CREATING A CULTURE OF QUALITY:
Pursuing Excellence in Care Transitions
Enhancing Safety in Kidney Patient Care

Patricia B. McCarley RN, MSN, ACNPc, CNN

Objectives:

Examine the effective transition programs:

- What are the components of a safe handoff?
- What steps can dialysis providers take to impact care transitions for patients with ESRD?

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Case Presentation

JM is a 78 year old female with ESRD secondary to diabetes mellitus 2. She was hospitalized for 5 days for an infected ulcer on right foot.

Other comorbidities include HTN, COPD, CAD with h/o MI and h/o CHF. She presents on Friday for her first dialysis after discharge.

The charge nurse calls the doctor on call for orders and is told to "*continue previous orders*." He does not order continuation of her IV medication nor does he adjust the dose of ESA. No adjustments are made to her dry weight.

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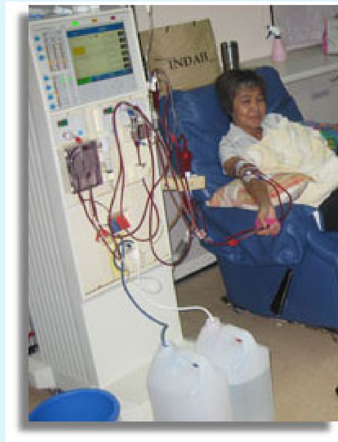
Case Presentation



No discharge summary is available.
JM does bring in her discharge
sheet. She is unsure of any new medications.

810381623

HF = Congestive heart failure

Discharge Date 7/14/09 Time 1155

542201 6/25/2009 F 48Y 518000202

PATIENT IDENTIFICATION

GENERAL INFORMATION

ACCOMPANIED BY	METHOD	DESTINATION
☐ Employee	☒ Wheelchair	☒ Home
☐ Volunteer	☐ Car	☐
☐ Self	☐ Walk	☐ Home health care

DIET/NUTRITION

☒ General ☐ Diabetic diet
☐ 2,000 mg sodium/low fat/low cholesterol
☒ Other
☐ Food/Drug interaction

ACTIVITIES ☐ No restrictions

Shower	☐ Restrictions:	Push/pull	☒ Restrictions	
Tub bath	☒ Restrictions:	Drive car	☒ Restrictions	
Climb stairs	☐ Restrictions:	☐ Other		
Lift objects	☒ Restrictions:	When restrictions are lifted, exercise 30 minutes/day		

IMPORTANT CONSULT YOUR PHYSICIAN IF:

- ☒ Pain begins or becomes more severe.
- ☒ Temperature above 101° F.
- ☒ Wound drainage begins, increases, or becomes foul smelling.
- ☒ Nauseated or vomiting.
- ☒ Redness around incision.
- ☒ Sudden onset of chest pain or shortness of breath.
- HF – Weight gain 2–3 lbs. overnight/5 lbs. in one week.
- HF – Shortness of breath, swelling in legs/ankles/belly.
- ☒ Other

SPECIAL INSTRUCTIONS OR TREATMENTS

HF – Weigh yourself first thing every morning.
Stop smoking.
Limit alcohol intake.

MEDICATIONS	SCHEDULE	ACTION/USE	COMMENTS
☐ See attached Medication Reconciliation sheet			

ASSISTING SERVICES

For home nursing care and equipment, you may contact **Memorial Home Care** at (574) 273-2873.

For your convenience, medications are available at **Memorial Family Pharmacy**; their phone number is (574) 647-7178.

PHYSICIAN FOLLOW-UP You are scheduled to see:

Physician	Date	Phone	Comments
Dr Madden		237-	
Dr.		237-7340	

SIGNATURES

I have received and understand the above instructions, and all of my medications and personal items have been returned to me.

Patient Signature — Date 7/14/09 — Nurse Signature

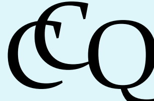
If other than patient, relationship to patient is: — Physician Signature (Optional) — Date

Page 1 of 1 Records from Materials

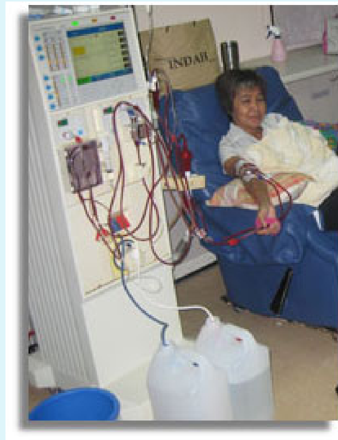
ORIGINAL - Patient COPY - Medical Record

579530

DISCHARGE INSTRUCTIONS



Case Presentation



JM presents at her target weight. Her blood pressure is 172/90. She undergoes dialysis without complications. No fluid is pulled as she is at her target weight. No labs are checked. The usual meds are given.

