

Patient Video Ethnography

Care of High Risk Patients

Care Transitions Forum

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Lindy Alves
Emily Brower
Sue Farrell
Diane Gilworth
Patrice Horgan
Zeev Neuwirth
Debbie Nolan

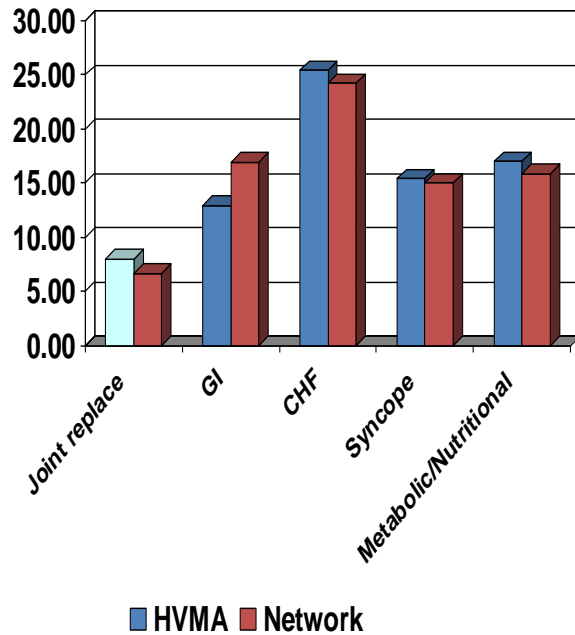
Ethnoworks



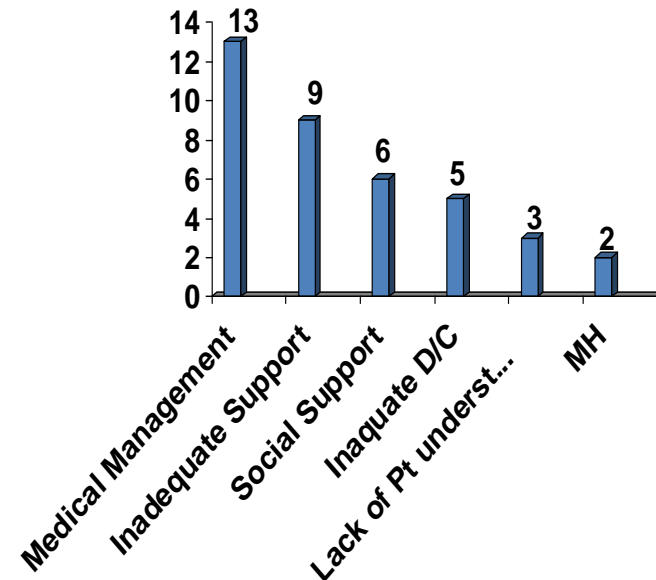
Objectives

- Understand the “reason for action”
- -why we needed the patient’s voice
- -how the patient’s voice and the provider’s voice helped us to change our focus
- How ethnography can help us see new relationships and forge new partnerships with our patients and ourselves

We approached re-admissions as if this is a technical problem, with a “fix” that is readily available



Causes of Re Admissions, Chart Reviews 12/2009



50 charts, 38 deemed to be preventable admissions

“technical fixes”

- Root cause analysis
- Teach back during discharge
- Post discharge phone calls
- Coleman coaching
- Guided Care, Intensive Home Based NP Program, Complex Chronic Care Program
- Medical Reconciliation
- STARR

....but where is the patient in all of this.....and is any of this what the patient wants and needs?

“ a great gulf exists between the way we think about disease as (physicians) and the way we experience it as people. Much of this separation derives from our basic assumptions about what illness is....phenomenology is used to present a vision of disease that begins with an understanding of illness as it is lived...”

