H2H Hospital to Home

Institute for Healthcare Improvement

American College of Cardiology

Excellence in Transitions

Hospital to Home (H2H)

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VA CHF QUERI

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What is H2H?

- H2H is a 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 Dec 2012

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?

How is the VA Involved?

- The Undersecretary for Health has signed a letter offering support as a Strategic Partner.
- However, each facility needs to join separately.

Who Can Join?

Hospitals are the focus. Our goal is to have each VA inpatient facility involved.

However, anyone committed to reducing unnecessary readmission is a welcome participant.

Participant Commitments

- **All Participants**
  - Implementing a quality improvement program
  - Contributing to and learning from the community

- **“ Fully- Committed” Participants (Facilities)**

1. Obtaining Administrative Support
2. Assembling an Improvement Team
3. Developing an Improvement Plan
4. Reporting on Progress

How Does My Hospital Join?

- A representative goes to H2Hquality.org and fills out an online form indicating your facilities commitment to reducing readmissions.

How Much Does it Cost?

- It is free to participate.
- Your facility will need to allocate resources as needed for any intervention aimed at reducing readmission rates.

What Are the Incentives for My Director?

- Hospital specific heart failure (and MI) readmission rates will be reported (performance measure)
- Reduced readmission rates should reduce costs.
- Undersecretary for Health has signed the VA up as a strategic partner
- Patient Care Services is recommending Enrollment

What Are the Incentives for the Heart Failure Provider?

- Opportunity to have your Director increase funds for heart failure care.
- Involvement with a large community dedicated to improving heart failure care.
- Webcasts and online tools.

What is Expected of Participants

I Obtain Administrative Support

II Assemble an Improvement Team

III Develop and Improvement Plan

IV Report on Progress through periodic responses to brief surveys

What Can I Do to Encourage My Facility to Enroll?

- CHF QUERI will provide data on your current readmission rates.
- Go to your administration with a list of talking points, ideas for improving care.
  - CHF QUERI will provide a draft talking point list, will be available for consultation
- Agree to lead/contribute to the effort for your facility.

Strategic Questions for Achieving - System Level Results

- Is reducing the hospital's readmission rate a strategic priority for the executive leaders at your hospital? Why?
- Do you know your hospital's readmission rate for patients with HF and AMI?
- What is your understanding of the problem?
- Have you declared your improvement goals?
- What will help drive success in your quality improvement initiatives?
- What projects, when combined, will help you achieve your goals?
- Do you have the capability to make improvements?
- How will you provide oversight for the improvement projects, learn from the work and spread successes?

Set-up for Hospitals Participating in H2H

- Have the Director designate an **Executive Leader** to sponsor the hospital's participation in H2H
- Convene an **Improvement Team** of stakeholders within the
- hospital and from across the continuum of care for the initial
- pilot unit work and to develop spread/dissemination plan
- Identify opportunities for improvement and establish aims that are consistent with the goals of H2H
- Select one or two medical or surgical units for the front-line improvement work
- Identify a **Day-to-Day Leader** to drive the work on the pilot unit(s)

Potential Team Members

- Patients and Family Members
- Hospital Staff
- Nurse Manager, Staff Nurses and Nurse Educators
- Pharmacist
- Cardiologists and Hospitalists
- Case Managers and Social Workers
- Quality Improvement Leaders
- Nursing and Physician Leaders from skilled nursing facilities
- Primary Care Physicians, Cardiologists, Nurses and Nurse Practitioners from office practices and clinics
- Case Managers and Home Care Nurses

Sample Aim Statement

- *To reduce unplanned 30-day readmissions among patients discharged with HF from 18% to 9% or less by December 31, 2010 and to improve these patients' experience of care at discharge as measured by satisfied or highly satisfied from 68% to 95% or more.*

Team Activities

- Start by focusing on one of the key changes/questions
- Identify the opportunities/failures/successes in the current processes and select a process to work on
- Conduct iterative PDSA cycles (tests of change)
- Understand common failures to redesign the process to eliminate those failures
- Specify the who, what, when, where and how for the process (standard work)
- Use process measures to assess your progress over time

Identifying Opportunities for Improvement

Review the last five patients that were readmitted within 30 days after discharge

- Reviews the charts of the last five readmissions
  - Chart Review Template Available
- Conduct interviews with these patients and/or family caregivers
- Conduct interviews with clinicians who also know these patient (physicians, nurses in the skilled nursing facility, home care nurse, etc.) to identify problem areas from their perspective.

Key Process Changes	Status of Improvements	Ideas for Testing & Designing Reliable Processes	Who will lead? Timeline?
Medication Management Post-Discharge: .Is the patient familiar and competent with his or her medications and how to access to them?			
Early Follow-Up. Does the patient have a follow-up appointment within a week of discharge?			
Symptom Management: Does the patient comprehend the signs and symptoms that require medical attention and whom to contact if they occur?			

Next Steps

- CHF QUERI will send readmission rates, talking point draft
- You should decide how you would like to improve care.
- You should meet with your administration to get their support/sign up on the website.

For More Information

- visit www.H2HQuality.org
- email hospital2home@acc.org
- Or email CHF QUERI at anju.sahay@va.gov or paul.heidenreich@va.gov