Transitions of Care

Project BOOST

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Morton Plant Mease Healthcare

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Unit Business Manager
Med-Surg/Oncology Unit

Morton Plant Mease
BayCare Health System
"Medicine used to be simple, ineffective, and relatively safe. It is now complex, effective, and potentially dangerous."

- Sir Cyril Chantler. BMJ 1998;317:1666
Morton Plant Mease at a glance...
Rates of Readmission within 30 Days after Hospital Discharge

Current State

- Complex
- Uncoordinated/fragmented
- Loose ends
- Communication
- Poor quality information
- Poor preparation: do the patients know the plan?
  - Patients don’t get the care they need
  - Patients get care they don’t need
Dangers of Discharge

At Discharge:

– 42% were able to state their diagnosis
– 37% are able to state the purpose of all their medications
– 14% knew their medications’ common side effects
– 40-80% of medication information is immediately forgotten
– Almost half of the information was remembered incorrectly
– The more information that was given, the more that was forgotten

Inner city NY hospital
Readmissions
NEJM 2009. 2003-2004 Medicare patients

• 11,855,702 beneficiaries

• 19.6% readmission rate within 30 days

• A significant number of medical patients had not been seen by a primary care physician at the time of re-hospitalization

• About 10% of re-hospitalizations were planned

• $17.4 billion spent on readmissions

Future: public reportable, shared incentives, shared accountability
Risk of Readmissions

• Patients don’t understand treatment side effects
• Patients don’t know when to resume normal activities
• Patients don’t know what questions to ask
• Patients don’t know what warning signs to look for
• Patients lack confidence in their ability to assume the care plan
“Project BOOST (Better Outcomes for Older adults through Safe Transitions) is a comprehensive program that aims to significantly reduce hospital readmissions by optimizing care transitions from the hospital to home, while improving communication among health care providers.”

Society of Hospital Medicine
What is Project BOOST?

• $1.4 million grant from The John A. Hartford Foundation to the Society of Hospital Medicine (SHM)
  – Phase 1 (Sep 08): 6 sites
  – Phase 2 (Mar 09): 24 sites
  – Other sites include UCSF, Emory, Michigan, MUSC, Aurora Medical Center, Cooper Health, Sanford USD

• Resources
  – Mentor: Mark Williams, MD, Northwestern, Lead Investigator
  – Implementation Guide
  – Ongoing web/phone conferences
  – ListServ with other sites
  – eNewsletter
BOOST Toolkit

• Tools for identifying patients at high-risk of readmission

• Patient and family/caregiver preparation
  – Diagnosis
  – Test results
  – Treatment plan during and after hospitalization
  – Follow up plans
  – Medication Reconciliation

• Discharge summary communication
BOOST Toolkit

• Follow-Up Phone Call Post-Discharge
• Interdisciplinary Rounds
• TARGET Assessment
  – 7 Ps
  – Universal Patient Discharge Checklist
  – GAP Analysis
• PASS (Patient Preparation to Address Situations)
• Teach-Back
• Who are the high risk patients?

• 7P scale
  – Problem medications
  – Punk (depression)
  – Principal diagnosis
  – Polypharmacy (5 or more meds)
  – Poor health literacy (inability to do Teach Back)
  – Patient support
  – Prior hospitalization
Baseline Data (May 08 – Apr 09)
MPH % 30 Day Readmissions

% 30 Day Readmits
MPH

Month
May 08 Jun 08 Jul 08 Aug 08 Sep 08 Oct 08 Nov 08 Dec 08 Jan 09 Feb 09 Mar 09 Apr 09

% 30 Day Readmits
8.01% 9.01% 10.01% 11.01% 12.01% 13.01% 14.01%
LCL 0.080075156
UCL 0.133325290
+2 Sigma
+1 Sigma
Average
-1 Sigma
-2 Sigma
LCL
Trend Line

10.67%
Baseline Data (May 08 – Apr 09)
MPH Average Length of Stay

MPH ALOS

Month
May 08 Jun 08 Jul 08 Aug 08 Sep 08 Oct 08 Nov 08 Dec 08 Jan 09 Feb 09 Mar 09 Apr 09