The discharge coordinator is off today. Attempts to reach JM's family are unsuccessful.

Case Presentation

Five days after discharge JM is readmitted to the hospital with c/o SOB and fever.

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Hospitalizations and Readmissions

- 19.6 % of nearly 12 million Medicare beneficiaries (1 in 5) discharged from the hospital were re-hospitalized within 30 days; 34% within 90 days

Leading diagnosis

- CHF, PNA

Predictors

- # of Rehospitalizations, LOS > DRG

ESRD

Jencks, et al., NEJM, 2009, 360: 1418-1428.

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Increase Risk of Rehospitalizaton

- Risk Assessment Tool: 8Ps
  - Problem medication
  - Psychology (depression)
  - Principle diagnosis (diabetes, CHF)
  - Polypharmacy (> 5 meds)
  - Poor health literacy
  - Patient support
  - Prior hospitalization (past 6 months)
  - Palliative Care

http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/06Boost/03_Assessment.cfm

Patients with ESRD The "Perfect" Storm

- Prior hospitalization – 2/year
  14 hospital days per year
- Polypharmacy – ↑pill burden
- Problem medications
- Problem diagnosis (DM, CHF)
- Psychology – Depression
- ESRD – predictor of re-hospitalization

Patients with ESRD
The "Perfect" Storm

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Care Coordination Models

- BOOST – Better Outcomes for Older adults through Safe Transitions
- RED – Reengineered Discharge
- Transitional Care Model for Heart Failure
- EverCare
- Care Transition Program
- FMS – Care Partners

Objectives

- What are the components of a safe handoff?
- What steps can dialysis providers take to impact care transitions for patients with ESRD?

Components of Successful Care Coordination N3C

- Targeting patients at risk of hospitalization
- In- Person Contact – did use telephonic contact with face to face once per month
- Access to timely information
- Demonstrated close interaction between care coordinators and PCP
- Provided services that focused on assessing, care planning, educating, monitoring, coaching on self management, teaching how to take medications, and assistance with social supports
- Relied on registered nurse to deliver the bulk of the intervention

Brown, R. 2009.The National Coalition on Care Coordination N3C

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BOOST

Better Outcomes for Older adults through Safe Transitions

- Developed from 1.4 million dollar grant – National initiative led by Society of Hospital Medicine
- Provides project management tools, QI tool kit
- Key elements
  - Broad assessment of admitted patients
  - Follow-up calls in 72 house of discharge
  - Risk-specific patient/caregiver discharge preparation using teach back method

http://www.hospitalmedicine.org/boost

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Teach Back

- Asking patients to repeat **in their own words** what they need to know or do, in a non-shaming way.
- **NOT** a test of the patient, but of how well ***you*** explained a concept.
- A chance to check for understanding and, if necessary, re-teach the information

http://www.hospitalmedicine.org/boost

> "Asking that patients recall and restate what they have been told" is one of the 11 top patient safety practices based on the strength of scientific evidence."

AHRQ, 2001 Report, *Making Health Care Safer*

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BOOST – Results

- St Louis, Mo – St. Mary's Medical Center
  - Twice weekly team meetings
  - Risk patients identified, charts flagged, "BOOSTED"
  - Teach back (used I-phone video)
  - Patient PASS form used
  - Call patient in 72 hours
- Results
  - Decreased its 30-day readmission rates from 12% to 7% within 3 months
  - Patient satisfaction increased 53% to 68%

http://www.hospitalmedicine.org/boost

BOOST – Results

- Atlanta, Ga – Piedmont Hospital
  - Patient Pass is the DC form
  - Teach back medication instructions
  - White Board – tracks patient's goal
  - DC diagnosis – librarian accesses handouts
  - Pt called in 72 hours
- Results: Intervention unit vs non-intervention unit
  - Lower length of stay 4.09 vs 4.96 days for patients under 70
  - Lower mortality for all patients
  - Fewer 30 day re-admissions 8.5% vs 25.5% < 70yo 22.16% vs 26.1% > 70yo

