

Hospital to Home (H2H) How We Can Drive Down Costs

Michael Schroyer, RN, MSN, MBA, FACHE

What is H2H?

The H2H national quality initiative, cosponsored by the American College of Cardiology and the Institute for Healthcare Improvement, is an effort to improve the transition from inpatient to outpatient status for individuals hospitalized with cardiovascular disease. H2H is intentionally broad-based and inclusive, incorporating the viewpoints of patients and family caregivers, clinicians across the continuum of care, integrated health systems, communities, policy-makers, and payers.

Current Status

- Heart Failure readmission rates are high, almost half of Medicare patients were readmitted within 6 months.
 - Studies have shown that comprehensive discharge planning plus post-discharge support for older patients with Heart Failure significantly reduced readmission rates and may improve health outcomes such as survival and QOL without increasing costs.
- Indiana currently in second quartile for readmission rate at 17.7%, which rates third lowest in the Midwest behind Wisconsin at 17% and Nebraska at 17.3%.
- Readmission has been labeled a national priority by MedPac.

Readmission rates and Costs:

Condition	# of Admissions with Readmissions	Readmission Rate	Ave Medicare Payment for Readmission	Total Spending on Readmissions
Heart Failure	90,273	12.50%	\$6,531	\$590,000,000
COPD	52,327	10.70%	\$6,587	\$345,000,000
Pneumonia	74,419	9.50%	\$7,165	\$533,000,000
AMI	20,866	13.40%	\$6,535	\$136,000,000
CABG	18,554	13.50%	\$8,136	\$151,000,000
PTCA	44,293	10.00%	\$8,109	\$359,000,000
Other Vascular	18,029	11.70%	\$10,091	\$182,000,000
Total of 7 Conditions	318760			\$2,296,000,000
Total DRG's	1,134,483			\$7,980,000,000
Percent of Total	28.10%			28.8%

- Source: 3M analysis of 2005 Medicare discharge claims data.

Reform and Readmission

- Give uninsured access to care (insurance reform)
- Improve the care of those who have access
- Reduce the growth in costs
- Reduce healthcare payments to partially fund new insured patients
- \$16 billion in Medicare spending per year in avoidable readmissions
- Perception is key-even if all readmissions are explainable

Reform and Readmission

- Provisions
 - Penalties for hospitals with high readmission rates
 - Pilots to test bundled payments for hospitals and physicians 30 days post discharge
 - Expanded use of readmission as a performance measure
 - Study to determine how to apply readmission penalty to physicians

3 Question Framework

- Medication Management Post-Discharge
 - Is the patient familiar and competent with his or her medications and is there access to them?
- 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?

H2H

- National quality improvement initiative to reduce unnecessary readmissions for cardiovascular patients
- Goal is to reduce all-cause re-admission rates among patients discharged with heart failure or acute myocardial infarction by 20% by December 2012
- Catalyze action to improve patients' care transitions
- Reducing Readmissions Collaborative
 - 12 month improvement project with multiple organizations- beginning fall 2009
- Teams work intensely with IHI faculty and each other to achieve the goal of reducing readmissions
- Rapid testing of changes that have been shown to improve care
- Learning through
 - Virtual sessions
 - An extranet for sharing data and experience
 - A face-to-face meeting

What's Next

- Enroll your hospital at www.H2HQuality.org
- Currently 18 Indiana hospitals have signed up
- H2H Webinars planned 2009 and 2010
- Participant Commitments
 - Implement quality improvement program
 - Contribute to and learn from community
 - Fully-Committed Participants
 - Administrative Support
 - Assemble improvement teams
 - Develop improvement plan
 - Report progress

Indiana CCA Involvement

- Started working on project in March
- Now working with Indianapolis Coalition for Patient Safety
 - Facilitating the handoff between the patient and their next caregiver
 - Discharge summary is completed at the time of patient discharge and either accompanies the patient to their next care provider or is forwarded to the next provider within 24 hours
 - Written discharge plan is provided to the patient at the time of patient discharge
 - Person is responsible for making the follow-up appointments with the next care provider prior to patient discharge
 - Timeliness of follow-up appointments with the next care provider is based on patient risk
 - Use existing or new resources to function as Transition Coach or Discharge Advocate for the patient while an inpatient up to 30 days following hospital discharge

QUESTIONS?????