2014 Gage Awards

Reference #	7473366
Status	Complete
Name of hospital or health system	Stony Brook University Medical Center
Name of project	BOOST (Better Outcomes for Older Patients through Safe Transitions)
CEO name	Dr. Reuven Pasternak
CEO approval	Check here to confirm that your CEO approves of this project being submitted for a 2014 Gage Award
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Within which of the two categories does your application best align?	Population Health

1. Provide a brief description of the project. (This section should resemble an abstract for a poster presentation or an abstract for a peer reviewed journal. Include an objective, data sources, study design, findings, and conclusions.)	Background: Unplanned hospital re-admissions have significant detrimental effects on Medicare beneficiaries' health, their families, and hospital through-put since these re-admissions are consuming emergency department resources and inpatient beds. The impact on the U.S. health care system is enormous: the estimated Medicare cost of unplanned re-hospitalizations in 2004 was $17.4 billion, and in 2009 ballooned to $26 billion. 20% of beneficiaries who were re-hospitalized occurred within 30 days of discharge. Most of these re-admissions were for exacerbations of a chronic illness. The Office of Management and Budget estimates that reducing re-admissions could reduce health care costs by $26 billion over the next 10 years. There has been much literature describing models to identify individuals at high risk for readmission, but there is little available data on results of specific interventions to decrease hospital re-admissions in these high-risk individuals. Objectives: 1) Identify Medicare beneficiaries at high risk for hospital re-admissions. 2) Determine if implementing a transitional care model in an acute-care setting will reduce hospital re-admissions for those identified high risk beneficiaries. Study Design: We have implemented Project BOOST, a Transitions of Care Program, over the past two years in phases. Setting: Initially 15N, a general medicine unit; later expanded to both 15N and 15S. Population: Based on the literature, we defined "high risk patients" as those admitted to 15N/S, age 70 or greater, taking five or more medications at home, admitted from home and discharged to home. Interventions: "Phase 1": a) For admitted patients, pharmacist documented medication history and Nurse Practitioner (NP) performed medication reconciliation; b) NP made phone call within 48 hrs after discharge; c) Pharmacist made follow-up phone call after discharge. "Phase 2": a) Includes "Phase 1" interventions with addition of full-time BOOST pharmacist and caseworker ; b) Initiation of daily morning interdisciplinary rounds on 15/S for each medicine team. Measures: 30-day readmission rate. Analytic procedures: Direct comparison of readmission rates. Results: Phase 1 BOOST interventions resulted in 30-day readmission rate decrease from baseline 19% to 13.5% (n = 89). Phase 2 BOOST interventions from June through September 2013 time period have resulted in 30-day readmission rate further decrease to 9.1% (n = 241). Conclusion: We can Identify high risk Medicare beneficiaries and implement relatively simple interventions which can potentially reduce re-admissions among these high-risk individuals.

2. Describe the methods use in this project. Include where, why, and how the project was accomplished.	Study Design: We have implemented Project BOOST, a Transitions of Care Program, over the past two years in phases. Setting: Initially 15N, a general medicine unit; later expanded to both 15N and 15S. Population: Based on the literature, we defined “high risk patients” as those admitted to 15N/S, age 70 or greater, taking five or more medications at home, admitted from home and discharged to home. Interventions: “Phase 1”: a) For admitted patients, pharmacist documented medication history and Nurse Practitioner (NP) performed medication reconciliation; b) NP made phone call within 48 hrs after discharge; c) Pharmacist made follow-up phone call after discharge. “Phase 2”: a) Includes “Phase 1” interventions with addition of full-time BOOST pharmacist and caseworker ; b) Initiation of daily morning interdisciplinary rounds on 15N/S for each medicine team. c) BOOST Project Manager made a follow up appointment, within 3 days of discharge, for the patient with their Primary Care Physician. If they did not have a PCP, she set them up with one of our physicians in the Resident's Clinic d) Medicine Team "G" was designated a "Geriatric Team", led by a Hospitalist and Geriatric Fellow, who oversees all BOOST patients on the pilot units and coordinates care with the BOOST Project Manager and Pharmacist. e) The BOOST Team created a "Teachback" video to standardize and train physicians in the best ways to ensure that patients and family members understand their disease process and medications they are required to take.
3. Describe the results of the project. What data was used to support improvement results?	Measures: 30-day readmission rate. Analytic procedures: Direct comparison of readmission rates. Results: Phase 1 BOOST interventions resulted in 30-day readmission rate decrease from baseline 19% to 13.5% (n = 89). Phase 2 BOOST interventions from June through September 2013 time period have resulted in 30-day readmission rate further decrease to 9.1% (n = 241). Conclusion: We can Identify high risk Medicare beneficiaries and implement relatively simple interventions which can potentially reduce re-admissions among these high-risk individuals.
4. Describe what happened as a result of the project. Was the improvement related to the intervention? Can the project be duplicated by other organizations?	As a result of this Pilot Project our hospital is now exploring hiring additional Care Management, Nursing and Pharmacy staff to allow roll out to the rest of institution. We were able to correlate improvement in re-admission rates on our pilot units directly to the BOOST Project by comparing pre and post implementation readmission rates for demographically, as well as clinically, similar patient groups.
5. Describe how patients, families, and if appropriate, community was included in the work.	Patients and families are constantly educated, using "TeachBack", as well as asked for their input, during their inpatient stay. They are also called and visited in their homes for several weeks after discharge to ensure they are able to deal with any barriers or obstacles that might arise. Discharge Nurses and the BOOST Team also ensure that the patient's Primary Care Physician receives the patient's discharge summary within a few days of discharge
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