Project BOOST

Janet Nagamine, MD, RN, SFHM
Co-Investigator, Project BOOST
Chair, BOOST California Collaborative

www.hospitalmedicine.org/BOOSTCA
Overview

• Transitions of Care
  – looking back and going forward

• What is BOOST?
  – Review of Tools, Interventions and rationale
  – The year-long Mentored Implementation process
  – Review of preliminary outcomes data

• Q & A
Evolution of Inpatient Care

- Dramatic increase in acuity and complexity of patients while LOS decreased
  - Average LOS for >65yo in US Hospitals:
    - 1970 was 12.6 days
    - 2005 was 5.5 days
  - Acuity: shift to outpatient care
    - Bridge therapy, home IV and TPN
    - the hospital is “one big ICU”

- Our discharge processes have not kept up with the magnitude of change that has occurred
Average LOS: US Hospitals

> 65 = 12.6 to 5.5 days

Observational study of 6,955,461 Medicare FFS hospitalizations for HF; 1993 and 2006, with 30-day f/u.
- Mean age = 80
- 52% Htn, 38% DM, 37% COPD

LOS 8.8 days down to 6.3

In-hospital mortality declined from 8.5% to 4.3%
30-day mortality declined from 12.8% to 10.7%
Discharges to SNF increased from 13% to 20%
- Discharge to home decreased from 74% to 67%
30 day readmission increased from 17.2% to 20.1%
- Post-discharge mortality increased from 4.3% to 6.4%
We Have Made Progress.

- Study of about 7 million Medicare CHF patients admitted to the hospital between 1993 to 2006,
  - mean LOS decreased from 8.8 days to 6.3 days
  - In-hospital mortality decreased from 8.5% to 4.3%
  - Unadjusted 30-day mortality decreased from 12.8% to 10.7%
    Bueno, H et al. JAMA 2010;303(21):2141-2147

- The consequences
  - Discharges to SNF increased from 13% to 20%
  - Discharges to home/home care decreased from 74% to 67%
  - 30 day readmission rates increased from 17.2% to 20.1%
So Where Are the Opportunities?

- Find the sweet spot: the LOS-readmission balancing act
- Prevent the preventable
  - Improve our processes, coordination
- Metrics around interventions and data that is meaningful and actionable
What’s Preventable?

• > 4 million Preventable Admissions
  - Cost $31 billion
  - Heart Failure and Pneumonia=half of the $ problem
  - COPD – 16%
  - Diabetes – 13%

• One recent study found that only 49% of patients had timely followup (within 30 days) and those without followup were 10 times more likely to be readmitted
  Misky, Wald, Coleman JHM 2010;5:392-397.

• Our challenge is to identify these specific opportunities
Rehospitalizations among Patients in the Medicare Fee-for-Service Program

Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H.

- 1 in 5 Medicare patients rehospitalized in 30 days
- Half never saw an outpatient doctor within 30 days after discharge
- Costs $17.4 billion
Harm: The Dangers of Discharge

Annals of Internal Medicine

The Incidence and Severity of Adverse Events Affecting Patients after Discharge from the Hospital

Alan J. Forster, MD, FRCPC, MSc, Harvey J. Murff, MD; Josh F. Peterson, MD; Tejal K. Gandhi, MD, MPH; and David W. Bates, MD, MSc

- 19% of patients had a post discharge AE
  - 1/3 preventable and 1/3 ameliorable

Ann Intern Med 2003; Vol. 138

Adverse events among medical patients after discharge from hospital

Alan J. Forster, Heather D. Clark, Alex Menard, Natalie Dupuis, Robert Cherish, Natasha Chandok, Asmat Khan, Carl van Walraven

- 23% of patients had a post discharge AE
  - 28% preventable and 22% ameliorable

CMAJ 2004;170(3)
Healthcare Reform

The Patient Protection & Affordable Care Act (ACA)

- Reducing Readmission Rates
- Improving Care Transitions
- Bundled Payments
- Hospital Value-Based Purchasing
## Reducing Readmissions

