

Centers for Medicare & Medicaid Services
National Conference on Care Transitions
Friday, December 3, 2010

Matthew Schreiber:

Thank you very much, Mark. My name is Dr. Matthew Schreiber. I'm the Chief Medical Officer at Piedmont Hospital, a 500 bed facility in Atlanta. And I just want to take a quick second to thank Dr. Berwick for fighting through all the local traffic just to come here and hear me speak. That was very kind of him.

In the next 15 minutes, I hope to answer the three most common questions I get asked about my involvement in Project BOOST. That is number one, why did I join? Number two, what was my magic in implementation? And number three, were you actually able to move the proverbial dot?

I believe that the primary reason that Piedmont was so successful with implementing Project BOOST was because it was embedded in the total process redesign that the patient care experience in our hospital.

That is to say for me care transitions is really inseparable from transitioning the way health care is delivered. BOOST has become the way our hospitalists do the work of discharge and now, we're working to make

it the way that the hospital does business.

The reality is that care in the U.S today is too costly, outcomes are not good as they should be and our patients and workforce are intensely dissatisfied. But I'm very pleased to announce to Dr. Berwick today that I have the answer to what ails medicine and it's stunningly simple.

All we need to do is find a way to make people happier to do more work better. Piece of cake. Before I talk about how we moved from the current state that you see on the slide which I think is a pretty common current state in hospitals around the country and how we move to a place where we had people happier to do more work better, I need to tell you about three key humbling realizations I had before we got started. The first was, I wasn't going to be the one with the idea that changes the world. That was going to come from the people who do the work. Second is that historically we spend the majority of our time preparing to change, we develop metrics, we develop dashboards, then we spend the next largest increment of our time analyzing the data and we

Centers for Medicare & Medicaid Services
National Conference on Care Transitions
Friday, December 3, 2010

spend least the amount of our time, actually doing the behavior change and verifying that we are continuing to do the behavior change. And I understood that we are going to have to turn that energy pyramid upside down. Thirdly, I understood that personal leadership is the tool that helps you overcome the dissidence of change and that creating win-win relationships is the key to sustainability. So I took one med/surg unit to experiment with and I got everybody that interfaced with the patient around the table and I asked them a series of questions.

I ask them, "Have you ever thought the world would be a better place if only everyone would let you to call the shots? Have you ever thought why am I doing job X when person Y really is the expert in that or why is person Y doing what I could really do best? Have you ever had the experience that no one completed the task that was everyone's job? Have you ever found out the hard way that no one was responsible for something that was very important? Have you ever felt that the patient was getting in the way of our care process?|| And then they looked at me and said, "Have you ever felt that the

retorical questions would never end?"

So these are the lessons that I learned from our process. I learn that if you ever have a problem, you need to ask the people that do the work. They have all the answers even though they may not know that they have them. I also believe with all of my heart that you cannot buy, contract or write a job description that will get you anywhere beyond good. You need to tap into people's mission motivation.

And amazing things will happen when you tap into that motivation and when you collaborate with exceptional individuals, in order to reach a common goal. I also believe with all of my heart that people in health care are superior people that every single person who works in health care could probably earn more for doing less in some other field, yet here they are.

I believe that taking exceptional care of people is the best business plan. I believe that we are our greatest asset and that the best recruitment plan is a retention plan. I believe that when you get people together to sit around the table, you need to force them to always say

Centers for Medicare & Medicaid Services
National Conference on Care Transitions
Friday, December 3, 2010

what they can contribute to the solution of the problem, no matter how small that is, otherwise you sit around and hear statements like the only problem with my department is your department and you get nowhere.

I believe we need to be focused on the outcomes, and we need to hold ourselves accountable and say out loud that we are not going to accept effort dependent failures. It is not acceptable to fail because we didn't try hard enough. I also think that we need to focus in the hospital on post discharge services and phone follow-ups because ultimately the patient success is the only thing that matters. And that our responsibility for the outcome of patients does not disappear when the patient disappears.

The tools that we employed to change the way we do our work are neither novel nor rocket science. If Piedmont deserves any credit for doing anything at all new, it's for actually implementing the things that the experts say work for the problems we all know we have.

One of the key things that we did was to organize the med/surg unit around the attending physician, instead of

around nursing expertise or disease state. This allowed us to redeploy physician time that was previously wasted just walking from unit to unit and channel it into tasks that were more value added to the patient care experience.

We also reshuffled the job descriptions and responsibilities of the people working on the units in an intelligent fashion. We made sure that one person was clearly responsible for each major task and that everyone on the unit knew who that was. We used a whiteboard located centrally to make sure that everyone on the unit could see everyone else's work here.

We made sure that assessments turned into actions and that the patients and families were included in those plans and results. And we used the BOOST toolkit to guide us for the discharge piece of our process and up on the screen you can see the elements that helped guide our discharge process provided to us by BOOST.

I think one of the things people like to hear from me is in granular detail, how do you begin to win the sort of hand to hand combat that occurs at the transactional level on the med/surg units? That's really our kind of the

Centers for Medicare & Medicaid Services
National Conference on Care Transitions
Friday, December 3, 2010

niche that I fill. So I feel like we have a 50 dollar whiteboard that provided Piedmont Hospital with about a million dollar impact. And I'd like to walk you through one little example of how this works.

