Mark Williams:

Thanks, Jeff. It does, I feel like I’m at a convention of people attempting to reduce readmissions and I'm incredibly honored to be able to speak same day as Don Berwick. I'm going to talk to you a little bit about Project BOOST. And I’m going to assume this is going to advance. There we go. And our website is there, hospitalmedicine.org/BOOST, which is the Society of Hospital Medicine. And so this emanated from hospitalists who are caring for a lot of the patients in hospitals as you're well aware. There's now probably about 32,000 hospitalists in the United States, so that we outnumber cardiologists, and about the same number as emergency medicine.

And I think there a tremendous opportunity to have a quality improvement lever in the hospital to, honestly, put ourselves out of business. I’d like to have fewer patients coming to the hospital overall. And I want to also thank Tina Budnitz, who's been the project director and driver of Project BOOST. And I especially want to thank John A. Hartford Foundation who has been funding care transition work for a long time before it was a popular issue, because it was the right thing to do. So thanks to the John A. Hartford Foundation.

And this has been a problem for a long time. In fact, this has been a problem my entire life, and I mean, since the day I was born. I found this article published in 1979. It talked about how for more than 20 years we've been advocating improvements in patient continuity of care, but this simply has not happened. Out of this, this study emphasizes the current lack of effort by health care providers in hospital and nursing homes to find a workable solution.

Back in 1979, go back 20 years, you know when I was born then, so it's been 50 plus years and we really haven't really fixed this. And I'm thrilled that now we have this congregation of a lot of smart minds to, finally, maybe fix this continuity issue. I was incredibly lucky to be able to collaborate with Steve Jencks and with Eric Coleman when we did this analysis of the Medicare database finding out that we weren’t doing well.

That one in five Medicare Fee-For-Service patients

were getting rehospitalized in 30 days. Half of them never saw an outpatient doctor before they were readmitted. And this also impacted patients who were originally hospitalized for a surgical issue, and that 70 percent of them were getting rehospitalized for their chronic medical illnesses. And a big price gap. And that’s why CMS and the health care reform legislation are targeting reductions in readmissions. And you'll see in these slides -- highly variable across the United States. And so we can certainly learn from each other.

This was a more recent article that I think we need to look at. And I'm going to go over it because there is some very important information in it. Seven million Medicare patients with heart failure studied from 1993 to 2006 with 30-day follow-up. Now, what you heard on the news was the fact that length of stay during this time in the hospital dropped from nearly nine days down to less than six and a half. So, a two and a half day reduction in length of stay. You also heard, though, that 30-day readmission rates increased from 17 to 20 percent and post-discharge mortality increased during this time.

So the message that came across was, we're kicking the patients out of the hospital sooner and they're either coming back or dying. And I don't think that's that’s the message of this article honestly. I think what we need to look at is that as you go down further, in-hospital mortality declined and overall 30-day mortality declined. But what is really the message is the patients are incredibly ill and complex. The mean age – now this just took Medicare patients getting hospitalized – but the mean age of people in this sample was 80. Half of them had high blood pressure, over a third had diabetes, and over a third had COPD.

In addition to their heart failure. We have a tough task ahead of us. But we really haven't done a great job about the discharge process. I love this quote. I always use it. Roger Resar, Senior Fellow with the Institute of Healthcare Improvement describes the discharge process as “random events connected to highly variable actions with only a remote possibility of meeting implied expectations.” Now, he's a lot smarter than me because he has this terrific title. He's an agent of Tremendous

Change and Global Innovation Seeker. I want to become that someday.

Now, I got told a long time ago, the way to succeed is to work with the people smarter than you. And that's what we did with Project BOOST. We got Eric Coleman to chair our advisory board. And then we got representatives from those groups that are actually taking care of the patients and helping them transition from the hospital to home. Social workers, case managers, geriatric medicine, health IT people, insurers, regulatory agencies. And we involved patients in developing our toolkit to try and improve the discharge transition process.

And these people did a great job. And they held our feet to the fire. We originally were trying to call this Extra Stops. And they told me pretty bluntly on a phone call "That's stupid. No one wants to stop what they're doing as they're trying to move patients through the system. Why don't you try and move things along quicker?‖ And, thus, we came up with BOOST -- Better Outcomes for Older Adults through Safe Transitions.

And so BOOST is a toolkit. It's freely available, thanks to the Hartford Foundation, on the web. We have comprehensive risk assessment tools to identify which patients are at high risk for readmission. We have a patient-centered discharge process. And I was thrilled to hear the story that Don told about… engaging the patient, they are truly the experts. So we use teach-back. We use checklists so we don't forget this. We use and ensure that patients have follow-up appointments prior to discharge, and that they actually follow up.

There's good evidence coming out that scheduling the follow-up appointment doesn't solve much. It's getting the patient there. And we have follow-up with the patients at 72 hours with phone calls as a recommendation. And then I'll talk more about mentored implementation. But this is, if you will, the secret sauce. Helping hospitals implement these quality improvement projects. And we've developed a BOOST community collaborative to share our learning. And so, I'm thrilled to see that CMS is looking to develop increasing learning collaboratives.

So I'm going to show you a couple of the tools. What

we refer to as our TARGET, our Tool for Adjusting Risk, A Geriatric Evaluation for Transitions. And there are these eight Ps. Does the patient have a prior hospitalization? That's actually the biggest predictor of whether or not they are going to get rehospitalized. Are they on problem medications such as (inaudible), insulin, (inaudible), medications that are very risky for patients to take and they really need to understand them and make sure we've got a safety net in place as we transition them from the hospital to the home.