<table>
<thead>
<tr>
<th>Section</th>
<th>Details</th>
</tr>
</thead>
</table>
| §3026   | • Beginning in FY 2011  
          • Community-Based Care Transitions Program |
| §3501   | • For Period FY 2011-2014  
          • $20 Million in AHRQ funding for projects related to QI research and technical assistance. Topics identified include reducing readmissions. |
| §399KK  | • March 2012  
          • Program for eligible hospitals to improve their readmission rates through Patient Safety Organizations (PSOs) |
| §3025   | • Beginning in FY 2013  
          • Hospitals with higher than expected readmissions rates will experience decreased payments for Medicare discharges |
Healthcare Reform: HR 3590

- Hospital Readmissions Reduction Program (HR 3590 Section 3025)
  - FY2013
  - Financial penalties on hospitals for “excess” readmissions vs. “expected”
  - HF, AMI, Pneumonia
  - $7.1 billion in savings over 10 years
Physician Consortium for Performance Improvement® (PCPI) proposed accountability measures

Measure #1: Reconciled Medication List Received by Discharged Patients

Measure #2: Transition Record with Specified Elements Received by Discharged Patients (Inpatient setting)

Measure #3: Timely Transmission of Transition Record (to facility or primary physician for follow up care)

Measure #4: Transition Record with Specified Elements Received by Discharged Patients (ED setting)

An intermediate step is proposed for the following measure title, with no measure proposed at this time:

Measure #5: Patient Understanding of Post-Discharge Care Needed
What is BOOST?
Advisory Board

Chair: Eric Coleman, MD, MPH
Co-Chair: Mark Williams, MD

with organizational representatives from:

- Social work
- Case management
- Clinical pharmacy
- Geriatric medicine
- Geriatric nursing
- Health IT
- Blue Cross/Blue Shield
- United Health
- Health systems
- NQF
- AHRQ
- TJC
- CMS
- National Consumer’s League
- Other content experts
<table>
<thead>
<tr>
<th>Risk Assessment: SP Screening Tool (Check all that apply)</th>
<th>Risk Specific Intervention</th>
<th>Signature of individual responsible for insuring intervention administered</th>
</tr>
</thead>
</table>
| **Problem medications** (anticoagulants, insulin, aspirin & clopidogrel dual therapy, digoxin, narcotics) | □ Medication specific education using Teach Back provided to patient and caregiver  
□ Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin, insulin)  
□ Specific strategies for managing adverse drug events reviewed with patient/caregiver  
□ Follow-up phone call at 72 hours to assess adherence and complications |  |
| **Psychological** (depression screen positive or h/o depression diagnosis) | □ Assessment of need for psychiatric aftercare if not in place  
□ Communication with aftercare providers, highlighting this issue if new  
□ Involvement/awareness of support network insured |  |
| **Principal diagnosis** (cancer, strokes, DM, COPD, heart failure) | □ Review of national discharge guidelines, where available  
□ Disease specific education using Teach Back with patient/caregiver  
□ Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms  
□ Discuss goals of care and chronic illness model discussed with patient/caregiver |  |
| **Polypharmacy** (≥5 more routine meds) | □ Elimination of unnecessary medications  
□ Simplification of medication scheduling to improve adherence  
□ Follow-up phone call at 72 hours to assess adherence and complications |  |
| **Poor health literacy** (inability to do Teach Back) | □ Committed caregiver involved in planning/administration of all general and risk specific interventions  
□ Aftercare plan education using Teach Back provided to patient and caregiver  
□ Link to community resources for additional patient/caregiver support  
□ Follow-up phone call at 72 hours to assess adherence and complications |  |
| **Patient support** (absence of caregiver to assist with discharge and home care) | □ Follow-up phone call at 72 hours to assess condition, adherence and complications  
□ Follow-up appointment with a aftercare medical provider within 7 days  
□ Involvement of home care providers of services with clear communications of discharge plan to those providers |  |
| **Prior hospitalization** (non-elective; in last 6 months) | □ Review reasons for re-hospitalization in context of prior hospitalization  
□ Follow-up phone call at 72 hours to assess condition, adherence and complications  
□ Follow-up appointment with a aftercare medical provider within 7 days |  |
| **Palliative care** (Would you be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness?) Yes to either | □ Assess need for palliative care services  
□ Identify goals of care and therapeutic options  
□ Communicate prognosis with patient/family/caregiver  
□ Assess and address bothersome symptoms  
□ Identify services or benefits available to patients based on advanced disease status  
□ Discuss with patient/family/caregiver role of palliative care services and benefits and services available |  |
## Universal Patient Discharge Checklist