“An Introduction into Medical Phenomenology: I Can't hear you While I am Listening.” Ann of Int Med, 1985: 103-606

Video Ethnography

- We hired Ethnoworks.....to
 - Teach us to see the real social process of health care at HVMA, hospitals, ECF, and in our patient's home
 - Help us to understand how our interactions and systems of “care” feel to patients
 - Explode our own learned assumptions (our truths)
 - Discover new themes,
 - Generate new knowledge
 - Inform our future care model development



"voo zha-day"

Noticing something..... for the first time

..... that has been there all along

the realization that you've been unaware of something

you should have noticed

.....a long time ago

HVMA'S VIDEO ETHNOGRAPHY EVENT

- Selection of patients & logistics of visits
- Prepare Discussion Guide with key headings
- Videotaped Interviews
- Storyboard on each patient
- Patterns distilled
- Theme development
- Systematic data-collection & analysis methods based on science of anthropology



DRAFT Discussion Guide - Care of High Risk Pts

Introduction:

- **Thanks** for agreeing to talk with us
- We're doing some research for **Harvard Vanguard Medical Associates**.
- **Backgrounds** of researchers. I am a nurse practitioner / in care coordination / in case management.
- **Explanation** of project. We'd like to **understand why people end up going in & out of the hospital**. We would like to **speak with you about your experience** so we can **improve the quality of your care**.

- We'd like to have an **informal discussion** to get to know your perspective.
- We **value anything thing you have to say**, positive or negative, so please **don't edit yourself**.
- Any **questions**, please ask.
- Please try to **answer in full sentences**.
- As you likely noticed from our previous communications, we'll want to document our visit with **audio** recordings, **video** & still **pictures**.
- **Consent** form

Warm-Up / Personal Story

1. **BREAK THE ICE**: Could you **tell us a little about yourself** (where you're from, how long you've lived here, your family, who you live with, etc.)
 - Can describe a **typical day** at home? What do you do during the day?
 - What are some **things** that make you **feel good**? **What do you enjoy** doing?

Hospital Experience

1. Can you tell me **what brought you** into the hospital? (Prompt further)
2. When was the **last time you were in the hospital**? Can you tell me a little bit about that?
3. What was it like for you **in the hospital**? What do you remember most about your stay?
4. What are some of the **things you missed about not being home**?

Transition from Hospital to Home

5. Did you feel like you were **ready to go home** when you did? Why or why not?
6. **How were you prepared** for going home? How were you involved?
7. What did they tell you to **prepare you before you left the hospital**? (Probe)
8. How did you **get to & from the hospital**?

9. How did it go for you **when you got home**?
10. Can you describe the **first few days after your return home**? What kinds of care & support did you receive? How did that go for you?
11. **What**, if anything, **has changed in your typical day** since your hospital stay? What are some things you're doing differently?

Family & Social Support

12. Who did you **spend time with** over the last week? What did you do together?
13. **When you need help, who** do you ask?
14. **How do you decide who to call** when you're not feeling well? (probe for example)
15. **At what point do you reach out to others**? to whom? (probe for trigger to call doctor)

Motivations/Barriers:

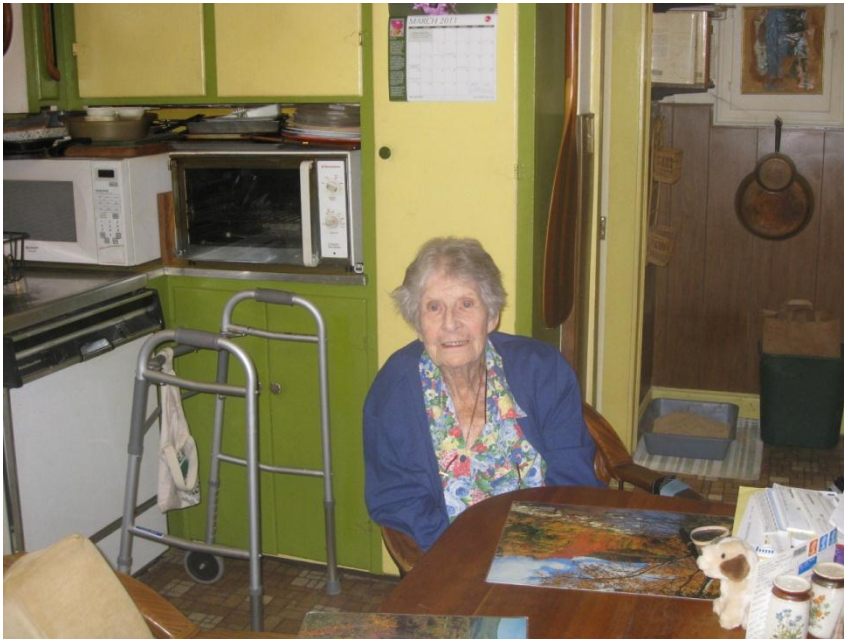
1. **What's most important to you** in life? What motivates you most?
2. What **satisfies** you most?
3. When do you **feel most engaged**? Most enthusiastic?
4. When do you **notice medical symptoms** most?
5. What things are **most difficult** for you? What gets in your way?
6. What sorts of **activities have you stopped doing**? when & why?
7. How **easy** is it for you to **get your health concerns addressed**? What's most urgent to you now?
8. What **frustrates you most**?

