Restructuring Patient Care and Education at the Bedside

Michael H. Kim

March 8, 2012
Overview

• Understand the principles of patient and family centered care
• Recognize the benefits of patient and family centered care
• Understand how patient and family centered care was developed at UMMC
• Learn how to put patient and family centered care into practice
• Discuss the future of hospital-based patient care
The Project Team

• **Project Manager:**
  – Angela Quiram, Lean Six Sigma

• **Physicians:**
  – Dr. Michael Kim, Medicine
  – Dr. Jeffrey Chipman, Surgery
  – Dr. Ben Baechler, Smiley’s Family Medicine
  – Dr. Kimberly Viskocil, Medicine Chief Resident
  – Dr. Mara Antonoff, Surgery Resident

• **Nurses:**
  – Michele Diers, Medicine RN (5B)
  – Ben Millmann, Medicine RN (5A)
  – Sara Van Horn, Surgery RN (7C)

• **Care Coordinators and Social Workers**
  – Rebecca Loftus, Social Worker (Medicine, 5A)
  – Jennifer Miu, Care Coordinator (Medicine, 5B)
  – Madonna Waletzke, Social Worker (Surgery, 7C)

• **Patient Advisor**
  – Doretta Stark
The Leadership

• Department Chairs
  – Dr. Wes Miller, Medicine
  – Dr. Selwyn Vickers, Surgery

• Hospital Leadership
  – Marjorie Page, VP of Adult Services
  – Dr. David Rothenberger, Surgical Services Medical Director
  – Dr. Craig Weinert, Non-surgical Services Medical Director

• UMMC Innovations Committee
  – Sommer Alexander, Committee Chair
  – Diane Adler, 5B Nurse Manager
It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has.

-- Sir William Osler

I never teach my pupils. I only attempt to provide the conditions in which they can learn.

-- Albert Einstein
Great Patient Care

#1: Patients need to be *actively* involved in all medical decisions.

Corollary: Families need to be included wherever possible.
Great Patient Care

Patients need:

• Comprehensive information about their care
• Great nursing
• Ancillary services (Therapists, pharmacist, nutrition, etc)
• Appropriate transitions from hospital care
Traditional (Sit-down) Rounds

- **Patient rounds were:**
  - Physician-centric
  - Patient *focused* rather than patient *centered*

- **Significant variation in practice existed**
  - Different per each service, physician, and unit

- **Standard of care was not provided**
  - Did not meet institutional or clinical goals
# Staff Survey

3. With respect to current rounding, please rate the following:

<table>
<thead>
<tr>
<th>Quality of communication about the plan with the patient</th>
<th>Very poor</th>
<th>Poor</th>
<th>Neutral</th>
<th>Good</th>
<th>Very good</th>
<th>Response Count</th>
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<table>
<thead>
<tr>
<th>Quality of communication about the plan with the bedside nurse</th>
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<th>Very good</th>
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<table>
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<th>Very good</th>
<th>Response Count</th>
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<table>
<thead>
<tr>
<th>Quality of communication about the plan with ancillary services (PT/OT, Nutrition, Pharmacy, etc.)</th>
<th>Very poor</th>
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<th>Neutral</th>
<th>Good</th>
<th>Very good</th>
<th>Response Count</th>
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<td>21.7% (15)</td>
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<table>
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<th>Good</th>
<th>Very good</th>
<th>Response Count</th>
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<td>1.4% (1)</td>
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<table>
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<tr>
<th>Ability of patient to contribute to the discussion</th>
<th>Very poor</th>
<th>Poor</th>
<th>Neutral</th>
<th>Good</th>
<th>Very good</th>
<th>Response Count</th>
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<tr>
<th>Question answered</th>
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<td>skipped question</td>
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## Resident Survey

### Question 4: Rating of Current Rounding

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</thead>
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<tr>
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<td>Quality of communication about the plan with the care coordinator and social worker</td>
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<td>7.1% (5)</td>
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<td>8.6% (8)</td>
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<td>0.0% (0)</td>
<td>20.0% (14)</td>
<td>52.9% (37)</td>
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<tr>
<td>Impact on my learning and development</td>
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<td>61.4% (43)</td>
<td>10.0% (7)</td>
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- **Answered question:** 71
- **Skipped question:** 1
4. With respect to current bedside rounding, please rate the following:

