
# Welcome

**Take Home Messages**

- Understand the connection between the success metrics and the tool kit
- Share your ideas, needs, and experiences for meeting success measures on the listserv
- Refer to the Signs and Symptoms Assessment and Tool Kit to help get you started

Quality Improvement
for Institutions

# Webinar Format

| Topic | Presenter | Time |
|---|---|---|
| Welcome | Shilpa Patel | 5 min |
| H2H Overview | Shilpa Patel | 5 mins |
| Signs and Symptoms Overview | Shilpa Patel | 5 mins |
| Signs and Symptoms Evidence | Sandra Oliver-McNeil | 15 min |
| Signs and Symptoms Toolkit | Joy Pollard | 15 min |
| Question-and-Answer | All | 15 min |

Quality Improvement for Institutions

# Speaker Bio

**Sandra Oliver-McNeil DNP, ACNP-BC, CHFN, AACC**

- Academic Heart and Vascular Cardiology Group, Beaumont Health System Royal Oak
- Assistant Professor (Clinical), Wayne State University
- CCA liaison MI chapter ACC
- Doctor of Nursing Practice and Masters of Nursing, Wayne State University

Quality Improvement for Institutions

# Speaker Bio

**Joy A Pollard PhD ACNP-BC**

- Cardiology acute care nurse practitioner, St Joseph Mercy - Oakland
- Immediate past CCA liaison MI chapter ACC
- Doctorate in Nursing at the University of Michigan,
- MSN and BSN degrees in Nursing from Wayne State University

Quality Improvement for Institutions

# 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: Actively motivate patients to recognize early warning signs and have a plan to address them.

Quality Improvement for Institutions

## H2H Challenge Components

- 1 topic focus
- Success metrics
- Self-Assessment
- 1 tool kit
- 3 webinars

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

Quality Improvement for Institutions

## Success Metrics and Tools

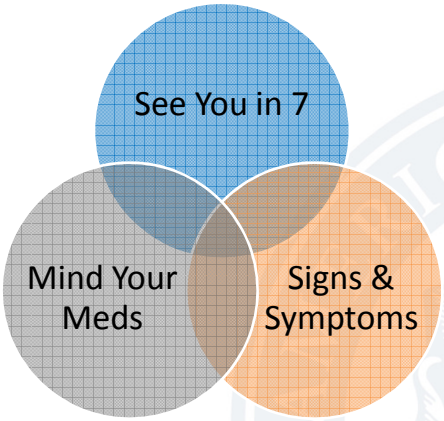
**Reducing readmissions is possible if-**

- The clinician does…
- The patient does…

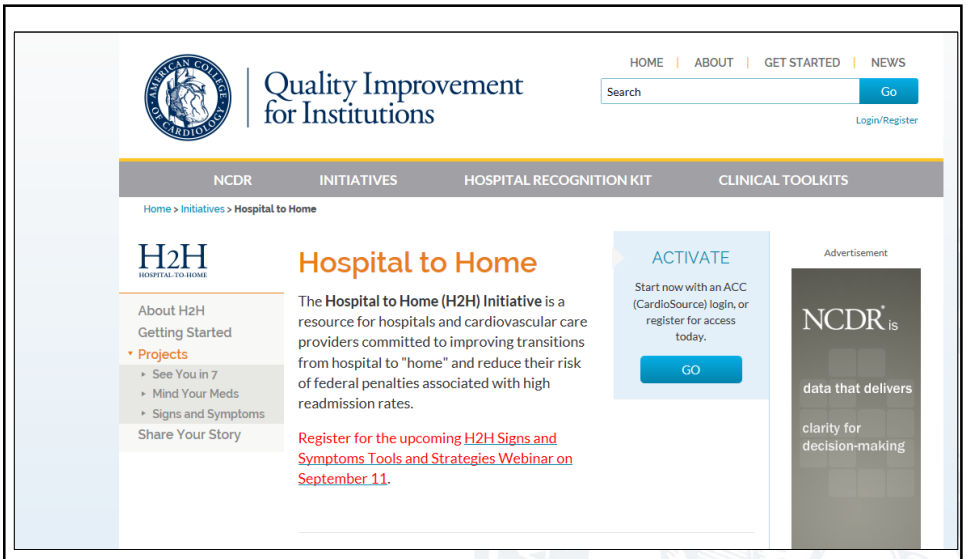
**To help the clinician and patient be successful, H2H provides *tools* for each metric.**


