



BOOSTING A TEAM APPROACH TO PATIENT CARE

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Society of Hospital Medicine

Hospitalists. Transforming Healthcare.
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PROJECT BOOST: BOOSTING A TEAM APPROACH TO PATIENT CARE

Piedmont Hospital:

A 481-bed acute care, non-profit hospital located in Atlanta, Georgia.

The Problem

“The discharge process is broken,” says Matthew Schreiber, chief medical officer at Piedmont Hospital. “There is no one taking responsibility for discharge, and the lack of communication around discharge to the patient, and among providers, is woefully inadequate.” The results at hospitals nationwide include poor quality care, illustrated by high rates of preventable readmissions. Policymakers are taking aim at such readmissions, changing payments, and proposing incentives to encourage hospitals to address this weak, but crucial, link in hospital care.

The Solution

Piedmont Hospital got an early jump on fixing its own broken discharge process. In September 2008, Piedmont Hospital fully implemented Project BOOST (Better Outcomes for Older adults through Safe Transitions), an evidence-based, quality improvement and implementation toolkit designed to enhance the care of patients transitioning from the hospital to home.

Experience to Date

Thanks to Project BOOST, Piedmont Hospital is seeing better vital signs in the hospitalist unit where the intervention was first introduced, compared to non-hospitalist units, including:

- Lower length of stay, 4.09 days vs. 4.96 days, for patients under age 70, and 5.6 days as compared to 5.7 days for older patients.
- Lower rates of mortality, 0.19% vs. 0.98%, among patients under age 70, and 0.83 vs. 3.48 for patients 70 and up.
- Fewer 30-day readmissions, 8.5% vs. 25.5%, for those under age 70, and 22.16% vs. 26.1% for older patients.

Piedmont's Story

When Piedmont Hospital implemented the Project BOOST toolkit on a 20-bed unit run by hospitalists in September 2008, as a small pilot to improve hospital discharge, frontline staffers smelled a “flavor-of-the-month” effort. After implementing, however, Piedmont caregivers have found the intervention is having a positive and lasting impact.

“Within three months, we found that this whole environment of BOOST became our way of doing business,” says Schreiber, who at the time was chief of hospital medicine across the Piedmont system. Piedmont found that BOOST, designed to make the transition from hospital care to home more manageable, and sensible for patients and families, was the catalyst for improving efficiency and provider and patient satisfaction, reducing length of stay, mortality and readmission, and revitalizing patient care.

The toolkit provided Piedmont with research-backed solutions to bring order to the chaotic discharge process via patient assessment tools, checklists, and handy one-page patient-friendly “Patient PASS” form that is supported by a discharge preparation method that has patients “teaching” or mimicking back medication instructions, important things to watch for and steps to take with their diagnosis, and other important things to safely transition to home.

Just as important, the toolkit offers providers an easy way to implement a quality improvement project. Adopting BOOST, Piedmont received several helpful resources to guide its efforts, including BOOST mentors. “Hearing from others helps us to not have to learn everything from ground zero,” Schreiber says.

Project BOOST quickly expanded to a second 20-bed unit, then a third. The BOOST “Patient PASS” form is now Piedmont’s official discharge form. “Everyone—the hospitalist team, nursing staff and patients—loves this form.” Upon discharge, patients get the one-pager highlighting customized steps they should take, and describes their condition, prescribed medicines, physician contacts, and more.

“It’s customized for each patient”, says Betsy Anderson, lead hospitalist staff nurse. “I was in the hospital because:” the Patient PASS reads at the top, followed by scheduled follow-up appointments, steps they should take from medication regimen, warning signs to watch for, tests and issues a patient should talk to their doctor about, and important contact information. The form is a handy tool for patients and for post-hospital care providers who suddenly have essential patient information. “It’s invaluable to the home health nurse,” Anderson adds.

The revamped discharge form is the culmination of a process that sees a care team — from hospitalist physicians, nurses and pharmacists to social workers, physical therapists and others—working on behalf of patients. A white board on the unit allows team members to track each patient with a goal of helping to empower both patient and family with information so that the transition to home is successful. “The hospital is the place to come to get well enough so you can go home to get completely well,” Anderson observes.

