better...

2. You know, there are a lot of you – doctors and nurses all around me – do you ever talk to each other? ...It would be great if you talked to each other...

3. I’ve been here a lot, in fact, I’ve probably been in the hospital more than you have...if you ask me what I think, I can help you…”

Pt feedback from “Kevin,” retold by Dr. Donald M. Berwick
Administrator, Centers for Medicare and Medicaid Services (CMS); December 3, 2010
Why involve patients and families?

Key Themes from Patients & Family Members in Interviews and Focus Groups

• Discharge materials are ineffective

• Pts unsure of when/who to call when experiencing problems, wait, then go to ED

• Many pts felt responsible for asking to leave the hospital too soon– less likely to call when there’s an issue

• Too many silos for patients to manage/coordinate on their own (many want a “single point of contact”)

• Patients/families don’t feel like they can contribute to their plan; or when concerns are voiced may be ignored; afraid to push back and be labeled a “difficult” patient

• Discharge was too fast; no time to process what was happening & ask questions

• PCP seemed unaware of hospitalizations

• Specialists appointments weren’t scheduled in a timely manner / not clear to pt why it was needed
How has BIDMC involved patients and families?

Patient and family involvement is vital to improving care transitions and, at BIDMC, the level of patient and family involvement has evolved overtime.

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients &amp; Families as Advisors</th>
<th>Patients &amp; Families as Team Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>Patient Family Advisory Council</td>
<td>My Care Conference Pilot</td>
</tr>
<tr>
<td></td>
<td>STAAR Cross-Continuum Team</td>
<td>HCA Care Transitions Pilot</td>
</tr>
<tr>
<td>2011</td>
<td>Patient Family Advisory Council</td>
<td>DC Med List Focus Group</td>
</tr>
<tr>
<td></td>
<td>STAAR Cross-Continuum Team</td>
<td>HF Pt Pathway Focus Group</td>
</tr>
<tr>
<td>2012</td>
<td>Patient Family Advisory Council</td>
<td>With Increased Advisors</td>
</tr>
<tr>
<td></td>
<td>STAAR Cross-Continuum Team</td>
<td>With Increased Advisors</td>
</tr>
</tbody>
</table>

Beth Israel Deaconess Medical Center
PFAC and STAAR Advisors Have Offered Valuable Insight to These Changes

**Post-Hospital Interventions**
- Post-discharge Telephone Outreach
- Transitions Coach Intervention (Home Visit)

**Hospital-Based Interventions**
- Admission Checklist
- Teach Back Method for Patient Education
- Readmission Huddles
- Revised DC Instructions
- Condition-focused Inpatient Education
- Automated Fax to PCP (on admission & discharge)
- Care Connection Appointment Scheduling Service
- Pharmacist Assisted Medication Reconciliation
- Discharge Checklist
- Discharge Summary Curriculum
- Enhanced Sharing of Electronic Records
- Anticoagulation Mgmt Initiative

**Post-Hospital Interventions**
- Extended Care Facility
- VNA & Home Care

**Hospital-Based Interventions**
- Preventing Unnecessary Hospitalization
  - ED-based Cardiologist During Peak Admitting Hours
  - Case Management “Leveling” Patients in the ED

**Transition Back to Primary Care**
- Hospitalist-staffed Post-discharge Clinic
- Enhanced VNA-PCP Coordination
- Enhanced ECF-PCP Communication

**Appropriate Hospitalizations**
- Contingency Management

**Transition Back to Primary Care**
- Cardiology “Heart Line” for patients after discharge
- Improved Access to Urgent Care Visits
- Outpatient Diuresis Clinic

**Contingency Management**
Example: My Care Conference

My Care Conference
Connecting Patients with Their BIDMC Team

Care Conferences are multidisciplinary meetings to assist in post-discharge planning. They are facilitated by a social worker who helps the patient and family prepare for meeting. The 20-30 min Conference is a dedicated communication encounter that occurs outside of routine care processes.

Returned to PFAC to share success based on recommended changes.

Preliminary challenges shared with PFAC, and opportunities for improvement were identified.

Patient representative on project team that developed workflow and patient support materials.

Patient representative continued to be involved during the initial implementation.
**Example: Discharge Medication List Focus Group**

**Initial State:**
Complex, hard to read/interpret list of medications

**Goal:**
Develop a simplified tool to help patients more effectively manage their medications.

---

### Part 1: Summary of changes for the first day home

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dose</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lipitor (atorvastatin)</td>
<td>80 mg Tablet</td>
<td>This is a new medication for your heart attack</td>
</tr>
<tr>
<td>Lisinopril 5 mg Tablet</td>
<td>1 Tablet(s) by mouth twice daily</td>
<td></td>
</tr>
<tr>
<td>Metformin 850 mg Tablet</td>
<td>1 Tablet(s) by mouth daily</td>
<td></td>
</tr>
<tr>
<td>Levoquin 500 mg Tablet</td>
<td>1 Tablet(s) by mouth daily</td>
<td></td>
</tr>
<tr>
<td>Percocet 75 mg Tablet</td>
<td>2 Tablet(s) by mouth q6 hrs</td>
<td></td>
</tr>
<tr>
<td>Glipizide 10 mg Tablet</td>
<td>1 Tablet(s) by mouth 5 times daily</td>
<td></td>
</tr>
</tbody>
</table>

### Part 2: Daily Tool to Use Going Forward

#### Daily Medications

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Morning</th>
<th>Midday</th>
<th>Evening</th>
<th>Bedtime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>325 mg Tablet</td>
<td>1 Tablet(s) by mouth daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levoquin (levofloxacin)</td>
<td>500 mg Tablet</td>
<td>1 Tablet(s) by mouth daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glipizide (Glucophage)</td>
<td>300 mg Tablet</td>
<td>1 Tablet(s) by mouth daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lisinopril 10/100 Tablet</td>
<td>1 Tablet(s) by mouth 5 times daily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lopressor 100 mg Tablet</td>
<td>1 Tablet(s) by mouth twice daily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lopressor 5 mg Tablet</td>
<td>1 Tablet(s) by mouth twice daily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lopressor</td>
<td>1 Tablet(s) by mouth twice daily</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**When I Should Take My Medications**

Based on the changes made to my medications in the hospital, this is when I should take my medications at home.
Challenges to Date

Our Main Challenges in Involving Patients and Families in this Work

- **Time Commitment**
  - Sometimes hard to identify the “line” between engaging a patient or family member in a project and asking too much of a volunteer.
  - The best times for patients and families to meet are not always the most convenient time for staff.

- **Committee Readiness**
  - Newly developed committees / teams are often hesitant to involve patients and families until they feel the group is more organized.

- **“Representative” Population**
  - The patient and family members who volunteer their time to these initiatives may not be fully representative of our entire hospital population.
Impact of Patient & Family Involvement is Measured Through our Social Work Division

- Representation on workgroups and committees
- 360-like review process for patient/family participant and team leader
- Quantitative outcomes for the hospital as result of the projects patients and family members have worked on:
  - For Example:
    - Decreases in readmission rates
    - Improvements in patient satisfaction