Quality Improvement for Institutions

# H2H Projects



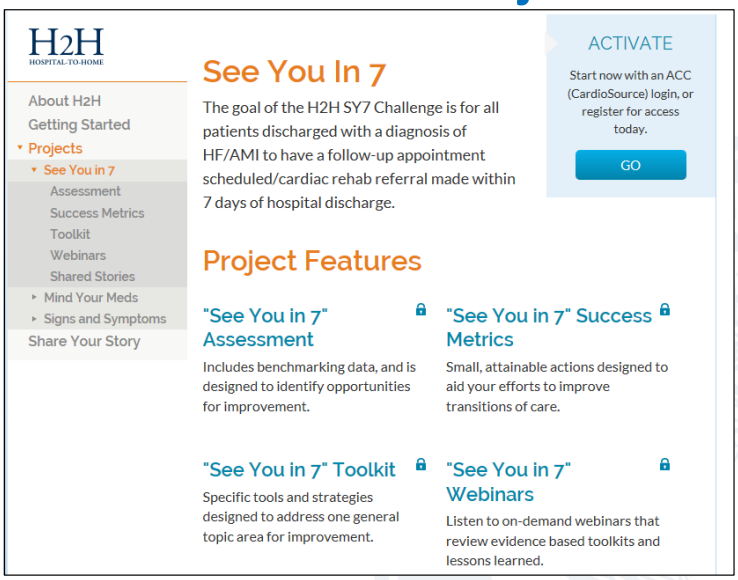

Quality Improvement for Institutions




**Go to CVQuality.acc.org and activate for FREE today!**

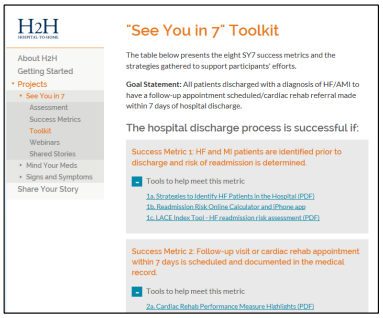
Quality Improvement for Institutions

# "See You in 7" Project

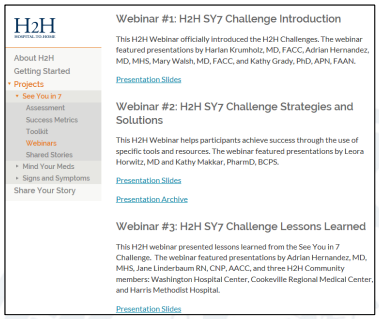



Quality Improvement for Institutions

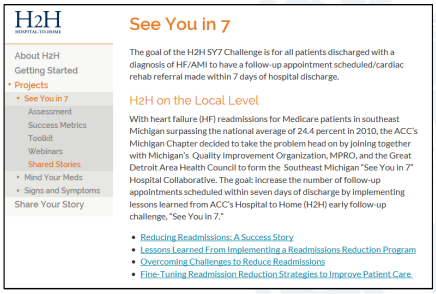
## Toolkit




## Webinars




## Shared Stories




Quality Improvement for Institutions

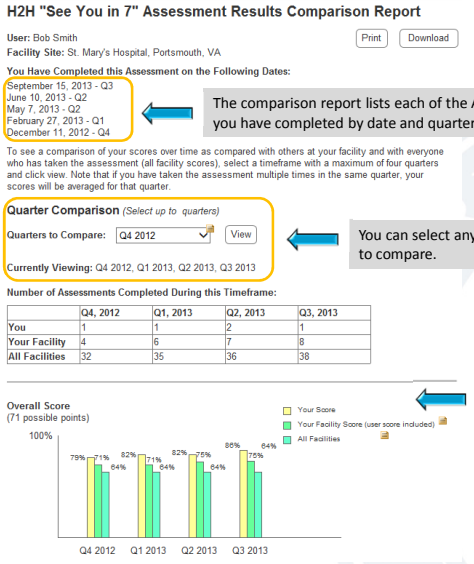
# Self-Assessment Surveys

- Helps hospitals **prioritize** QI efforts
- **Identifies tools** for improvement
- Enables hospital to **monitor progress** quarterly
- **Compares** hospitals that have completed the assessment


Quality Improvement for Institutions

# Assessments Results Comparison Report

***After receiving your Assessment Results, you can compare them to previous quarters or to other facilities.***




| | Q4, 2012 | Q1, 2013 | Q2, 2013 | Q3, 2013 |
|---|---|---|---|---|
| You | 1 | 1 | 2 | 1 |
| Your Facility | 4 | 6 | 7 | 8 |
| All Facilities | 32 | 35 | 36 | 38 |

The comparison report lists each of the Assessments that you have completed by date and quarter.

You can select any 4 quarters to compare.