ALOS
- 2 Sigma
- 1 Sigma
+ 1 Sigma
+ 2 Sigma
Average
UCL
LCL
Trend
Baseline Data (Oct 08 – Oct 09)
HCAHPS Patient Satisfaction
Morton Plant Hospital

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<thead>
<tr>
<th>Domain Question</th>
<th>Quarter to Date</th>
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<tbody>
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<td>Staff talk about help when you left</td>
<td></td>
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<tr>
<td>Percent Top Box</td>
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<td>10/1/2008 n=157</td>
<td>34</td>
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<tr>
<td>12/31/2008 n=157</td>
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<td>1/1/2009 n=156</td>
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Percentile Rank (All DB)

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Baseline Data (Oct 08 – Oct 09)
HCAHPS Patient Satisfaction
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<tr>
<td>Percent Top Box</td>
<td>Info re symptoms/prob to look for</td>
<td>Quarter Date</td>
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What does the data tell us?

• ALOS is increasing at MPH and nationwide

• Readmission rate is probably greater than 10.67%
  – Only 70% are readmitted to a BayCare hospital

• In 2008, 8.9% of Morton Plant Hospital’s readmissions were potentially preventable

• “Staff talked to you about help when you left”
  – 66\textsuperscript{th} percentile 3\textsuperscript{rd} quarter 09

• “Staff talked to you about symptoms/problems to look for”
  – 33\textsuperscript{rd} percentile 3\textsuperscript{rd} quarter 09

  – We are good, but we can do better!
MPH Project BOOST Six Sigma Team Prioritized Opportunities

1. **Improve interdisciplinary communication**
   - TARGET (Tool for Addressing Risk: a Geriatric Evaluation for Transitions)
   - Discharge summary completed & faxed to Primary Care Physician within 24-48 hours

2. **Improve communication between the caregiver & patient/family**
   - PASS (Patient Preparation to Address Situations after discharge Successfully)
   - Teach-Back
3. Begin discharge planning on admission
   • 7 Ps

4. Streamline documentation of the discharge process
   • Beacon

5. Improve follow-up post discharge
   • Follow-up appointment within seven days of discharge scheduled prior to discharge
   • Follow-up phone call within 72 hours of discharge
MPH Project BOOST Six Sigma Team
Next Steps

• Prioritize tools to be implemented
• Redesign the current process to support implementation of the tool, if needed

• Develop an action plan for implementation
• Communicate & educate on pilot unit
• Implement pilot
• Measure & evaluate results
• Repeat!
**MPH Project BOOST Six Sigma Team**

**Champions:**
- Hal Ziecheck, MPH COO
- Dr. Donald Pocock, Chief Medical Officer
- Joan Conrad, Director, Patient Care

**Process Owners:**
- Dr. Jordan Messler, Hospitalist Director
- Diana Cripe, Director, Health Mgmt Services

**Black/Green Belt:**
- Lori Smithson, Six Sigma Black Belt II
- Jerry Corsello, Unit Business Manager

**Project Team:**
- Nursing, Clinical Education, Social Services, Pharmacy, Clinical Documentation/Research, Primary Care Physician
Health Policy Future

- Increased accountability of professionals
- Financial incentives
- Documentation of cross site communication necessary for reimbursement
- Care transitions need to be a distinct benefit
- Performance measures
  - Readmissions, medication errors, patient satisfaction
  - No validated instruments
Overview

The BOOSTing (Better Outcomes for Older adults through Safe Transitions) Care Transitions resource room provides a wealth of materials to help you optimize the discharge process at your institution. We developed this through support from the John A. Hartford Foundation (Read more about Project BOOST mentoring and training opportunities). We based the approach and tools on principles of quality improvement, evidence-based medicine as well as personal and institutional experiences. Of note, we are piloting the contents at multiple hospitals and will be constantly revising the resource room based on this invaluable experience.

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
What questions do you have?

- donald.pocock@baycare.org
- HCUP.ahrq.gov
- www.hospitalmedicine.org/boost
- NQF: www.qualityforum.org
- www.NTOCC.org
- www.ihi.org