H2H
HOSPITAL-TO-HOME

Improving Transitions from the Hospital to Community Settings

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Take Home Messages

At the end of this session, you will be able to:

1. Identify the core features of H2H
2. Identify *good* practices for reducing readmissions and improving transitions of care gathered from the H2H community
3. Identify common elements with similar improvement programs

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What is H2H?

- Hospital to Home initiative
- Launched 2009 for all facilities committed to goal of reducing readmissions
- National quality improvement program
  - Providing a national infrastructure
  - Complementing similar initiatives
  - Sharing best practices on implementation
  - Creating a web-based community

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Goal

To reduce 30-day, all-cause,
risk-standardized readmission rates
for patients discharged with
heart failure or acute myocardial infarction
by 20%

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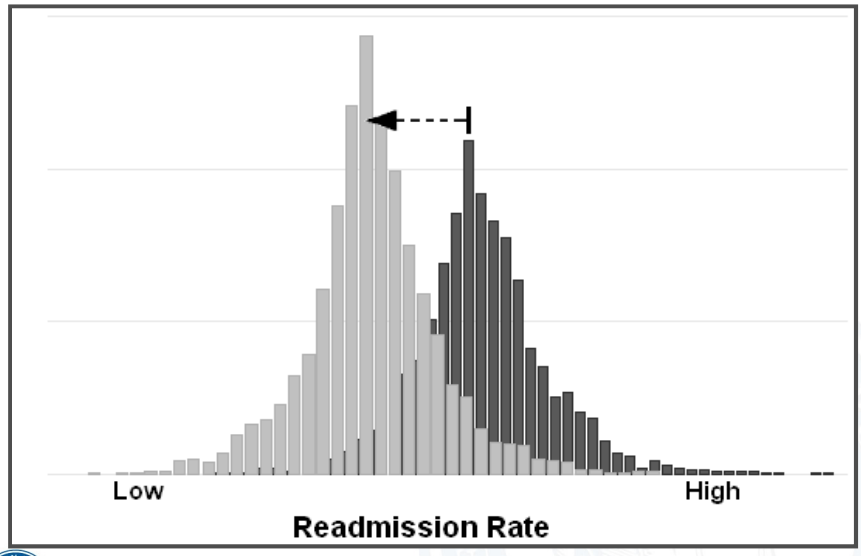
The goal is to shift the curve



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H2H from 2009 to 2013

Community Reach

- 1700+ Organizations
- 3700+ Participants
- 35 Partners
- 25 QIOs
- $70K grants in 2010
- **Still growing!**

Key Activities

- 30+ presentations
- 5+ listserv topics/month (200+ messages/quarter)
- 6 best practice webinars
- 500 people per webinar
- Best practices study with Yale and the Commonwealth Fund

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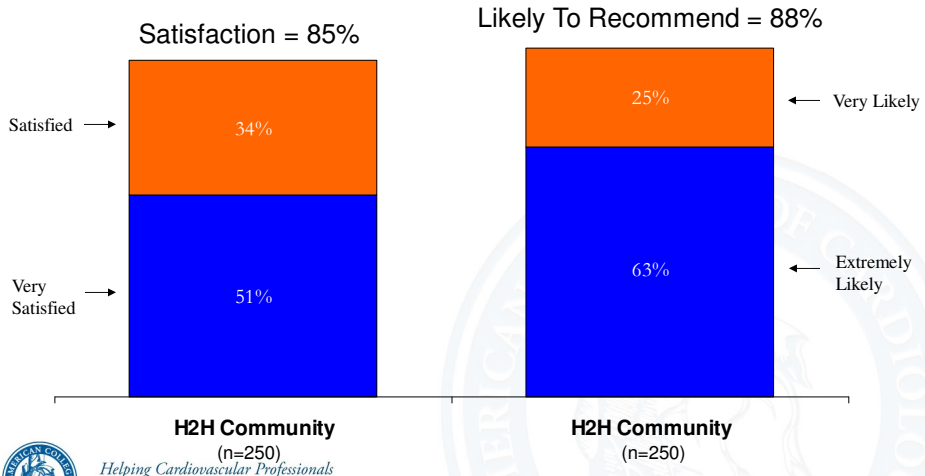
H2H Community Satisfaction and Likelihood To Recommend H2H

Community Members are very satisfied with the H2H initiative and highly likely to recommend participation in H2H to their colleagues.