Comparison results will be graphed; your score is compared to:

- Yourself, over time
- Your Facility (Aggregate of other users at your facility)
- All Facilities (Aggregate of other facilities that have taken assessment)

Quality Improvement for Institutions

# Getting Started with Signs and Symptoms

**How you can participate:**

1. Review the "Signs and Symptoms" success metrics
2. Complete the online Self-Assessment
3. Identify one or a more metrics for improvement
4. Test one or a combination of strategies/tools for those metrics
5. Agree to a standard collection of data to track your improvement
6. Participate in the webinars
7. Share your best practices and lessons learned through the listserv

Quality Improvement for Institutions

# Reduce Risk and Cost

**Self care for managing signs and symptoms helps to reduce:**

- **Hospitalization:** Studies have shown that self-care activities can significantly reduce HF hospitalizations.[20]
- **Mortality:** HF patients who carry out self-care at an above average level are much less likely than patients who are below average in self-care ability to die or be admitted to the hospital.[20]
- **Cost:** HF patients who are confident in their ability to perform self-care have lower inpatient costs than patients who do not perform self-care or those with low confidence.[20]

Quality Improvement for Institutions

# Improve Patient Quality of Life

Successful management of heart failure requires patient behavior change through healthy choices.[23] Symptom management is key to managing heart failure and improving patient quality of life.

Most HF patients have poor symptom recognition.[16, 21] HF Patients need to have the ability to recognize symptoms in order to successfully manage their heart failure.[16] Patients who can recognize symptoms are able to participate in other self-care behaviors successfully.[16]

Quality Improvement for Institutions

# Monitoring Symptoms

- HF patients often delay seeking care after HF symptoms begin.[20] They may wait days or weeks after symptoms appear to seek medical attention.[20,23] The cause of the delay may be due to patients not monitoring their symptoms or not being able to recognize their HF symptoms.[5,15,6] Patients report that they rarely monitor their symptoms.[3]

- In a study about heart failure patients seeking medical care based on symptoms, though 87% of HF patients believed their symptoms could be serious, 80% waited for the symptoms to disappear.[5] However, research shows that 50% of HF patients who delay seeking treatment for worsening symptoms did not realize that their health status was deteriorating.[15,16]

Quality Improvement for Institutions

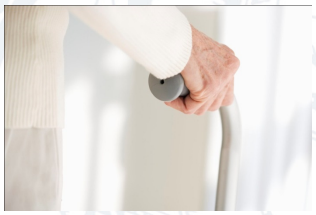
# Patient Barriers to Recognizing Signs and Symptoms

Potential barriers to symptom recognition include:[6]

- Lack of symptom monitoring
- Lack of understanding the importance of symptoms
- Belief that symptoms are not severe[6]
- Belief that symptoms are not related to heart failure
- Lack of self empowerment: Patients may not know that they are capable of managing their symptoms

Potential barriers to self care for HF patients include:[20]

- Co-morbid conditions
- Mental illness (e.g., depression and anxiety)
- Age (younger [vulnerable] and elderly [cognitive impairment])
- Sleep disturbances
- Poor health literacy
- Issues with healthcare system
- Lack of social support



Quality Improvement for Institutions

# Patient Barriers to Receiving Care

Common barriers to patients receiving care for signs and symptoms of HF include.[6, 20]

- Patients may not recognize worsening HF symptoms and delay seeking care.
- Patients who recognize worsening symptoms often do not know how to obtain medical care outside of the ER, and patients may want to avoid going to the ER.
- If patients try to contact their physician, they may wait hours to days for a response or weeks to get an appointment.
- Patients seeing multiple physicians may be unsure who to contact for a symptom.
- Patients may be too debilitated to go to their physician's office.
- Patients may be concerned about the cost.
- Patients may not follow-up with an appointment to see a HF specialist.

Quality Improvement for Institutions

# Recognizing Symptoms and Self-Care

Patients who are able to recognize early signs and symptoms are more likely to engage in self-care.[20]

**Areas of self-care for HF patients include:** [20,18]

- Dietary Adherence
- Fluid Restriction
- Alcohol Restriction
- Weight Loss
- Exercise
- Smoking Cessation
- Preventive Behaviors
- Nonprescriptive Medication

Quality Improvement for Institutions

# Multidisciplinary Teams

A multidisciplinary team can ensure comprehensive care and support for HF/AMI patients and families.[10]

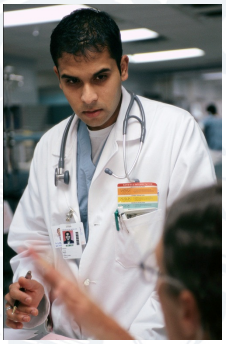
Team members who can assist patients with recognition of signs and symptoms[10]:

- **Physician**
- **Nurse**
- **Social worker**
- **Occupational therapist**
- **Pharmacist**

Quality Improvement for Institutions

# Provider Communication

- Healthcare professionals can encourage self-care and address self-care barriers by helping patients to ***understand HF & HF symptoms, reviewing treatment plans (e.g., re medications and lifestyle), and establishing a positive relationship*** withpatients.[27]
- Providers should, "***communicate in an empathetic, non-judgemental, collaborative way*** and ask open-ended questions."[17]
- Studies have shown that improved communication between providers and patients result in a 16% reduction in mortality and a 31% decrease in HF related rehospitalizations.[19, 22]
- Providers should treat patients and family/ caregivers as partners when communicating about self-care.[19]
- Thus, it's all about "adherence" and not "compliance".