| 1. GAP assessment (see below) completed with issues addressed | YES □ NO □ | __________ |
| 2. Medications reconciled with pre-admission list | YES □ NO □ | __________ |
| 3. Medication use/side effects reviewed using Teach Back with patient/caregiver(s) | YES □ NO □ | __________ |
| 4. Teach Back used to confirm patient/caregiver understanding of disease, prognosis and self-care requirements | YES □ NO □ | __________ |
| 5. Action plan for management of symptoms/side effects/complications requiring medical attention established and shared with patient/caregiver using Teach Back | YES □ NO □ | __________ |
| 6. Discharge plan (including educational materials; medication list with reason for use and highlighted new/changed/discontinued drugs; follow-up plans) taught with written copy provided to patient/caregiver at discharge | YES □ NO □ | __________ |
| 7. Discharge communication provided to principal care provider(s) | YES □ NO □ | __________ |
| 8. Documented receipt of discharge information from principal care provider(s) | YES □ NO □ | __________ |
| 9. Arrangements made for outpatient follow-up with principal care provider(s) | YES □ NO □ | __________ |

**For increased risk patients consider Not applicable**

| 1. Interdisciplinary rounds with patient/caregiver prior to discharge to review aftercare plan | YES □ NO □ | __________ |
| 2. Direct communication with principal care provider before discharge | YES □ NO □ | __________ |
| 3. Phone contact with patient/caregiver arranged within 72 hours post-discharge to assess condition, discharge plan comprehension and adherence, and to reinforce follow-up | YES □ NO □ | __________ |
| 4. Follow-up appointment with principal care provider within 7 days of discharge | YES □ NO □ | __________ |
| 5. Direct contact information for hospital personnel familiar with patient’s course provided to patient/caregiver to address questions/concerns if unable to reach principal care provider prior to first follow-up | YES □ NO □ | __________ |

**Confirmed by:**

**Signature**

**Print Name**

**Date**

### General Assessment of Preparedness (GAP)

Prior to discharge, evaluate the following areas with the patient/caregiver(s). Communicate concerns identified as appropriate to principal care providers.

**A = beginning upon Admission; P = Prior to discharge; D = at Discharge**

#### Logistical Issues

| 1. Functional status assessment completed (P) | YES □ NO □ N/A □ |
| 2. Access (e.g. keys) to home insured (P) | YES □ NO □ N/A □ |
| 3. Home prepared for patient’s arrival (P) | YES □ NO □ N/A □ |
| 4. Financial resources for care needs assessed (P) | YES □ NO □ N/A □ |
| 5. Ability to obtain medications confirmed (P) | YES □ NO □ N/A □ |
| 6. Responsible party for insuring med adherence identified, prepared, if not patient (P) | YES □ NO □ N/A □ |
| 7. Transportation to initial follow-up arranged (D) | YES □ NO □ N/A □ |
| 8. Transportation home arranged (D) | YES □ NO □ N/A □ |

**Psychosocial Issues**

| 1. Substance abuse/dependence evaluated (A) | YES □ NO □ N/A □ |
| 2. Abuse/neglect presence assessed (A) | YES □ NO □ N/A □ |
| 3. Cognitive status assessed (A) | YES □ NO □ N/A □ |
| 4. Advanced care planning documented (A) | YES □ NO □ N/A □ |
| 5. Support circle for patient identified (P) | YES □ NO □ N/A □ |
| 6. Contact information for patient obtained and provided to patient (D) | YES □ NO □ N/A □ |