http://www.hospitalmedicine.org/boost

project BOOST
Better Outcomes For Older Adults Through Safe Transitions

Patient PASS

Patient Preparation to Address Situations (after discharge) Successfully

I was in the hospital because ____________________________

If I have the following problems ...	I should ...	Important contact information:
1. ______________ ______________ 2. ______________ ______________ 3. ______________ ______________ 4. ______________ ______________ 5. ______________ ______________	1. ______________ ______________ 2. ______________ ______________ 3. ______________ ______________ 4. ______________ ______________ 5. ______________ ______________	1. My primary doctor: ______________ (___) __________ 2. My hospital doctor: ______________ (___) __________ 3. My visiting nurse: ______________ (___) __________ 4. My pharmacy: ______________ (___) __________ 5. Other: ______________ ______________
My appointments: 1. ______________ On: __/__/___ at __:__ am/pm For: ______________ 2. ______________ On: __/__/___ at __:__ am/pm For: ______________ 3. ______________ On: __/__/___ at __:__ am/pm For: ______________ 4. ______________ On: __/__/___ at __:__ am/pm For: ______________	**Tests and issues I need to talk with my doctor(s) about at my clinic visit:** 1. ______________ ______________ 2. ______________ ______________ 3. ______________ ______________ 4. ______________ ______________ 5. ______________ ______________	I understand my treatment plan. I feel able and willing to participate actively in my care: ______________ Patient/Caregiver Signature ______________ Provider Signature ___/___/____ Date

Other instructions:
1. ____________________________
2. ____________________________
3. ____________________________

shm project BOOST
Better Outcomes for Older adults through Safe Transitions

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HF = Congestive heart failure

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☐ Employee	☒ Wheelchair	☒ Home	☐ 2,000 mg sodium/low fat/low cholesterol
☐ Volunteer	☐ Car	☐	☒ Other [illegible]
☐ Self	☐ Walk	☐ Home health care	☐ Food/Drug interaction

ACTIVITIES ☐ No restrictions

Shower	☐ Restrictions: [illegible]	Push/pull	☒ Restrictions [illegible]
Tub bath	☒ Restrictions: [illegible]	Drive car	☒ Restrictions [illegible]
Climb stairs	☐ Restrictions: [illegible]	☐ Other	[illegible]
Lift objects	☒ Restrictions: [illegible]	When restrictions are lifted, exercise 30 minutes/day	

IMPORTANT CONSULT YOUR PHYSICIAN IF:	SPECIAL INSTRUCTIONS OR TREATMENTS
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☒ Temperature above 101° F.	Stop smoking.
☒ Wound drainage begins, increases, or becomes foul smelling.	Limit alcohol intake. [illegible]
☒ Nauseated or vomiting.	[illegible]
☐ Redness around incision.	[illegible]
☒ Sudden onset of chest pain or shortness of breath.	[illegible]
HF – Weight gain 2–3 lbs. overnight/5 lbs. in one week.	[illegible]
HF – Shortness of breath, swelling in legs/ankles/belly.	[illegible]
☒ Other [illegible]	[illegible]

MEDICATIONS	SCHEDULE	ACTION/USE	COMMENTS	ASSISTING SERVICES
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[illegible]	[illegible]	[illegible]	[illegible]	For your convenience, medications are available at Memorial Family Pharmacy; their phone number is (574) 647-7176.
☐ See attached Medication Reconciliation sheet				

PHYSICIAN FOLLOW-UP You are scheduled to see:

Physician	Date	Phone	Comments
Dr. [illegible]		237-[illegible]	[illegible]
Dr. [illegible]		237-7340	[illegible]

SIGNATURES

I have received and understand the above instructions, and all of my medications and personal items have been returned to me.

Patient Signature ______ Date 7/14/09 ______ Nurse Signature ______

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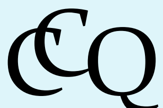

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RED
Re-Engineered Discharge

- Boston College project located at an urban hospital that servers low-income, ethnically diverse population
- Intervention: Standardized DC, DC advocate (nurse) focused on a number of components:
  - educate patient throughout stay, assess understanding
  - organize post DC services
  - reconcile medications
  - review what to do if problems arise
  - written DC plan and expedite the transmission of DC plan
  - call to reinforce DC plan, problem solving 2-3 days post DC