Quality Improvement for Institutions

# Signs and Symptoms Success Metrics

**The clinician is successful if:**

1. **Clinician assesses the patient's** knowledge of condition, learning style, cognitive level, emotional status, support system, and motivation.
2. **Clinician assesses the patient's ability to perform self-care** (monitoring signs and symptoms, contacting clinicians if deterioration in signs and symptoms occur, and taking medications as prescribed, etc.) and **activities of daily living** (walking , cooking, performing light house work, etc.)and documents in the medical record.
3. Clinician provides the patient/caregiver **with written and verbal information on their condition** that includes education on treatment regimen (self-care plan), including warning signs and when to call their healthcare provider.
4. Clinician communicates in an empathetic, non-judgmental, collaborative manner that **establishes and maintains a positive relationship with the patient and caregiver.**
5. Clinician provides the patient/caregiver with **community resources** for health care.

Quality Improvement for Institutions

# Signs and Symptoms Success Metrics

**The patient is successful if:**

6. Patient/Caregiver demonstrates their knowledge **of condition-related signs and symptoms (i.e.,** frequency and severity of symptoms) **and management**.
7. Patient/Caregiver participates in **developing a self-care plan with their clinician** to better manage his/her condition. (Patient keeps a daily log and records symptoms, weight, medications, diet and activities when directed by their clinician).
8. Patient **identifies contact name and number** if he/she needs to contact his/her clinician (e.g., about signs and symptoms).
9. Patient/Caregiver **brings his/her daily log and medication list** to each and every clinic visit (when directed by their clinician).
10. Patient/Caregiver **discusses challenges** or questions about their condition with clinician.
11. Patient/Caregiver is knowledgeable about and uses **community resources** for health care, as needed**.**

Quality Improvement for Institutions

# Success Metrics and Tools

**H2H "Signs and Symptoms" Tool Kit**
**Success Metrics and Strategies**

The H2H "Signs and Symptoms" Challenge gathers the expertise and experience of H2H Community members and leaders around one topic proven to reduce unnecessary hospital readmissions and improve transitions of care for patients with HF and AMI. *The goal of the "Signs and Symptoms" Challenge is for clinicians to activate patients to recognize early warning signs and have a plan to address them.* To achieve this goal, H2H Community members are challenged to meet success metrics that break improvement approaches down into small, simple, and targeted strategies.

**How to use this document:**
1. Select at least one success metric
2. Identify barriers to being successful on that measure
3. Select at least one strategy that addresses the barrier and helps you be successful
4. Test the strategy you selected

| # | Success Metric | Barrier to meet the success measure | Strategy to help meet the success measure |
|---|---|---|---|
| | **The clinician is successful if:** | | |
| 1 | **Clinician assesses the patient's** knowledge of condition, learning style, cognitive level, emotional status, support system, and motivation. | poor health literacy, role assignment often unclear, limited time | 1a. H2H Health Literacy Tools Chart (PDF)<br>1b. University of Alabama at Birmingham Cultural Competence Online for Medical Practice (CCOMP) |
| 2 | **Clinician assesses the patient's ability to perform self-care** (monitoring signs and symptoms, contacting clinicians if deterioration in signs and symptoms occur, and taking medications as prescribed, etc.) and **activities of daily living** (walking , cooking, performing light house work, etc.) and documents in the medical record. | role assignment often unclear, limited time, lack of tool/method for assessment, co-morbid conditions, lack of social support input, lack of time to talk and discuss patient needs/preferences, lack of re-assessment | 2a. PINNACLE Heart Failure Practice Solutions<br>2b. AMA Physician Resource Guide to Patient Self- Management<br>2c. Qualidigm Evidence Based Education for Health Care Professionals (Module 1,2,3)<br>2d. Hartford Institute for Geriatric Nursing Katz Index for Independence in ADLs |

Quality Improvement for Institutions

# Success Metric and Tool

**Success Metric 1**

**Clinician assesses the patient's** knowledge of condition, learning style, cognitive level, emotional status, support system, and motivation.