**Confirmed by:**

**Signature**

**Print Name**

**Date**
For Selected *Increased* Risk Patients Strongly Consider:

- Direct communication with principal care provider *before* discharge
- Follow-up appointment with principal care provider within 7 days of discharge
- Telephone contact arranged within 72 hours post-discharge to assess condition, discharge plan comprehension and adherence, and to reinforce follow-up
- Direct contact information for hospital personnel familiar with patient’s course provided to patient/caregiver to raise questions/concerns *if unable to reach principal care provider* prior to first follow-up
Northwestern Solution

Creating a Better Discharge Summary: Improvement in Quality and Timeliness Using an Electronic Discharge Summary

Kevin J. O’Leary, MD¹
David M. Liebovitz, MD²
Joseph Feinglass, PhD²
David T. Liss²
Daniel B. Evans, MD²
Nita Kulkarni, MD¹
Matthew P. Landler, MD¹
David W. Baker, MD, MPH²

1 Division of Hospital Medicine, Feinberg School of Medicine, Northwestern University, Chicago, Illinois.
2 Division of General Internal Medicine, Feinberg School of Medicine, Northwestern University, Chicago, Illinois.

Supported by the Dr. Steven DeAngeles Continuity of Care Fund, administered through the Northwestern Memorial Foundation.

Journal of Hospital Medicine 2009;4:219

- Significantly improved the quality and timeliness.
- Better documentation of f/u issues, pending tests, and info provided to patients and/or family.
- PCPs more satisfied with timeliness and quality
- >95% of discharge summaries completed in < 1 week
“First, they should require that hospitals deliver more than 90 percent of their discharge summaries to the follow-up provider within 24 hours of hospital discharge. We know that rates of readmissions are stunningly high; one reason is that more than two-thirds of follow-up providers lack a discharge summary when they see patients for the first time after discharge. That’s crazy, and it’s unacceptable. TJC could fix it tomorrow.”
Key Components of BOOST

• **BOOST Tools & Intervention**
  – Comprehensive risk assessment 8Ps
  – 72 hour followup call for high risk patients
  – Patient centered discharge process
    – Teachback, GAP, Universal Patient Checklist
    – User friendly discharge forms, transfer tools
    – F/U appt scheduled prior to discharge
  – Standardized PCP communication

• **Mentored Implementation**
  – Longitudinal support throughout planning and implementation

• **BOOST Community/Collaborative**
Life-Cycle Project BOOST

**Training & Preparation**
- **Planning**
  - Analyze processes
  - Institutional Support
  - Assemble Team
  - Baseline Data
- **2 Day Training**
  - Intervention Toolkit
  - Teach-back Training
  - Peer-learning
  - Project Planning
  - Mentor reviewed action plan

**Implementation**
- Redesign care processes
- Staff education
- Tailor tools
- Develop policies, procedures, order sets
- Evaluation Plan

**Intervention**
- Implement intervention
- Keep stakeholders informed
- Monitor core elements

**Surveillance**
- Analyze data
- Adjust intervention components
- Report to stakeholders
- Spread gains

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**Training** 6-9 months 9-12 months

**Overview**
- BOOST: Better Outcomes for Older adults through Safe Transitions
- Training & Preparation: Planning, 2 Day Training, Implementation
- Interventions: Redesign care processes, Staff education, Tailor tools, Develop policies, procedures, order sets, Evaluation Plan
- Surveillance: Analyze data, Adjust intervention components, Report to stakeholders, Spread gains

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**Dates**
- 6-9 months
- 9-12 months
Discharge Plan and Transition Records: The PASS*