Jack, BW. *ANN Int Med*. 2009. 150:1178-187

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RED – Results

Primary Outcome: Hospital Utilization within 30d after Discharge

	Usual Care (n=368)	Intervention (n=370)	P-value
Readmissions			
Total # of visits	76	55	
Rate (visits/patient/month	0.20	0.15	
ED Visits			
Total # of visits	90	61	
Rate (visits/patient/month)	0.24	0.16	
Hospital Utilizations *			
Total # of visits	166	116	
Rate (visits/patient/month)	0.45	0.31	0.009

https://www.bu.edu/fammed/projectred/presentations.html

RED – Results

Cost (dollars)	Usual Care (n=368)	Intervention (n=370)	Difference
Hospital visits	412,544	268,942	+143,602
ED visits	21,389	11,285	+10,104
PCP visits	8,906	12,617	-3,711
Total cost/group	442,839	292,844	+149,995
Total cost/subject	1,203	791	+412

Reducing readmissions from 20 – 15% saves Medicare 17 billion over 5 years

https://www.bu.edu/fammed/projectred/presentations.html

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EACH DAY follow this schedule:

MEDICINES

What time of day do I take this medicine?	Why am I taking this medicine?	Medication name Amount	How much do I take?	How do I take this medicine?
Morning	Blood pressure	PROCARDIA XL NIFEDIPINE 90 mg	1 pill	By mouth
	Blood pressure	HYDROCHLOROTHIAZIDE 25 mg	1 pill	By mouth
	Blood pressure	CLONIDINE HCl 0.1 mg	3 pills	By mouth
	cholesterol	LIPITOR ATORVASTATIN CALCIUM 20 mg	1 pill	By mouth
	stomach	PROTONIX PANTOPRAZOLE SODIUM 40 mg	1 pill	By mouth

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https://www.bu.edu/fammed/projectred/presentations.html

** Bring this Plan to ALL Appointments**

John Doe

What is my main medical problem?

Chest Pain

When are my appointments?

Tuesday, October 24th at 11:30 am	Thursday, October 26th at 3:20 pm	Wednesday November 1st at 9:00 am
Dr. Brian Jack Primary Care Physician (Doctor)	Dr. Jones Rheumatologist	Dr. Smith Cardiologist
at Boston Medical Center ACC – 2nd floor	at Boston Medical Center Doctor's Office Building 4th floor	at Boston Medical Center Doctor's Office Building 4th floor
For a Follow-up appointment	For your arthritis	to check your heart
Office Phone #: (617) 444-2222	Office Phone #: (617) 444-7777	Office Phone #: (617) 555-1234

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October 2006

Sunday	Monday	Tuesday	Wednesday	Thu		
1	2	3	4	5		
8	9	10	11	12	13	14
15	16	17	18	19	20 Left hospital	21
22	23 Pharmacist will call today or tomorrow	24 Dr. Jack at 11:30 am at Boston Medical Center ACC – 2nd floor	25	26 Dr. Jones at 3:20 pm at Boston Medical Center Doctor's Office Building – 4th floor	27	28
29	30	31				

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https://www.bu.edu/fammed/projectred/presentations.html

Questions for
Dr. Jack
For my appointment on
Tuesday, October 24th at 11:30 am

Check the box and write notes to remember what to talk about with Dr. Jack

I have questions about:

- ☐ my medicines ________________________________
- ☐ my pain ________________________________
- ☐ feeling stressed ________________________________

What other questions do you have? ________________________
____
____
____

Dr Jack:
When I left the hospital, results from some tests were not available. Please check for results of these tests.

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https://www.bu.edu/fammed/projectred/presentations.html

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Evercare ™ Care Model

Founded in 1987 by 2 NPs – Awarded Demonstration Status 1995 by CMS

- Large Health Coordination Program for patients with advanced illness, older or with disabilities, complex needs
- Enhanced primary care by NP or case manager:
  - Enhanced monitoring of the "big" picture
  - Strong emphasis on preventions
  - Strong advocacy for patients
  - Increased involvement of patient and families and more consistent communication

http://www.innovativecaremodels.com/care_models/17/overview

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Evercare ™ Care Model – Results

- Reduce hospitalization by 45%: the incidence reduced from 4.63 to 2.43 per 100 patient in 15 months ($p<0.001$)
- Reduced ED visits by 50%
- Cost savings $103,000 a year in hospital costs per NP

Kane, RL. et. al*. J of Am Geriatric Soc.* 2003; Oct:51(10):1427-34.