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<th>Very good</th>
<th>Response Count</th>
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<td>43.3% (47)</td>
<td>15.9% (17)</td>
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6. In your experience, what is the impact of nurse participation in bedside rounds on the following:

<table>
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<tr>
<th></th>
<th>Large positive impact</th>
<th>Some positive impact</th>
<th>No impact</th>
<th>Some negative impact</th>
<th>Large negative impact</th>
<th>Response Count</th>
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<tbody>
<tr>
<td>Patient satisfaction</td>
<td>48.6% (35)</td>
<td>44.4% (32)</td>
<td>5.6% (4)</td>
<td>1.4% (1)</td>
<td>0.0% (0)</td>
<td>72</td>
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<tr>
<td>Physician productivity (overall)</td>
<td>41.7% (30)</td>
<td>43.1% (31)</td>
<td>5.6% (4)</td>
<td>6.9% (5)</td>
<td>2.8% (2)</td>
<td>72</td>
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<tr>
<td>Nurse productivity (overall)</td>
<td>45.1% (32)</td>
<td>43.7% (31)</td>
<td>5.6% (4)</td>
<td>5.6% (4)</td>
<td>0.0% (0)</td>
<td>71</td>
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<tr>
<td>Quality of care</td>
<td>55.7% (43)</td>
<td>38.1% (28)</td>
<td>2.8% (2)</td>
<td>1.4% (1)</td>
<td>0.0% (0)</td>
<td>72</td>
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<tr>
<td>Timely discharge</td>
<td>51.4% (37)</td>
<td>27.8% (20)</td>
<td>18.1% (13)</td>
<td>2.8% (2)</td>
<td>0.0% (0)</td>
<td>72</td>
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<tr>
<td>Interdisciplinary communication</td>
<td>61.1% (44)</td>
<td>34.7% (25)</td>
<td>2.8% (2)</td>
<td>1.4% (1)</td>
<td>0.0% (0)</td>
<td>72</td>
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<tr>
<td>Resident / medical student learning</td>
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<td>4.2% (3)</td>
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answered question 72
skipped question 10
7. In your experience, what is the impact of nurse participation in bedside rounds on the following:

<table>
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<th>Large positive impact</th>
<th>Some positive impact</th>
<th>No impact</th>
<th>Some negative impact</th>
<th>Large negative impact</th>
<th>Response Count</th>
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</thead>
<tbody>
<tr>
<td>Patient satisfaction</td>
<td>25.0% (17)</td>
<td>51.5% (35)</td>
<td>22.1% (15)</td>
<td>1.5% (1)</td>
<td>0.0% (0)</td>
<td>88</td>
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<tr>
<td>Physician productivity (overall)</td>
<td>36.8% (25)</td>
<td>30.9% (21)</td>
<td>16.2% (11)</td>
<td>16.2% (11)</td>
<td>0.0% (0)</td>
<td>88</td>
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<tr>
<td>Nurse productivity (overall)</td>
<td>34.3% (23)</td>
<td>40.3% (27)</td>
<td>10.4% (7)</td>
<td>14.6% (10)</td>
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<tr>
<td>Quality of care</td>
<td>41.2% (29)</td>
<td>54.4% (38)</td>
<td>7.0% (6)</td>
<td>0.0% (0)</td>
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<td>Timely discharge</td>
<td>16.2% (11)</td>
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<td>32.4% (22)</td>
<td>2.9% (2)</td>
<td>0.0% (0)</td>
<td>88</td>
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<td>Interdisciplinary communication</td>
<td>41.8% (28)</td>
<td>49.3% (33)</td>
<td>9.0% (8)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>87</td>
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</table>

answered question 68
skipped question 4
Great Patient Care

Patients need:
• Comprehensive information about their care
• Great nursing
→ #2: Nurses participate in care decision and planning.