**Instruments to Assess Health Literacy[3]**

| Tool Acronym | Tool's Full Name | Time to Administer | Pros | Cons | Scoring |
|---|---|---|---|---|---|
| FSSQ | Duke-UNC Functional Social Support Questionnaire | Depends on Clinician | • Identifies social support issues.<br>• Assesses a person's need for and perception of their social support. [2] | • Does not resolve social support issues.<br>• Does not include other barriers to medication adherence.[2] | • Questions scored on a 1-5 scale.<br>• Scores from all 8 questions are tallied and divided by 8 to get an average.<br>• The higher the score, the greater is the need for social support[2] |
| Medication Knowledge Survey | Medication Knowledge Survey | Depends on Clinician | • Assesses a person's knowledge of each medication they are taking<br>• Helps in developing a plan for improving knowledge[2] | • The patient needs to bring all their medication bottles to the appointment at the time of the test[2] | Mark each correctly answered question. Incorrectly answered questions should be used to identify knowledge gaps and develop a knowledge improvement plan. [2] |
| MMAS-8 | Morisky Medication Adherence Scale | Depends on Clinician | • Identifies adherence problems[2]<br>• Used to monitor adherence over the course of treatment[2]<br>• Measures specific medication-taking behavior[2] | • Subject to recall bias[2]<br>• Subject to overestimation of adherence[2] | 1 point for every yes.<br><br>Score of 8 = Highly adherent<br>Score 6-8 = Medium adherers<br>Score 0-6 = Low adherers[2] |
| NVS | Newest Vital Sign | 3 minutes[3] | • It is available online<br>• It is in English and Spanish[3]<br>• Correlates with TOFHLA<br>• The test is limited to 6 items[2] | • It can only be validated in primary care settings[3]<br>• It only assesses reading nutritional labels, not general written text[3] | 0-4 questions correct= low literacy<br>5-6 questions correct= patients likely do not have low literacy[4] |
| Readiness Ruler | Readiness Ruler | Depends on Clinician | • Assess readiness to change (motivation) for a specific activity [2] | • Does not specifically discuss how to address barriers[2] | The patient marks their own readiness on a scale of 0-10. A score above 5 shows that a person is ready to change. [2] |

Quality Improvement for Institutions

# Instruments to Assess Health Literacy

- Duke-UNC Functional Social Support Questionnaire
- Medication Knowledge Survey
- Modified Morisky Scale
- Newest Vital Sign
- Readiness Ruler
- Rapid Estimate of Adult Literacy in Medicine, Revised
- Short Assessment of Health Literacy for Spanish Speaking Adults
- Test of Functional Health Literacy in Adults (long and short versions)

Quality Improvement for Institutions

# Success Metric and Tool

**Success Metric 3 & 7**

- Clinician provides the patients/caregivers **with written and verbal information on their condition** that includes education on treatment regimen (self-care plan), including warning signs and when to call their healthcare provider.
- Patients/Caregivers participate in **developing a self-care plan with their clinician** to better manage their condition. (Patients keep a daily log and record symptoms, weight, medications, diet and activities when directed by their clinician).

| | Clinician should: | Available Tools |
|---|---|---|
| **General** | • Develop a trusting, open and non-judgmental relationship<br>• Motivate patient to engage in self-care strategies<br>• Involve the patient perspective and goals into self-care plan<br>• Develop a treatment plan that takes into consideration patient's religious/cultural beliefs<br>• Use the teach-back method to ensure patient understanding of medications | ***Patient Tools:***<br>• CardioSmart Patient Resources<br>• Qualidigm Living with Heart Failure: Education for Patients, Families and Caregivers<br>• Qualidigm HF Educational Booklet<br>• HFSA Taking Control of Heart Failure<br>• HFSA Self-care: Following Your Heart Failure Treatment Plan and Dealing with Your Symptoms<br><br>***Patient and Provider to do together:***<br>• CardioSmart My Heart Health Plan<br>• TMF Heart Failure Self-Management Zones<br>• Qualidigm HF Zones Worksheet<br>• TMF Patient Self-Care Workbook |
| **Medications** | • Educate patient/caregiver on dose, type and frequency of prescribed medications<br>• Educate patient/caregiver about medication benefits, side-effect management, duration of therapy, and expectations<br>• Provide patient medication handouts and visual reminders such as trackers or pill organizers<br>• Confirm that the patient's primary support (spouse, child or friend) understands and can help with medication regimen<br>• Ask patients about difficulties with taking medications | ***Patient and Provider do together:***<br>• HFSA Patient Medicines Module<br>• Med Action Plan for Heart Failure<br>• AHRQ Pill Card |

Quality Improvement for Institutions

# CardioSmart Tools

**CardioSmart Heart Explorer iPad App:**

- Cardiac graphics and animations of the heart's anatomy
- Interactively review and discuss common heart problems and treatment options with patients and their caregivers