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Transitional Care Model

- Pre and post discharge co-ordination of care for high-risk, elderly patients with chronic illness by TCNs
  - TCN – primary coordinator of care
  - In-hospital visit and assessment
  - Home visit with patient in 24 – 48 hours
  - Evidenced based plan of care, focused on patient
  - Emphasis on early identification and response to health care risks, symptoms and avoidance of AE
  - Active engagement of patient and family
  - Communication to, between and among all parties
  - Web-based clinical information system, tools

Naylor, MD, et al. JAMA, 1999; 281:613-620
http://www.innovativecaremodels.com/care_models/21/key_elements

Transitional Care Model – Results

- Significantly less likely to be re-hospitalized at least once within six months
  (37.15 vs. 20.3%; $p < 0.001$)
- Patients in the TCM group incurred half the average health care costs at six months than control patients
  ($3630 vs. $6661: $p < 0.001$)

Naylor, MD, et al. JAMA, 1999; 281:613-620.

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Care Transition

- Fosters improved self-management program in 4 week program
- Transition coach – home visit in 72 hours, call post discharge day 2, 7, 14
- 4 main components
  - Medication self management
  - Patient Centered Health Record
  - Follow-up with physician
  - Knowledge of “red flags” and warnings/signs and how to reasons

http://www.caretransitions.org/documents/Evidence_and_Adoptions_2.pdf

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Care Transition Results

- 158 elderly patients admitted with 1/10 conditions (HF, COPD, Diabetes, stroke, hip fracture, peripheral vascular disease, spinal stenosis, arrythmias and DVT/PE)
- Patients in program significantly less likely to be re-hospitalized than controls at 30, 90 and 180 days (adjusted adds ratio at 30 days = 0.52; 95% CI=0.28-0.96)
- Time to re-hospitalization was significantly longer (225.5 days vs 217.0 days; $p=0.003$)
- Adopted by 470 organizations in 30 states
- Anticipated cost saving: 1 coach for 350 pt. $330,000 over a period of 12 months

Coleman, EA, et al *J Am Geriatric*. 2004:52(11):1817-1825.
Voss, R et al *Archives of Internal Med*. 2011:171;(14):1232-1237.

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P H R

Personal Health Record of:

____
(NAME)

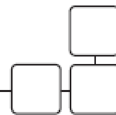
If you have questions or concerns,

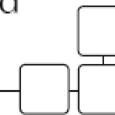
contact ______________________

at (______) ______ - ________

© Eric A. Coleman, MD, MPH

REMEMBER to take this record with you to all doctor visits





http://www.caretransitions.org/

THE CARE TRANSITIONS PROGRAM

Questions for my Primary Care Doctor:

My Health Conditions:

1. ______
   - Red Flags: ______
   - Action Steps: ______
2. ______
   - Red Flags: ______
   - Action Steps: ______
3. ______
   - Red Flags: ______
   - Action Steps: ______
4. ______
   - Red Flags: ______
   - Action Steps: ______
5. ______
   - Red Flags: ______
   - Action Steps: ______

http://www.caretransitions.org/

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The Care Transitions Program

Discharge Preparation Checklist

Before I leave the care facility, the following tasks should be completed:

- ❑ I have been involved in decisions about what will take place after I leave the facility.
- ❑ I understand where I am going after I leave this facility and what will happen to me once I arrive.
- ❑ I have the name and phone number of a person I should contact if a problem arise during my transfer.
- ❑ I understand what my medications are, how to obtain them and how to take them.
- ❑ I understand the potential side effects of my medications and whom I should call if I experience them.
- ❑ I understand what symptoms I need to watch out for and whom to call should I notice them.
- ❑ I understand how to keep my health problems from becoming worse.
- ❑ My doctor or nurse has answered my most important questions prior to leaving the facility.
- ❑ My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- ❑ If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

This tool was developed by Dr. Eric Coleman, UCHSC, HCPR, with funding from the John A. Hartford Foundation and the Robert Wood Johnson Foundation

