Family-Centered Care: Impact on Process of Care at WCHOB

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Goals and Objectives
- Review Concept of Family Centered Care
- Discuss FCC Team Models here at Women and Children’s Hospital
- Focus on Improvement of Process of Care

What is Family-Centered Care?
- The priorities of patients and their families drive the delivery of services.

Family-Centered Care
- Recognizes that the family is the constant force in a child’s life
- Respect family values, beliefs, religious and cultural backgrounds
- Provide information to allow families to make educated choices
- Share information with families to enable them to make informed decisions
- Support families
- Recognize that care-givers need to be flexible

2003 AAP Policy Statement on Family-Centered Care
- Ensure that there are systems in place that facilitate children and families’ access to consumer health information and support
- Encourage and facilitate family-to-family support and networking
- Create ways for children and families to serve as advisors

2003 AAP Policy Statement on Family-Centered Care
- Ensure that the core concepts of family-centered care are incorporated into all aspects of professional practice
- Conduct attending physician rounds in the patients’ rooms with the family present
- Provide education and training in family-centered care to all physicians, nurses, residents, students and hospital staff
2003 AAP Policy Statement on Family-Centered Care

- Design facilities to promote the philosophy of Family-Centered Care
- Hire staff with the expectation of Family-Centered Care
- Conduct research on outcomes and implementation of Family-Centered Care

Role of Rounds in FCC

- Historically, patients have been discussed in area separate from family
- Physicians then see patient in room and tell them plan for day
- Does not include family in discussion of care

New Model of FCC Rounds

- Team rounds in room of patient
- Communication is directly to family/patient
- Overnight events summarized
- Plan for day reviewed
- Discharge plans and criteria are reviewed
- Family questions are directly answered

Family-Centered Care Team

- Attending
- Residents
- Medical Students
- Charge Nurse
- Pharmacist
- Future goal: discharge planner and bedside nurse

Goal of Bedside Rounds

- Include relevant medical personnel
- Involve the family in decisions
- Communicate directly with families
- Improve opportunities for teaching both families and health care providers
- Encourage evidence-based learning
- Improve process of care
- Improve patient/family satisfaction

New Team System at WCHOB

- 2 Hospitalist teams (PHS-Red and PHS-Blue): All ambulatory pediatricians, hospital inpatients and outpatients, including patients without admitting privileges. Hospitalist attending, senior resident, intern and medical student.
- 1 Private team (Green): patients who have a Community Pediatrician or Family Medicine Physician with admitting privileges. This team currently has an FTF assigned for teaching.
- 1 Subspecialty team (Purple): This team includes patients admitted to all subspecialty services.
- This replaces prior floor-team model.
Background history

- Floor based rounding system until July 2007
- New rounding system separates patients based on service but not on age
- Advantage is that residents can now round with attending of record on 2 hospitalist teams

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Literature suggests that there is a decrease in LOS with hospitalist system vs. private doctor system

- Boyd, et al [1] compared 2 private groups to 1 hospitalist group and looked at length of stay. Hospitalist group shorter average LOS

- A number of studies [2, 5] found an average 10-16% decrease in LOS with use of hospitalists

Other Hospital Examples

- Cincinnati Children’s Hospital:
  - Increase in the number of patients who go home without delay since implementing FCC rounding
  - Demonstrated significant differences in average length of stay for common diagnoses

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Hypothesis

- The new rounding system will
  - Facilitate timely discharges
  - Decrease the length of stay
  - Change the time of discharge to earlier in the day
**Study Design**

- Retrospective Cohort Study

**Population**

- Patients on the hospitalist service during the time of July 1\textsuperscript{st} to December 31\textsuperscript{st} during 2006 and 2007

**Intervention**

- **Changing of rounding system**
  - Old system: residents and students would round in the rooms without attending
  - New system: residents, students, and attending round on patients together

**Comparison**

- The exposure for this study is the new rounding system
- Study compared patients from July 1\textsuperscript{st} – December 31\textsuperscript{st} in 2006 (old system) with patients from July 1\textsuperscript{st} – December 31\textsuperscript{st} in 2007 (new system)

**Outcome Measures**

- Length of stay (number of hours the patient was in the hospital)
- Time of Discharge (time patient was discharged from the Kaleida system)

**Methods**

- After data was collected, certain patients were eliminated
  - LOS > 2 weeks
  - PICU admission
  - NICU admission
  - Discharge to place other than home
  - Anyone admitted initially under another service
Data Collection and Analysis

- **Retrospective Chart Review**
  - Charts were obtained based on the admitting physician (PHS physicians)
- **Data analyzed using a simple t-test and chi-square analysis**

Results

No significant change of Length Of Stay (p-value=0.6640)

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<th>Lower CL mean</th>
<th>Mean</th>
<th>Upper CL Mean</th>
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Results

No significant change in Time Of Discharge (p-value=0.2019)

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<th>Variable</th>
<th>Year</th>
<th>Lower CL mean</th>
<th>Mean</th>
<th>Upper CL Mean</th>
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Results

No significant change on discharge time before/after 3pm (p-value=0.4154)

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<th>% Percent</th>
<th>% Col Percent</th>
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<tr>
<td></td>
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<td>50.49</td>
<td>60.49</td>
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</table>

Results

- In 2006, only 78 patients were discharged between 9am and 12:30pm
- In 2007, number of patients discharged during this time increased to 126

Why no change?

- **First 6 months of new system**
  - Not as efficient
  - Logistics: patients are spread over 3 floors
  - Adjustment time for nurses, residents, and attendings
**Possible Barriers to Early Discharge**

- Is patient waiting to make a goal?
  - Tolerating Room Air
  - Able to tolerate lunch

- Inefficient Discharge Planning
  - Patients awaiting home care supplies
  - Waiting to have prescriptions filled
  - Patients unaware of discharge and awaiting rides

**Possible Solutions**

- Discharge goals (starting in November)
  - Written on admission and verbalized each day on rounds

- Discharge rounds (began April 21)
  - One location with nursing supervisor, charge nurses, senior resident of each team, and discharge planner
  - Discharge planner to round with the teams
  - Address needs for potential discharges and facilitate arrangement of these needs

**Limitations of Research**

- Discharge times/Length of Stay isn’t able to look at different diagnosis
  - For example, for FROS that is fixed 48 hours, are we actually getting people out closer to the 48 hours than before?

- Look at case by case basis to see where delays are
  - Resident’s not writing orders, waiting for medications, waiting for rides, waiting for nursing to finish with another patient before discharging

- Significant change between PHS and Private Teams
  - Dr. Joyce Lee is looking at this currently

**Resources**

- Dr. Tom Black
- Dr. Michael Leonard
- Sandy McDougal