Designing for Doctor and Patient Interactions in the Leave-taking Experience

Cleveland Clinic  Office of Patient Experience
A founding principle: innovation

“The future belongs to those who seize the opportunities created by innovation.”

Delos M. Cosgrove, MD
CEO & President
Kinds of healthcare innovation

INTRODUCTION

PROBLEM

HYPOTHESIS & RESEARCH

PRODUCT

CONCLUSION

Quality & safety innovation

- University of Pittsburgh Medical Center
  (Center for Quality Improvement & Innovation)

- Reagan UCLA
  (Center for Health Quality & Innovation)

- Johns Hopkins Hospital
  (Center for Innovation in Quality Patient Care)

- University Hospitals - Ohio
  (Research & Innovation Center)

- Massachussetts General Hospital
  (Stoeckle Center for Primary Care Innovation)

- University of Washington Medical Center

Biomedical research innovation

- Barnes - Jewish/Washington University

- Mount Sinai Hospital

- New York - Presbyterian

- Hospital of the University of Pennsylvania

Humanistic care

- Cleveland Clinic

- Arizona State University
  (Herberger Institute)

- University Hospitals - Ohio
  (Medical Innovation Center)

- University of Washington

Service innovation

- Kaiser Permanente
  (Garfield Center)

- Mayo Clinic
  (SPARC)

- Duke University - Medical & Business School
  (Center for Entrepreneurship & Innovation)

- University of Michigan Health System
  (Medical Innovation Center)

- University of Michigan Health System
  (Medical Innovation Center)

- Mayo Clinic

Mechanistic care

- Mayo Clinic

Technological/device innovation

- Mayo Clinic

- Mayo Clinic

- Mayo Clinic
Innovation at Cleveland Clinic

Quality & safety innovation

Humanistic care

Service innovation

Quality & Patient Safety Institute

Office of Patient Experience

Lerner Research Institute

Cleveland Clinic Innovations & GCIC

Biomedical research innovation

Mechanistic care

INRODUCTION

PROBLEM

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HCAHPS themes

Totality of hospital experience

Communication (Interaction/behavior)

Information (Knowledge)

Services (Response/tasks)

Environment (Physical space)

HCAHPS Questions:
1. How often did nurses treat you with courtesy and respect?
2. How often did nurses listen carefully to you?
3. How often did nurses explain things in a way you could understand?
4. During hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?
5. How often did doctors treat you with courtesy and respect?
6. How often did doctors listen carefully to you?
7. How often did doctors explain things in a way you could understand?
8. How often were your room and bathroom kept clean?
9. How often was the area around your room quiet at night?
10. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?
11. How often was your pain well controlled?
12. How often did the hospital staff do everything they could to help you with your pain?
13. How often did hospital staff tell you what the medicine was for?
14. How often did hospital staff describe possible side effects in a way you could understand?
15. Did hospital staff talk with you about whether you would have the help you needed when you left the hospital?
16. Did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
17. Using any number from 0-10, where 0 is the worst hospital possible and 10 is the best, what number would you use to rate this hospital during your stay?
18. Would you recommend this hospital to your friends and family?
Caregiver-patient communication

HCAHPS Questions:
1. How often did nurses treat you with courtesy and respect?
2. How often did nurses listen carefully to you?
3. How often did nurses explain things in a way you could understand?
4. During hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?
5. How often did doctors treat you with courtesy and respect?
6. How often did doctors listen carefully to you?
7. How often did doctors explain things in a way you could understand?
8. During hospital stay, how often was your room and bathroom kept clean?
9. How often was the area around your room quiet at night?
10. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?
13. How often was your pain well controlled?
14. How often did the hospital staff do everything they could to help you with your pain?
16. How often did hospital staff tell you what the medicine was for?
17. How often did hospital staff describe possible side effects in a way you could understand?
19. Did hospital staff talk with you about whether you would have the help you needed when you left the hospital?
20. Did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
21. Using any number from 0-10, where 0 is the worst hospital possible and 10 is the best, what number would you use to rate this hospital during your stay?
22. Would you recommend this hospital to your friends and family?
Physician-led organization

Cleveland Clinic
Office of Patient Experience
Physicians Putting Patients FIRST...
Problem statement

It is difficult for Cleveland Clinic caregivers to change the behaviors of physicians with patients (and also their families).
Entire patient journey
Hypothesis

Focusing on building **quality encounters** between physicians & patients during the **discharge phase** makes a memorable impression and will benefit an important part of the patient journey.
Discharge or leave-taking phase
Discharge or leave-taking phase

Patients
Discharge or leave-taking phase

Patients

Families
Discharge or leave-taking phase

Patients  Families  Caregivers
Conference participation
H.E.A.R.T. Service Recovery program

Respond with H.E.A.R.T.® Course Objectives

To increase awareness of the opportunities for service recovery.

