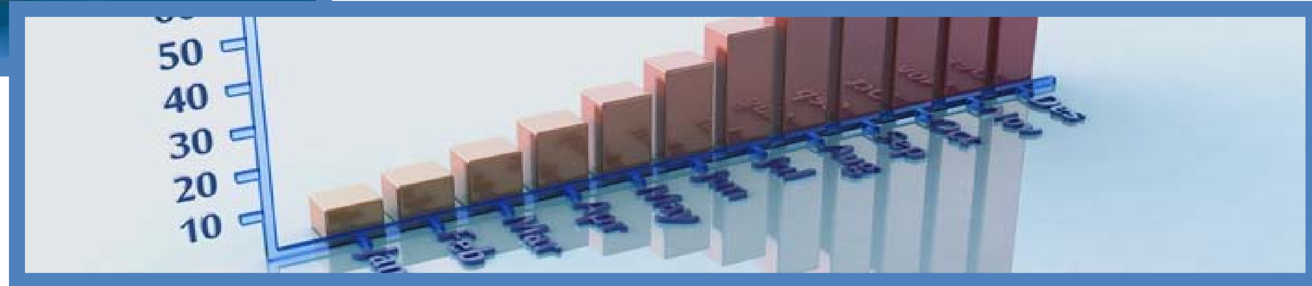
Beth Israel Deaconess Medical Center

Involving Patients and Families to Improve Care Transitions



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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

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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
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Measure	Your Hospital's Comparative Performance	Number of Eligible Admissions at Your Hospital	Your Hospital's RSRR (Lower Limit, Upper Limit of 95% Interval Estimate)	U.S. National Rate
AMI 30-day Readmission	Worse than U.S. National Rate	709	22.6% (20.0%, 25.1%)	19.8%
HF 30-day Readmission	Worse than U.S. National Rate	1,187	28.2% (26.0%, 30.3%)	24.8%
PN 30-day Readmission	Worse than U.S. National Rate	675	21.9% (19.4%, 24.4%)	18.4%

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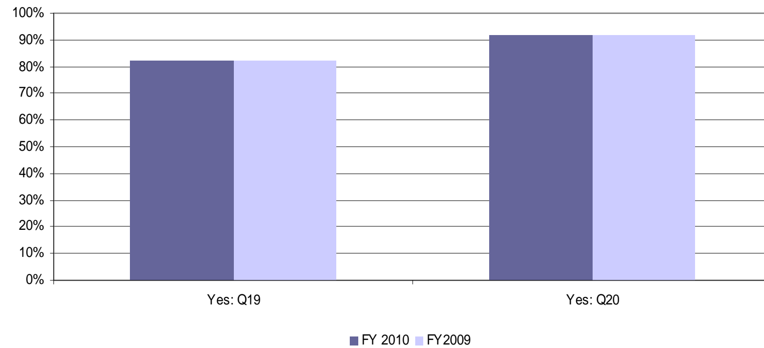
Why involve patients and families?

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

H-CAHPS Hospital Wide Results for Questions 19 & 20 FY09 & FY10



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)

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*

Question *(On a scale of 1 -5, where 5= Strongly Agree)*	**Average Response**
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.	4.1
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.	4.2
When I left the hospital, I clearly understood the purpose for taking each of my medications.	4.4

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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

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.

	2010	2011	2012
Patients & Families as Advisors	Patient Family Advisory Council	Patient Family Advisory Council	Patient Family Advisory Council
	STAAR Cross-Continuum Team	STAAR Cross-Continuum Team *With Increased Advisors*	STAAR Cross-Continuum Team *With Increased Advisors*
	Patient Family Interviews	DC Med List Focus Group	HF Pt Pathway Focus Group
Patients & Families as Team Members	My Care Conference Pilot	HCA Care Transitions Pilot	

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PFAC and STAAR Advisors Have Offered Valuable Insight to These Changes

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

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

Recovery

Extended Care Facility

VNA & Home Care

Return to Primary Care

Hospital

Patient & Family

Primary Care

Appropriate Hospitalizations

Contingency Management

Emergency Department

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

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

Contingency Management
- Cardiology “Heart Line” for patients after discharge
- Improved Access to Urgent Care Visits
- Outpatient Diuresis Clinic

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.

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

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

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.

Hosted Multi-Disciplinary Focus Group

BETH ISRAEL DEACONESS MEDICAL CENTER
DISCHARGE MEDICATION INSTRUCTIONS
ZZMEDRECTEST, JAMES
Unit # 1477352 DOB 04/01/1926 Allergies: SULFA
Inpatient doctor: John Smith, 617-667-4700
Nurse: Mary Jones, 617-632-2323
Primary Care Doctor: William Jones 617-734-5016

Below is a summary of the changes made to your medications while you were in the hospital.

Stop taking these medications	
Stopped medications	**Comments**
Simvastatin 20 mg Tablet 1 Tablet(s) by mouth daily	This medication has been stopped and replaced with Lipitor.
Digoxin (Lanoxin) 0.25 mg Tablet 1 Tablet(s) by mouth daily	This medication has been stopped because it is no longer needed.
Venlafaxine (Effexor) 75 mg Tablet 1 Tablet(s) by mouth daily	This medication has been stopped and replaced with Celexa

Start taking these medications		
New Medications	**When to Take First Dose at Home**	**Comments**
Clopidogrel (Plavix) 300 mg Tablet 1 Tablet(s) by mouth daily		This is a new medication for your heart attack
Lisinopril 5 mg Tablet 1 Tablet(s) by mouth twice daily		This is a new medication for hypertension
Lipitor (atorvastatin) 80 mg Tablet 1 Tablet(s) by mouth daily		This is a new medication for high cholesterol
Levoquin (levofloxacin) 500 mg Tablet 1 Tablet(s) by mouth daily		This is a new medication for pneumonia. You will need to take this for the next 6 days and then stop
Percocet 5 mg-325 mg Tablet 2 Tablet(s) by mouth q6 hrs		This is a new medication for pain
Carbidopa-Levodopa (Sinemet) 10/100 Tablet 1 Tablet(s) by mouth 5 times daily		This is a new medication for Parkinson's disease

Part 1:
Summary of changes for the first day home

Part 2:
Daily Tool to Use Going Forward

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

Daily Medications	Morning	Midday	Evening	Bedtime
Aspirin 325 mg Tablet 1 Tablet(s) by mouth daily				
Lipitor (atorvastatin) 80 mg Tablet 1 Tablet(s) by mouth daily				
Levoquin (levofloxacin) 500 mg Tablet 1 Tablet(s) by mouth daily				
Clopidogrel (Plavix) 300 mg Tablet 1 Tablet(s) by mouth daily				
Lisinopril 5 mg Tablet 1 Tablet(s) by mouth twice daily				
Lopressor 100 mg Tablet Tablet(s) 1 Tablet by mouth twice daily				
Warfarin 2.5 mg Tablet 1 Tablet(s) by mouth at bedtime				
Lorazepam 1 mg Tablet 2 Tablet(s) by mouth evening				

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*