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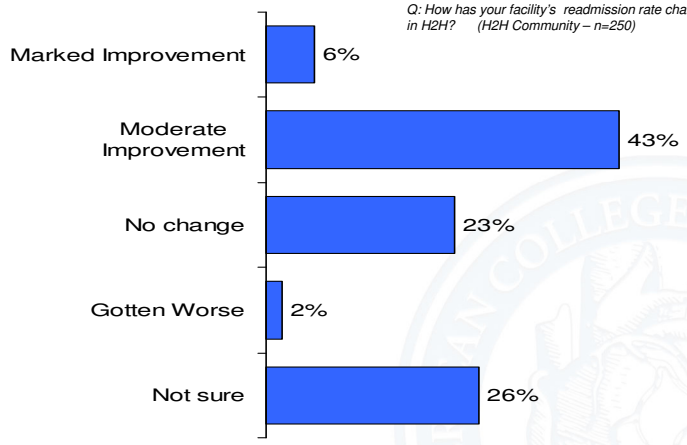
Facility Readmission Rate Since Enrollment

Nearly half of participants (49%) believe that their facility's readmission rate has shown some improvement since they have enrolled in H2H.

Q: How has your facility's readmission rate changed since your enrollment in H2H? (H2H Community – n=250)



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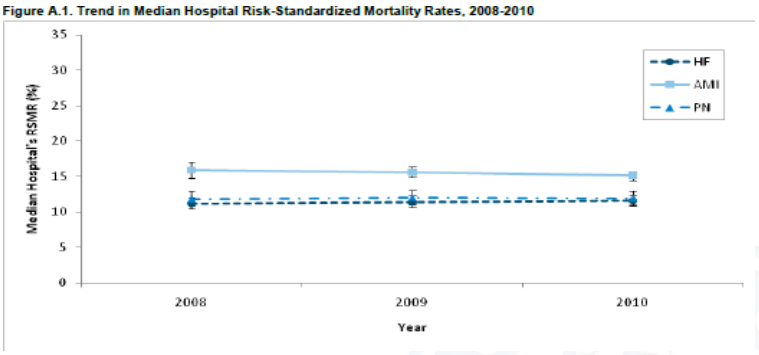
Are Readmission Rates Changing Over Time?



Between 2008 and 2010 a slight decrease of 0.5% and 0.3% in hospital readmissions for AMI and Heart Failure was noted, respectively.

Trends and Distributions
CMS Medicare Hospital Quality Chartbook 2012 Performance Report on Outcome Measures, 2012

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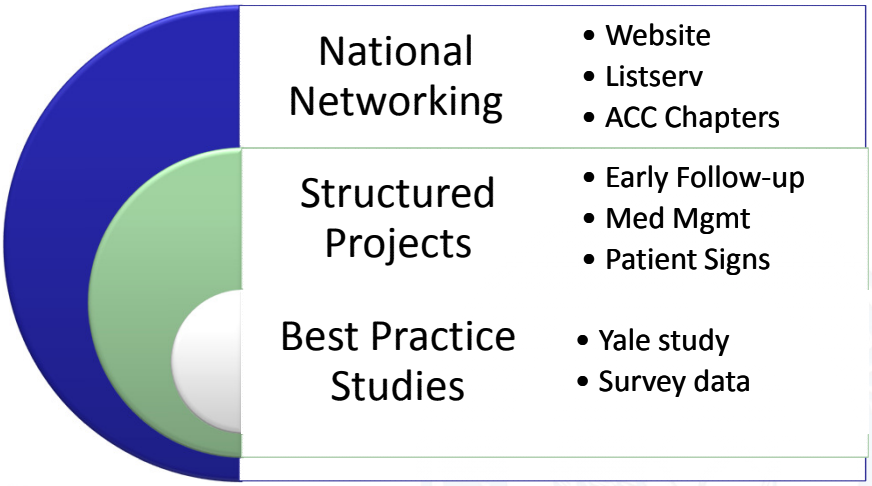
H2H's Core Features



