H2H
HOSPITAL-TO-HOME

H2H Early Follow-up Challenge: "See You in 7"

Webinar #2- Strategies & Solutions
Wednesday, June 29, 2011
1:00 pm – 2:00 pm ET

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Welcome

Take Home Messages

- Understand the connection between the survey and tools with success measures
- Complete the SY7 Survey
- Share your ideas, needs, and experiences for meeting success measures on the listserv
- Refer to the SY7 Tool Kit to help get you started

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Webinar Format

Topic	Presenter	Time
Welcome	MaryAnne Elma, MPH	5 min
SY7 Survey	Leora Horwitz, MD	20 min
SY7 Tool Kit	Kathy Makkar, PharmD, BCPS	20 min
Question-and-Answer	All	15 min

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H2H Challenge #1:

Early Follow-up
After Discharge

See You in 7

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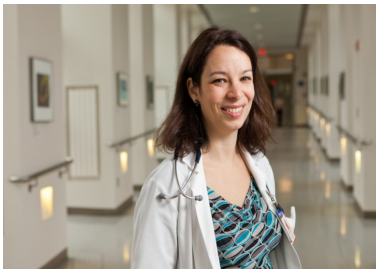
H2H Early Follow-Up Challenge: "See You in 7"

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 within 7 days to go to cardiac rehab (when appropriate)

SY7 Survey



Leora Horwitz, MD

- Dr. Horwitz is a general internist and an assistant professor of medicine at Yale.
- She conducts research on transitions of care including readmissions and chairs the Yale-New Haven Hospital readmission reduction committee.

Getting Started with the Challenge

How you can participate:

1. Review the "pre-flight checklist" online
2. Submit the initial assessment survey
3. Test one or a combination of suggested tools
4. Participate in the webinars
5. Share your ideas through the listserv
6. Submit the post-intervention survey

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SY7 Survey Purpose and Format

The purpose of this initial assessment survey is to help you validate your performance, assess your culture, and assess your actual processes.

- 17 questions total
  - 16 multiple choice
  - 1 open-ended
- No clinical data collected
- Not at the patient-encounter level
- To be completed by any individual in the hospital

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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 in the medical record.
3. Patient is provided with documentation of the scheduled appointment (e.g., appointment card).
4. Possible barriers to keeping the appointment are identified in advance, addressed, and documented in the medical record.

SY7 Success Measures

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

5. HF patient arrives at follow-up appointment **or** AMI patient is referred to cardiac rehab, within 7 days of discharge from hospital.
6. Discharge summary (including summary of hospitalization, updated medication list) 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 and patient brings referral letter or clinician prescription.

Success Measure and Survey

Success Measure

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

Survey 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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Success Measure and Survey

Success Measure

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

Survey Question

10. Does your facility currently do any of the following to ensure discharged HF patients go to their follow-up clinic visit within 7 days of discharge? Please select all that apply.

- ☐ Provide a patient appointment card with date, time, and location
- ☐ Discuss availability of transportation to appointment
- ☐ Communicate with family members
- ☐ Call patients to remind them
- ☐ Identify potential barriers
- ☐ Other, please specify
- ☐ None

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Success Measure and Survey

Success Measure

6. Discharge summary (including summary of hospitalization, updated medication list) available to follow-up clinician.

Survey Question

13. How often is a discharge summary (summary of hospitalization, medication list) sent directly, or made readily available to HF and AMI patient's follow-up clinician?

- ○ Always
- ○ More than half of the time
- ◉ Less than half of the time
- ○ Never
- ○ Not sure

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Success Measure and Survey

Success Measure

8. Reason for referral available to cardiac rehab center and patient brings referral letter or clinician prescription.

Survey Question

16. What type of documentation are AMI patients given for their cardiac rehab referral? Please select all that apply.

- ☐ Referral letter
- ☐ Physician prescription
- ☐ Call to CR center
- ☐ Other, please specify
- ☐ None
- ☐ Not sure

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SY7 Tool Kit

Kathy Makkar, PharmD, BCPS

- Dr. Makkar is a cardiology clinical pharmacy specialist at Lancaster General Health and adjunct assistant professor of pharmacy at University of the Sciences.
- She received cardiology pharmacy practice residency training at University of the Sciences in conjunction with the University of Pennsylvania Health System.

"Tool Kit" Development

How the SY7 Tool Kit was developed:

- Identified barriers to achieving each success measure
- Reviewed H2H Listserv for ideas to address each barrier
- Reviewed published literature to support strategies
- Presented strategies to panel for discussion/refinement
- Developed documents to support strategies discussed

The first SY7 Tool Kit is a starting point. It relies on your participation to identify, share, and develop more solutions in this framework.

Success Measure and Tool

Success Measure

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

Tool

Identifying Patients with Heart Failure (HF) in the Hospital

Consistent and accurate identification of HF patients in the hospital can be a challenge. Here are helpful strategies from the H2H Community to identify patients with HF prior to discharge. Identifying patients with HF in the hospital can ensure they receive the appropriate care they need and potentially prevent them from being unnecessarily readmitted.