- PASS, plus a patient centered med list, goes home with the patient.
- *Optional format. Suggested content.
- Discharge Patient Education Tool (DPET) is another option.
<table>
<thead>
<tr>
<th>I was in the hospital because:</th>
<th>I should ...</th>
<th>Important contact information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1.</td>
<td>1. My primary doctor:</td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
<td>(__<strong>)</strong>______________________</td>
</tr>
<tr>
<td>3.</td>
<td>3.</td>
<td>2. My hospital doctor:</td>
</tr>
<tr>
<td>4.</td>
<td>4.</td>
<td>(__<strong>)</strong>______________________</td>
</tr>
<tr>
<td>5.</td>
<td>5.</td>
<td>3. My visiting nurse:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(__<strong>)</strong>______________________</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. My pharmacy:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(__<strong>)</strong>______________________</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Other:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(__<strong>)</strong>______________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My appointments:</th>
<th>Tests and issues I need to talk with my doctor(s) about at my clinic visit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1.</td>
</tr>
<tr>
<td>On: <strong>/</strong>/__ at <strong>:</strong> am/pm</td>
<td>2.</td>
</tr>
<tr>
<td>For: __________________________</td>
<td>3.</td>
</tr>
<tr>
<td>2.</td>
<td>4.</td>
</tr>
<tr>
<td>On: <strong>/</strong>/__ at <strong>:</strong> am/pm</td>
<td>5.</td>
</tr>
<tr>
<td>For: __________________________</td>
<td>6.</td>
</tr>
<tr>
<td>3.</td>
<td>7.</td>
</tr>
<tr>
<td>On: <strong>/</strong>/__ at <strong>:</strong> am/pm</td>
<td>8.</td>
</tr>
<tr>
<td>For: __________________________</td>
<td>9.</td>
</tr>
<tr>
<td>4.</td>
<td>10.</td>
</tr>
<tr>
<td>On: <strong>/</strong>/__ at <strong>:</strong> am/pm</td>
<td>I understand my treatment plan. I feel able and willing to participate actively in my care:</td>
</tr>
<tr>
<td>For: __________________________</td>
<td>Patient/Caregiver Signature:</td>
</tr>
</tbody>
</table>

Other instructions:
1. 
2. 
3. 

Provider Signature: 

______/____/____

Date: 
• Discharge Patient Education Tool

**DIAGNOSIS**
- I had to stay in the hospital because: 
- The medical word for this condition is: 
- I also have these medical conditions:

**TESTS**

<table>
<thead>
<tr>
<th>While I was in the hospital I had these tests:</th>
<th>which showed:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TREATMENT**

<table>
<thead>
<tr>
<th>While I was in the hospital I was treated with:</th>
<th>The purpose of this treatment was:</th>
</tr>
</thead>
</table>
FOLLOW-UP APPOINTMENTS
After leaving the hospital, I will follow up with my doctors.

Primary Care Doctor: ________________
Phone Number: ________________
DATE: ____________, __ __, 200__
TIME: ___:___   __m

Specialist Doctor: ________________
Phone Number: ________________
DATE: ____________, __ __, 200__
TIME: ___:___   __m

FOLLOW-UP TESTS
After leaving the hospital, I will show up for my tests.

<table>
<thead>
<tr>
<th>TESTS</th>
<th>LOCATION</th>
<th>DATE</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>__________, __ <strong>, 200</strong></td>
<td><em><strong>:</strong></em>   __m</td>
</tr>
</tbody>
</table>

Call your Primary Care Doctor for the following:

Warning signs

1)   4)

LIFE STYLE CHANGES
After leaving the hospital, I will make these changes in my activity and diet.

Activity: _______________________________, because _______________________________
Diet: _______________________________, because _______________________________

教回 (Teach Back)

**NEW CONCEPT:**
Health Information, Advice, Instructions or Change in Management

- Explain / Demonstrate New Concept
  - PatientRecalls and Comprehends/ Demonstrates Mastery

- Assess Patient Recall & Comprehension
  - Ask Patient to Demonstrate

- Clarify & Tailor Explanation

- Re-assess Recall & Comprehension
  - Ask Patient to Demonstrate

- Adherence/ Error Reduction

- assessed recall & comprehension
- demonstrated mastery
Overview

The BOOSTing (Better Outcomes for Older adults through Safe Transitions) Care Transitions Resource Room provides a wealth of materials and tools to help you optimize the discharge process at your institution. We developed the BOOSTing approach and tools with the support of the John A. Hartford Foundation and in consultation with leading hospitals and experts in the field. This resource room is part of a broader effort to improve, evidence-based medicine as we know it today.

