Project Gives BOOST to Discharge Planning

BY JOYCE FRIEDEN

NATIONAL HARBOR, MD. — The Society of Hospital Medicine wants to give hospitals a boost when it comes to discharge planning and preventing hospital readmissions.

"The field of hospital medicine has been characterized by some as the worst thing to ever happen to continuity of care," Dr. Winthrop F. Whitcomb, cofounder and past president of the SHM, said at the World Health Care Congress Leadership Summit on Hospital Readmissions. "We really want to be part of the solution, not just part of the problem."

To that end, in 2008 the society started Project BOOST (Better Outcomes for Older Adults Through Safe Transitions), a quality improvement initiative aimed at increasing coordination between inpatient and outpatient care and solving problems with the discharge process. "It's a team intervention to bring together hospitalists, other providers, and the hospital itself," Dr. Whitcomb explained. (See HOSPITALIST News, June 2009, p. 1.)

The project has been implemented in 30 sites nationwide in two phases, with 6 hospitals coming on board in the first phase and the remaining 24 joining in the second phase. Each phase began with a kickoff meeting for all of the new sites, with experts delivering lectures and eliciting discussion on best practices; each site then received a visit from a hospitalist mentor assigned to that particular facility.

"The mentor has regular phone calls with the project team to review barriers and [talk about] how things might be done better," said Dr. Whitcomb, an internist at Mercy Medical Center, Springfield, Mass.

In addition to the mentoring component, the project identifies a hospitalist on staff at each site who will be part of the team, he said. "We want to help hospitalists realize their potential as change agents."

One of the project's goals is to reduce the rate of readmissions to the hospital, he continued, noting that a recent study found that one in five Medicare patients who were admitted to the hospital were rehospitalized within 30 days at a cost to Medicare of $17.4 billion. Half of the readmitted patients never saw their outpatient physician before they were readmitted.

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The Project BOOST toolkit includes Web-based tools and a listserv. In addition to those resources, the medical literature gives several clues as to what methods work well for coordinating the transition from inpatient to outpatient, Dr. Whitcomb said. These include multidisciplinary rounds, assessing and enhancing patients' understanding of their condition and treatment, a proactive approach to assessing patients' problems, patient-friendly discharge information including a reconciled medication list, and good communication. "BOOST gets everybody talking to each other, which doesn't necessarily happen if you don't go out of your way to make that happen," he said.

To make sure patients understand their discharge instructions, project teams use the "teach back" method, in which patients teach back to providers what the discharge instructions are. There is also a discharge form that patients must fill out, which explains the reason for their hospital stay and their discharge instructions, including what to do and who to call if certain medical problems arise.

The team also calls high-risk patients within 72 hours of discharge to assess how they're doing, and makes sure they have defined appointments with their primary care physicians. Figuring out which patients are at high risk of readmission can be tricky, so the program team uses the "7 Ps" test:

- ▶ Principal diagnosis.
- ▶ Problem medications.
- ▶ Polypharmacy.
- ▶ Poor health literacy.
- ▶ Patient support lacking in the community.
- ▶ Psychiatric issues.
- ▶ Prior hospitalizations.

The "7 Ps" are "a way for the site to prioritize which patients get more intensive application of the BOOST toolkit," Dr. Whitcomb said.

Hospitals participating in the project thus far say that some parts of Project BOOST are easier to implement than others, said Dr. Luke O. Hansen, an analyst for the project. Among the parts they find easy: improving communication, standardizing discharge information, and tracking length of stay, readmission rates, and satisfaction with the program.

Some of the more difficult issues include bridging silos between different parts of the hospital, dealing with the required changes in workflow and culture, arranging expedited follow-up appointments, and finding resources to make follow-up phone calls. "There is no 'one-size-fits-all' approach" to the program, said Dr. Hansen, of Northwestern University, Chicago. "Each hospital is a unique climate that will facilitate change [for] some elements and create barriers around others."

