

Hospital2Home (H2H):

Improving Readmission Rates through
Excellence in Care Transitions

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Readmissions

- About 20% of Medicare patients are readmitted within 30 days
- HF is the most common diagnosis
- 2004 cost of readmissions \$17.4 billion

H2H

- National quality improvement initiative
- Effort to reduce cardiovascular-related hospital readmissions and improve the transition from inpatient to outpatient status for individuals hospitalized with CV disease
- Aims to create a rapid learning community where people can share their knowledge and best practices regarding this critical move
- Co-led by American College of Cardiology and Institute for Healthcare Improvement

H2H

- Catalyze action to improve the transition home after hospitalization for HF or AMI
- Leveraging national initiatives that have demonstrated efficacy in reducing readmissions
- Bringing together evidence, best practice, experts in the field
- Web-based community of hospitals, physician practices, and other care providers to share tactics, resources, tools and best practices

Current Enrollment

- 861 Facilities
- 1354 Individuals
- Strategic Partners:
 - 34 National Organizations
 - 25 QIOs

Indiana Participants

- **Ball Memorial Hospital**
- **Clarian Health Partners, Inc.**
- **Clarian North Medical Center**
- **Columbus Regional Hospital**
- **Community Hospital (Munster)**
- **Community Hospital East**
- **Elkhart general hospital**
- **Floyd Memorial Hospital and Health Services**
- **Harrison County Hospital**
- **Indianapolis Coalition for Patient Safety**
- **Lutheran Hospital of Indiana**
- **Parkview Hospital, Inc.**
- **Reid Hospital and Healthcare Services**
- **Right at Home**
- **Riverview Hospital**
- **Saint Anthony Medical Center**
- **Specialty Home Health Care**
- **St. Anthony Memorial**
- **St. Catherine Hospital**
- **St. Elizabeth Regional Health**
- **St. Francis Hospital-Indianapolis**
- **St. Mary Medical Center**
- **St. Vincent Hospital and Health Care Services, Inc.**
- **St. Vincent Heart Center of Indiana**
- **Terre Haute Regional Hospital**
- **The Heart Hospital @Deaconess Gateway LLC**
- **The Indiana Heart Hospital**
- **University of Southern Indiana**
- **VA Medical Center - Richard L. Roudebush**
- **Wishard Health Services**

H2H

Goal: Reduce all-cause readmission rates among patients discharged with heart failure or acute myocardial infarction by 20% by 2012

Provides a central clearinghouse of information and tools, building on what others are doing and have done to improve care transitions and reduce readmissions.

3 Core Concepts

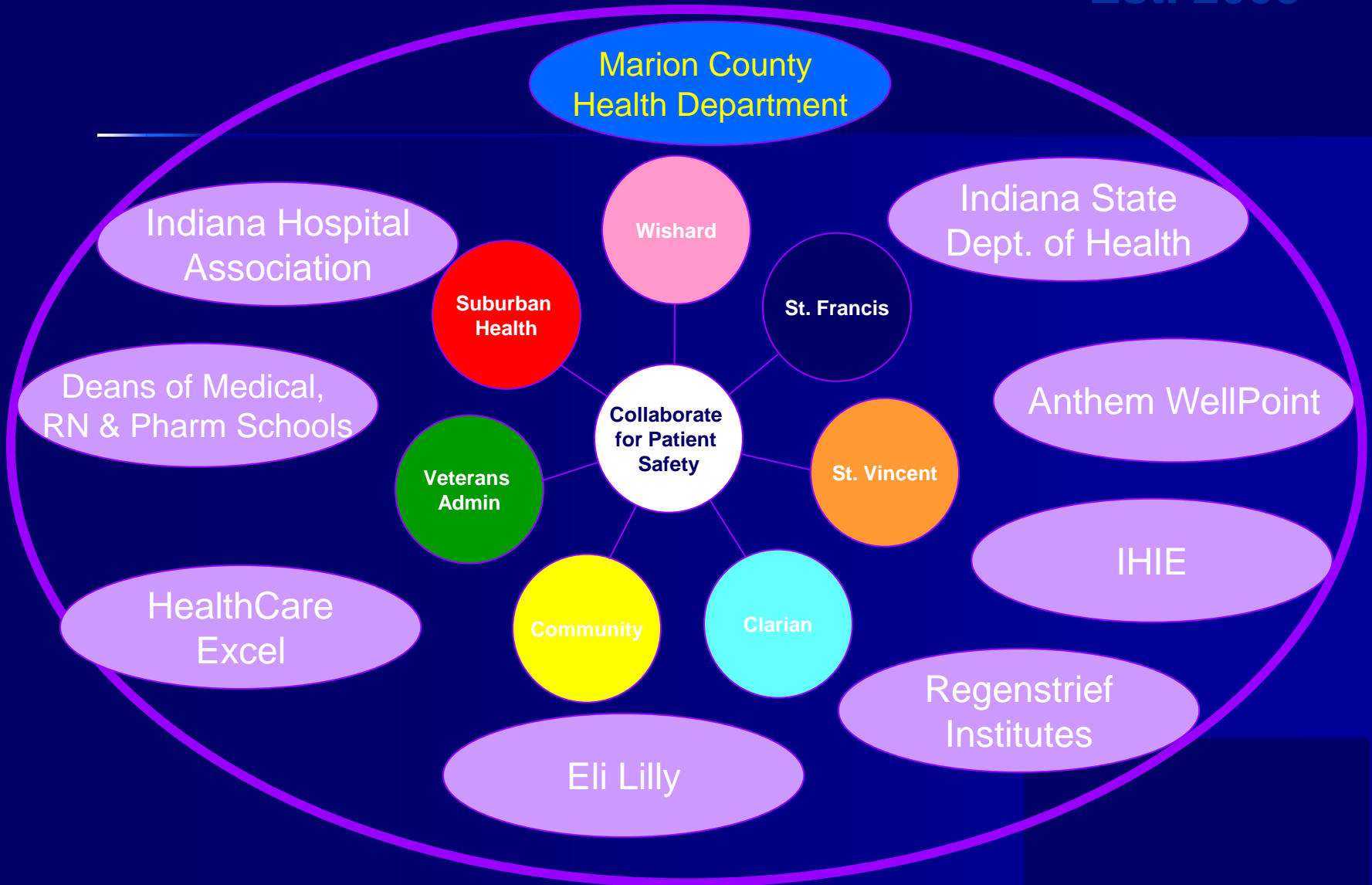
- **Medication management post discharge**
 - Is the patient familiar and competent with their medication and does he or she have access to them?
- **Early follow up**
 - Does the patient have a follow-up visit scheduled within a week of discharge and is he or she able to get there?
- **Symptom management**
 - Does the patient fully comprehend signs and symptoms that require medical attention, and whom to contact if they occur?

