Project BOOST

- Project BOOST was developed through a $1.4 million grant from The John A. Hartford Foundation. The Society of Hospital Medicine (SHM) continues to fund the collaborative through the following programs:
  - Blue Cross Blue Shield Association of Michigan contributes to supporting 14 mentor sites
  - The California Health Care Foundation is providing funding to partially support tuition for 20 sites
  - Tuition based sites pay $28,000 per site; 14 hospitals have enrolled

- Participating Mentor Sites: There are currently 60 mentor sites, located in 26 states, with an additional site in Canada. By the end of 2011, the number of enrolled sites is expected to exceed 100.

By improving discharge processes, Project BOOST aims to:

- Reduce 30 day readmission rates for general medicine patients (with particular focus on older adults)
- Improve facility patient satisfaction scores
- Improve the institution’s H-CAHPS scores related to discharge
- Improve flow of information between hospital and outpatient physicians
- Ensure high-risk patients are identified and specific interventions are offered to mitigate their risk
- Improve patient and family education practices to encourage use of the teach-back process around risk specific issues.
Project BOOST is an effective tool for reducing unnecessary readmissions and improving transitions of care. It provides a foundation for and complements initiatives such as Dr. Eric Coleman’s Care Transitions Program or Dr. Mary Naylor’s Transitions of Care Model. The recently passed healthcare reform legislation includes several provisions aimed at reducing readmissions and improving care transitions.

Key Elements

- A Comprehensive Intervention developed by a panel of nationally recognized experts based on the best available evidence.
- A Comprehensive Implementation Guide provides step-by-step instructions and project management tools, such as the TeachBack Training Curriculum, to help interdisciplinary teams redesign work flow and plan, implement, and evaluate the intervention.
- Longitudinal Technical Assistance provides face-to-face training and a year of expert mentoring and coaching to implement BOOST interventions that build a culture that supports safe and complete transitions. The mentoring program provides a train the trainer DVD and curriculum for nurses and case managers on using the TeachBack process, as well as information on the educational needs of other team members including administrators, data analysts, physicians, nurses and others.
- The BOOST Collaboration allows sites to communicate with and learn from each other via the BOOST Listserv, BOOST Community site, and quarterly all-site teleconferences and webinars.
- The BOOST Data Center, an online resource center, allows sites to store and benchmark data against control units and other sites and generates reports.

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.

http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions.html_CC/12ClinicalTools/01_Toolkits.cfm
The Project Plan
Planning Phase Activities (months 1-3)

- Secure institutional support for the initiative: engage senior leaders, secure needed resources
- Assemble a multidisciplinary team that is focused on improving the quality of care transitions in your institution.
- Develop specific aims or goals that are time defined, measurable, and achievable.
- Analyze current processes and gain a full understanding of the discharge process status quo and how all stakeholders (physicians and hospital staff, housestaff, patients and families, your administration) contribute to or are affected by the current processes.
- Assemble baseline data that describe current performance

It Takes A Team!

Team Membership May Include

- Clinical nursing staff
- Physicians involved in the discharge process (including resident if present at your hospital)
- Primary Care Physicians/Geriatricians/follow-up specialty physicians
- Physicians who care for patients at subacute and acute rehabilitation facilities
- Allied health professionals (nurse-practitioners and physician assistants)
- Social Work
- Case management
- Pharmacists
- Medical Records department
- Hospital informatics
- Home care referral coordinator
- Data analyst
- Nutrition/dietary
- Emergency department (paramedics/ambulance drivers) – has proven for hospital-to-SNF transfers
- Patients who have hospitalized at your institution in the past
- Family/caregiver

Include individuals with roles described in bold in your core working group.

You Are Here!
Understanding Your Institution’s Discharge Transition Processes

- Standardized Discharge Processes
  - What standardized processes for discharge transitions and monitoring already exist, particularly for older adults?
  - What elements of the discharge process need to be more customized to a specific patient population?
- Patient/Family Caregiver Preparedness
  - How are patients/family/caregivers assessed regarding understanding of medical issues (e.g., diagnoses, treatment, testing, and results) and follow-up plans/care?
  - Are there tools to assist in this process?
  - When does this process start?
- Medication Safety
  - How is medication reconciliation accomplished?
  - How are high-risk medications addressed?
  - What kind of standardized monitoring is in place for medications that are at high risk?
  - How is patient understanding of medication administration assessed?
- Follow-Up Care
  - What is the quality of the discharge communication to the outpatient follow-up clinician?
  - What is the timing of this communication?
  - How is quality assessed regularly?
  - Are there any programs available for self-management after discharge?
  - How is care coordinated with the follow-up physician?