To learn service recovery concepts and skills that position our organization to be World Class.

To introduce how to utilize H.E.A.R.T. as a process for continuous quality improvement.
Brainstorming with the OPE
Observations
Interviews
## Research tools & methods

### Cleveland Clinic Patient Discharge Experience: Service Blueprint Exercise

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### INTRODUCTION

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### HYPOTHESIS & RESEARCH

### PRODUCT

### CONCLUSION
Analysis: blueprint of discharge

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Recovering
Patient is on medication and is waiting to hear information from physician on next steps. Patient's assessment: how they feel v. how they usually at home.

Accepting
Patient may bring in residents/interns into the room and discuss patient's condition in front of interns. Other caregivers are assessing various data.

Choosing
Patient will have to make a decision with family about what to do; at this point, patients may choose whether to go to a rehab facility/long-term care (LTC) or skilled nursing facility (SNF).

Planning
Patient is given instructions regarding medications, a recap of the treatment or procedure, and extensive information for reference once patient is gone.

Learning
Patient is in the care of a family doctor or other caregivers at another location. Patient (and family) may be adjusting to another lifestyle.

Leaving
Patient is being discharged soon and is told that going home will not be possible; in some cases, the option is to go to a rehab facility/long-term care (LTC) or skilled nursing facility (SNF).

Transitions
Outpatient medical team may take over at this point. May reinforce medication or provide instruction(s) contrary to what patient heard at Clinic.

Recovering
Patient is trying to optimize biomedical condition. May not have continuity of care (same doctor as before). "Technicians" and not "holistic healers" may see their work done at this point.

Accepting
Family may be directly involved in finding a facility. Asking patient and family what is meaningful to them.

Choosing
Physician consults with caregivers to decide where to transition. Inter/attending tells patient she/he is to be discharged care.

Planning
Physician may bring in residents/interns into the room and discuss patient's condition in front of interns.

Learning
Patient has been given the approval to leave and must manage to gather belongings and concern about billing and payment.

Leaving
Physician may bring in residents/interns into the room and discuss patient's condition in front of interns.

Preparing
Intern discussing d/c with case manager or d/c planner. Researching and contacting possible rehab or nursing facilities for patient to go to.

Researching
Intern starts d/c summary (personalized narrative for what happened during patient’s stay). Sent to attending for approval.

Finalizing d/c orders
Intern or physician is finalizing d/c orders. This is needed for nurses to do their job of instructing the patient. Rehab/nursing facilities need information about patient to transition. The other option is going home. Patients will have to make a decision with family about what to do; at this point, patients may choose whether to go to a rehab facility/long-term care (LTC) or skilled nursing facility (SNF).

Discharging
Patient is on medication and is waiting to hear information from physician on next steps. Patient's assessment: how they feel v. how they usually at home.

Communicating
Case manangers communicating with potential rehab or nursing facilities and determining feasibility and possibility of having patient go there (Case managers have to pre-certify patient).

Educating
Usually the nurse provides d/c summary notes along with other information, such as medication instructions, to patient at this point.

Continuing care
Outpatient medical team may take over at this point. May reinforce medication or provide instruction(s) contrary to what patient heard at Clinic.

Assessing: biomedical
Physician is trying to optimize biomedical condition. May not have continuity of care (same doctor as before). "Technicians" and not "holistic healers" may see their work done at this point.

Providing options
Based on patient’s insurance condition, caregivers will have gathered some possible locations to where patients can transition. The other option is going home. Interns send d/c order and let attending know.

Discharging
Patient is in the care of a family doctor or other caregivers at another location. Patient (and family) may be adjusting to another lifestyle.

Assessing: functional
Nurses usually in charge of this. For worst cases, need a social worker or d/c planner. Physical therapist may help with ADL and IADL.

Communicating
Case managers communicating with potential rehab or nursing facilities and determining feasibility and possibility of having patient go there (Case managers have to pre-certify patient).

Finalizing d/c orders
Intern or physician is finalizing d/c orders. This is needed for nurses to do their job of instructing the patient. Rehab/nursing facilities need information about patient to transition. The other option is going home. Patients will have to make a decision with family about what to do; at this point, patients may choose whether to go to a rehab facility/long-term care (LTC) or skilled nursing facility (SNF).

Discharging
Intern or resident able to function "Will patient be able to function at home?". "Technicians" and not "holistic healers" may see their work done at this point.