This resource room will help you to:

- Analyze current workflow processes
- Select effective interventions
- Redesign workflow and implement interventions
- Educate your team on best practices
- Promote a team approach to safe and effective discharges
- Evaluate your progress and modify your interventions accordingly

Each section of this resource is described below.

How to Use

How to Use:

Implementation Guide

The BOOSTing (Better Outcomes for Older adults through Safe Transitions) Care Transitions Resource Room is the online version of the Care Transitions Implementation Guide. To use the resource room, simply select the section you need for your institution and follow the steps provided.

Developing Interventions

The BOOST Tools

The TARGET

Risk Assessment Tool: the 7Ps

Risk Specific Interventions

The GAP

Written Discharge Instructions
Overview

The BOOSTing Care Transitions (Resource Room) Care Transitions resource room provides a wealth of materials to help you implement successful processes at your institution. We developed this through support from the John A. Hartford Foundation and based the approach and tools on principles of quality improvement, evidence-based medicine as well as personal experiences. Of note, we are piloting the contents at multiple hospitals and will be constantly revising the experience.

This resource room provides:

- Analysis
- Select
- Redesign
- Implementation
- Establish General Aims & Scope
- Clarify Aims

Each section above is described below.

QI Resources
Download the Implementation Guide
Institutional Support
Needs/Resource Assessment
Stakeholders and Approval
Build a Team and Team Rules
Establish General Aims & Scope
Clarify Aims
Who Are the Mentors?

• Content and Process Experts
  – Hospitalists with experience improving care transitions at their own sites
  – Scholarly interest in care transitions
  – Experience mentoring/coaching others
  – Knowledgeable in Quality Improvement methods
Project BOOST Team

• Mark V. Williams, MD
  Principal Investigator
  Co-Chair, Advisory Board
  Mentor

• Eric Coleman, MD, MPH
  Chair, Advisory Board

• Tina Budnitz, MPH
  Project Director

• Luke Hansen, MD, MHS
  Lead Analyst

• Kathleen Kerr
  Project Advisor

• Lauren Valentino
  Project Coordinator

Mentors:

• Jeff Greenwald, MD
  (Lead developer, clinical tools)

• Janet Nagamine, MD
  (Chair, CA Collaborative)

• Chris Kim, MD
  (Chair, MI Collaborative)

• Lakshmi Halasyamani, MD
• Eric Howell, MD
• Dan Dressler, MD, MS
• Greg Maynard, MD
• Arpana Vidyarthi, MD
• Win Whitcomb, MD
• Rich Balaban, MD
• Rebecca Daniels, MD
What to Expect from your Mentor

• Guidance and support for local team
  – Addressing barriers and challenges
  – Brainstorming, identifying next steps
  – Setting target dates for completion of next steps

• Develop local experts, engage staff
  • One year of “on the job training” about Transitions of Care and Quality Improvement process
  • Improves sustainability after the collaborative
Interacting with your Mentor

- Kickoff meeting
- Site visit: grand rounds, meetings
- Scheduled phone mentoring sessions 1, 3, 6, 9 and 12 months following conference
- Ad hoc communications via phone or email
The Mentoring Experience

Role of the mentor

Mentor Calls: Focus areas
Planning
- Institutional support
- Project team & stakeholders
- Goals, aims and scope
- Process mapping
- Assembling baseline data

Implementation
- Process redesign
- Staff education/outreach
- Policies, procedures, forms

Intervention Phase Topics
- Use or adaptation of TARGET
- Use or adaptation of GAP
- Use or adaptation of Teach-back
- Pt discharge plan standardization
- DC summary to PCP

Project Surveillance & Management Topics
- Data collection and measurement
- Reporting

The Site Visit

Feedback from Teams
BOOST Community

• BOOST Network
  – E-mail, call between sites
  – BOOST listserv
  – Forum for sharing ideas, challenges, solutions
  – Shortens the learning curve

• BOOST eNewsletter
  – Key milestones
  – BOOST updates
  – Site status reports, aggregate outcomes
Modified BOOST Tools (Site Specific):

These documents, submitted by participating BOOST Sites, are the BOOST tools modified to fit their specific institution's needs.