www.h2hquality.org

**INACC CCAs' Collaboration
with Indianapolis Coalition for
Patient Safety**

Indianapolis Coalition for Patient Safety

Est. 2003



Work Group Members

- Clarian Joanna Kingery
- Community Cindy Adams
- HCE Nancy Meadows
- Hendricks Jo Morton
- IPSC Betsy Lee
- Riverview Barb Buer / Liz James
- St Francis Linda Ostermeier / Michele Wood
- St Vincent Lisa Sorenson / Mary Fischer
- Wishard Jennifer Kitchens / Rhenita Cain
- VA Barb Goines / Judy Birt

Aligns with H2H

- **Consists of Four Focus Areas:**

- **Early Follow-Up:** *Does the patient have a follow up appointment scheduled within a week of discharge and is he or she able to get there?*
- **Symptom Management:** *Does the patient fully comprehend the signs and symptoms that require medical attention and whom to contact if they occur?*
- **Medication Management Post-Discharge:** *Is the patient familiar and competent with his or her medications and is there access to them?*
- **Care Management Post Discharge:** *Has the HF Patient been evaluated for homecare referral?*

Work Plan

- Develop **Tactics** for the four Hospital 2 Home Focus Areas
- Develop “**Change Ideas**” for consideration by hospitals to achieve tactics
- **Measures**
 - **percent of tactics implemented**, constantly discussing obstacles & sharing success stories
 - **HF readmission reduction** (CMS PEPPER report; self reported data)

% Tactics Implemented

<u>Hospital</u>	<u>Mar 2010</u>	<u>Sept 2010</u>
A	24%	38%
B	54%	68%
C	63%	71%
D	88%	90%
E	78%	88%
F	74%	84%
G	45%	66%

Medicare PEPPER Report

All Cause Readmits/All Discharges (Baseline)

Hospital

Q1 2010

A	13 %
B	19 %
C	21 %
D	12 %
E	17 %
F	19 %
G	16 %
H	17 %

Heart Failure Readmissions Any Cause/Heart Failure Discharges (Baseline)

Hospital

May 2010

A	9 %
B	24 %
C	22 %
D	19 %
E	11 %
F	3 %
G	7 %
H	20 %

Heart Failure Readmissions for Heart Failure/Heart Failure Discharges (Baseline)

Hospital

May 2010

A	0	%
B	10	%
C	0	%
D	8	%
E	3	%
F	7	%
G	8	%

Lessons Learned Thus Far

- Obtaining self reported internal data for tracking monthly readmission of HF patients for HF diagnoses is inconsistent and labor intensive, *however*, all hospitals are evaluating reasons for readmissions
- Impact of patient refusal of care interventions resulting in readmission - under-estimated