**CardioSmart Med Reminder,** *Powered by Drugs.com:*

- Easy-to-use app helps patients take and refill medications as prescribed
- Also functions as personal medication record
- Patients can set reminders, save notes, access drug data and more


Quality Improvement for Institutions

# Success Metric and Tool

**Success Metric 4**

Clinician communicates in an empathetic, non-judgmental, collaborative manner that **establishes and maintains a positive relationship with the patient and caregiver.**

**Teach Back Checklist**

Patient Name: Date:
Caregiver Name: Clinician:

The purpose of this checklist is to help the clinician work with the patient to ensure that s/he has a full understanding of how to properly manage her/his HF. It allows the clinician to document the patient's response and understanding of the information given to her/him.

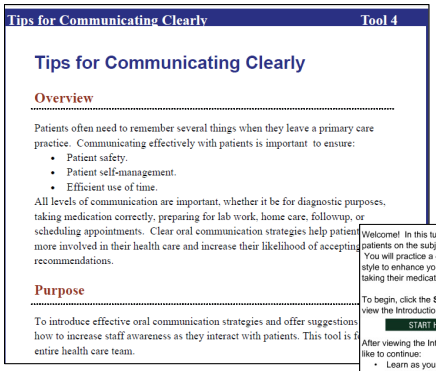
***How to use this tool:***

1. Ask patient Question
2. Document patient response
3. Use teach back script to clarify and provide more information to the patient
4. Have the patient repeat back to you what you have told them
5. Document if the patient has a full understanding

| Specific Heart Failure Questions | Learner Response | Teach Back Performed Y | Teach Back Performed N | Teach Back Script | Pt. Understands Y | Pt. Understands N |
|---|---|---|---|---|---|---|
| **WEIGHT** | | | | | | |
| When should you weigh yourself? | | | | You should weigh yourself each morning after you go to the bathroom but before you eat. | | |
| What weight gain should you call your doctor? | | | | You should report immediately if you have a weight gain of 3lbs in 2 days. | | |
| Why should you weigh yourself? | | | | Weighing yourself helps you know if there is too much fluid in your body. Too much fluid means your heart has to work harder to pump blood. | | |
| How will you remember to weigh yourself every day? | | | | Ask patient to associate weighing themselves with a daily habit. | | |

Quality Improvement for Institutions

**AHRQ Communication Tips**


Tips for Communicating Clearly Tool 4

Tips for Communicating Clearly

Overview

Patients often need to remember several things when they leave a primary care practice. Communicating effectively with patients is important to ensure:

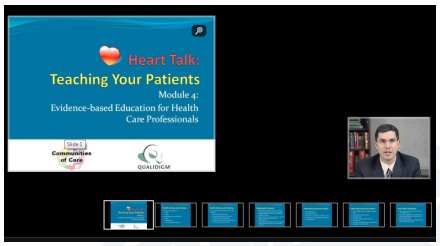
- Patient safety.
- Patient self-management.
- Efficient use of time.

All levels of communication are important, whether it be for diagnostic purposes, taking medication correctly, preparing for lab work, home care, followup, or scheduling appointments. Clear oral communication strategies help patient more involved in their health care and increase their likelihood of accepting recommendations.

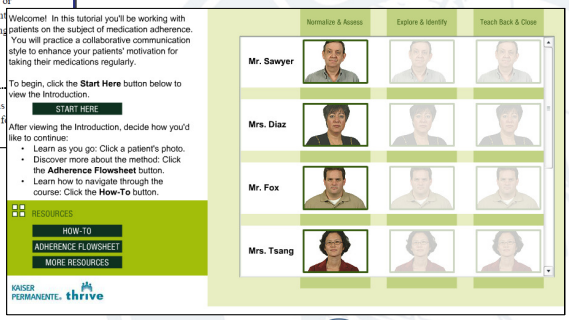
Purpose

To introduce effective oral communication strategies and offer suggestions how to increase staff awareness as they interact with patients. This tool is f entire health care team.

**Qualidigm Teaching Patients Module**




**Kaiser's Clinician-Patient Communication Module**



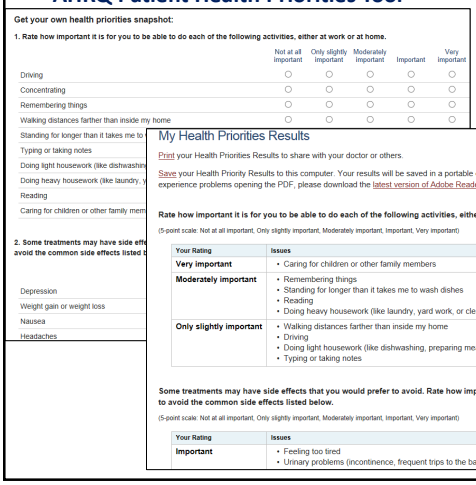

Quality Improvement for Institutions

# Success Metric and Tool

## Success Metric 10

Patients/Caregivers discuss challenges or questions about their condition with clinician