Morton Plant’s Patient PASS- A Transition Record:

This document is a modified BOOST PASS tool.
View Morton Plant’s modified PASS tool

Mission Hospital’s Passport and EMRs:

This document is heavily modeled on the PASS, but the goal is an iterative passport that would act as a compliment to the generated discharge instructions- a tool that would be used as a part of teach back, and would primarily act as a tool and reference for patients and families during the hospitalization. It incorporates some key elements: What to expect from the hospital (almost like a dc bill of rights), What we expect from you the patient (you are also responsible), Who’s taking care of me (the doctors), What’s happened to me (the tests/treatments), and Why am I here (diagnoses).
View Mission Hospital’s Passport and EMRs

Southwestern Vermont Medical Center’s Discharge Summary (Discharge PASS)

This document pulls data from fields entered from the various disciplines involved in the patient discharge. It is used for the patient and also sent to the primary care physician in real time.
View Southwestern Vermont Medical Center’s Discharge Summary (PDF format)

Southwestern Vermont Medical Center’s Roles and Responsibilities for Disciplines

This document incorporates the 7-P screening items, and delineates who is responsible for which part of the discharge process
View Southwestern Vermont Medical Center’s Roles and Responsibilities for Disciplines (PDF format)

University of Pennsylvania Modified 7p Tool and Script for 72 Hour Follow-Up Calls to High Risk Patients:
posted: January 13, 2010 4:24 PM
subject: RE: Project Boost and EMRs

Katie,
And also Mark Williams, Kendall Rogers, David Leibovitz, Percy Pentecost, Lauren Valentino,

Regarding Project BOOST, the MATCH Program, Cerner and multisite collaboration.

I am very interested in collaboration. I think that there may be several opportunities for synergy.

BOOST and EMR Support: In May, I surveyed the 30 BOOST participating sites regarding perceptions about EMR support for the project and got approximately 11 responses (attached). 5 of them were Cerner sites. Baptist Hospital, Nashville which is part of Ascension Health, Billings, Emory, Mission Hospital and University of New Mexico responded. I don't have any information regarding the other 19 sites.

Locally, information-technology is optimistic about being able to help with BOOST. We are currently muddling through the process of trying to determine how to develop and apply EMR/BOOST tools in a way that has the least negative impact on nurse and hospitalist work flow and is achievable without straining the always packed agenda of the IT department. Our goal is to start very small and grow.
Dear all,

My apologies for repeating a similar question off the listserv from last summer, but we were wondering if any of you could share updates with us about post-discharge follow-up phone calls. We are hoping to move in to the second phase of our pilot and need to work out some logistical details. If you have any answers to the following questions (either from your institution or research of other programs), we'd greatly appreciate any information you are able to share.

1. Who makes the calls (RN, hospitalist, CM, volunteer, etc?) If case manager, can you specify if this is an RN/case manager?
2. For providers who make calls, is this their primary job or do they do this in addition to their usual daily responsibilities?
3. For hospitals with dedicated FTEs for f/u phone calls, how many patients are called in an eight-hour day? (Or in your experience, how many calls would you plan for in one business day if you had a dedicated FTE to do this?)
4. Do you document the call in your EMR? If so, is this automatically integrated with a software program (such as discharge call manager) to your EMR?
5. Does every patient receive a call? If not, how are you screening which patients to call?
6. What hours/days are you making calls (daytime, weekends, etc.)?
7. Any other information (sample of your phone call script, early data on how this has affected pt satisfaction or health outcomes, etc.) is greatly appreciated.
BOOST Outcomes
Readmission Data

