

# How do I avoid a hospital readmission for my Heart Failure patient?

*Update in Cardiology*  
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# The Hospitalized Patient

- Post discharge systems of care, if available, should be used to facilitate the transition to effective outpatient care for patients hospitalized with HF

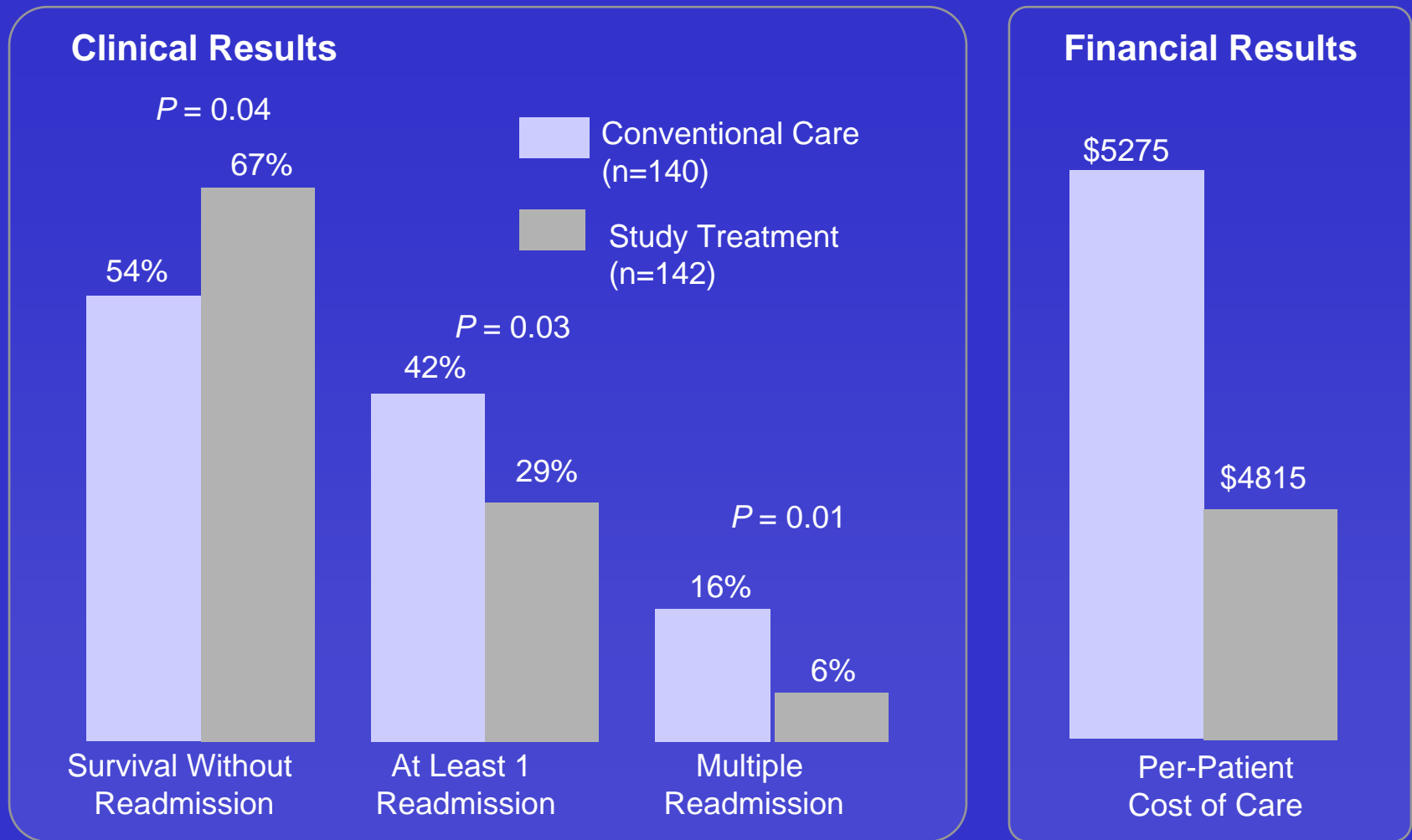
*ACC/AHA 2005 Practice Guidelines*

# Decreasing Readmission: What Seems to Work

- A single home visit
- Home visits +/-or frequent telephone contact
- Extended home care services
- Patient education

