Video Ethnography – Learning From Patients About Preventing Readmissions

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Readmissions Summit
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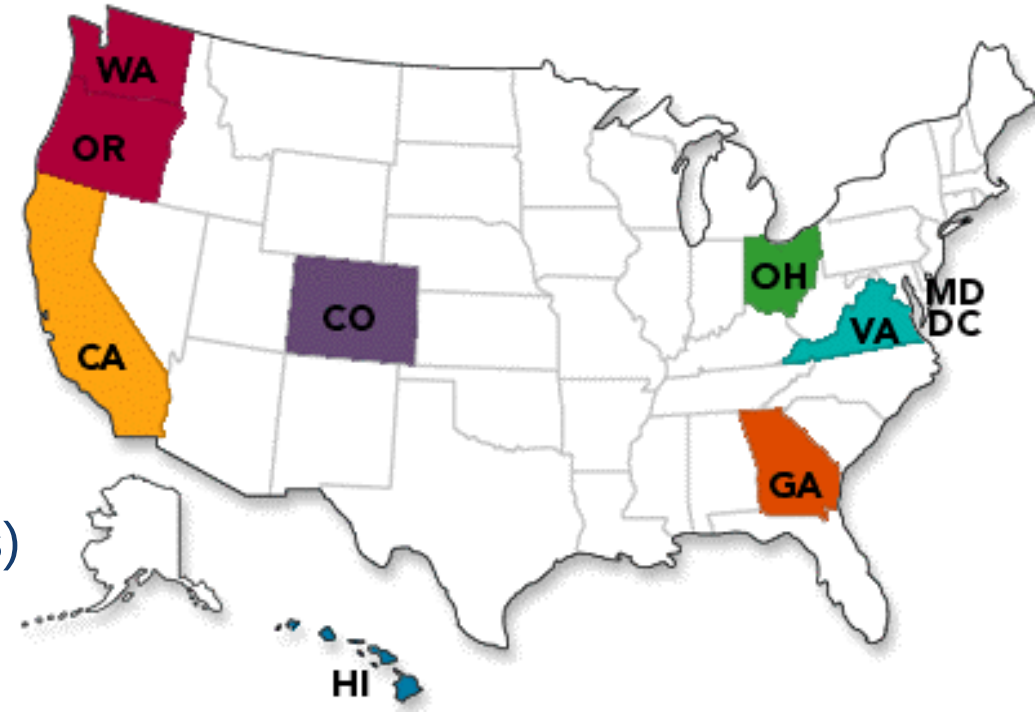
Kaiser Permanente

- 8 regions serving 9 states and the District of Columbia
- 8.9 million members
- 15,000 physicians
  - We hire only 11% of MD applicants in California
- 164,000 employees
  - 45,000 nurses
- 35 medical centers (with hospitals)
- 454 medical offices
- $42 billion operating revenue (2009)
  - 90% reinvested in caring for our members



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KP's Care Management Institute

CMI partners with KP Regions, providing the tools and techniques that enable Kaiser Permanente to deliver superior care for its members

"Making the right thing easy to do"

CMI serves as a gathering point for development of new clinical approaches, with a focus on…

- Keeping members at the center
- Harnessing technology
- Care coordination
- Applying evidence-based care
- Measuring results
- Spreading successful practices

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Our members are our strongest force to help get us where we want to go

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Many ways of bringing patients into improvement

More people

- Surveys
- Focus groups
- Video ethnography
- Patient councils
- Patients on the team

