Improving Transitions from the Hospital to Community Settings

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
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

Goal

To reduce 30-day, all-cause, risk-standardized readmission rates for patients discharged with heart failure or acute myocardial infarction by 20%
The goal is to shift the curve

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
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.

- Satisfaction = 85%
- Likely To Recommend = 88%

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.

- Marked Improvement: 6%
- Moderate Improvement: 43%
- No change: 23%
- Gotten Worse: 2%
- Not sure: 26%

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

H2H’s Core Features

- National Networking
  - Website
  - Listserv
  - ACC Chapters

- Structured Projects
  - Early Follow-up
  - Med Mgmt
  - Patient Signs

- Best Practice Studies
  - Yale study
  - Survey data
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

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

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
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

H2H’s Core Parts

- National Networking
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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.

What is a H2H Challenge?
A structured improvement project...

<table>
<thead>
<tr>
<th></th>
<th>See You in 7: Early Follow-up within 7 days</th>
<th>Mind Your Meds: Medication Management</th>
<th>Patient Signs and Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tool Kit</td>
<td>Jun 2011</td>
<td>Dec 2011</td>
<td>2014</td>
</tr>
<tr>
<td>Webinar #3: Lessons Learned</td>
<td>Sep 2011</td>
<td>Apr 2012</td>
<td>2014</td>
</tr>
</tbody>
</table>
H2H Challenge Components

H2H Challenges

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

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

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.
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

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
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.

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.
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
H2H Challenge Toolkit

Success Measure

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

Tool

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

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

- Beaumont Hospital Grosse Pointe
- Crittenton Hospital Medical Center
- Garden City Hospital
- Henry Ford Macomb Hospital
- McLaren-Macomb, Providence Hospital
- St. John Macomb-Oakland Hospital
- St. John Hospital and Medical Center
- St. Joseph Mercy Hospital Ann Arbor
- St. Joseph Mercy Hospital Livingston
- St. Joseph Mercy-Oakland
- VA Ann Arbor Healthcare System

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

**Focus** | **Methods/Tools** | **Meetings**
--- | --- | ---
Pre-Implementation | 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 | 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 | Data collected will be evaluated; Lessons learned to be shared; Quarterly Progress Report Post-Implementation Data Submission | 2 Conference Calls/Webinars; 1 Quarterly Meeting
Learning Session and In-person Meetings At-a-Glance

- Walk In With: Initial Assessment
- Results

- Walk Out With: SY7 Toolkit and Collaborative Basics

Session 1
In-Person
May 21, 2012

- 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.

Session 12
Webinar
April 17, 2013

Walk In With: Post-Intervention Data Request (DOC C) Quarterly Progress Report (DOC G)

Walk Out With: Understanding of impact on early follow-up and readmissions and of participants’ successes and barriers

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
Preliminary Findings

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.

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.
Success Metric and Tool

Success Metrics 3 & 4
Possible external barriers to obtaining prescribed medications and barriers to patients remembering/understanding the need to take medications are identified in advance, addressed, and documented in the medical record.

Tool

<table>
<thead>
<tr>
<th>Barriers and Solutions to Help Patients Adhere to their Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Common Barriers</th>
<th>Possible Solutions</th>
<th>Available Tools</th>
</tr>
</thead>
</table>
| 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 PIL Card  
• NTOCC Medication List  
• My Pill Box Medication Schedule  
• Pill Box |
| • Choose medications with the least amount of side effects taking the patient’s lifestyle into Patient and Provider Tools:  
• H2H/AHA Heart Failure Practice |

H2H Challenge #3: Signs and Symptoms

Goal
To ensure patients can recognize early warning signs of clinical deterioration and have a plan to address them.
H2H’s Core Features

- National Networking
  - Website
  - Listserv
  - ACC Chapters
- Structured Projects
  - Early Follow-up
  - Med Mgmt
  - Patient Signs
- Best Practice Studies
  - Yale study
  - Survey data

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
Percentage of Hospitals Implementing 10 Key Practices

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

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
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

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
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

H2H Initiative Alignment

H2H aligns with other core interventions

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<tr>
<td>IHI STAAAR</td>
<td>Ensure timely post-hospital care follow-up</td>
<td>Assessment of post-hospital needs</td>
<td>Effective teaching enhanced learning</td>
</tr>
<tr>
<td>SHM BOOST</td>
<td>TARGET</td>
<td>Risk specific interventions</td>
<td>Teach-Back training</td>
</tr>
<tr>
<td>Project RED</td>
<td>Make appointment for follow-up</td>
<td>Confirm medication plan with patient</td>
<td>Review the steps if problems arise</td>
</tr>
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Helping Cardiovascular Professionals
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