### AHRQ Patient Health Priorities Tool



Get your own health priorities snapshot:

1. Rate how important it is for you to be able to do each of the following activities, either at work or at home.

| | Not at all Important | Only slightly Important | Moderately Important | Important | Very Important |
|---|---|---|---|---|---|
| Driving | ○ | ○ | ○ | ○ | ○ |
| Concentrating | ○ | ○ | ○ | ○ | ○ |
| Remembering things | ○ | ○ | ○ | ○ | ○ |
| Walking distances farther than inside my home | ○ | ○ | ○ | ○ | ○ |
| Standing for longer than it takes me to | | | | | |
| Typing or taking notes | | | | | |
| Doing light housework (like dishwashing | | | | | |
| Doing heavy housework (like laundry, y | | | | | |
| Reading | | | | | |
| Caring for children or other family mem | | | | | |

2. Some treatments may have side effe
avoid the common side effects listed

Depression
Weight gain or weight loss
Nausea
Headaches

My Health Priorities Results

Print your Health Priorities Results to share with your doctor or others.

Save your Health Priority Results to this computer. Your results will be saved in a portable document format (PDF). If you experience problems opening the PDF, please download the latest version of Adobe Reader.

**Rate how important it is for you to be able to do each of the following activities, either at work or at home.**

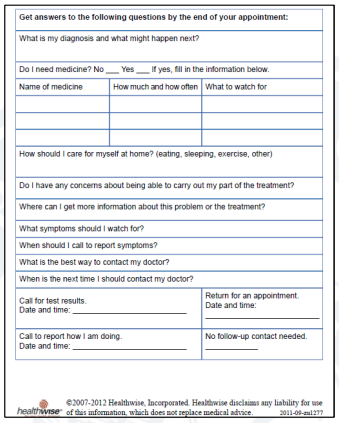
(5-point scale: Not at all important, Only slightly important, Moderately important, Important, Very important)

| Your Rating | Issues |
|---|---|
| **Very important** | • Caring for children or other family members |
| **Moderately important** | • Remembering things<br>• Standing for longer than it takes me to wash dishes<br>• Reading<br>• Doing heavy housework (like laundry, yard work, or cleaning a bathtub) |
| **Only slightly important** | • Walking distances farther than inside my home<br>• Driving<br>• Doing light housework (like dishwashing, preparing meals, or making a bed)<br>• Typing or taking notes |

**Some treatments may have side effects that you would prefer to avoid. Rate how important it would be for you to avoid the common side effects listed below.**

(5-point scale: Not at all important, Only slightly important, Moderately important, Important, Very important)

| Your Rating | Issues |
|---|---|
| **Important** | • Feeling too tired<br>• Urinary problems (incontinence, frequent trips to the bathroom) |



| Get answers to the following questions by the end of your appointment: | | |
|---|---|---|
| What is my diagnosis and what might happen next? | | |
| Do I need medicine? No ___ Yes ___ If yes, fill in the information below. | | |
| Name of medicine | How much and how often | What to watch for |
| | | |
| | | |
| | | |
| How should I care for myself at home? (eating, sleeping, exercise, other) | | |
| Do I have any concerns about being able to carry out my part of the treatment? | | |
| Where can I get more information about this problem or the treatment? | | |
| What symptoms should I watch for? | | |
| When should I call to report symptoms? | | |
| What is the best way to contact my doctor? | | |
| When is the next time I should contact my doctor? | | |
| Call for test results.<br>Date and time: _____ | | Return for an appointment.<br>Date and time: _____ |
| Call to report how I am doing.<br>Date and time: _____ | | No follow-up contact needed.<br>_____ |

healthwise ©2007-2012 Healthwise, Incorporated. Healthwise disclaims any liability for use of this information, which does not replace medical advice. 2011-09-ea1277

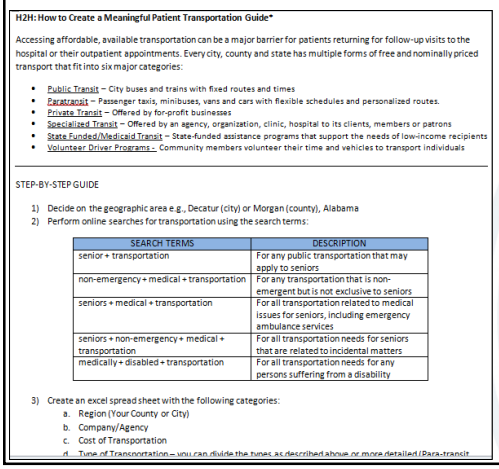
**CardioSmart Partnering with Your Doctor**

