

Improving Quality from Hospital to Home

By Pat Lucken, F.N.P.-C., C.P.H.Q.

By taking the time to recognize barriers to patient understanding and ensuring that we have met the three steps in the H2H process, we can reap the benefits of improved patient satisfaction, better outcomes and huge cost-savings.

The ACC and the Institute for Healthcare Improvement (IHI) launched a new program last month designed to enhance quality and reduce costs by limiting unnecessary readmissions. The Hospital to Home (H2H) initiative aims to reduce 30-day readmissions for both acute myocardial infarction (AMI) and congestive heart failure (CHF) by 20 percent by December 2012.

The focus of H2H will be to create excellence in care transitions between inpatient and outpatient settings. The post-discharge period is a vulnerable period, a gap during which patients are at highest risk of readmission.

The H2H Steering Team envisions a three-step process starting prior to discharge. The process is one in which we as cardiac care team members can have a significant impact through open communication with the patient:

1. The first priority is to ensure patients understand the medications prescribed, and to be sure they have the ability to access them.
2. The next step is to ensure a follow-up appointment is scheduled, along with reliable transportation to the appointment. The appointment should be within a week of the hospital discharge.
3. Finally, the patient should be able to recognize symptoms to report and know how and when to access that care.

Barriers to Learning

I know from personal experience working with heart failure

patients that there can be multiple barriers to effective learning that lead to avoidable readmissions. Some barriers are cultural: A Saudi-Arabian gentleman told me he was drinking two gallons of water a day because

he was a "desert man." Some patients are hesitant to question a doctor's orders or "pester" a health care professional to be sure they understand the orders. One patient was taking an NSAID three times daily for the past five years but could not tell me why. His response was, "My doctor told me to take it."

Other issues include socio-economic factors. We wonder why a patient doesn't weigh herself as instructed only to discover she cannot afford the luxury purchase of a scale.

Often there are literacy issues. I once asked a bachelor who had been readmitted for heart failure to create a food diary. Every night he would consume a can of chili. That can of chili had a full day's worth of sodium in it. Another gentleman insisted he never consumes salt, then told me, "My family eats TV dinners."

And finally there is the sodium indiscretion, as in the case of a patient who held his diuretic to attend a wedding and then indulged in a few margaritas ... with the salty rim.

Reducing avoidable readmissions by 20 percent by 2012 is an attainable goal. By taking the time to recognize barriers to patient understanding and ensuring that we have met the three steps in the H2H process, we can reap the benefits of improved patient satisfaction, better outcomes and huge cost-savings. If your facility is not already participating, I hope you will consider joining. To learn more and enroll, go to www.h2hquality.org.

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ACC Launches Readmissions Initiative with Webinar

The ACC, in partnership with the Institute for Healthcare Improvement (IHI), on Oct. 22 launched a new national quality improvement initiative to reduce the rate of preventable readmissions for patients discharged with a diagnosis of acute myocardial infarction (AMI) or heart failure (HF), called Hospital to Home (H2H). More than 2,000 attendees participated in the launch Webinar that featured H2H Steering Committee Co-Chair **Harlan Krumholz, M.D., F.A.C.C.**, and **Donald Goldmann, M.D.**, of IHI. The Webinar familiarized participants with the design and goals of the initiative and also

included an update on readmissions in the health care reform bills.

Currently, about 20 - 25 percent of patients hospitalized with AMI or HF are readmitted to the hospital within 30 days. Many of these admissions are preventable through improvements in the transition from inpatient to outpatient status. H2H will assist providers in overcoming the systemic barriers to improving readmission rates, with the goal of reducing 30-day all-cause, risk-adjusted readmission rates for HF and AMI patients by 20 percent nationally by 2012. H2H

will catalyze action by harnessing the collective knowledge of its key strategic partners and participants in a rapid learning community.

Since the launch, more than 350 facilities have enrolled in the program. More information, including the archived Webinar, a CVN video, and information on how to enroll, is available at: www.h2hquality.org or by e-mailing hospital2home@acc.org. Also, H2H Steering Committee Co-Chair Harlan Krumholz, M.D., F.A.C.C., discusses the initiative in greater detail on ACC's blog, available at: lewinreport.acc.org.