Visit the American Society for Quality (ASQ) website for information on process analysis tools.
Identified Core Principles as Central to the Interventions.

- Patient centeredness
- Empowerment
- Risk Appropriateness
- Team Oriented
- Bridging

The intervention developed by Project BOOST attempts to incorporate each of these principles.

The Project Plan
Implementation Phase Activities (months 4-6)

- Redesign care processes to incorporate all key features of BOOST into the workflow.
- Engage in staff education/outreach to ensure that all stakeholders are aware of your efforts and as appropriate have an opportunity to offer input.
- Develop policies, procedures, forms, tools, order sets and other documents needed to support new or redesigned processes.
- Identify metrics and an evaluation strategy that address the needs of your various stakeholders. Who will need to know what about your work, when will they need to have this information and what report format will be most useful to them?

Start by creating broad goals that generally define the purpose of your program.

- General aim 1: Substantially improve the discharge process for hospitalized patients. Is converted to specific aim - In six months, 90% of patients discharged from the hospitalist service will have a phone call to the follow-up clinician outlining the postdischarge issues prior to discharge.
- General aim 2: Decrease 30-day readmissions. Is modified to specific aim - By January 2012, the 30-day readmissions for patients discharged with a principal diagnosis of heart failure will decrease by 50%.
- General aim 3: Improve patient satisfaction regarding the discharge process.
- General aim 4: Increase the knowledge of nurses and physicians in optimizing the discharge process.
Defining Target Population

- Will you target one ward or a service?
- Will you target one or more groups of physicians?
- How long will the pilot intervention last?
- Will you focus on one or more aspects of the transition?
- Which patient population(s) will be targeted?

It may be reasonable to start small and spread your improvement methods to other areas.

Tool for Addressing Risk: A Geriatric Evaluation for Transitions: TARGET

- The TARGET is a 4-part tool that includes:
  - Risk stratification process (the 8P tool).
  - Risk-specific intervention plan linked to the 8P risk score summary.
  - Universal set of expectations for all patients being discharged from the hospital to home (the Universal Checklist).
  - General Assessment of Preparedness (GAP), a component list of issues important to providers and patients (and their caregivers) surrounding the readiness of patients for transition out of the hospital.

The Project Plan

Intervention Phase Activities (months 6-9)

- Monitor functioning of each core element of BOOST following implementation
  - a. Use of the 8P screening tool
  - b. Offering risk specific interventions for each of the P's
  - c. Use of the General Assessment of Preparedness (GAP) tool
  - d. Use of the Universal Patient Checklist
- Reassess your evaluation plan: verify that data identified in your evaluation plan are being collected and appropriately capture the quality and quantity of your work
- Keep stakeholders apprised of progress
Utilizing the Risk Assessment Tool: The 8Ps

- Problem medications
- Psychological
- Principal diagnosis
- Polypharmacy
- Poor health literacy
- Patient support
- Prior hospitalizations in the last 6 months
- Palliative care

TARGET - Tool for Addressing Risk: A Geriatric Evaluation for Transitions

Risk Specific Interventions: Checklist

- General Assessment of Preparedness (GAP) assessment completed with issues addressed
- Medications reconciled with preadmission list
- Medications use/side effects reviewed using teach back with patients/caregivers
- Teach Back used to confirm patient/caregiver understanding of diagnosis, prognosis, self-care requirements, and symptoms of complications requiring immediate medical attention
- Action plan for management of symptoms/side effects/complications requiring medical attention established and shared with patient/caregiver using Teach Back
- Discharge education plan completed, taught, provided to patient/caregiver at discharge
- Discharge communication provided to post-hospitalization care providers
- Documented receipt of discharge information from principal care providers
- Direct communication with principal outpatient provider at discharge
- Telephone contact arranged within 72 hours of discharge in order to assess the patient's condition and adherence and to reinforce follow-up
Discharge Checklist