Hierarchical time series analysis of readmission rates (one year prior to kick-off through one year post kick-off) 12/10

Cohort 1 (n=6) kickoff: 12/08
Implementation Survey: 6/09
Cohort 2 (n=24) kickoff: 12/09

Cohort implementation and analysis timeline:
- Cohort 1 (n=6) kickoff: 12/08
- Implementation Survey: 6/09
- Cohort 2 (n=24) kickoff: 12/09
- Hierarchical time series analysis of readmission rates: 12/10

Boosting the discharge process to improve outcomes and reduce unnecessary readmissions.
Prelim Quantitative Results

| • Across sites average readmission rates decreased from 14.2% to 11.2% |
|-----------------|---------------------|-----------------|----------------|
|                 | a relative reduction of 21% and absolute reduction of 3%. |
|                 | 6 months pre-BOOST Intervention to 6 months post |
|                 | Readmission rates rose in non-BOOST units by 2% |
| • Marked increased patient satisfaction at some sites |
| • Other positive early observations related to: LOS, ED visits, staff satisfaction, staff turnover |
• 481-bed hospital
• Outcomes after BOOST:
  – 30 day readmissions <70yo 8.5% vs 25.5%
  – 30 day readmissions >70yo 22.1% vs 26.1%
  – LOS 4.09 vs 4.96 days
  – Mortality 0.19% vs 0.98% <70yo
  – Mortality 0.83% vs 3.48% >70yo
• Other outcomes
  – Lower nursing turnover
• 582 bed community teaching hospital
  – Pilot on 30 bed hospitalist unit
  – In 3 months:
    • 30 day readmissions 7% vs 12%
    • Patient satisfaction 68% vs 52% very satisfied
    • LOS 4.1 vs 4.6
• Web-based data management system
• Custom built data capture
• HIPAA compliant
• Auto generation of tables and run charts
### Site Data Entry

**Table**: Hospital Name, Type, SHM Identifier, State, Region, Area, License, 30-Day Readmit List Site, 30d Read Site, 30d Read Site Limits, 30d Read NatAvg, 30d Read All, 30d Regional Comp, 30d RegComp DeID

#### 30-Day Readmit Rate for Site Units

**Graph**: 30-Day Readmit Rate by Year/Month (Hospital and Units)

- **Legend**: Whole Hospital, BOOST Unit, Comparison Unit

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**Project BOOST**: Better Outcomes for Older adults through Safe Transitions
The BOOST Program

• Year long support to help customize and operationalize the toolkit
  – Interdisciplinary Teamwork and Quality Improvement skills
  – Improving systems, not just rates
  – Sustainable change, not band aids
  – Developing local teams/expertise so that it remains on site
“Being selected as a BOOST pilot site has energized our administration as well as nursing staff to effectuate a change that will enhance transitions of care. The mentors have helped guide us through the process and keep us on track. BOOST list serve has given us access to creative ideas across the country from other BOOST sites and also serves as a companion during this initiative. The tools that the BOOST team has equipped us with will help not only with this project, but also set the tone and skill set for future initiatives.”

-Nick Fitterman, MD
Huntington Hospital, NY

“BOOST is allowing us to collaborate across departmental lines. It is adding form to what was a scattered attempt at effecting discharge. We now sense that we have a roadmap to make a difference.”

Tye B. Young, D.O.
Hospitalist and Dept Chair
Billings Clinic
“Project BOOST brings me back to what I thought nursing was really about. BOOST helps patients and families understand what they need to do to go home. This is why I went into nursing.”
BOOST is Here in California!

- Collaboration between California Healthcare Foundation (CHCF) and Society of Hospital Medicine (SHM)
  - Tuition reduced 50%, courtesy of funding by CHCF
  - 20 sites in California
  - Kickoff of first 3 sites last week

- Two more cohorts this year
  - summer (May) and fall (Sept)
How to Apply

- www.hospitalmedicine.org/BOOSTCA
- Applications currently accepted
- Application requires one executive sponsor
Thank you!