• Ancillary services (Therapists, pharmacist, nutrition, etc)
• Appropriate transitions from hospital care
→ #3: Care coordinators and social workers must have up to date information on patient status.
The Solution

Bedside Rounding

Interdisciplinary Teamwork
Bedside Rounding Initiative

- **Moving patient rounding to the bedside:**
  - Provides care that is respectful of and responsive to individual patient preferences, needs and values
  - Improves the productivity of all disciplines, without compromising the educational needs of the medical and surgical residents

- **Engaging patients and their nurses**
  - Invite active participation by the patient and family in decision-making
  - Inclusion of the bedside nurse and other disciplines as appropriate to facilitate patient needs
Improved Quality of Care Goals

1. Improve the patient experience
   – Improve patient satisfaction

2. Reduce errors
   – Decrease medication errors
   – Improve patient reporting of symptoms

3. Increase efficiency
   – Improve productivity without sacrificing education
   – Improve provider, nursing, and staff satisfaction

4. Decrease costs
   – Decrease length of stay
What Does the Literature Say?

• Strong evidence that patients like bedside rounds (Institute for Patient and Family Centered Care)

• Learners initially don’t like bedside presentations, but become comfortable with experience (Institute for Patient and Family Centered Care)
  – Family-centered rounds challenges MDs to move beyond their comfort zone and approach uncertainty at the bedside
  – Post-implementation at Cincinnati Children’s Hospital Medical Center, “reluctance to family centered rounds among residents has all but disappeared” (Muething, 2007)
What Does the Literature Say?

• Outcome - Improved resident learning
  – Provides the opportunity for feedback on ACGME core competencies: patient communication and professionalism (Sisterhen, 2007)

  – Post-implementation at Cincinnati Children’s Hospital Medical Center, “residents now believe that that teaching is better and that they are learning in ways that were not possible in the conference room” (Muething, 2007)

• Outcome - Improved interdisciplinary communication
  – “A care plan, truly comes together and becomes maximally effective when family, nurse, and physician can listen to each other’s points of view” (Simmons, 2006)
What Does the Literature Say?

• Outcome – Improved overall MD productivity
  – While family centered rounds can take longer than teaching rounds, “participants believe that their time is used more efficiently and that family-centered rounds saves time later in the day” (Muething, 2007)

• Outcome - Improved patient and family experience
  – Majority of patients enjoy bedside teaching rounds and feel that it improves their understanding of medical problems (Fletcher, 2007)
  – “This gives me more opportunity to connect with the doctor” (Knoderer, 2009)
Examples

• Cincinnati Children’s Hospital Medical Center (Cincinnati, OH)
  – Post implementation (Muething, 2007)
    • Staff, including bedside nurses, feel more knowledgeable about the care plan
    • Order errors decreased from 9% to 1%
    • Decreased overall daily time per patient (however, rounding took 20% longer)
    • Increased patient satisfaction
    • Increased faculty and learner satisfaction

• Concord Hospital Cardiac Surgery Program (Concord, NH)
  – Post implementation (Uhlig, 2002)
    • Decreased mortality by 50%
    • Increased patient satisfaction to 99th percentile
    • Improved staff satisfaction
Examples

• MCG Health, Child and Adult Services (Augusta, Georgia)
  – 3 years post implementation (Institute for Patient and Family Centered Care, 2003)
    • Improved patient satisfaction from 10th to 95th percentile
    • Decreased LOS by 50%
    • Decreased RN vacancy rate from 8% to 0%
    • Increased faculty and learner satisfaction

• University of Pittsburgh
  – Resident Bedside Rounding Workshop (JGIM, 2010)
    • Duration of rounds did not significantly change (15 vs 16 min per pt)
    • Patient satisfaction of rounds increased (99% vs 83%)
    • Most residents believed they provided better patient care (73%)
The Pediatric Experience
Current State- Pt Complaints

Children's Service Line - 5A
"Pt Complaint/Grievance Rate Per 1000 Pt Days"

Rate Per 1000 Pt Days

Time Period

1Q 07  2Q 07  3Q 07  4Q 07  1Q 08  2Q 08  3Q 08  4Q 08  1Q 09  2Q 09  3Q 09  4Q 09
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<td>UMMC Hospital Overall</td>
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<td>→</td>
<td>60.7%</td>
<td>60.5%</td>
<td>63.5%</td>
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<td>UMMC Inpatients</td>
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<td>77.4%</td>
<td>79.5%</td>
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<tr>
<td>UMMC Inpatients - Adults</td>
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<td>↓</td>
<td>65.0%</td>
<td>67.0%</td>
<td>66.0%</td>
<td>69.0%</td>
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</table>
“Patient-centeredness” is a dimension of health care quality in its own right… Its proper incorporation into new health care designs will involve some radical, unfamiliar, disruptive shifts in control and power, out of the hands of those who give care and into the hands of those who receive it.

