Keck Medicine of USC Person-Centered Care Project Summary Presentation

HASC 2019

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Evolution of Aim

What we initially thought we would do

- Two projects – Orthopedics & Oncology
- To better understand the needs of frail older patients (over 80 years) undergoing surgery and chemotherapy
- *How we refined our focus, and why*
- Incorporated frailty and brain health assessments, as well as *what matters to you* questions, in 65+ populations to drive person-centered care

Team Members & Structure

Which team members (and their roles) in our organization were key to this work

- CHSI: Carol Peden, MD; Katy Roberts, MS, MBA; Veronica Pagán
- Orthopedics: Jay Lieberman, MD, *Orthopedic Surgery*; Karen Campbell, RN, *Orthopedic Surgery*; Amy Surnock, RN, *Orthopedic Surgery*; Lynne Zawacki, RN, *Orthopedic Surgery*; Char Ryan, *Patient Experience*; Pat Nerad, *Patient Experience*; Joana Rodriguez, *Case Management*; Daniel Kudryashov, PharmD, *Pharmacy*
- Oncology: Afsaneh Barzi, MD, *Oncology*; Irene Kang, MD, *Oncology*; Carol Marcusen, *Social Work*; Susan Glaser, *Social Work*; Jane Ruiterman, *Social Work*; Katie Jordan, *Occupational Therapy*; Michelle Lee, *Occupational Therapy*; Allie Schmiesing, *Occupational Therapy*

Which existing hospital committee(s) helped design and direct our efforts?

- None specifically, although members of the patient experience team were involved

Post-acute & Community Partners

How we developed shared strategy with the Orthopedics and Oncology

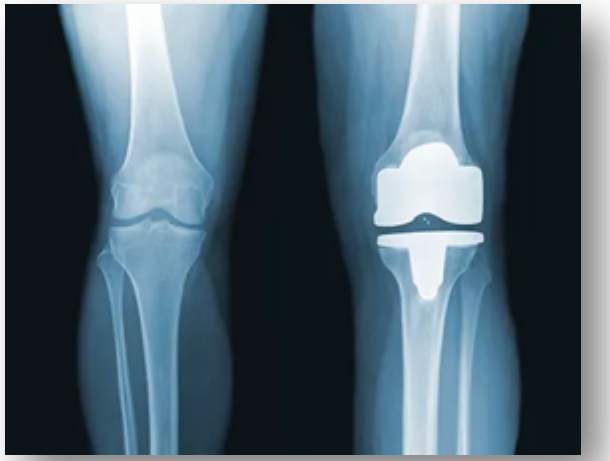
- Orthopedics: Presented project to Ortho partners and worked with nursing to implement
- Oncology: Collaborated with clinical leads to develop and implement changes

What was "natural" about this partnership, and what was more difficult than expected

- Orthopedics: Restrictions on access to patients, resistance to implementing change
- Oncology: far fewer older patients than expected. Scheduling challenges