More compelling

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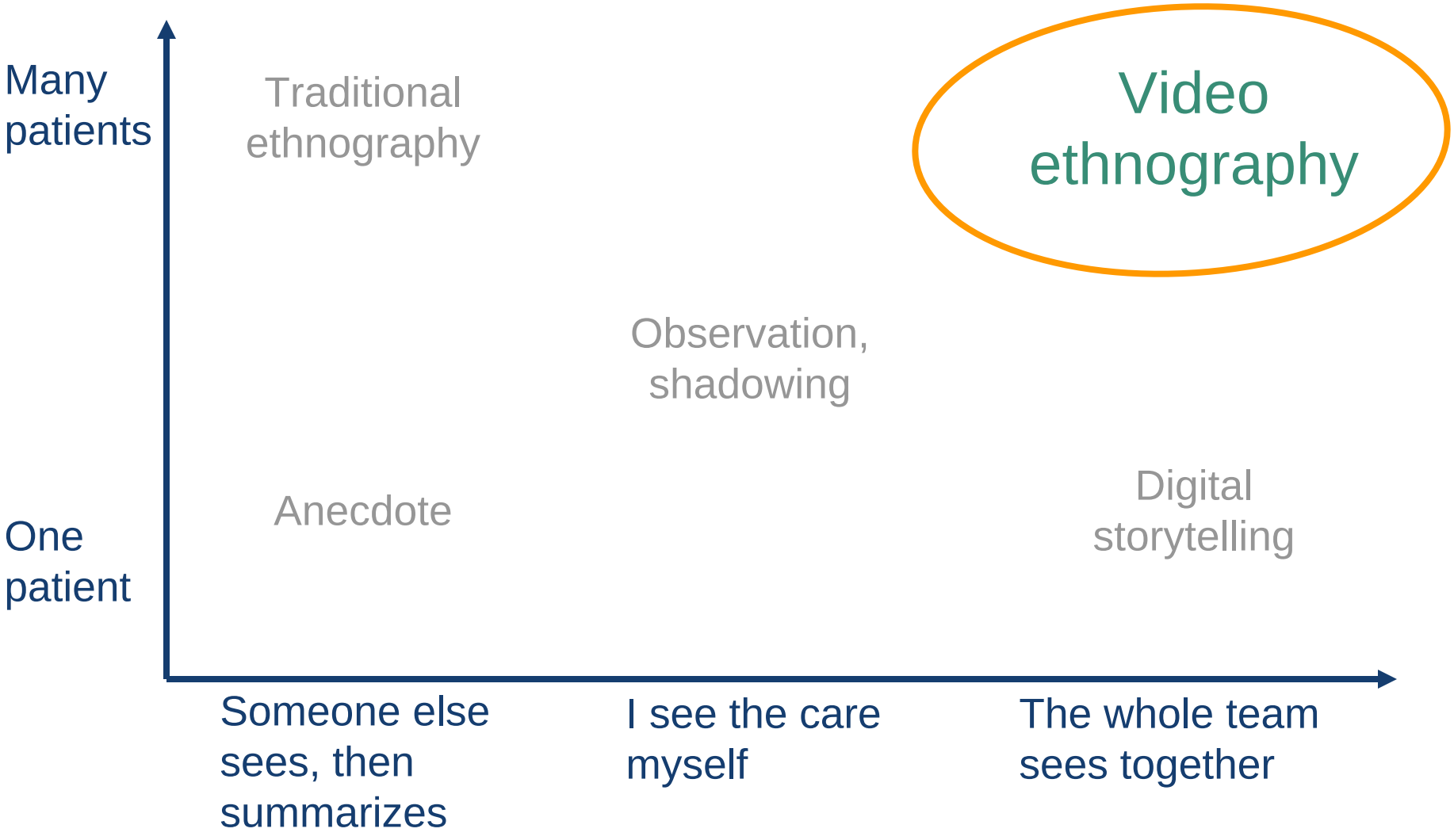
A new tool – Video Ethnography

Ethnography:
a qualitative method that involves interviews and observation to understand, interpret, and describe experience, systems, organizations and cultures

Video Ethnography:
applying rapid ethnographic methods and then using video to communicate learnings to stakeholders

With video ethnography, the whole team sees



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All video is not created equal

Training or marketing video

- Messages
- Script
- Filming

Video Ethnography

Study design → Data collection (interviews, observation) → Coding and Analysis → Identification of *most actionable* opportunities → Re-Analysis → *Actionable* messages → **Video**

QI strategy

← Learning →

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The ethnographic mindset

- Openness and curiosity
- Deep listening
- The patient as the expert
- Asking… Why? How?
- Hearing use of language

  “One foot out the door”
- Noting inconsistencies

➔ *Vuja de* – Seeing the familiar as if it were new

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Video ethnography – 3 paths to improving care

- When we see our care through patients' eyes, do we like what we see?
- Do the parts of our care combine to a better whole?