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Core Concept Areas

Follow-up

- Patient has a follow-up within a week of discharge
- Patient can get to appointment

Post-discharge medication management

- Patient is familiar and competent with medication
- Patient has access to medications

Patient recognition of signs and symptoms

- Patient recognizes warning signs and knows what to do

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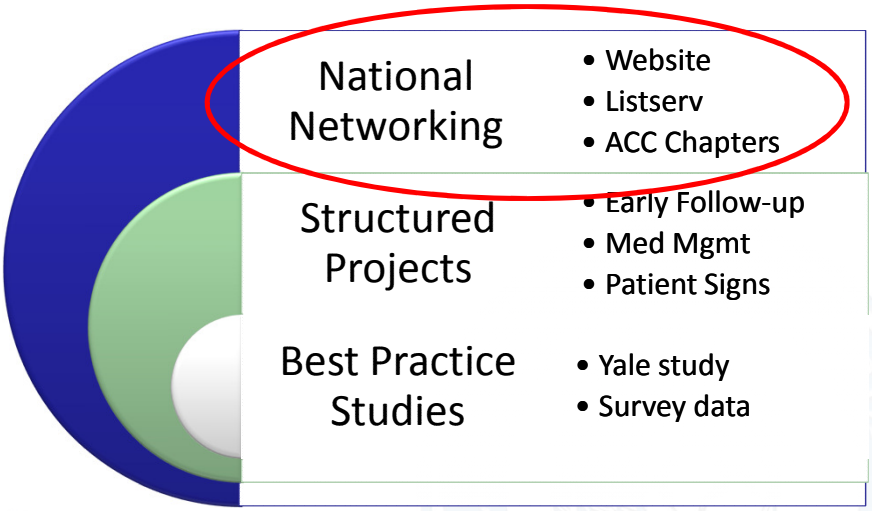
H2H's Core Features



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National Networking: Website

- Getting started
  - Help identify institutional readmission rates
  - Review Readmission tools
- Learning sessions
  - Archived webinars, handouts
- Tools and strategies, organized by concept
- Links to other campaigns and resources
- 5,000+ visits/quarter

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National Networking: Listserv

- 35 topic areas, 20 messages/week, 200+/quarter
- Increased volume over 2011 (150/quarter then)
- Success stories
- Barriers to success
- Focused discussions re: core concepts

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National Networking: H2H and ACC Chapters

Build local H2H infrastructure to:

- Align state health leaders
- Make reducing readmissions a priority
- Focus on heart failure first
- Set local improvement goals
- Identify local leaders
- Encourage colleagues to participate

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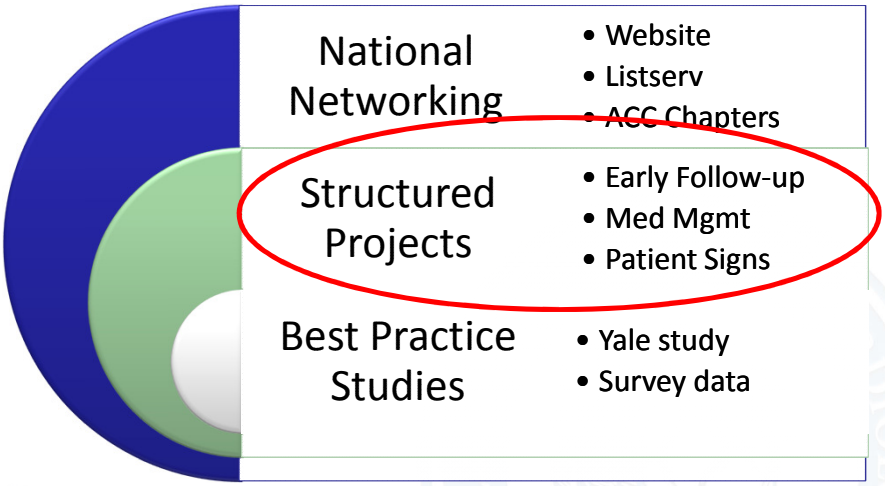
H2H's Core Parts



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H2H "Challenge" Projects

"See You in 7" Challenge

Goal: All patients discharged with a diagnosis of HF and MI have a scheduled follow-up appointment /cardiac rehab referral made within 7 days of discharge

"Mind Your Meds" Challenge

Goal: Clinicians and patients discharged with a diagnosis of HF/MI work together and ensure optimal medication management.