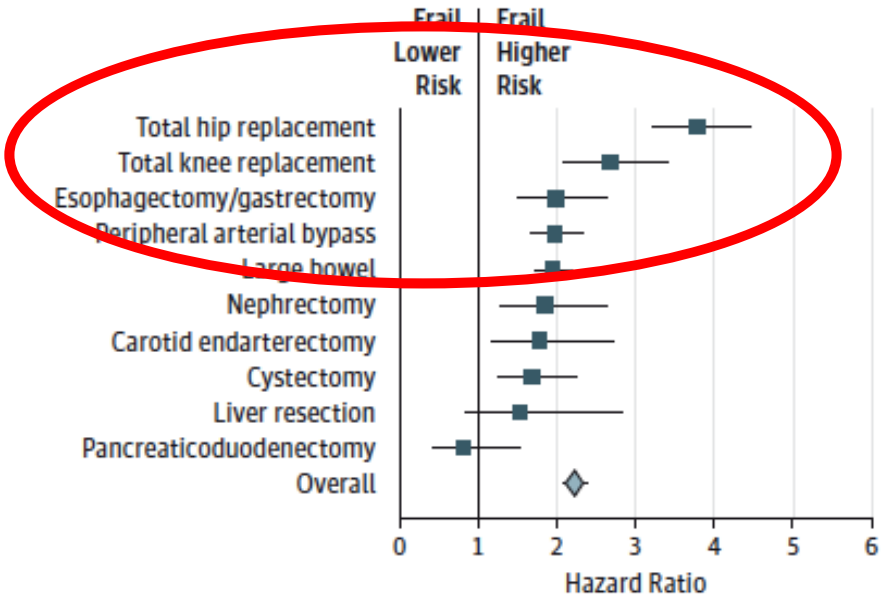
Orthopedic Joint Project

- Identified Orthopaedic Surgery as Ideal Partner
  - CMS Complete Joint Replacement Program (CJR)
  - Target population – elderly age 65+
  - Good outcomes (e.g. no infections, etc.)
  - Engaged support staff
  - Readily available data
  - Initial data analysis



The Impact of Frailty

Figure 3. Hazard Ratio for Effect of Interaction Between Frailty and Surgery Type on 1-Year Mortality Risk