Strategies for Identifying HF Patients prior to Discharge

These approaches are useful for finding HF patients in the hospital, whether HF is their primary or secondary diagnosis.

What to look for

Common information "triggers" in a search for patients with HF in the hospital:

- Admission diagnosis codes for HF, AMI, shortness of breath, swelling, edema, fluid overload
- Secondary diagnosis codes for HF, shortness of breath
- History of HF or AMI
- Abnormal BNP or NT-proBNP levels
- Treatment with IV diuretics within the last 24 hours

Success Measure and Tool

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.

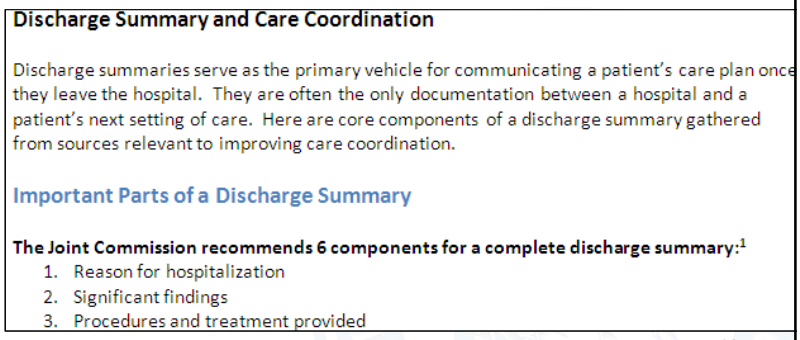
Common Barriers	Possible Solutions
System Barriers	
Appointment Access within 7 days	• Use of block scheduling to restructure appointments • Follow-up by nurse practitioners, physician assistants, or clinical pharmacist instead of a cardiologist or primary care clinician • Follow-up by home health service 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	

Success Measure and Tool

Success Measure

6. Discharge summary (including summary of hospitalization, updated medication list) available to follow-up clinician.

Tool



Discharge Summary and Care Coordination

Discharge summaries serve as the primary vehicle for communicating a patient's care plan once they leave the hospital. They are often the only documentation between a hospital and a patient's next setting of care. Here are core components of a discharge summary gathered from sources relevant to improving care coordination.

Important Parts of a Discharge Summary

The Joint Commission recommends 6 components for a complete discharge summary:[1]

1. Reason for hospitalization
2. Significant findings
3. Procedures and treatment provided

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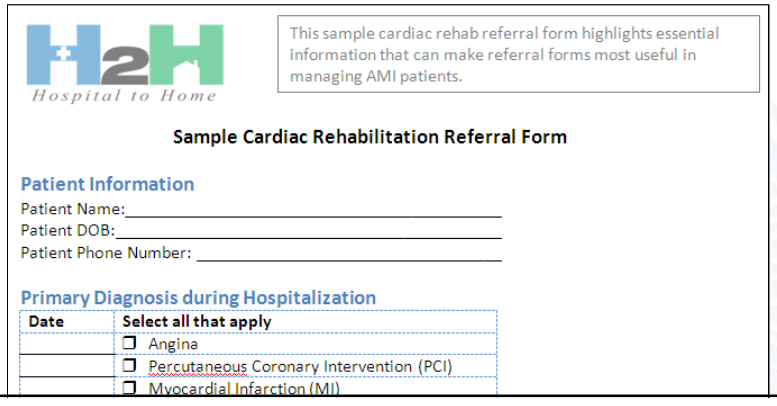
Success Measure and Tool

Success Measure

8. Reason for referral available to cardiac rehab center and patient brings referral letter or clinician prescription.

Tool



H2H Hospital to Home

This sample cardiac rehab referral form highlights essential information that can make referral forms most useful in managing AMI patients.

Sample Cardiac Rehabilitation Referral Form

Patient Information

Patient Name:_____

Patient DOB:_____

Patient Phone Number: _____

Primary Diagnosis during Hospitalization

Date	Select all that apply
	❒ Angina
	❒ Percutaneous Coronary Intervention (PCI)
	❒ Myocardial Infarction (MI)

What can you do next?

Participate in the H2H Challenge:

- Try a suggested strategy or tool
- Submit the surveys to share your experience
- Participate in the webinars
- Share ideas or questions through the listserv
- *Tell us your strategies for improvement*

Upcoming Activities

- SY7 Tool Kit live on Fri Jul 1
- SY7 Survey #1 launched on Fri Jul 8
- SY7 Lessons Learned Webinar – Aug/Sep
- SY7 Survey #2 launched – Aug/Sep

The H2H SY7 Challenge Webinar launch from March 3, 2011 is available online

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

Moderated Question-and-Answer Session

Please submit your question online at this time.

Thank You

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