H2H Early Follow-up Challenge: “See You in 7”

Webinar #1
Thursday, March 3, 2011
3:00 pm – 4:00 pm ET

Welcome

Take Home Messages
- Renew your H2H commitment
- Participate in the first H2H Challenge
- Help build the H2H Tool Kit of tools
Webinar Format

<table>
<thead>
<tr>
<th>Topic</th>
<th>Presenter</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome</td>
<td>MaryAnne Elma, MPH</td>
<td>5 min</td>
</tr>
<tr>
<td>H2H Vision</td>
<td>Harlan Krumholz, MD, FACC</td>
<td>10 min</td>
</tr>
<tr>
<td>Early Follow-up</td>
<td>Adrian Hernandez, MD, MHS</td>
<td>15 min</td>
</tr>
<tr>
<td>H2H Challenges</td>
<td>Mary Norine Walsh, MD, FACC, Kathy Grady, PhD, APN, FAAN</td>
<td>20 min</td>
</tr>
<tr>
<td>Question-and-Answer</td>
<td>All</td>
<td>10 min</td>
</tr>
</tbody>
</table>

H2H Vision

Harlan Krumholz, MD, FACC
- Harold H. Hines, Jr. Professor of Medicine, Epidemiology and Public Health
- Yale University School of Medicine
Where we’ve been

Community Reach
• 1000+ Organizations
• 1600+ Participants
• 34 Partners
• 25 QIOs
• $70K grants in 2010

Key Activities
• 25+ presentations
• 3+ listserv topics/month
• 8 best practice webinars
• 900 people per webinar
• Best practices study with Yale and the Commonwealth Fund

Where we’re going

H2H Challenges
• 6-month projects
• 1 topic focus
• 1 tool kit
• 4 webinars
• 2 surveys

Community call-to-action
Accept the H2H Challenge

Over the next 6 months:
• Succeed in the H2H Challenge!
• Try a recommended strategy or tool
• Submit the surveys to share your experience
• Participate in the webinars
• Post to the listserv
• Tell us your strategies for improvement

H2H Challenge #1:
Early Follow-up
After Discharge

See you in 7
Early Follow-up

Adrian Hernandez, MD, MHS

- Dr. Hernandez is a cardiologist at Duke University Medical Center and an Associate Professor of Medicine at the Duke Clinical Research Institute.
- He is actively involved in clinical research from quality of care to clinical trials with a focus on heart failure.
- Dr. Hernandez earned his MD from University of Texas-Southwestern.
- He completed residency at the University of California-San Francisco and fellowship at Duke University.

Why focus on early follow-up?

- Trends in care with greater segmentation of providers into inpatient vs. outpatient.
- Days immediately following discharge are a vulnerable period.
- Care is often complicated and coordination is important in preventing readmission.¹
- Often there are additions or changes in therapies that may have unknown effects or even worsen a patient’s clinical status or other co-morbid conditions.²


Decreasing Continuity of Care

Lack of Outpatient Physician Visit between Discharge and Rehospitalization
Timely follow-up and Readmission: Care Transitions Intervention- A Randomized Control Trial

- Intervention
  - Medication self-management,
  - Patient-centered record
  - Timely follow-up with primary or specialty care,
  - List of "red flags" indicative of a worsening condition and instructions on how to respond to them.
- Intervention patients with lower rehospitalization at 30 days (8.3% vs. 11.9; \( p=0.048 \))


Relationship Between Early Follow-up and 30 Day Readmission

Objectives
- To characterize hospitals’ patterns of physician follow-up after hospital discharge.
- To determine the association of early follow-up with readmission after hospitalization for heart failure.

Methods
- Study Population:
  - 225 hospitals in Get With The Guidelines –Heart Failure
  - Linked with Medicare Claims for follow-up
  - 65 years and older admitted with heart failure
- Early Follow-up: Any visit within 7 days after discharge from index hospitalization

Hernandez AF et al. JAMA. 2010; 303(17): 1716-1722
Hospital Variation in Early Follow-up

Median Follow-up Visit within 7 days = 37.5%

225 GWTG-HF Hospitals

Follow-up by Physician Type

<table>
<thead>
<tr>
<th>Days</th>
<th>Any Physician</th>
<th>Cardiologist</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>38.3</td>
<td>7.5</td>
</tr>
<tr>
<td>14</td>
<td>64.6</td>
<td>17.1</td>
</tr>
<tr>
<td>21</td>
<td>76.5</td>
<td>25.2</td>
</tr>
<tr>
<td>28</td>
<td>81.5</td>
<td>31.3</td>
</tr>
</tbody>
</table>
Follow-up by Same Physician