"Signs and Symptoms" Challenge

Goal: Activate patients to recognize early warning signs and have a plan to address them.

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What is a H2H Challenge?

A structured improvement project…

	See You in 7: Early Follow-up within 7 days	Mind Your Meds: Medication Management	Patient Signs and Symptoms
Webinar #1: Intro to Evidence	Mar 2011	Oct 2011	Jun 2012
Tool Kit	Jun 2011	Dec 2011	2014
Webinar #2: Tools and Strategies	Jun 2011	Dec 2011	2014
Webinar #3: Lessons Learned	Sep 2011	Apr 2012	2014

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H2H Challenge Components

H2H Challenges

- 6-month projects
- 1 topic focus
- Success metrics
- 1 tool kit
- 3 webinars

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Community call-to-action to help build tools and strategies

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Success Metrics and Tools

Reducing readmissions is possible if-

- The clinician does…
- The patient does…

To help the clinician and patient be successful, H2H provides *tools* for each metric.

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H2H Challenge Webinars

- Webinar #1
  - introduce the evidence
  - introduce the success metrics
- Webinar #2
  - strategies and solutions from the field (“tool kit”)
- Webinar #3
  - lessons learned
  - community members present

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H2H Challenge #1:

Early Follow-up

After Discharge

“See You in 7”

Goal

All patients have a follow-up appointment or cardiac rehab referral scheduled within seven days of discharge

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SY7 Success Measures

The hospital discharge process is successful if:

1. HF and MI patients are identified prior to discharge and risk of readmission is determined.
2. Follow-up visit or cardiac rehab referral within 7 days is scheduled and documented.
3. Patient is provided with documentation of the scheduled appointment (e.g., appointment card).
4. Possible barriers to keeping the appointment are identified, addressed, and documented.

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SY7 Success Measures

The follow-up or cardiac rehab referral is successful if:

5. HF patient arrives at appointment **or** AMI patient is referred to cardiac rehab.
6. Discharge summary (including summary of hospitalization, updated medication list) is available to follow-up clinician.
7. Patient brings his/her medications or a medication list to clinic visit.
8. Reason for referral available to cardiac rehab center

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SY7 Self-Assessment

Success Metric

1. HF (and MI) patients are identified prior to discharge and risk of readmission is determined

Self-Assessment Question

3. Which criteria does your facility use to identify HF patients prior to discharge? Please select all that apply.

- ☐ Diagnosis codes for HF, shortness of breath, swelling, edema, or fluid overload
- ☐ Secondary diagnosis for HF or shortness of breath
- ☐ History of HF or AMI
- ☐ Abnormal BNP or INT-proBNP lab results
- ☐ Treatment with IV diuretics in the last 24 hours
- ☐ Chest X-ray with evidence of HF or pulmonary edema
- ☐ Other, please specify
- ☐ None

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SY7 Self-Assessment Scorecard

H2H SY7 Success Measures Scorecard

The following table shows your results by success measure. Use this table to help you identify opportunities for improven lowest scores.

Overall Score (64 possible points) Your Score:	23
Organizational Priority (9 possible points) Your Score:	5
Identification of HF/AMI patients (15 possible points) Your Score:	5
Follow up visit scheduled (1 possible point) Your Score:	0
Patient provided appointment documentation (9 possible points) Your Score:	4
Appointment barriers addressed (6 possible points) Your Score:	2
Patient arrives at appointment (7 possible points) Your Score:	1
Discharge summary available (10 possible points) Your Score:	3
Patient brings medication list (3 possible points) Your Score:	2
Patient referral available to provider (4 possible points) Your Score:	1

H2H Challenge Toolkit

Success Measure

4. Possible barriers to keeping the appointment are identified in advance, addressed, and documented in the medical record.

Tool

Barriers and Solutions to Help Patients Keep their Follow-Up Appointment

Possible barriers to ensuring the follow-up appointment occurs should be identified in advance. Here are common barriers and possible solutions from the H2H Community. Anticipating and addressing barriers to early follow-up can help patients receive the appropriate care they need and potentially prevent them from being unnecessarily readmitted.