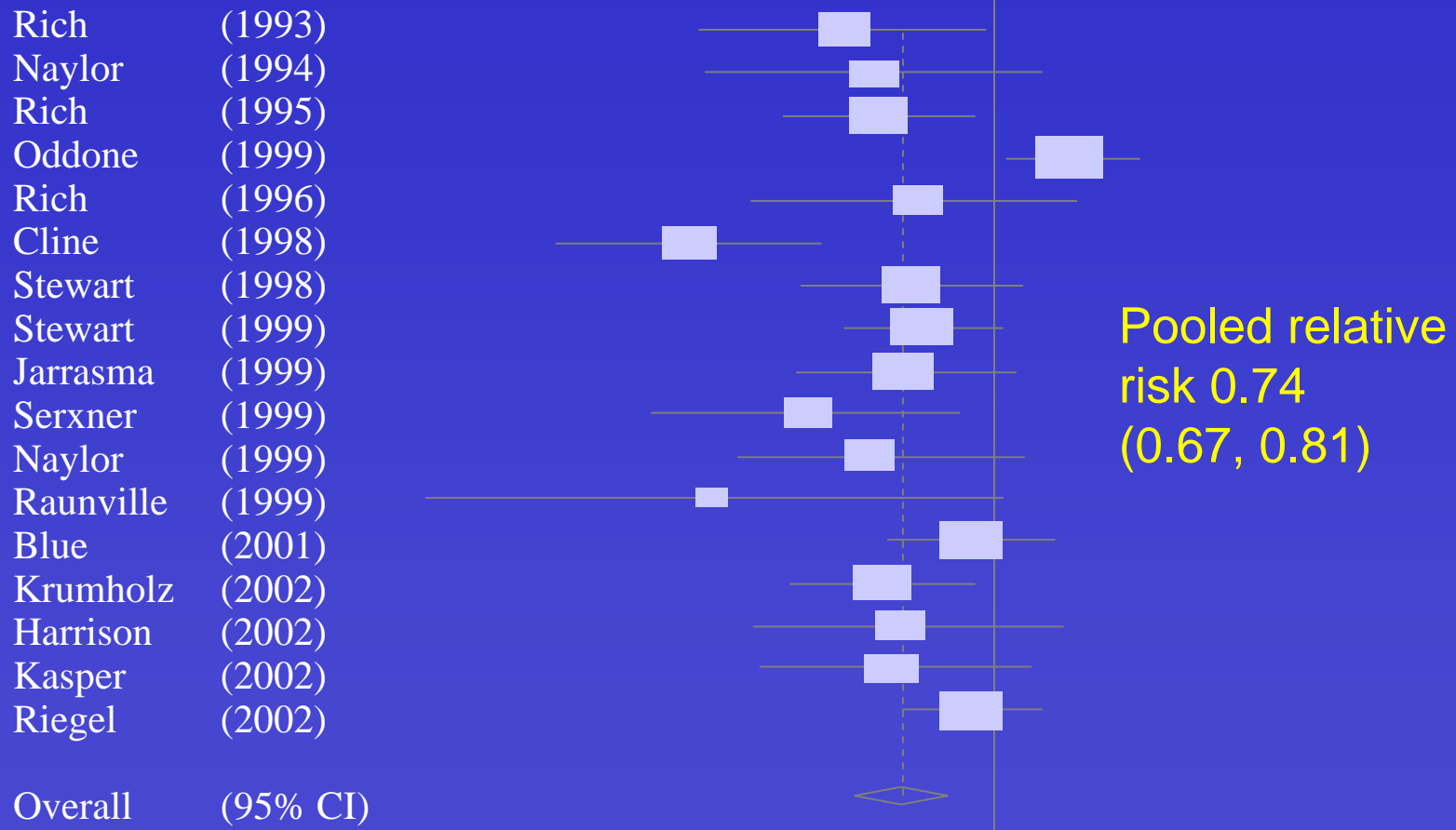
*Increased frequency of clinic follow-up alone has not consistently worked!*