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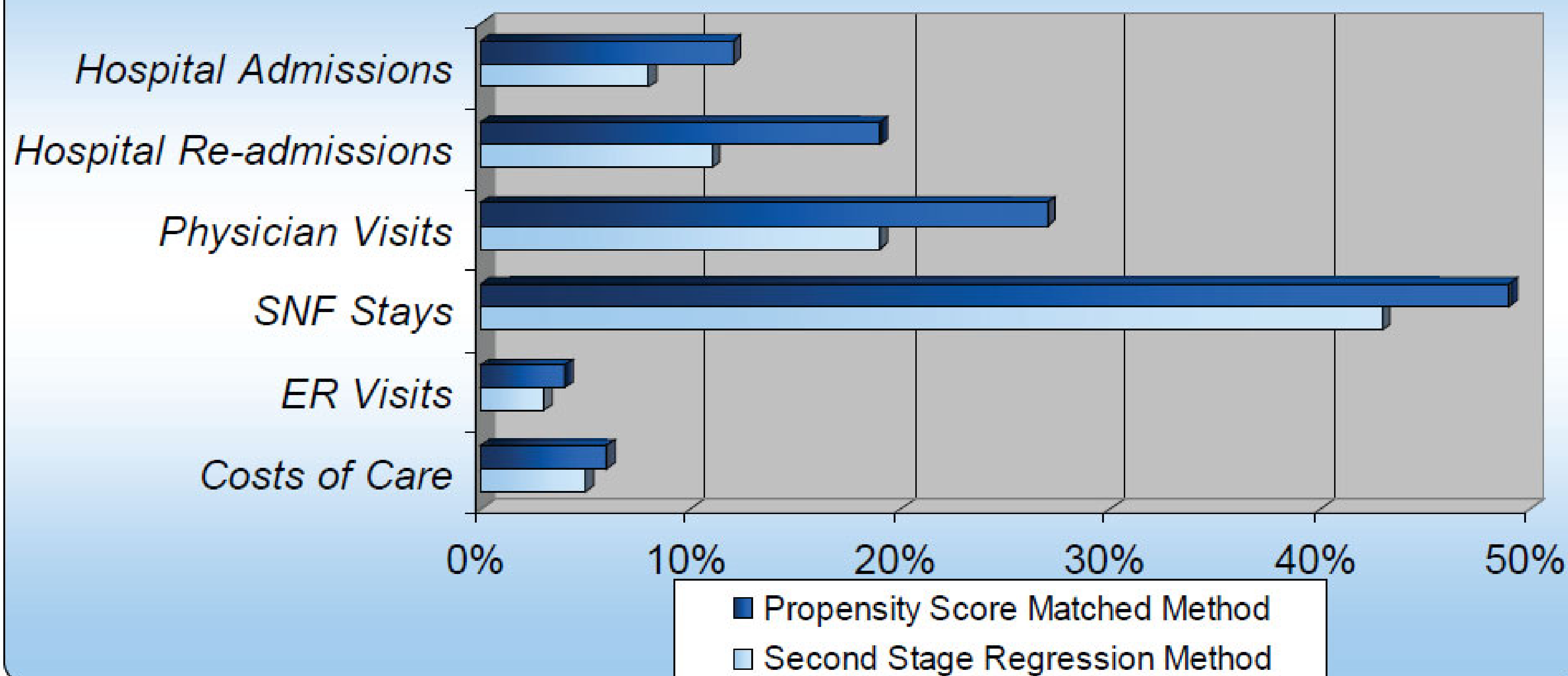
ESRD Demonstration Project

- Fresenius Health Partners –Care Management Team
- Nurse Care Managers – centerpiece of the integrated care model
- Included in activities:
  - Address the needs of high-risk patients (follow-hospital patients and assist with discharge planning and conduct follow-up contacts post discharge)
  - Assist patient with new or changed medications
  - Work with patient's healthcare team to facilitate continuity of care
  - Telehealth monitoring for daily communication and collection of Patient information

Fresenius Health Partners



http://www.fmchp.com

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Care Coordination – Challenges

- Decreased length of stay (LOS), continuing therapy after discharge
- Aging population – greater complexity, many co-morbidities
- Many care venues, many providers, poor communication
- Practice defined by location (i.e hospitalist, PCP)
- Current Fee for Service does not reimburse care coordination

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Care Coordination – Dialysis Providers

- Multidisciplinary Team
- Knowledge of patient history
- Patient seen within 72 hours of discharge
  - Assessment
  - Medication reconciliation
  - Social and Dietary issue addressed
- Providers in common

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Activity

Your Multidisciplinary QI Team is meeting. You have decided to identify short-term action steps to address a specific barrier.
There are 8 barriers.