Are they suffering from psychological issues as depression? This was mentioned by Jeff. This definitely increases readmission rates. Do they suffer from a principal diagnosis such as heart failure or COPD, which is the third most common cause of readmission? Polypharmacy, you increase the number of medicines, you increase the complications and the likelihood that they are going to have problems. Poor health literacy, I'm thrilled that this is getting some attention, we've been looking at it since 1991. So, slowly, things are getting the attention they deserve.

And then is there adequate patient support at home? Are we engaging their caregivers? So, that that's whose taking care of them. You're going to hear from Matt Schreiber of Piedmont Hospital. And he told this wonderful story, I'm going to steal from him. As he commented, when I walk into a room, I ask the patient do they have a daughter. If they do, whew, things will probably work out OK.

And then palliative care, we actually added this P because we've realized that we need to help patients to discuss their goals of care as they're transitioning through this complicated system. And, again, we've develop checklists. I'm a huge believer in them. And if you've not read it, please read Atul Gawande's Checklist Manifesto.

We've got something called the General Assessment of Preparedness that we try to implement at hospitals. I'm not going to go through this, but I think it's important just to look at the fact. There's three columns here. The discharge process begins on admission, and that's when the checklists need to be initiated. And then as you get closer to discharge, there are other issues and then

finally the ones at discharge. And sometimes things as simple as does the patient have keys to get back in their home when they're leaving the hospital.

We highly recommend a very patient-centered education tool. We've got something called the PASS and then another tool called the Discharge Patient Education Tool. I'm mainly going to show you some clips out of the DPET, or Discharge Patient Education Tool just because it's easier to see. Either one works. The PASS has the advantage in that it's one page and it's what they've implemented at Piedmont so you'll hear more about it.

But if you look here, these are patients that are comments "I had to stay in the hospital because…,‖ the medical word for this condition is, I also have these medical conditions and we check through this using teach-back to make sure patients understand. We also go over what happened to the patients in the hospital. We have some evidence that we're going to be submitting for publication soon where we found that one out of five patients don't even know what the reason for their hospitalization, they don't know their diagnosis. And this is at a hospital with a good insured population.

So, go over their tests. Go over their treatments, making sure they understand them and making sure they have their follow-up appointments and if they understand what warning signs and symptoms they need to look out for and how to respond to them. And the how to respond to them is not call 911 and go to the emergency room. That's a great way to ensure readmissions. So mentored implementation is what we consider the secret sauce for Project BOOST. And this is providing the hospitals that are trying to implement this toolkit an experienced hospitalist who has quality improvement experience and understands care transitions to help these sites identify their barriers and then overcome them.

And as I learned moving through the land, you never can be a prophet in your own hospital. And so these mentors serve as the outside experts, if you will, consultants to help hospitals implement the toolkit and check up on them. And also hold their feet to the fire to move along their timelines.

We've developed the network now where hospitals participating in BOOST communicate with each other via listservs, emails. We have forums for sharing ideas. We have a newsletter that we send out showing how hospitals have reached their key milestones. And we have updates, status reports, and so forth. So, it is truly a BOOST community. It's growing rapidly. You'll see a bunch of dots in Michigan, and that's because BlueCross BlueShield in Michigan implemented the project.

You are going to be seeing a lot more dots soon in California because the California Health Care Foundation has provided funding to enroll hospitals. And I just heard yesterday that L.A. Care is funding another 10 hospitals in southern California so it'll be going from there and I hope to be announcing within a week another collaborative with BlueCross BlueShield of Illinois to implement Project BOOST as a platform for the discharge process.

So we've got some analysis, we've been calling hospitals up, a lot of this is going into peer review. The hospitals felt that the BOOST toolkit enhanced care for the patients, the site mentors were essential for this and that very importantly that participating in this facilitated quality improvement across the hospital in other areas.

In other words, there was value delivered beyond just Project BOOST and I think it was because we brought quality improvement tools to the hospital. How to run a meeting. How to enhance collaborative teamwork.

Other important barriers to identify. Most hospitals, as they began to look into this, especially developed flow maps came to realize that their discharge process was worse than they realized. Roger Resar was right. There are a lot of competing demands in hospitals and a lot of quality improvement issues. But there's nothing like funding and penalties to focus people on this issue so I'm actually delighted that the health care reform legislation is now being rolled out, if you will.

And a lot of them pointed out there's lack of resources or administrative support for this and this is why we try and work with hospitals to have BOOST activities replace efforts that aren't necessarily working not just (inaudible) on additional levels.

One quick example, we've had number of case studies we going to be finalizing and closing our data collection at the end of this month, actually and we're excited about it but I need to wait until I've got further data. But this is one example of a hospital. 582 bed community teaching hospital that piloted BOOST on one 30-bed unit and in three months they saw 30-day readmissions decline from 12 percent to 7 percent. Again, these are same hospital readmissions, so we don't know what happened outside their hospital.

Very importantly, they saw dramatic increase in patient satisfaction and this got their hospital CEO quite excited along with a decrease in length of stay. You are going to hear a much more detailed discussion or review of implementation of Project BOOST with one hospital and so I'm basically going to hand this over to Matt Schreiber from Piedmont Hospital in Atlanta.