Common Barriers	Possible Solutions
System Barriers	
Appointment Access within 7 days	• Use of block scheduling to restructure appointments • Follow-up by nurse practitioners, physician assistants, or clinical pharmacist instead of a cardiologist or primary care clinician • Follow-up by home health service or visiting nurse association • Development of an outpatient HF clinic or HF discharge clinic • Hospital partnership with community physicians to prioritize discharged patients for appointments
Environmental Barriers	

H2H at the Local Level

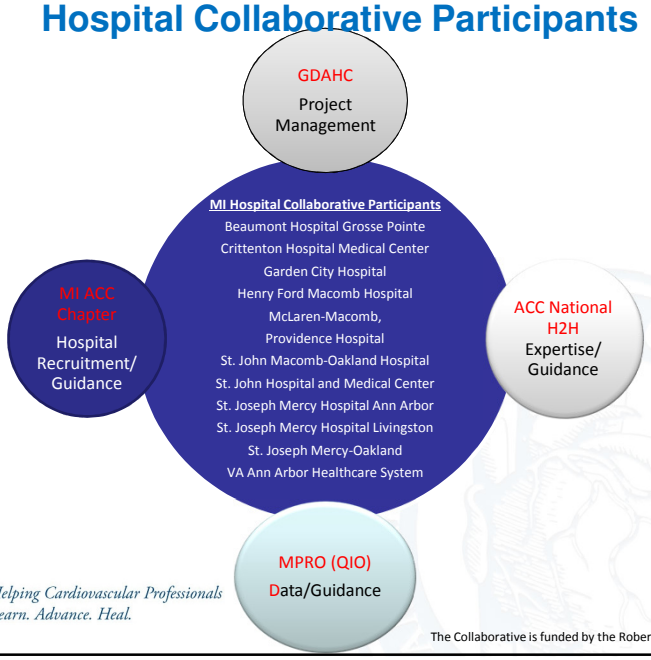
Three ways to "do H2H" locally*:

1. Communications Campaign
   - Promote H2H and recruit hospitals
2. Local Flash Talks
   - Share best practices at the local level
3. Improvement Project
   - Conduct a "challenge" project locally

   (Example: Michigan Collaborative)

**Partner with state Quality Improvement Organization*

Southeast Michigan "See You in 7" Hospital Collaborative Participants



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The Collaborative is funded by the Robert Wood Johnson Foundation.

Greater Detroit Area Health Council, INC.

Michigan CHAPTER

Southeast Michigan "See You in 7" Hospital Collaborative: What to Expect

Focus	Methods/Tools	Meetings
Pre-Implementation May - July	ACC Online Initial Assessment; ACC "See You in 7" Toolkit; Selection of "See You in 7" Process Measures; Analysis of where hospital is, where it should be, and how to get there	Kickoff Meeting; 2 Conference Calls/Webinars
Test Intervention Aug - Jan	Plan for Improvement; Pre-Implementation Data Submission; Collaborative hospitals to share best practices, barriers; Quarterly Progress Reports	2 Quarterly Meetings; 4 Conference Calls/Webinars
Evaluation Feb - April	Data collected will be evaluated; Lessons learned to be shared; Quarterly Progress Report Post-Implementation Data Submission	2 Conference Calls/Webinars; 1 Quarterly Meeting

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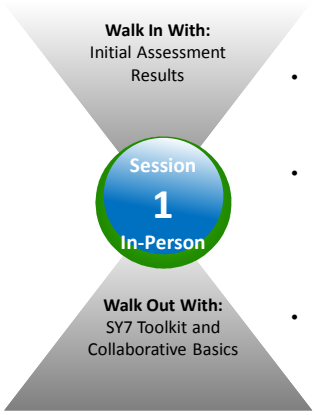
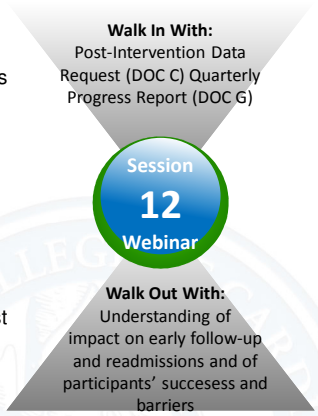
Learning Session and In- person Meetings At-a-Glance



- There were 12 Learning Sessions (5 in-person meetings and 7 webinars).
- Quarterly learning sessions required participants to complete a quarterly progress report and a plan for improvement on their selected process metrics.
- Sessions focused on sharing best practices.



