Video Ethnography – Learning From Patients About Preventing Readmissions

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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
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
Our members are our strongest force to help get us where we want to go
Many ways of bringing patients into improvement

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

More people

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

Many patients

Traditional ethnography

Anecdote

Observation, shadowing

Someone else sees, then summarizes

I see the care myself

The whole team sees together

Video ethnography
All video is not created equal

Training or marketing video

Video Ethnography

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

QI strategy
Learning
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
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?
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?

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

Interview, shadowing, observation
Watch…

CMI Video About VE
(2 min version)
Hospital-to-home transitions are a perfect application for VE

**WILL**
- No provider fully “owns” transitions

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

**EXECUTION**
- 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
## Study design and sampling frame

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Team members</td>
<td>3</td>
</tr>
<tr>
<td># of Days in the field</td>
<td>2</td>
</tr>
<tr>
<td># of Weeks from initial planning to completion</td>
<td>10</td>
</tr>
<tr>
<td># of Patients and family members interviewed</td>
<td>8</td>
</tr>
<tr>
<td># of Clinicians &amp; staff interviewed or observed</td>
<td>7</td>
</tr>
<tr>
<td># of Processes observed (i.e. inpatient assessment, home health, etc)</td>
<td>6</td>
</tr>
</tbody>
</table>

*South Bay Medical Center Project*
Translating learning into action

Number of PDSAs conducted and patients contacted

Video shared during kick-off meeting

# patients Pharm  # patients UM  # PDSAs

Kick Off  week 1  week 2  week 3  week 4  week 5  week 6  week 7  week 12
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
NW “transition bundle” was based on learnings about patient needs

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

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

- **Implementation Phase**
- **Testing Phase/Partial Implementation**
- **Planning Phase**
- **No activity yet**

Kaiser Permanente
VE is best combined with other data

KP Northern California’s Readmission Diagnostic

433 Patient/Caregiver Interviews
Patient 255
Caregiver 178

600 Chart Reviews
30 cases x 20 medical centers

Final Assessment
MD + RN

538 Treating Physician Interviews
PCP 234
HBS 166
Specialist 111
SNF MD 14
Other 13

Triangulation

18 Video Vignettes

Methods adapted from IHI
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
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
If you want to learn more…

- Read our toolkit:

- 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!
“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