- What changes would most improve care?
- How can the members of our team work together to provide a great care experience?

- Are we delivering what we intend? Reliably?
- Beneath our data, what does our execution look like?

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VE aligns with KP's approach to improvement

- What are we trying to accomplish?
- How will we know that change is an improvement?
- What change can we make that will result in improvement?

Assess	Develop/ Identify Change	Test	Implement/Control
➪Process map ➪VOC ➪MVS	➪Standardize and simplify: • 5s • Remove waste • Cause/effect • OPI • FMEA ➪Apply evidence based practice ➪Just do it		➪Process capability ➪Managing variation ➪Process controls ➪Sustain ➪Spread plan

Interview, shadowing, observation

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Watch…

CMI Video About VE
(2 min version)

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Hospital-to-home transitions are a perfect application for VE

- No provider fully “owns” transitions

- Each provider sees only part of the transition experience
  - Views: hospitalist, discharge nurse, home health, PCP, etc
- No providers see patients’ experience arriving home

- It’s tempting to believe, for example, that we have provided discharge instructions patients can understand

Our readmissions journey started with needfinding

Patient needs for successful hospital-to-home transition

- Translating knowledge into safe, healthful actions at home
- Including caregivers at every step of the transition process
- Having readily available problem-solving resources
- Feeling connected to and trusting providers
- Addressing emotional goals
- Anticipating needs at home and identifying solutions
- Having necessary arrangements in place

Improvement case study – Heart Failure Transitional Care Program

South Bay Medical Center
Harbor City, CA

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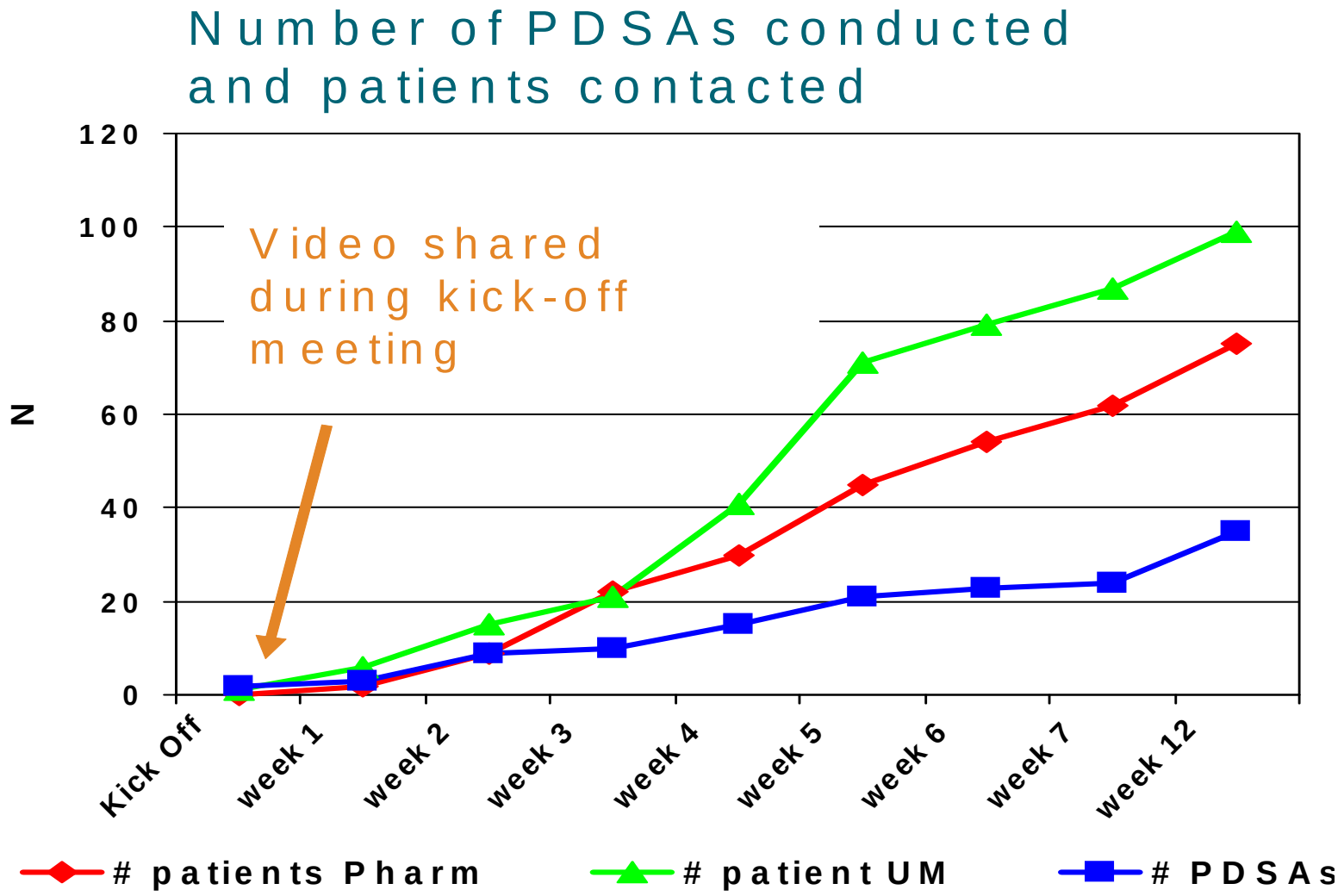
Study design and sampling frame

