

# H2H

*Hospital to Home*

## WHY H2H

Nearly 20 percent of Medicare patients are readmitted to the hospital within 30 days of discharge, with heart failure listed as the most common reason for readmission. In 2004 alone, the total cost of these readmissions was \$17.4 billion.

## WHAT IS H2H?

The H2H Quality Initiative serves as a national rallying point and learning initiative:

- catalyzing action to improve the transition home for patients discharged with heart failure or acute myocardial infarction
- leveraging an array of national initiatives that are all contributing to reducing readmissions
- bringing together what is known from experts, the literature, and best practices
- creating a web-based community of hospitals, office practices and other care providers in the community to share tactics, resources toolkits and best practices

## H2H GOAL

To reduce all-cause readmission rates among patients discharged with heart failure or acute myocardial infarction by 20 percent by 2012.

## H2H FOCUS

H2H will focus on three main domains that provide opportunities for improvement:

- 1. Medication Management Post-Discharge:** Is the patient familiar and competent with their medications and do they have access to them?
- 2. Early Follow-Up:** Does the patient have a follow-up visit scheduled within a week of discharge and are they able to get there?
- 3. Symptom Management:** Does the patient fully comprehend the signs and symptoms that require medical attention and who to contact if they occur?

## H2H LEADS AND PARTNERS

The H2H initiative is co-led by the American College of Cardiology (ACC) and the Institute for Healthcare Improvement (IHI). Other strategic partners include specialty societies, nursing organizations, hospital associations, integrated health systems, payers and patient and family caregivers.

For more information or to enroll, e-mail [hospital2home@acc.org](mailto:hospital2home@acc.org) or visit [www.h2hquality.org](http://www.h2hquality.org)