May 21, 2012

April 17, 2013

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The Michigan Experience

Infrastructure

- Established a multi-disciplinary team
- Improved data collection and data tracking
- Created an automatic daily report in the EMR

Medication Management

- Had unit pharmacist do med rec at admission/discharge

Discharge Process

- Simplified discharge summary and incorporated into EMR
- Created a transportation guide, patient educational booklet
- Created call scripts
- Established relationships with physician offices, skilled nursing facilities

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Preliminary Findings

MPRO

For the MI Collaborative hospitals:

- Trends of 30-day hospital readmissions are decreasing and 7-day follow-up increasing (these trends include the baseline period).
- The decline in 30-day readmissions for those with 7-day follow-up was largest in the first quarter of the Collaborative compared with all previous declines.
- There was a 4% improvement rate in early follow up between May-Oct 2011 and May-Oct 2012.

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H2H Challenge #2:

Post Discharge Medication Management

"Mind Your Meds"

Goal

Clinicians and patients discharged with a diagnosis of HF/MI will work together to ensure optimal medication management.

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Success Metric and Tool

Success Metrics 3 & 4

Possible **external barriers to obtaining prescribed medication**s and barriers to **patients remembering/understanding the need to take medications** are identified in advance, addressed, and documented in the medical record.

Tool

Barriers and Solutions to Help Patients Adhere to their Medications

Possible barriers to ensuring optimal medication management should be identified in advance. Here are common barriers and possible solutions from the H2H Community. Anticipating and addressing barriers to medications can help patients receive the appropriate care they need and potentially prevent them from being unnecessarily readmitted.

Common Barriers	Possible Solutions	Available Tools
Medication Barriers		
Medication Complexity	• Use of combination medications to reduce the number of pills • Simplifying dosing regimens • Patient handouts on medications	***Patient and Provider to do together:*** • AHRQ Pill Card • NTOCC Medication List • My Pill Box Medication Schedule • Pill Box
	• Choose medications with the least amount of sides effects taking the patient's lifestyle into	***Patient and Provider Tools:*** • PINNACLE Heart Failure Practice

H2H Challenge #3:

Signs and Symptoms

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Goal

To ensure patients can recognize early warning signs of clinical deterioration and have a plan to address them

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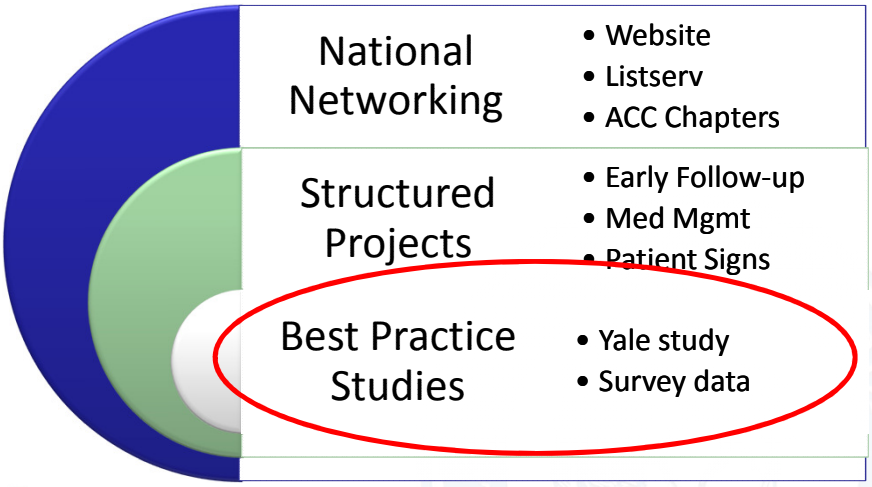
H2H's Core Features



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H2H Best Practices Study

- Funded by Commonwealth Fund
- Conducted by Yale researchers
- Survey 594 H2H participants
- Response rate 91%
- Descriptive summary of findings
- Performance against readmission data
- 1-year follow-up evaluation