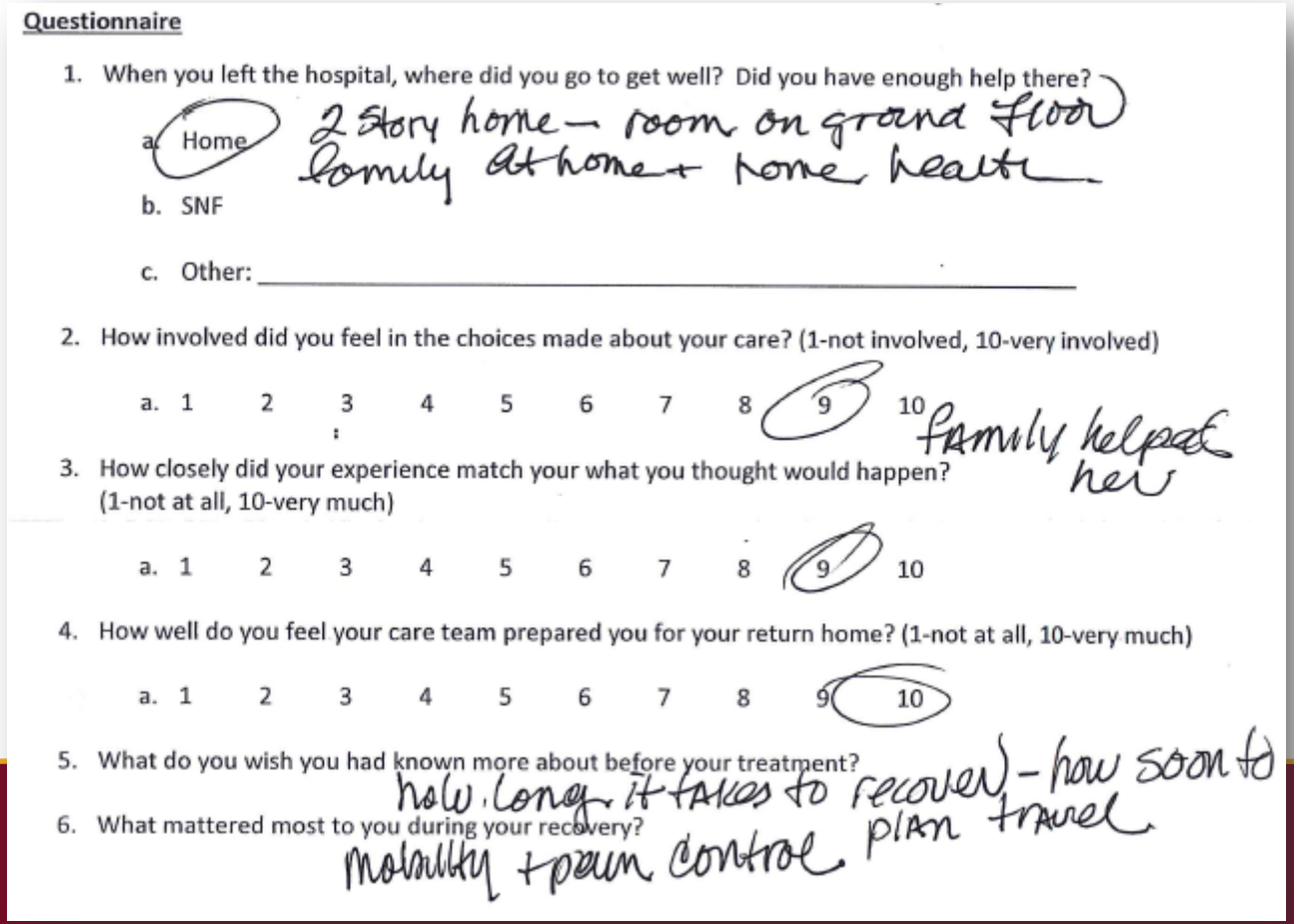


The hazard ratio (adjusted for patient age, sex, and neighborhood income) measuring the association between frailty and 1-year mortality is presented for each surgical type. Hazard ratios whose lower 95% CI excludes 1 indicate a significantly increased risk of 1-year death in frail patients.

- ***McIsaac et al Association of Frailty and 1-Year Postoperative Mortality Following Major Elective Non-cardiac Surgery: A Population-Based Cohort Study. JAMA Surgery 2016;151:583-45***
- Big data 203,000 patients >65y
- Hazard greatest post-op day 3
- HR for 1year mortality after THR 3.79 and 2.68 for TKR

Data – Orthopedic Joint Project

- 46 Interviews
  - Conducted at median 6 weeks post-op
- Most questions answered 10/10 (excellent)



Questionnaire

1. When you left the hospital, where did you go to get well? Did you have enough help there?
   a. (Home) 2 story home – room on ground floor family at home + home health
   b. SNF
   c. Other: _____
2. How involved did you feel in the choices made about your care? (1-not involved, 10-very involved)
   a. 1 2 3 4 5 6 7 8 (9) 10 family helped her
3. How closely did your experience match your what you thought would happen? (1-not at all, 10-very much)
   a. 1 2 3 4 5 6 7 8 (9) 10
4. How well do you feel your care team prepared you for your return home? (1-not at all, 10-very much)
   a. 1 2 3 4 5 6 7 8 9 (10)
5. What do you wish you had known more about before your treatment? how long it takes to recover – how soon to plan travel
6. What mattered most to you during your recovery? mobility + pain control

Initial Findings – *What matters most?*

Issues revealed through survey/interview questions.

- Vast majority of patients very happy with their care.
- Areas for improvement:
  - Discharge paperwork
    - Confusing to patients
    - Perceived as different from verbal instructions
    - High volume of paperwork – driven by aim to meet regulatory requirements

Initial Findings – *What matters most?*

Issues revealed through survey/interview questions.

- Variation in Practice
  - Example: Continuous Passive Movement (CPM) Machines
    - Difficult/awkward to manage for patients
    - Variation in usage by MDs and patients
- Expectation management for post-surgery movement
  - Fear of pain
  - What does it mean to "walk" on day one?
  - Unexpected sounds and sensations