# of Team members	3
# of Days in in the field	2
# of Weeks from initial planning to completion	10
# of Patients and family members interviewed	8
# of Clinicians & staff interviewed or observed	7
# of Processes observed (i.e. inpatient assessment, home health, etc)	6

South Bay Medical Center Project

Translating learning into action



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Specific changes implemented

Patients didn't understand their medications when they were home

Real-time med rec

Home health RN can reach inpatient PharmD by phone to resolve any discrepancies

Social worker role in discharge was variable and poorly understood

Structured social worker roles

Social workers use standardized patient needs assessment and follow-up guidelines

Some patients didn't couldn't translate "low sodium diet" into practice

Improved dietary instructions

Patient information at discharge includes specific, culturally-diverse examples

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NW “transition bundle” was based on learnings about patient needs

What does the patient need?	Transition Bundle
I will have what I need when I return home	▪ Standardized assessments and risk stratification with tailored care
I know when I should call and what number to dial if I need help	▪ Specialized phone number on discharge instructions
My regular doctor will know what happened to me in the hospital	▪ Standardized same-day discharge summary
I understand my medications, how to take them, and why	▪ Pharmacist medication review in hospital and when patient is at home (high risk)
I know someone will check on me when I am home.	▪ RN follow-up call within 48 hours (+ case management if high risk) ▪ MD appointments made in hospital, for visit within 10 days (5 days if high risk)

The NW transition bundle is spreading across KP

Transition Bundle Elements	NW	B	C	D	E	F	G	H
Risk stratification and tailored care			P				P	
Special transition phone # on discharge instructions (expedited access to MD)			P				P	
Standardized same day discharge summary			P				P	P
Medication reconciliation redundancies across settings							P	P
Follow-up phone call within 48 hours								
Timely MD follow-up appointments scheduled in hospital							P	

Implementation Phase | **Testing Phase/ Partial Implementation** | **P** **Planning Phase** | **No activity yet**

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VE is best combined with other data