Quality Improvement for Institutions

# Success Metric and Tool

## Success Metric 5 & 11

- Clinician provides the patient/caregiver with **community resources** for health care.
- Patients/Caregivers are knowledgeable about and use **community resources** for health care, as needed**.**



**H2H: How to Create a Meaningful Patient Transportation Guide***

Accessing affordable, available transportation can be a major barrier for patients returning for follow-up visits to the hospital or their outpatient appointments. Every city, county and state has multiple forms of free and nominally priced transport that fit into six major categories:

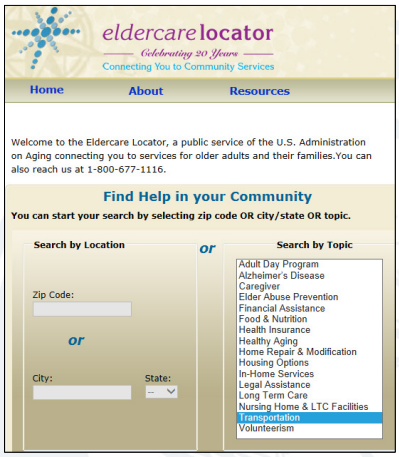
- Public Transit – City buses and trains with fixed routes and times
- Paratransit – Passenger taxis, minibuses, vans and cars with flexible schedules and personalized routes.
- Private Transit – Offered by for-profit businesses
- Specialized Transit – Offered by an agency, organization, clinic, hospital to its clients, members or patrons
- State Funded/Medicaid Transit – State-funded assistance programs that support the needs of low-income recipients
- Volunteer Driver Programs - Community members volunteer their time and vehicles to transport individuals

STEP-BY-STEP GUIDE

1) Decide on the geographic area e.g., Decatur (city) or Morgan (county), Alabama
2) Perform online searches for transportation using the search terms:

| SEARCH TERMS | DESCRIPTION |
|---|---|
| senior + transportation | For any public transportation that may apply to seniors |
| non-emergency + medical + transportation | For any transportation that is non-emergent but is not exclusive to seniors |
| seniors + medical + transportation | For all transportation related to medical issues for seniors, including emergency ambulance services |
| seniors + non-emergency + medical + transportation | For all transportation needs for seniors that are related to incidental matters |
| medically + disabled + transportation | For all transportation needs for any persons suffering from a disability |

3) Create an excel spread sheet with the following categories:
   a. Region (Your County or City)
   b. Company/Agency
   c. Cost of Transportation
   d. Type of Transportation – you can divide the types as described above or more detailed (Para-transit,



eldercare locator
Celebrating 20 Years
Connecting You to Community Services

Home About Resources

Welcome to the Eldercare Locator, a public service of the U.S. Administration on Aging connecting you to services for older adults and their families.You can also reach us at 1-800-677-1116.

**Find Help in your Community**

**You can start your search by selecting zip code OR city/state OR topic.**

Search by Location

Zip Code:

or

City: State:

or

Search by Topic

Adult Day Program
Alzheimer's Disease
Caregiver
Elder Abuse Prevention
Financial Assistance
Food & Nutrition
Health Insurance
Healthy Aging
Home Repair & Modification
Housing Options
In-Home Services
Legal Assistance
Long Term Care
Nursing Home & LTC Facilities
Transportation
Volunteerism

Quality Improvement for Institutions

## Getting Started

**Participate in the Signs and Symptoms Challenge:**

1. Complete the online Assessment
2. Try a suggested strategy or tool
3. Participate in the webinars
4. Share ideas or questions through the listserv
5. *Tell us your strategies for improvement*

Quality Improvement for Institutions

## What can you do next?

1. Activate your ACC Quality Improvement for Institutions account
2. Visit CVQuality.acc.org/H2H for more resources
3. Tune in for the next webinar in December 2014: "Lessons Learned"

Quality Improvement for Institutions

**Moderated Question-and-Answer Session**

*Please submit your question online at this time.*

Quality Improvement for Institutions

## *Thank you!*

H2H
HOSPITAL-TO-HOME

hospital2home@acc.org
CVQuality.acc.org/H2H

Quality Improvement for Institutions

Quality Improvement for Institutions

The Quality Improvement for Institutions program combines the ACC's NCDR data registries with toolkits and proven hospital-based quality improvement initiatives like Hospital to Home, the D2B Alliance and Surviving MI.

Release the power of your data at CVQuality.acc.org.

Quality Improvement for Institutions

AMERICAN COLLEGE of CARDIOLOGY