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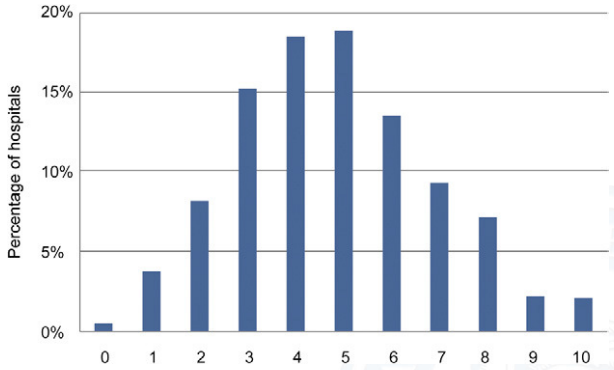
Percentage of Hospitals Implementing 10 Key Practices



*Of the 594 hospitals surveyed, 537 completed the survey.

- **Less than 3% had all 10 practices in place**
- **4.8 practices were reported to be in place**

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Bradley, E.H. et al (2012). Contemporary Evidence about Hospital Strategies for Reducing 30-day Readmissions. *Journal of the American College of Cardiology*, *60*, 607-614.

JACC Study: 10 Key Practices

Quality improvement resources and performance monitoring

1. **Having at least one quality improvement team for reducing readmissions for HF, AMI or both**
2. Monitoring proportion of discharged patients with follow-up appointment within 7 days
3. Monitoring 30-day readmission rates

Medication management

4. Providing information to all patients about medications (including the purpose of each medication; which medications were new; which medications had changed in dose or frequency; and which medications had been stopped)
5. **Having a pharmacist responsible for conducting medication reconciliation at discharge**
6. Having a pharmacy technician primarily responsible for obtaining medication history as part of medication reconciliation process

Discharge and follow-up

7. Providing patients or their caregivers direct contact information for a specific physician in case of an emergency and/or other type of emergency plan
8. Arranging an outpatient follow-up appointment before patients leave the hospital
9. Ensuring the outpatient physicians are alerted to a patient's discharge within 48 h
10. Calling patients regularly after discharge to either follow-up on post-discharge needs or to provide additional education

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Bradley, E.H. et al (2012). Contemporary Evidence about Hospital Strategies for Reducing 30-day Readmissions. *Journal of the American College of Cardiology*, *60*, 607-614.

Hospital Strategies Associated with RSRR for Heart Failure – July 2013

- *Circ Cardiovasc Qual Outcomes*
- Strategies that reflect effective communication links between hospital and follow-up care
  - Follow-up appointment
  - Discharge summary shared
  - Assigned staff to follow-up on test results
  - Partnering with local healthcare providers
- Need more information on implementation

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What Has Changed – Oct 2013

- *JAMA* Letter on 1yr follow-up survey
- **No change in proportion of hospitals:**
  - Which had a process in place for alerting physicians about discharged patients within 48h
  - Sending discharge summaries to primary care physicians
  - Conducting nurse-to-nurse report before discharge to nursing homes

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What Has Changed – Oct 2013

- *JAMA* Letter on 1yr follow-up survey
- **More hospitals are:**
  - Partnering with local hospitals
  - Discharging patients with follow-up apptmt
  - Tracking percentage of patients with 7d apptmt
  - Estimating risk for readmission
  - Using electronic form for med rec
  - Using teachback
  - Providing action plans to discharged HF patients
  - Calling patient after discharge

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H2H Initiative Alignment

H2H aligns with other core interventions

ACC/IHI H2H	See You in 7: Early Follow-up within 7 days	Mind Your Meds: Medication Management	Patient Signs and Symptoms
IHI STAAR	Ensure timely post-hospital care follow-up	Assessment of post-hospital needs	Effective teaching enhanced learning
SHM BOOST	TARGET	Risk specific interventions	Teach-Back training
Project RED	Make appointment for follow-up	Confirm medication plan with patient	Review the steps if problems arise

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Take Home Messages

1. Identifying HF patients before discharge
2. Understand all of the patient touchpoints during hospital stay
3. Build bridges between hospital and outpatient and community care settings
4. Try simple, focused solutions first
5. Share your experience with others

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