KP Northern California's Readmission Diagnostic

600 Chart Reviews

30 cases x 20 medical centers

433 Patient/Caregiver Interviews

Patient	255
Caregiver	178

18 Video Vignettes

Final Assessment

MD + RN

Triangulation

538 Treating Physician Interviews

PCP	234
HBS	166
Specialist	111
SNF MD	14
Other	13

Methods adapted from IHI

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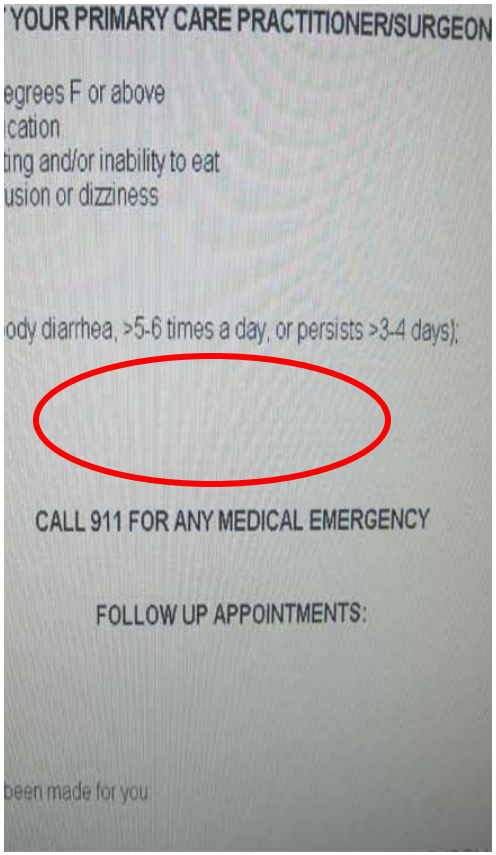
A picture speaks a thousand words!

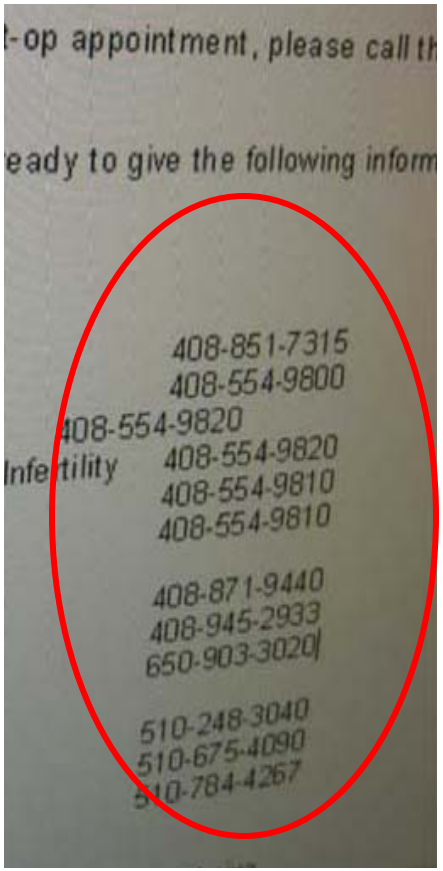
97% of patients received discharge instructions,
but …

Over half the discharge instructions did not specify who at KP to call if patients needed help

911 is often the only phone number given



Sometimes, many phone numbers are given



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Risks and mitigation

- Patient videos are Protected Health Information
  - Use consent and authorization forms
- Beware chasing after anecdotes …
  - Use qualitative learnings to develop hypotheses for further testing
  - Couple qualitative findings with quantitative data
  - Be thoughtful about sampling frame
- Our biggest challenge: *Demand!*
  - We are training VE teams across KP

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If you want to learn more…

- Read our toolkit:
  - http://kpcmi.org/cmi-news/tool-kits/
- Give it a try – start with “digital storytelling”
  - Go to the frontlines of care
  - Observe and interview 1 patient; focus on key touchpoints
  - Collect video
  - Use the video at your next meeting!

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Ready to start?

"If you want to change an organization's agenda, you need to change the data that routinely crosses people's desk."

Grenny, Maxfield, Shimber, 2008, MIT Sloan Management Review

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