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 clinic patients, un-referred patients and patients who have pediatricians without admitting privileges. Hospitalist attending, senior resident, interns and medical students
- **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

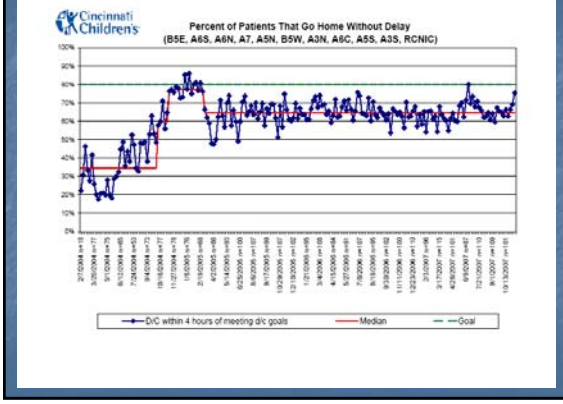
Background history

- 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

- 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 ***
  - **demonstarated significant differences in average length of stay for common diagnoses***



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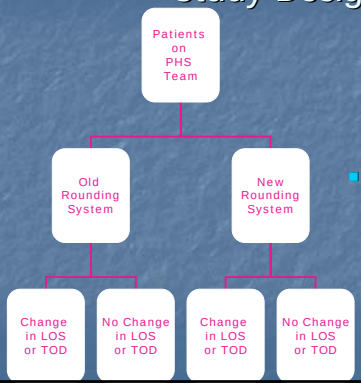
Impact on Admissions and Average Length of Stay for Fiscal Year 1996 - Fiscal Year 2007		
Condition	**Admission**	**Average Length of Stay**
Asthma	50% Decrease	30% Decrease
Bronchiolitis	29% Decrease	22% Decrease
Community-Acquired Pneumonia	12% Decrease	9% Decrease
Fever of Uncertain Source	71% Decrease	37% Decrease
Gastroenteritis	38% Decrease	12% Increase*

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 1st to December 31st 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 1st – December 31st in 2006 (old system) with patients from July 1st – December 31st 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)

Variable	Year	N	Lower CL mean	Mean	Upper CL Mean
LOS	2006	696	57.994	61.619	65.245
LOS	2007	824	57.136	60.52	63.905
LOS	Diff		-3.863	1.0991	6.0611

Results

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

Variable	Year	N	Lower CL mean	Mean	Upper CL Mean
TOD	2006	696	15.448	15.676	15.903
TOD	2007	824	15.29	15.483	15.676
TOD	Diff		-0.103	0.1927	0.4888

Results

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

Table of Discharge by Year

Discharge Frequency Percent Row Pct Col Pct	Year 2006	 2007	 Total
<3PM	293 19.28 44.60 42.10	364 23.95 55.40 44.17	657 43.22
>3PM	403 26.51 46.70 57.90	460 30.26 53.30 55.83	863 56.78
Total	696 45.79	824 54.21	1520 100.00

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

Discharge Goals

	Date/Time	Initials	
☐	Date/Time	Initials	
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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

- 1. Boyd, John, et al. Comparison of Outcome Measures for a Traditional Pediatric Faculty Service and Nonfaculty Hospitalist Services in a Community Teaching Hospital. *Pediatrics.* 2006;118:1327-1331.
- 2. Freed, Gary L, et al. Hospitalists in Children's Hospitals: What We Know Now and What We Need to Know. *The Journal of Pediatrics.* 2006;12:296-299.
- 3. Kaboli, Peter J, et al. Associations with Reduced Length of Stay and Costs on an Academic Hospitalist Service. *The American Journal of Managed Care.* 2004;10:561-568.
- 4. Landrigan, Christopher, et al. Impact of a Health Maintenance Organization Hospitalist System in Academic Pediatrics. *Pediatrics.* 2002;110:720-728.
- 5. Landrigan, Christopher, et al. Pediatric Hospitalists: A Systematic Review of the Literature. *Pediatrics.* 2006;117:1736-1744.
- 6. Smith, Peter C, et al. Primary care family physicians and 2 hospitalist models: Comparison of outcomes, processes, and costs. *The Journal of Family Practice.* 2002;51:1021-1027.
- 7. Dr. Tom Black
- 8. Dr. Michael Leonard
- 9. Sandy McDougal