<table>
<thead>
<tr>
<th>Universal Patient Discharge Checklist</th>
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<tbody>
<tr>
<td>1. Goal statement (see below) completed with all issues addressed:</td>
<td>YES</td>
</tr>
<tr>
<td>2. Medications (including over-the-counter medication) reviewed with patient:</td>
<td>YES</td>
</tr>
<tr>
<td>3. Instruction on how to use medications provided:</td>
<td>YES</td>
</tr>
<tr>
<td>4. Teach Back used to self-teach patients on understanding of disease, progress and self care measures:</td>
<td>YES</td>
</tr>
<tr>
<td>5. Action plan for management of symptoms during hospitalization, including when to call for help:</td>
<td>YES</td>
</tr>
<tr>
<td>6. Follow-up plan reviewed and patient taught to use plan:</td>
<td>YES</td>
</tr>
<tr>
<td>7. Goal of discharge communication provided to principal caregiver: (If patient is unable to provide this, have patient sign document)</td>
<td>YES</td>
</tr>
<tr>
<td>8. Discharge communication provided to primary care provider:</td>
<td>YES</td>
</tr>
<tr>
<td>9. Discharge communication provided to other health care providers:</td>
<td>YES</td>
</tr>
<tr>
<td>10. Discharge communication provided to other health care providers:</td>
<td>YES</td>
</tr>
</tbody>
</table>

General Assessment of Preparedness

Assessment of Preparedness (AP)

Prior to discharge, review the following areas with the patient and caregiver. Communication occurs best if a summary is provided one to provide:

- Medication management
- Nutrition
- Home care needs
- Follow-up plan
- Self-care measures
- Emergency contact information
- Advance care plans
- Financial arrangements

The Teach Back Method

1. Teach Back
2. Assess patient comprehension
3. Ask patient to demonstrate
4. Explain new concept
5. Demonstrate new skill
6. Patient recalls and comprehends
7. Demonstrates skill mastery
8. Re-assess recall and comprehension
9. Ask patient to demonstrate

The Project Plan

Project Surveillance & Management (months 10-12, and beyond)

- Analyze data to assess project performance
- Adjust interventions to address improvement opportunities identified by frontline staff or in your data
- Report data to key stakeholders
- Continue to monitor, improve, and report on your activities

Lessons Learned

- Think: Does this pass the “if this were your mother” test? (PATIENT CENTEREDNESS)
- Start by re-aligning roles and clarifying lines of communication and responsibility – clear and appropriate ownership is central. (ACCOUNTABILITY)
- It takes a village: a coordinated multidisciplinary approach is mandatory. (TEAMWORK)
- Empower the patient with disease and medication education – utilize nurses and clinical pharmacists as educators by freeing them from non-clinical tasks. (EMPOWERMENT)
- Be proactive and think prospectively about which patients are at risk and what you can do to intervene. (PREVENTION)
- Be an army of one, a great role model, and start today. (CHAMPION)

Analysis

- As of December 2010, the project BOOST toolkit had been downloaded by approximately 1,650 sites.
- The year long-mentoring program providing expert coaching to implement the program is in place at 60 sites. Project BOOST mentor sites are in various stages of planning implementation and data reporting.
- Early data from six sites, which implemented Project BOOST, reveals a reduction in their 30 day readmission rates from 14.2% before BOOST to 11.2% after implementation; also, producing a 21% reduction in 30 day all-cause readmission rates.
- Pilot sites indicate that BOOST tools are well received by health care teams and patients as it improved communication and collaboration across functions within the hospital and outpatient physicians.
- Patients reported a very positive response to what they perceive with an increased level of service and medical attention.
Resources

- American Society for Quality [www.asq.org](http://www.asq.org)
- Joint Commission [www.jointcommission.org](http://www.jointcommission.org)
- Massachusetts Coalition for the Prevention of Medical Errors [www.macoalition.org](http://www.macoalition.org)
- The MATCH (Medications at Transition Changes and Handoffs) [www.medrec.mnh.org](http://www.medrec.mnh.org)
- BOOSTing Care Transitions Resource Room [www.hospitalmedicine.org/BOOST](http://www.hospitalmedicine.org/BOOST)
- National Transitions of Care Coalition [www.ntocc.org](http://www.ntocc.org)