-- Don Berwick, IHI
Formation of a Patient Centered Process

A new method was developed by the project team

- Two similar processes were developed
  - One for medical care services
  - One for surgical/procedural based services
- Reviewed by pharmacy, therapy, nutrition and spiritual health
- Implementation on January 17, 2012
Summary of Roles by Discipline

• **Physician Team**
  – Contact each patient’s Bedside RN
  – Lead discussion with the patient & family
  – Update whiteboard

• **Bedside Nurse**
  – Join the physician team for bedside rounds (when possible)
  – Support and assist the patient and contribute to plan for the day
  – Update the whiteboard
  – Measure compliance on a daily basis

• **Care Coordinator and Social Worker**
  – Participate in bedside rounds for surgery patients
  – Update the whiteboard
  – Measure compliance on a daily basis
Process for Medical Services

- **7-8 am**: Unit NSTs / Bedside RNs input Ascom numbers in Epic
- **9-11 am**: MD team (1) calls Bedside RN prior to rounding on his/her patient or (2) checks in at the unit desk (all page is sent to RNs)*
- **9-11 am**: MD team rounds with Day Bedside RN
  - Discuss clinical content (as defined by checklist)
  - Update whiteboard (per new standardized guidelines)
  - RN supports and assists the patient and is engaged in plan of care
- **By noon**: MD teams check in with each unit’s CC and/or SW

*As determined by physician service
Process for Surgery/Procedural Services

• **5-7 am:** MD team checks in at unit desk (all page is sent to RNs)

• **5-7 am:** MD team rounds with Night Bedside RN
  – Discuss clinical content (as defined by checklist)
  – Update whiteboard (per new standardized guidelines)
  – RN supports and assists the patient and is engaged in plan of care

• **7-7:30 am:** Bedside hand off from Night to Day Bedside RN

• **Starting at 9 am:** Day Beside RN and CC and/or SW meet at bedside with patient
  – Inform patient that the “bedside” care team is working closely with the MD team to provide care and will help make note of and communicate any questions and concerns for the MD team
Baseline Data

University of Minnesota Hospital, Fairview
Percent of Times Physician/RN Round Together: Jan, Feb, Mar of 2011

2011 1st Quarter

<table>
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<th>Month</th>
<th>N</th>
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<td>January</td>
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<td>February</td>
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<td>March</td>
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Current Data

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What Will This Look Like?

Link to Demonstration Video 1: Bad Example
http://youtu.be/w9rKg0SRY3s

Link to Demonstration Video 2: Good Example
http://youtu.be/1A1u9jm1wfI
Putting Bedside Rounds Into Practice

• Each service and provider can modify the process (maintaining key principles)
• It takes practice to make this work well for providers and nurses
• Supervisors need to be more like a manager than a provider
Difficulties (My View)

- Being efficient (especially with green learners)
- Getting family involvement
- Getting learners to talk directly to patients using appropriate language
- Fitting in education time
  - Move to evaluating communication and professionalism
- Becoming comfortable with bedside discussions
Nurse Contact

• Contact NST/Charge Nurse
• Epic List
• Ascom phones
  – Outside (612-273-3555)
Family Involvement
Managing Rounds

• Set expectations
  – Define roles
    • Who calls nurse, who writes on whiteboard, how to supervise learners
  – Time expectations:
    • “This should be a 10 min visit.”

• Focus on patient communication
  – Learners talk directly to patients (not presenting to team)

• Place orders in the room
Video

MY EXAMPLE
Restructuring Education

• Set the stage
  – Develop brief educational goals for the bedside
• Take academic discussions outside the room
  – Focused topics (3-5 min)
• Increase education time outside of rounds
  – Afternoon didactics
  – Sit-downs for new patients
Communication with Interdisciplinary Team

- Daily updates to care coordinators and social workers daily for each patient
- Care coordinators will then communicate with ancillary services
Future Of Inpatient Care

- Patients will have more access to our outcomes data
- Compensation will be based (directly and indirectly) on these outcomes
- Bedside rounds allow for further quality improvement
  - Catheter removal
  - Discharge flow
- Computer decision support will increase (and hopefully improve care)
Bibliography

• Fletcher, K.E., Furney, S.L., Stern, D.T. Patients speak: What is really important about bedside interactions with physician teams. Teaching & Learning in Medicine, 19(2), 120-7.