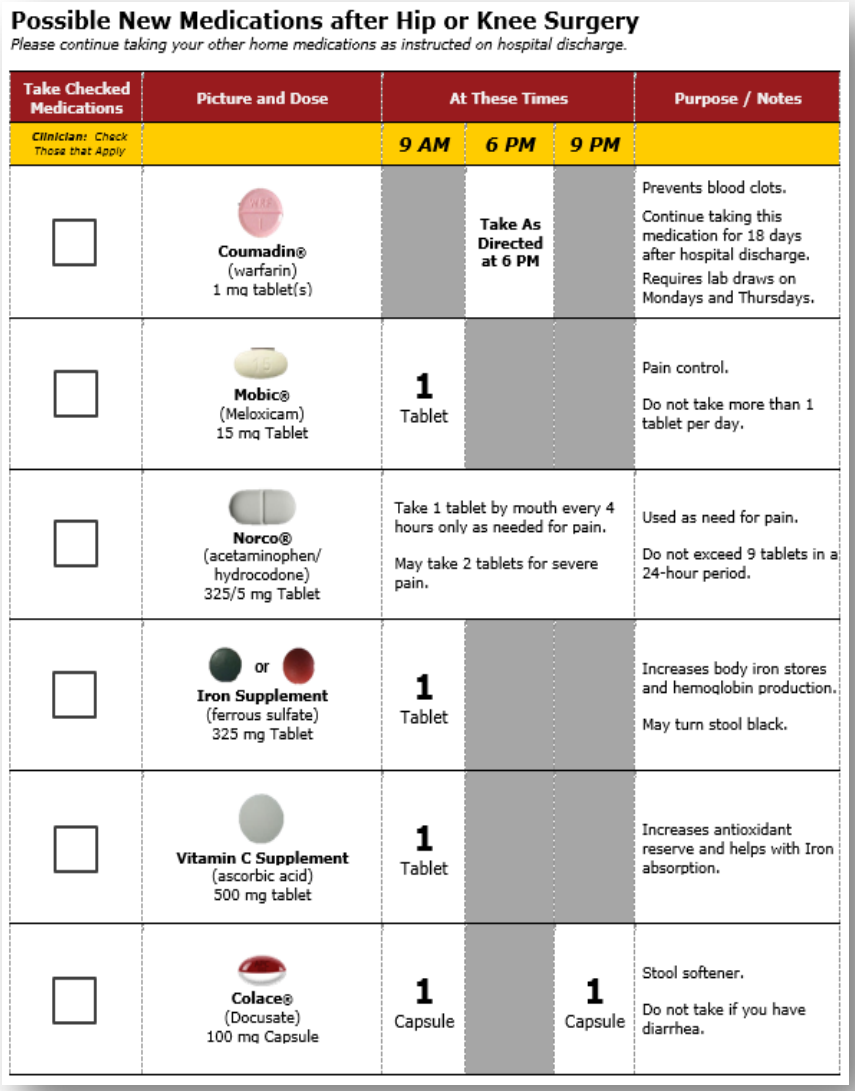
Changes to Process

Processes originating at the hospital

- We discovered discharge instructions varied with and within orthopedic teams – changed
- Continuous passive movement machine ordering
- Discharge medication

Processes taken on by our post-acute partners

- Clearer discharge instructions



Possible New Medications after Hip or Knee Surgery

Please continue taking your other home medications as instructed on hospital discharge.