- The number on your table matches your barrier
- A facilitator has been chosen to lead the discussion
- Brainstorm ideas
- Identify 3-4 action steps to address the barrier
- Choose a team member to present your action steps to the group- you will have 3 minutes for your presentation

Example

"Resume Previous Orders"

1. Identify Critical Information to communicate
   - Date of discharge, discharge diagnosis
   - Dry weight, Medication changes
   - F/U appointment, tests
2. Work with IT dept to develop phone app for physicians for communicating the information.
3. Work with nephrologist (in hospital) to utilize the app – Acute inpatient nurses to facilitate use of app and delivery to outpatient clinic

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#1

"Where's the Hospital Discharge Summary?"
Lack of real-time communication

Facilitator: Glenda Payne

Action Steps – Real time Communication

1. Identify hospital
2. Consider mandatory exchange of Information – “2730 e-script”
3. Proactive:
   - Establish relationships
   - Start Early in hospital stay
   - Request information daily
4. Get access to Electronic Health Record (EHR)
5. Patient Education – engagement “you are the only one present”
6. Care Coordinator – Nurse

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#2

"I can't read this!" Forms complicated and illegible

Facilitator: Denise Van Valkenburgh

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Action Steps – Discharge Form

1. Communicate with hospital regarding ownership of the form. Who completes the form?
2. Educate and empower nursing staff to collect information that is needed if the form is unreadable (immediate)
3. Medical Director to reach out to the CMO of hospital for a longer term solution, such as electronic communication both ways (long term plan)
4. No MD's complete the form due to poor handwriting (kidding aside)

#3

“Resume previous orders”

Facilitator: Doug Johnson

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Action Steps – Discharge Orders

1. Set in place a policy to question nephrologists upon receiving "resume previous order"
2. Need additional staff: a transition care coordinator (TCC)
3. Develop better process with each partner hospital
4. Develop a backup plan for "TCC" so there's a single point of contact – one phone number for hospital to call

#4

"I'm back!"
Need for patient assessment

Facilitator: Billie Axley

Action Steps – Patient Assessment

1. Need the 411 – needed information
   - Where was pt?
   - Why?
   - Current assessment
   - Paperwork? Discharge summary
2. Contact Nephrologists
3. Interdisciplinary Team Involvement
   - psychosocial
   - transportation
   - meds
   - diet
   - stable/unstable
   - pt concerns

#5

“No UF today– you’re at your target weight!”

Risk of volume overload

Facilitator: Lynda Ball

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Action Steps
Avoid Volume Overload

Develop protocol that will be instituted when Patient's weight is questionable

1. Complete RN physical assessment/report to MD because of:
   - Hospitalization
   - New orders not yet received
   - GI issues
   - scale discrepancy
2. Interview patient
3. Compare prior treatments deviation from baseline
4. Education to staff
5. Education to patients

#6

One "True" List –
Poor medication reconciliation

Facilitator: Melinda Martin-Lester

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Action Steps Medication Reconciliation

1. Patient Empowerment
   - Written tools
   - Brown bag
   - Change in meds
2. Facility Sharing
   - Med list
   - ECF sharing
3. Transition Coordinator

#7

Frequent Flyer

Facilitator: Terry Ketchersid

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Action Steps Frequent Hospitalizations

1. Frequent Flyer Definition= readmission, unplanned within 30 days.

   Follow for 6 months
2. Hospital – Dialysis communication transition form
3. Follow up within 72 hours by care coordinator liaison/flu assessment
4. Interdisciplinary team members to round and assess patient

#8

"I'm not sure!"
Lack of patient involvement

Facilitator: Glenda Harbert

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Action Steps
Increasing Patient Involvement

1. Targeted patient interview "CSI Investigation"
   - images for visual cues
   - open ended questions
   - Who took you home? ID for family contact to gain info
2. Target family interview if possible
3. Contact hospital/physician
4. Develop patient/family education
   - folder
   - written information
   - forms – things you should know at discharge
5. Contact by dialysis unit staff during hospitalization
6. Staff education concerning targeted interview
   - Provide script and patient/family education

Patient "Costs"

- Decline in functional capacity
- Nosocomial Infection
- Adverse event
- Decreased quality of life
- In hospital – mortality

BOOST – Atlanta, Ga

- "*Change does not come easy! Nurses pushed back. Hospital physicians resented the process.*

  It was all about breaking down history, changing people's workflow and job duties.

  The first 4 – 6 weeks are like diet and exercise, you just have to get through it!"

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Just Do It!!!!