# CHF Management Programs: Results at 90 Days

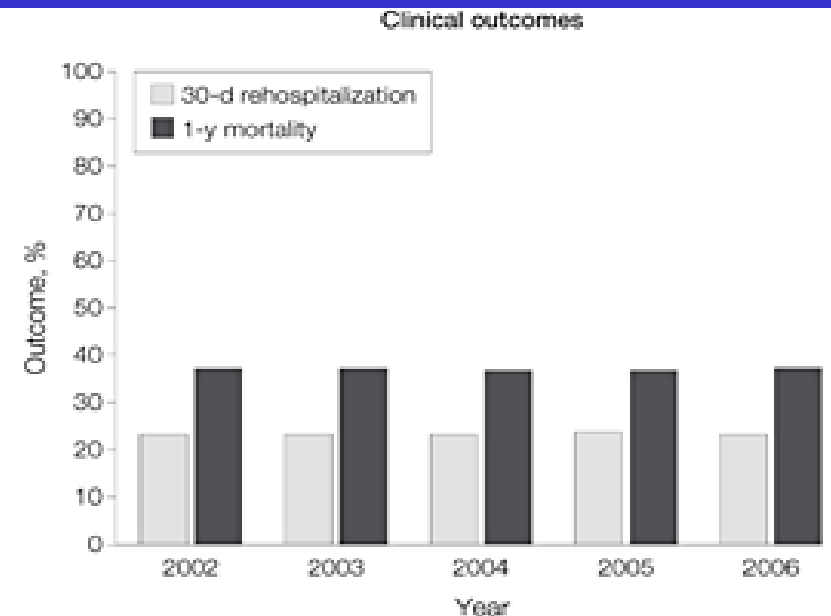
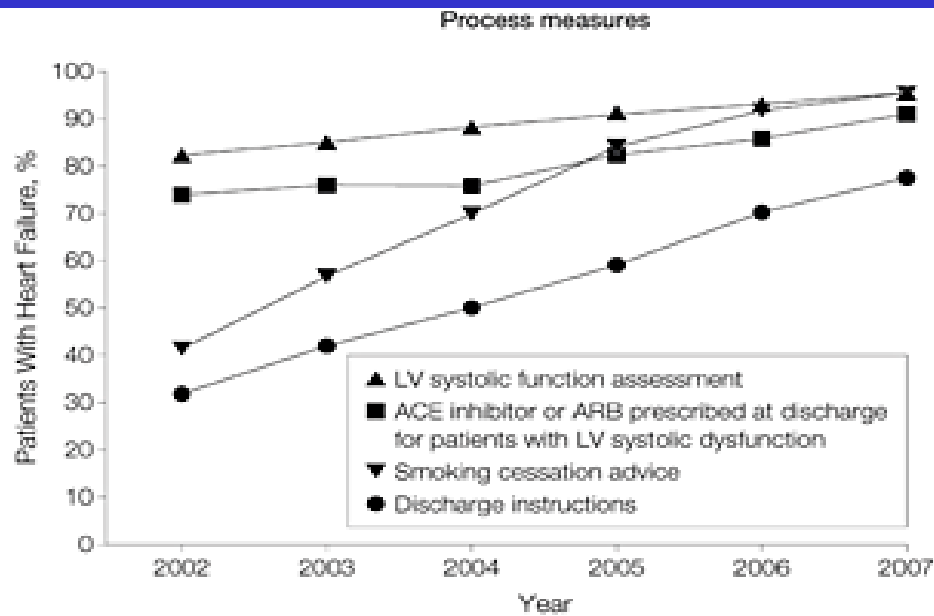


# Meta-analysis of CHF Disease Management Programs

## Impact on hospital readmissions:



# Temporal Trends in Process Measures and Clinical Outcomes for Medicare Patients Hospitalized With Heart Failure, 2002-2007



First heart failure hospitalizations, No. 503 055 520 095 519 716 499 804 466 474

Fonarow, G. C. et al. JAMA 2009;302:792-794.



*Hospital to Home*



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# **Hospital to Home (H2H)**

## ***Excellence in Transitions***



## **Hospital to Home (H2H)**

**A national quality improvement initiative of the American College of Cardiology and the Institute for Healthcare Improvement**

## **Building on Success**

- **ACC's Door to Balloon: An Alliance for Quality**
- **IHI's 100K Lives & 5M Lives Campaigns**



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## Goal

**Reduce 30 day, all-cause readmission rates for patients discharged with cardiac conditions by 20 percent by December 2012.**



## **H2H Core Concepts**

### **1. Medication Management Post-Discharge**

*Is the patient familiar and competent with his or her medications and is there access to them?*

### **2. Early Follow-Up**

*Does the patient have a follow up visit scheduled within a week of discharge and is she or he able to get there?*

### **3. Symptom Management**

*Does the patient fully comprehend the signs and symptoms that require medical attention and whom to contact if they occur?*



## H2H Resources

- Web-based community of hospitals, practices and other stakeholders
- Online exchange forums to share best practices, challenges, and successes
- Educational programs via webinar series
- Customizable implementation tools, strategies and systems



## Expectations of Hospitals & Practices

- Rally support at “The Top”
- Assemble dedicated *H2H Improvement Team*
- Home Grow an *H2H Improvement Plan*
- Report Back on Progress
  - *means sharing success stories and experiences... not new data collection!*



## Benefits to H2H Participants

- You become part of the solution
- Access to world-class experts and a curriculum on effective care transitions
- Online forums to exchange knowledge and improve performance
- Customizable strategies and tools
- Recognition for your good care



**Contact Information: [www.h2hquality.org](http://www.h2hquality.org)  
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