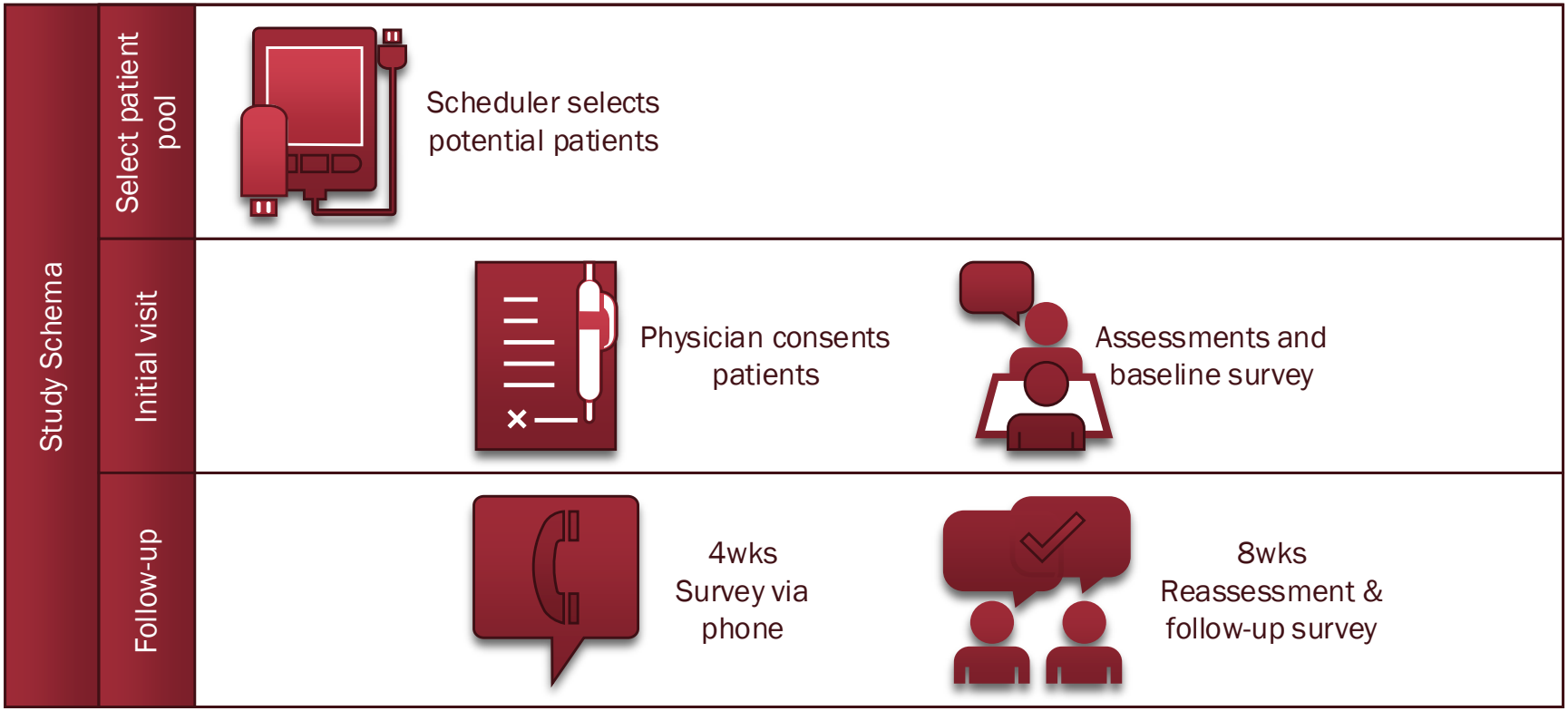
Take Checked Medications	Picture and Dose	At These Times			Purpose / Notes
Clinician: Check Those that Apply		9 AM	6 PM	9 PM	
☐	**Coumadin®** (warfarin) 1 mg tablet(s)		Take As Directed at 6 PM		Prevents blood clots. Continue taking this medication for 18 days after hospital discharge. Requires lab draws on Mondays and Thursdays.
☐	**Mobic®** (Meloxicam) 15 mg Tablet	1 Tablet			Pain control. Do not take more than 1 tablet per day.
☐	**Norco®** (acetaminophen/ hydrocodone) 325/5 mg Tablet	Take 1 tablet by mouth every 4 hours only as needed for pain. May take 2 tablets for severe pain.			Used as need for pain. Do not exceed 9 tablets in a 24-hour period.
☐	or **Iron Supplement** (ferrous sulfate) 325 mg Tablet	1 Tablet			Increases body iron stores and hemoglobin production. May turn stool black.
☐	**Vitamin C Supplement** (ascorbic acid) 500 mg tablet	1 Tablet			Increases antioxidant reserve and helps with Iron absorption.
☐	**Colace®** (Docusate) 100 mg Capsule	1 Capsule		1 Capsule	Stool softener. Do not take if you have diarrhea.

Person-Centered Oncology Care

Chemo-Naïve Elderly

USC *Norris Cancer Center*

Brief project plan



What Matters Most?

