Collaborative Care: Setting the Care Plan

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Individuals Involved with the Project: Chief Medical Officer, Chief Nursing Officer, Senior Director of Nursing, Director of Managed Care, and Lean Six Black Belt, plus direct patient care provider.

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Executive Summary: Utilizing feedback and observation obtained during a Kaizen event, PRMCE’s Collaborative Care Team implemented changes throughout the care process to resolve inefficiencies. Improvements included Interdisciplinary morning huddles to identify readmission risk at admission; nurse-physician rounding; and starting the discharge process at the time of admission, which successfully decreased average length of stay (LOS), 30-day readmission rates, and overall inpatient costs of care.
Objective of the Best Practice: Patients and their families have reported through surveys and in-person interviews that they would like to see more partnership within the care they receive. Several steps were taken to eliminate the waste, rework, and ambiguities in the patient’s healthcare journey. The Medical Hospitalist Team (MHT) worked towards geographic placement and alignment with the primary care team (MD/RN/Discharge Care Planner/Rehab.) to create smoother inpatient and outpatient episodes. AM Plan of Care Huddles were created as a process for daily proactive discharge planning, which ultimately contributed to decreased readmission rates (.85% reduction). In addition, an MD/RN Rounding dyad was implemented to ensure all care team members and the patients and families were aligned around the care plan and discharge preparation.

Background: In an effort to meet their expectations, and to drive collaboration, PRMCE set goals to measure progress. A Kaizen event that began in 2009, which included more than 150 hours of observations across 140 patients and 165 staff and physicians yielded a value stream map with several opportunities to improve the patient experience. These opportunities included fragmentation of care; multiple queues for patients, family, staff, and physicians; rework and undone work; variability in practice; and waste (overproduction, transportation, motion, waiting, processing, inventory, and defects).

Literature Review: It seems obvious that a team-based approach to patient care provides an opportunity for improved patient outcomes. In fact, Wagner (2000), says “…team care has generally been embraced by most as a criterion for high quality care.” However, he goes on to point out, “…team care, especially in the primary care setting, remains a source of confusion and some skepticism.” Further, once care enters the inpatient arena, opportunities for confusion and miscommunication proliferate. Communication and collaboration between care team members and patients and their family is critical. So much so that in establishing their National Collaborative Care model, the Canadian Medical Association (CMA) (2007), stated, “Collaborative care teams should foster and support patients, and their families, as active participants in their health care decision-making.”

Accountability and responsibility amongst the collaborative care team is imperative. Defined roles are vital, but mutual accountability amongst all team members in the care of the patient is more so. The CMA (2007) reminds its constituents “It is essential that all providers be responsible and accountable for the care that they provide and for the well-being of the patient.” The morning huddles, by the Collaborative Care team, are an example of this and provide an opportunity for all stakeholders to reevaluate the course of treatment, and to reinforce the responsibilities of all involved, during the episode of care.

Kaizen events seem an appropriate approach to reducing waste and improving processes in healthcare. Kaizen means “improvement” in Japanese and these events focus on pinpointing and implementing improvements to meet patient demands. In healthcare, these short-duration events provide an opportunity for “…front-line workers from different disciplines to work together to rapidly plan, implement, measure, and adjust improvements” (Fine et al, 2009). Providence continually utilizes Kaizen events because they enable team members from across their organization to collaborate for rapid evaluation and improvement.
**Implementation Methods:** For the project, PRMCE compiled a Collaborative Team under the premise: “As providers of Patient and Family Centered Care, we collaborate through specific, intentional interactions between all members of the care team.” PRMCE focused on the three general phases during the acute, inpatient journey, and involved staff members from each phase, including Admitting Staff, RNs, MDs, Support Staff, and Discharge Planners.

Patients and their families played an unprecedented role in this improvement work. In 2009, PRMCE adopted Patient and Family Centered Care (PFCC) as a philosophy built in the belief that the best care is founded on partnerships between the patient, their family, and their medical professionals. We believe that patients and families are part of the care team: We provide care with them, not for them or to them. Before launching the Collaborative Care project, PRMCE surveyed patients and families about their priorities for the ideal state. Their priorities focused on “Compassionate Care/Customer Satisfaction” and “Clinical Outcome/Quality and Safety.” Interestingly, based on this survey data, the patient’s, and family’s priorities were not aligned consistently with leadership priorities.

**Results:** Through this project, the team identified how the current systems and structures for patient’s assignment did not encourage collaboration of care teams, which lead to fragmentation of care and poor communication. Members of the care team were often misaligned around the patient’s journey, to include discharge timeline, and care transition needs. Further, team member roles were unclear, and responsibilities for patient care often lead to waste and rework. Finally, and most importantly, patients and families often were not clear about their inpatient journey nor about the level of teamwork “behind the scene.”

Finally, compared to the median length of stay (LOS) in 2010, we observed a statistically significant reduction of 1.8 hours. However, by modeling the median LOS growth rate of 3.09%, witnessed in August 2010, it is likely we may have observed much higher LOS growth (than the observed 3.09% in August 2010) if the Collaborative Care project had not addressed it.

**Conclusion:** The Kaizen event, and subsequent Collaborative Care project, resulted in actionable goals to improve the patient care journey, reduce the average length of stay, and decrease readmission rates. However, a major lesson of this project was that a “back to basics” approach was critical for success. Constantly reminding the health care team that “we are here to serve patient and family” was imperative. Further, without buy-in from the patient’s primary care physician, or community alignment, safe and effective transitions between inpatient and outpatient care are difficult to achieve, and can lead to unnecessary 30-day readmissions. Finally, a process change of this scope and scale takes time to align of all stakeholders. As such, perseverance and continued messaging by leadership are key to success.

Providence Regional Medical Center Everett (PRMCE) has been a leader within Providence Health & Services, receiving national recognition as one of the 10 “Islands of Excellence” (highest quality, lowest-cost care regions) both by the Dartmouth Atlas and the Institute for Healthcare Improvement (Providence, 2010). Despite PRMCE’s status as a clinical leader, in the spirit of the beloved Sisters of Providence, PRMCE continually strives to improve quality, enhance the patient’s and family’s experience, and reduce the costs of care in these difficult economic times.
References