<table>
<thead>
<tr>
<th>Quartile</th>
<th>Unadjusted HR</th>
<th>95% CI</th>
<th>P Value</th>
<th>Adjusted HR</th>
<th>95% CI</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quartile 1</td>
<td>1.0 (REF)</td>
<td></td>
<td></td>
<td>1.0 (REF)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quartile 2</td>
<td>0.86</td>
<td>0.78-0.94</td>
<td>&lt;.01</td>
<td>0.85</td>
<td>0.78-0.93</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Quartile 3</td>
<td>0.85</td>
<td>0.76-0.94</td>
<td>&lt;.01</td>
<td>0.87</td>
<td>0.78-0.96</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Quartile 4</td>
<td>0.87</td>
<td>0.79-0.95</td>
<td>&lt;.01</td>
<td>0.91</td>
<td>0.83-1.0</td>
<td>.05</td>
</tr>
</tbody>
</table>

Covariates: age, sex, race, anemia, atrial arrhythmia, COPD, CKD, CAD, depression, diabetes, hyperlipidemia, hypertension, PVD, prior CVA/TIA, smoker, creatinine, systolic blood pressure, serum sodium, hemoglobin, LVSD, discharge process, LOS>7 days, year of admission

30-Day Readmission & Early Follow-up with Any Physician
Study Conclusions

- Rates of physician follow-up within 1 week of discharge were low and varied substantially across hospitals.

- Patients discharged from hospitals with more consistent early follow-up with 7 days have lower risk of 30-day readmission.

- Enhanced transition planning and ensuring that patients are evaluated within a week of discharge represents an achievable target for hospital quality improvement.

Important Elements for Early Follow-up

- Establishing communication between sending and receiving clinicians
- Natural opportunity for reconciliation of medications
- Review outstanding tests and follow-up plans from recent tests
- Discussions about monitoring signs and symptoms of worsening conditions

Other Opportunities for Follow-up: Cardiac Rehabilitation

GWTG-CAD Hospitals
- Cardiac Rehabilitation Referral Rates After acute myocardial infarction, PCI, or CABG
  - Median referral rate by hospital was 43%


H2H Challenges

Kathy Grady, PhD, APN, FAAN
- Associate Professor, Feinberg School of Medicine
- Northwestern University
- Administrative Director, Center for Heart Failure
- Bluhm Cardiovascular Institute
- Division of Cardiac Surgery
H2H Early Follow-Up Challenge: “See You in 7”

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

- HF patients have an appointment to see any healthcare professional within 7 days
- MI patients have a referral to go to cardiac rehab within 7 days

Participant expectations
1. Review the “pre-flight checklist”
2. Submit the initial assessment survey
3. Test one or a combination of tools
4. Participate in the webinars
5. Post to the listserv
6. Submit the post-intervention survey
How this will work

Timeline

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Webinar #1: Introduction</td>
<td>Thu Mar 3</td>
</tr>
<tr>
<td>Survey #1: Initial assessment</td>
<td>Thu Mar 31</td>
</tr>
<tr>
<td>Webinar #2: “See You in 7” Tool Kit</td>
<td>Apr 15-30*</td>
</tr>
<tr>
<td>Webinar #3: Open Forum</td>
<td>May 15-31*</td>
</tr>
<tr>
<td>Webinar #4: Lessons Learned</td>
<td>Jul 15-31*</td>
</tr>
<tr>
<td>Survey #2: Post-intervention assessment</td>
<td>Mon Jul 25</td>
</tr>
</tbody>
</table>

* Exact dates to be determined.

Everything will be available online at http://www.h2hquality.org

H2H Challenges

Mary Norine Walsh, MD, FACC
- Medical Director, Heart Failure and Cardiac Transplantation
- St Vincent Heart Center of Indiana
How the tool kit will be developed

This is a similar process to the tool kit developed for D2B. The process is not random and relies on your participation.

*Target release of the “See you in 7” Tool Kit is April 26.*

<table>
<thead>
<tr>
<th>Best Practices Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summarize published evidence</td>
</tr>
<tr>
<td>Conduct qualitative research (focus groups, surveys, interviews)</td>
</tr>
<tr>
<td>Issue a “call for tools” to the community (this the H2H Challenge)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategy and Tool Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify strategies from research (themes with success)</td>
</tr>
<tr>
<td>Identify tools (something you can hold) to support strategies</td>
</tr>
<tr>
<td>Modify existing tools and/or develop new tools</td>
</tr>
</tbody>
</table>

“See You in 7” Success

The hospital discharge process is successful if:

- HF and MI patients are identified prior to discharge.
- Clinic or cardiac rehab appointment within 7 days is scheduled and documented in the medical record.
- Patient is provided with documentation of the scheduled appointment (e.g., appointment card).
  - Date, time, location, provider contact information
- Possible barriers to keeping the appointment are identified in advance, addressed, and documented in the medical record.
“See You in 7” Success

The follow-up clinic or cardiac rehab appointment is successful if:

• Patient arrives at appointment within 7 days of discharge from hospital.
• Discharge summary (including summary of hospitalization, updated medication list) available to follow-up provider.
• Patient brings his/her medications or a medication list to clinic visit.
• Reason for referral available to cardiac rehab center and patient brings referral letter or provider prescription.

Moderated Question-and-Answer Session

*Please submit your question online at this time.*
Thank You

H2H
HOSPITAL-TO-HOME