Prior to discharge, a nurse calls a patient’s discharge diagnosis to the hospital librarian, who does a literature search, assembling basic consumer-friendly care information, tailored to each patient’s conditions. Unlike some hospitals that target specific patients for BOOST, Piedmont BOOSTS all patients on the three units working with the intervention. “This is so valuable that everyone deserves this kind of care,” Anderson says. “We don’t discriminate.”

When patients get BOOSTed, care providers serve the patients. Workflow and job duties have been reworked; provider routines now accommodate patients, not vice versa. Unit pharmacists advise patients about their medicines, social workers make follow-up doctor appointments for patients—both crucial elements in reducing readmission rates—and nurses have more time at the patients’ bedside to care and educate their patients and respective family members. Nurses are no longer task-minded, scurrying from one duty to another but are now critical thinkers focused on patients, notes Anderson.

Within 72 hours of a patient’s discharge, the patient gets a call from the hospitalist nurse to follow up and see how they are doing, answer questions and to ensure the transition is smooth. “Patients are grateful,” says Anderson. “The follow-up calls we make are invaluable,” she says, adding they not only reassure some patients, but prevent unnecessary readmissions or ED visits. A follow-up call from a nurse to a patient with heart failure, complaining of shortness of breath, may discover the patient merely has a stuffy nose due to the heater running, and may advise running a vaporizing humidifier.

Additional benefits of such efforts include lower nurse turnover, more requests by nurses to work on the unit, and a doubling of bed turns. “The unit is about twice as efficient as the next efficient unit”, Schreiber says. Readmission rates for the hospitalist unit are down, as are lengths of stay. Mortality rates also dropped. “It was like a Godsend for me,” Schreiber says of Project BOOST.

Implementation Issues

Change does not come easily, however. Nurses at first pushed back on filling out both the Patient PASS and standard discharge forms. Hospitalist physicians initially resented taking on more patients than some other doctors. “Our whole culture was very communist, everyone did the same amount of work,” Schreiber quips.

“This can be very painful,” he adds. Before implementing BOOST, the unit spent a month preparing. “It was all about breaking down history, changing people’s workflow and job duties.” Medication reconciliation was lifted off nurses’ shoulders and given to pharmacists, who reengineered their processes in order to get a pharmacist on the unit. Radiologists no longer select the ordering of patient tests; the hospitalist team dictates the flow to prevent delays among higher need patients.

But things began clicking at Piedmont. After two months pushback among team members eased. Higher numbers of bed turns and throughput became evident. Teamwork gelled. “The first 4-6 weeks are like diet and exercise, you just have to get through it,” Schreiber explains. Patients seemed happier; nurse turnover fell, while requests to work on the unit rose. Hospitalist doctors understood that seeing 20 patients on the unit was better than seeing 14 scattered across the hospital.

The more dramatic outcome measures—readmissions, length of stay, mortality, and patient satisfaction—also improved. Within months, Schreiber overheard one doctor tell another, “You’re going to love it up there!” Schreiber adds, “It’s a whole different ballgame.”

The intervention does come at a slightly higher cost. A hospitalist team nurse was hired after the original plan of depending on a charge nurse didn’t work. There is more paperwork. Yet, the hospitalists working with BOOST are far more effective resulting in better outcomes. Such results should hold the hospital in good stead as payers look to bundle hospital payments and provide incentives for reducing readmissions.

Going Forward

“It’s not about the unit of work, but the impact of work,” Schreiber points out. “That’s what healthcare has to figure out for it to survive. We need to do better work, get better outcomes, and see more people, all with fewer resources. That’s the future.”

In addition to rolling out BOOST to three 20-bed units at Piedmont and the Patient PASS being co-opted as the hospital’s official discharge form, Piedmont sees BOOST as part of the solution for its future. Three affiliated hospitals will soon implement the intervention and experience the benefits for themselves.

About the Society of Hospital Medicine

SHM is the largest organization in the nation representing more than 10,000 hospitalists and the practice of hospital medicine. The Society’s mission is to promote the highest quality care for hospitalized patients, and provide opportunities and support to hospitalists. It is committed to enhancing the practice of hospital medicine by promoting education, research and advocacy, and does so in part by offering a host of evidence-based tools at www.hospitalmedicine.org/BOOST.

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