Researching
Researching and contacting possible rehab or nursing facilities for patient to go to. They have most likely moved on to other patients or may be in the middle of providing treatment/surgery.

Moving along
Attending or intern at this point does not really know what has happened with patient. They have most likely moved on to other patients or may be in the middle of providing treatment/surgery.

Finalizing d/c orders
Intern starts d/c summary (personalized narrative for what happened during patient’s stay). Sent to attending for approval.

Assessing: functional
Nurses usually in charge of this. For worst cases, need a social worker or d/c planner. Physical therapist may help with ADL and IADL.

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Researching and contacting possible rehab or nursing facilities for patient to go to. They have most likely moved on to other patients or may be in the middle of providing treatment/surgery.

Finalizing d/c orders
Intern starts d/c summary (personalized narrative for what happened during patient’s stay). Sent to attending for approval.

Arranging follow-up
Possible home-care nurses or home teams may visit homes. Visiting Nurse Association (VNA), independent organization may visit.

Supporting Processors
Interns or residents make daily progress notes. H & P (history & physical) info looked at

EPIC
Hypothetical patient pathway

Outpatient Care & treatment(s) recorded in EPIC (ideally)

Arranging follow-up
Possible home-care nurses or home teams may visit homes. Visiting Nurse Association (VNA), independent organization may visit.

Acknowledgments

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Interns or residents make daily progress notes. H & P (history & physical) info looked at

EPIC
Hypothetical patient pathway

Outpatient Care & treatment(s) recorded in EPIC (ideally)

Outpatient medical team may take over at this point. May reinforce medication or provide instruction(s) contrary to what patient heard at Clinic.
Patient is told that he cannot go home and will have to go to a nursing home. He is in a lot of emotional distress since he’s always said to himself, “I’d rather die than go to a nursing home.”
Synthesis: themes
Synthesis: themes

Time

Information
Synthesis: themes

Time

Information

Dignity
Synthesis: themes

- Time
- Information
- Dignity
- Transition
Product: interaction guide

Designing for Doctor and Patient Interactions in the Leave-taking Experience

A Project Report

Cleveland Clinic Office of Patient Experience
Discharge journey map

INSIGHTS FROM RESEARCH

• Patients view the discharge phase as a very complicated process.
• It’s hard for patients to see that various parts of the discharge experience are connected.
• Patients treasure what doctors give them even if it’s something small.
Dignity blanket

• Patients lose their sense of dignity when they can't go to the bathroom on their own, can't wear their own clothes, and have to expose their body parts

• Some doctors provide preferential treatment to people they know when they think patients and families are not looking
Top three kit

• Patients don’t remember a lot of things
• It’s better to provide the second best thing patient should do if it means patient will comply with it rather than the best thing that is complicated
• Patients treasure what doctors give them even if it’s something small
Patients first in last moments

- In many cultures, it’s rude to say goodbye and then close the door - people are expected to walk out to where the guest’s car is and wave goodbye as the guest leaves.

- There is no real interaction between doctors and patients as patients are leaving the hospital.
Decorated doctors

- Physicians are competitive at Cleveland Clinic
- When mandates from the top of the organization are enforced, physicians comply reluctantly
- Dr. Cosgrove’s story at Harvard Business School when audience member asked him if Cleveland Clinic teaches its doctors empathy
Implementation

Top 50 HCAHPS

Next Top 50 HCAHPS
Implementation

Top 50 HCAHPS

Next Top 50 HCAHPS
Thank you

Questions?
Vesture gesture

- Some patients consider doctors unapproachable because they always seem very busy.
- Patients also feel like it’s not appropriate to ask questions even though they may have a list of questions since they don’t want to be rude by asking for some personal time with doctors.
Guaranteed gifts

- Discharge is usually confirmed on the day of and it's really a moving target - therefore, during most of the discharge, caregivers can't make guarantees.

- Patients treasure what doctors give them even if it's something small.

- Small activities of daily living matter to patients.
• Doctors with great communication skills use cues from their environment or previous interactions with patient to follow up with something happening in patient’s life outside the hospital (e.g. family vacation)
• Patients have concerns about things happening outside the hospital, such as home and family
Dialing doctors

- One great way for doctors to spend time with patients is through a simple follow-up phone call when they have more time and when away from the stress of the hospital environment.
- Patients appreciate this simple gesture that is not often practiced and are surprised if it ever happens.
• Patients don’t know when to let the physician know that they don’t understand what he/she is saying. If medical jargon is used by physicians, patients may feel embarrassed to ask physicians to dumb down the language.