PRE-Questions:

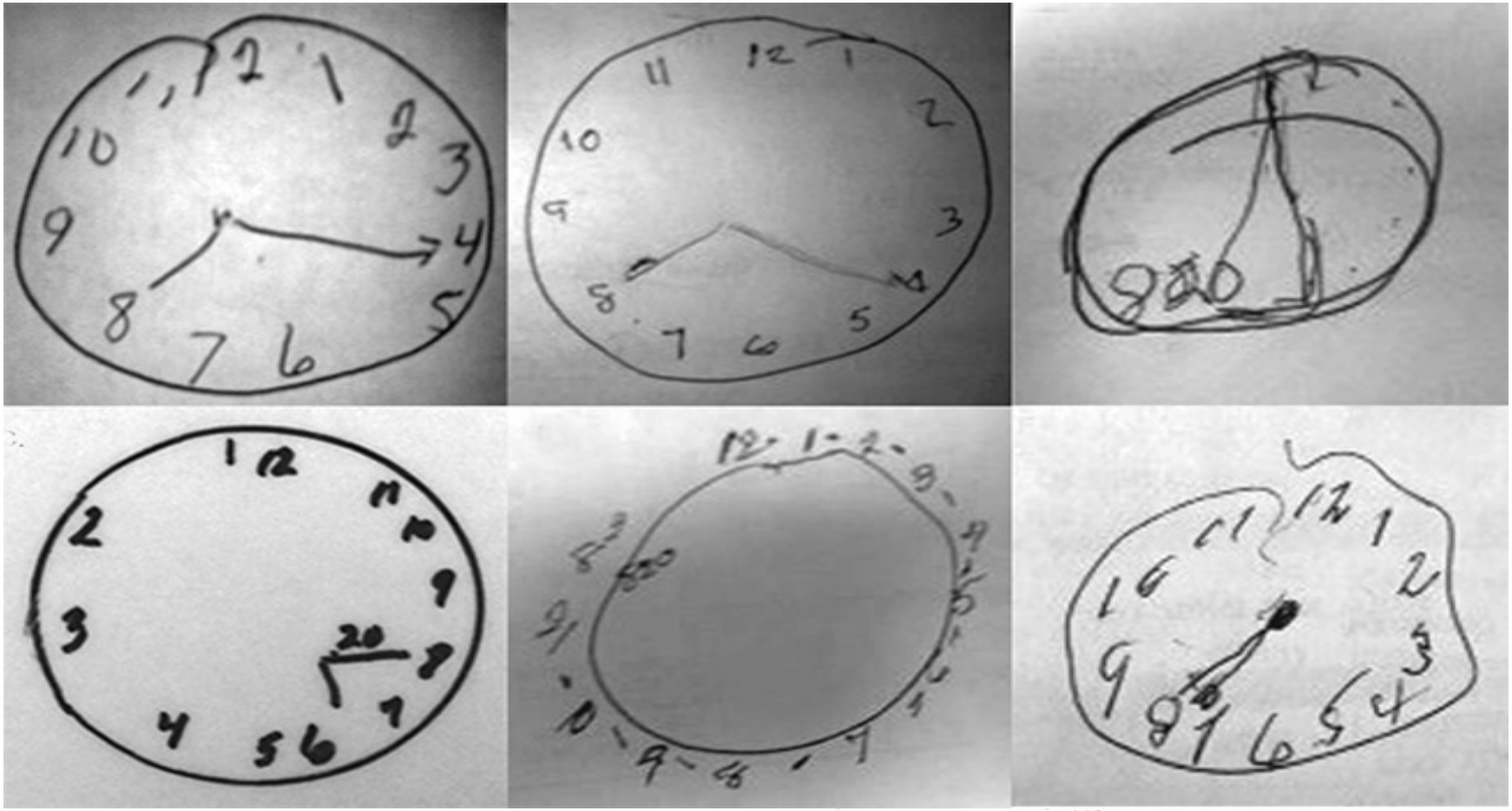
1. What are you worried about?
2. What matters to you most?
3. What is your current living situation?

POST-Questions:

1. How involved did you feel in the decisions made about your care? (1-not involved, 5-very involved)
   a. 1 2 3 4 5
2. How closely did your experience match your expectations? (1-not at all, 5-very much)
   a. 1 2 3 4 5
3. How well do you feel your care team prepared you for your return home? (1-not at all, 5-very much)
   a. 1 2 3 4 5
4. What do you wish you had known more about before your treatment?

5. After your treatment, did you need any changes in your living situation? Did you have enough help?

Cognitive Assessment –Mini-Cog



Assessment - Frailty

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frai**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging. Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173:489-495.