One difficulty that can crop up is getting nonmedicine specialists, such as surgeons, to go along with the program. "Physician extenders tend to help the surgeon a lot," Dr. Whitcomb said. "If a surgeon is in [an] operating room all day, is that surgeon really going to come out and spend 45 minutes on a good discharge? That is much more likely to happen if the surgeon uses a physician extender."

Another option for helping surgeons participate in the project is to "talk to a hospitalist about comanaging more of the nonmedicine cases—not just doing the discharge paperwork, but also [helping with medical issues such as] glycemic control and delirium prevention," he continued.

Next steps for the project include collecting and analyzing data, incorporating lessons learned, and expanding the number of sites, Dr. Hansen said, noting that project analysts hope to have preliminary results on hospital readmissions by the end of 2010. The project is currently adding another 15 sites in Michigan in partnership with that state's Blue Cross Blue Shield carrier, he added. ■

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Medicare Working to Prevent Beneficiary Readmissions

BY JOYCE FRIEDEN

NATIONAL HARBOR, MD. — Medicare wants to save money and improve quality of care by reducing the number of patients readmitted to the hospital within 30 days after their initial stay, Dr. Michael Rapp said.

Readmission is a problem within Medicare, said Dr. Rapp, director of the Quality Measurement and Health Assessment Group at the Centers for Medicare and Medicaid Services (CMS). In a recent study, nearly 20% of Medicare fee-for-service patients discharged from the hospital were readmitted within 30 days; 34% were readmitted within 90 days (N. Engl. J. Med. 2009;360:1418-28). The authors estimated the cost to Medicare of those unplanned readmissions at $17.4 billion.

There is "quite a bit of variability" in the 30-day readmission rate, depending on the patient's diagnosis, Dr. Rapp said at the World Health Care Congress Leadership Summit on Hospital Readmissions. For example, 25% of heart failure patients were readmitted within 30 days, compared with 20% of acute myocardial infarction patients and 18% of pneumonia patients.

Part of the problem stems from continuity of care issues, he continued. One study looked at 366 patients discharged from the hospital with a follow-up primary care appointment scheduled within 2 months. The researchers found that 42% of those patients had a medication continuity error, 12% had a work-up error, and 8% had a test follow-up error (J. Gen. Intern. Med. 2003;18:646-51). Subjects with work-up errors were six times more likely to be readmitted than were other subjects, Dr. Rapp noted.

Unplanned rehospitalizations often signal a failure of transition from the hospital to another source of care. Because any hospital admission is a source of revenue for a hospital, reducing the readmission rate means lost revenue for the facility; therefore, other incentives for reducing readmissions need to be worked out, he said.

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DR. RAPP

"One of the ways we've sought to [get hospitals engaged] is by publishing readmission rates," Dr. Rapp said. "We published them for the first time on the Hospital Compare Web site last July. It got quite a bit of interest."

Another way the CMS is trying to reduce readmissions is through the Care Transitions Intervention, a way of "coaching" patients during and after discharge. Under a pilot program, the CMS is paying 14 of Medicare's quality improvement organizations to implement this program in some locations. One QIO implementing the program with 130 patients achieved a 7.7% decrease in hospital readmissions, Dr. Rapp said. And 96% of patients said they had a good understanding of how to manage their health after the program was finished, compared with 63% at the start of the program.

Of the 14 communities involved in the pilot program, 9 have seen at least a 2% reduction in readmissions after instituting the program, he added.

Dr. Rapp said the CMS had learned several things from the project:

- ▶ Community meetings are a catalytic point in the process.
- ▶ Community recruitment and engagement can take longer than anticipated.
- ▶ Increased time and resources are required to engage outpatient physicians and specialists.
- ▶ Patients should be assigned a coach before discharge.

To improve the discharge procedure and reduce hospital readmissions, Dr. Rapp suggested several measures, including creating a collaborative forum that includes patients and families, exchanging quality data routinely, identifying the sickest patients and reviewing the way they get care, and implementing personal health records. ■

***Disclosures:** Dr. Rapp reported having no relevant conflicts.*