Wrap up

1. Thinking back: what **might have happened differently** so that you didn't need to go to the hospital?
2. Do you have **1 or 2 suggestions** you feel would help us improve your experience?
3. Are there **any other health issues** that you would like to tell us about?
 - **Thank you** so much for all your help.
 - Do you have any **questions for us**?

The People We Take Care Of

MARGARET



JIM



The People We Take Care Of

JOHN



CONNIE



Themes

- **Roles**

- Expectations of roles constrict, limit, dictates dr/pt interactions
- Traditional roles are hierarchical & disempower patient
- Traditional roles force patients into negative identity roles (noncompliant label)
- Call & Response Roles – patient voice/power diminish and de-prioritize

- ****Vulnerability**

- Patients are stripped of their identity as core part of medical care
- Medical system makes patients vulnerable
- Creates imbalance of power against patient
- ****Medical system doesn't recognize depth of patient vulnerability or adapt practices**
- There's a frustrating disconnect between patient expectations of empathy & medical system/care

- **Time**

- Time limitations & empathy are not mutually exclusive
- We let the system hurry us onto next step – does not encourage 'presence' with patient
- ****Fragmented health care system creates environment where each provider/org thinks they're 'on their own' – creates additional time pressure**



Themes



- ****Identity**

- Medical system imposes new ‘illness’ identity on patients
- MD system only addresses medical identity – current paradigm
- Patient drive to maintain ‘normal’ identity drives their behavior & shapes their care experience
- Patient ‘normal’ identity treated as counter-intuitive by providers
- System does not recognize pt identity always evolving
- ****Patient desire to maintain integrity of their ‘normal’ identity – in the moment – over-rides their physical health concerns, and creates an ‘immunity to change’**

- ****Control**

- Misalignment between expectations of control & actual experience
- No time provided to digest information
- Patient understands transition differently than medical system
- ****Patient struggles with multiple levels & understandings of transition (identity, emotional, physical)**

- **Trust**

- Patients want continual relationship with one individual they trust throughout the continuum of care – especially at times of stress
- Can build trust by timing touchpoints with patient at critical transitions/in-between visits

Themes

- ****Stress**

- ****Transition period is filled with stress & anxiety in which patient comprehension, decision making & memory are compromised**
- Medical system assumes patients can make competent decisions
- Patients are confused state during discharge and not in optimal receptive state
- “You can’t drive on dilaudid but we’ll ask you to make major decisions.”



HVMA'S VIDEO ETHNOGRAPHY EVENT

- Gained some significant insights about our elderly patients
 - Many of the “technical fixes” simply don’t work for patients
 - The discharge process is highly stressful and most patients can’t take in any new information during that time
 - There are many people interacting with the patients- they don’t understand our roles, are confused by all of us, and really are under the impression that we talk to each other
 - Patients want a relationship- ideally with their physicians, but they want and need a relationship with you.....
 - There is no time in the system for “cognitive processing”patients and staff alike don’t have the necessary time to really think about all the aspects of care.



We must forge new partnerships with patients and families
We must share decision making
We must put patients in control
We must share openly with each other

For “us” this means internalizing new ways of
Thinking
Seeing
Behaving

This kind of change requires developing new habits
Of mind and perspective
We must become more inclusive
of diverse view points
More permeable
More reflective

We have to let go
of the assumption that our perspective is
Identical to the patients perspective

Thank You for Your Attention

Diane Gilworth

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