DALHOUSIE UNIVERSITY
Inspiring Minds

Implementation Experience

Pleasant surprises or barriers encountered

Oncology

- Amazing staff very keen to get involved in project

Orthopedics

- Dedication to patients – 24/365 days per year
- Pharmacy resources

How barriers were overcome

- Adaptation… Sometimes they were not

Executive support

- No formal route of support for the project

Quality of Life Assessment

How did your Person-Centered Care Program address Quality of Life measures and discussions?

Orthopedics

We were unable to implement the QOL assessment with our orthopedics project.

Oncology

All patients took a Mini-Cog test, were assessed for frailty, underwent a psycho-social assessment by a social worker, and an occupational therapy assessment by OT staff. Staff followed up about every 2 weeks to reassess for any changes in QOL.

What We Accomplished

Orthopedic Surgery

Quantitative data about the population served with your new person-centered care process

- 46 Interviews
- Most questions answered 10/10 (excellent)

Qualitative findings about the Quality of Life and Functional Status discussions

- A formal QOL assessment was not given to these patients. Several expressed, however, that their expectation about walking post-surgery did not match reality.

What We Accomplished

Oncology

Quantitative data about the population served with your new person-centered care process

- 11 patients identified as eligible under study criteria, 7 patients fully assessed.
  - 3 patients assessed with needs identified.
    - 3 chose hospice care
    - Social work able to connect patients with additional outside resources
  - 4 assessed with no needs identified. Will follow-up later in treatment course for reassessment of needs.
  - 1 patient interested in Lifestyle Redesign

What We Accomplished

Oncology

Qualitative findings about the Quality of Life and Functional Status

- Untreated anxiety and depression.
  - Several patients could benefit greatly by having mental health services part of their care team.
- Cognitive dysfunction in 3/7 patients.
- Patients with revealed cognitive dysfunction were also the patients who chose hospice care
- Some level of frailty or vulnerability in 4/7 patients.
- What are you worried about?
  - Pain.
  - Being ready to die.
  - Feeling of isolation.
- What matters most to you?
  - Becoming healthy again.
  - Being there for family.
  - Fatigue
    - Lack of ability to do activities that provide joy and **socialization**.
    - Several patients could benefit from occupational therapy to improve strength and avoid further deterioration.
  - Being able to take care of oneself.

Benefits to our Organization

Quantitative Data about the time investment of our team members/process and the cost/benefit ratio

Oncology

- Full assessment takes ~1 hour, with follow-up calls taking ~10 minutes.

Orthopedics

- Survey completed in less than 5 minutes.

Qualitative assessment about what our team members and our organization gained

Oncology

- Team-based care. Care team that includes OT, PT, Social Work, and mental health services could benefit patients by preventing decline or better supporting the patient through the mental process of coming to terms with terminal illness.

Orthopedics

- Helped team better understand variation in their processes and extra work it causes.
- Brought to light unknown patient issues (CPM, discharge paperwork).

Overall Lessons Learned

Advice for other organizations?

- Executive/Department head support
- Enthusiastic clinical leads
- Collaborative environment and open communication

Person-Centered Care

How is your organization now better equipped to provide person-centered care?

- Team-based care that extends across the continuum has begun to take hold and processes put in place as a direct result of these projects. Influenced initiatives include:
  - Enhanced Recovery After Surgery (ERAS)
    - Cardiothoracic Surgery, Gynecology, Head and Neck Surgery, Spine Surgery, Thoracic Surgery, Urology
  - Brain Health Initiative
    - Focusing on person-centered care and proactive assessment to protect our older patient's brain during and after surgery to maintain QOL.

In Summary

- Complex projects which have took a lot of set up time
- Simple questions elicit a lot of very useful information
- Positive feedback from asking the “what matters most” question from patients and staff
- For truly excellent outcomes care must be delivered across the continuum
- Involving the patient in care redesign has added invaluable information to knowledge of our processes

Contact Information

Thank you for learning about our journey- which has really just begun! We would be happy to share any of our tools or forms if you would like to contact us…

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