Of course, we were focused on decreasing length of stay, reducing hospital cost and reducing readmissions. We recognized that one of many barriers to discharge for us was getting patients seen by our respiratory therapists to perform an exercise oximetry test on the day of discharge. We felt like we were losing valuable hours on the day of discharge because we couldn't get these timely assessments to determine whether or not patients on oxygen needed oxygen in order to be discharged safely.

Well, so when we took a look at why aren't these – why aren't these assessments happening in the timely fashion, it became abundantly clear that, the RT's time was swallowed up by delivering nebulizer treatments and that that got the higher priority and they just didn't have time to wean the oxygen.

We also discovered that despite having the typical

policies, procedures, and protocols that are designed to kind of reduce the frequency of nebulizer treatments to give the minimum necessary for the patient that it wasn't actually happening. So, on the whiteboard we developed a little symbol that indicated which patients were receiving nebulizer treatments and which patients were receiving oxygen.

This allowed us to identify for the physicians making rounds to pay particular attention everyday to those patients requiring nebulizers to make a critical assessment and judgment about whether they could reduce the frequency or discontinue the nebulizer treatments at all.

Then we took the time that we garnered from reducing the number of nebulizer treatments that were required on the unit to the RTs and told them, now you are responsible for being very aggressive about weaning our oxygen.

We decreased neb usage significantly. We ended up decreasing oxygen utilization on this unit by 50 percent which translated into a 30 thousand dollar savings to the

Centers for Medicare & Medicaid Services
National Conference on Care Transitions
Friday, December 3, 2010

hospital on the use of medical gas.

We had fewer patients that needed exercise oximetry on the day of discharge and those that did were getting more timely assessments, we improved our discharge times, we had – and we ended up having fewer readmissions for patients with respiratory illnesses. It's the addition of many multiple small elements like this that gave us our results.

So the next legitimate question is did we actually succeed in making people happier to do more work better? So you saw the current state about how people were feeling which are actual quotations that I collected are and these are pretty close to actual quotations that I collected a few months after we started this new process.

I heard from the hospitalists, "I'd rather see 20 patients like these than 15 patients the old way." They said, "I can discharge so many patients because I know they are no loose ends." I heard the nurses say, "When did all the hospitals get there lobotomies? They're so nice and so responsive now. It's great always having them around." I heard the doctors say, "When did the nurses

get all there lobotomies? They're excellent and they're so well informed and so helpful, they make sure everything goes right and they will take great care of our patients."

Of course, these are the same people who have been working together forever. It's just now they are in a team environment and great things happen when you collaborate with exceptional people.

Did we succeed in doing more work with the same amount of people? Well, the number of bed turns on this unit doubled compared to the same period on the same unit in the year prior. It also turned out that this unit had twice the number of bed turns than the next most efficient med/surg unit in the hospital.

The acuity of the patients was going up, we had nurses doing additional duties like actually going to the emergency department to bring patients up to the floor, going to the ICUs to bring patients to the unit, hanging blood, rounding with physicians, and their staffing metrics were still based on the traditional midnight census like they ever were.

Did we succeed in doing better work? I would argue

Centers for Medicare & Medicaid Services
National Conference on Care Transitions
Friday, December 3, 2010

that we had higher patient satisfaction. We had higher staff satisfaction amongst nursing, amongst the hospitalists, and amongst the ancillary support services. We had much better communication with our home health providers and primary care physicians. We were making appointments for our patients prior to discharge. We had a much higher rate of patient understanding and that they could teach-back why they were in the hospital when we called them at 72 hours. We saw clear reductions in our readmission rates. So I would argue that we did achieve better work.

The bottom line and this is my data slide, if you will. I know it's kind of busy but I just wanted you to have something to take home with you. The bottom line is that we decreased the variance between our length of stay and the geometric mean length of stay by 66 percent. I don't think there was anybody in our administration that thought I'd get anywhere more than 10 to 15 percent down.

At the same time as dramatic reduction in our length of stay we also have a very significant reduction in

readmissions. In our under 70 population, we saw a decline in readmission rate from 13 percent to 4 percent and in our over 70 population we saw a decline from 16 percent to approximately 11 percent.

And this happened in the context of higher volumes, as well as, increasing severity of illness for our patients, our case mix index had gone up from 1.3 to 1.45 which is really significant. The way I know we really had tapped into something is we spread this same process now to three other units and we saw the exact same trends happening in length of stay and readmission reduction as we did. And now these gains have been sustained for a period of approximately two years.

In the end, I think that medicine has focused on episodes and domains of care and responsibility. And we need to focus not on how well we did "our job" but rather on the patient outcome. The reality is we're going to need to accept the fact that we are all responsible for the whole shebang. That we choose to subdivide responsibility for our own convenience that is on the inpatient side we're responsible for what happens to the

Centers for Medicare & Medicaid Services
National Conference on Care Transitions
Friday, December 3, 2010

patients after they leave the hospital. In the community side, they're responsible for what happens to the patients prior to coming to the hospital. We are all interconnected and we must all focus on providing the best care of the patient.

I do recognize that about 90 percent of health care is actually delivered in the ambulatory environment, but I think the majority of the teachable moment if you will, occurs in the hospital. That's when they're our hostage, they're captive audience there and we need to make the most of their time that we spend with them while we are in the hospital. I also believe that we already have all the help that we need to cure what ails medicine and it's all of us. Thank you.