



**Ambassador Network Strategy Meeting
Michigan Chapter ACC Conference**

***Hospital to Home (H2H)
Excellence in Transitions***

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ACC President-Elect
October 16, 2009

ACC

Chartered as a teaching institution in 1949

Now serves more than 37,000 cardiologists, nurses, physicians' assistants, and pharmacists



The Problem

- ~1 in 5 patients over age 65 is rehospitalized within 30 days
- Cost of unplanned stays in 2004 was \$17.4 Billion
- Heart failure is the most common reason for rehospitalizations
- Heart failure is also the most frequent among surgical patients
- 52% of discharged heart failure patients had no outpatient visit

* Jencks SF, Williams MV, Coleman EA. Rehospitalizations among Patients in the Medicare Fee-for-Service Program. N Engl J Med 2009;360:1418-28



Hospital to Home

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



Goal

This signature effort of the ACC and IHI will reduce 30 day, all-cause readmission rates for patients discharged with cardiac conditions by 20% percent nationally by December 2012.



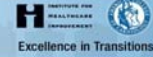
Why H2H?

- Readmission to the hospital is frightening for patients and their families and undermines confidence in care.
- The costs of preventable hospital readmissions, both personal and for the healthcare system are enormous.
- As medical professionals, we commit to providing reliable, safe, and effective transitions across sites of care.
- The 30-day, all-cause readmission rates for heart failure and acute myocardial infarction are now published on the *Hospital Compare website*.



Who and When?

- **Project Leads:**
 - Harlan M. Krumholz, M.D., F.A.C.C.
 - John S. Rumsfeld, M.D., Ph.D., F.A.C.C.
 - Donald A. Goldmann, M.D.
 - Janet S. Wright, M.D., F.A.C.C.
- Over a thousand hospitals are expected to enroll, as well as many collaborating organizations, health care systems and clinical practices
- The H2H initiative will officially launch October 22, 2009



H2H Core Concepts

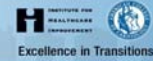
1. **Medication Management Post-Discharge:** Is the patient familiar and competent with their medications and do they have access to them?
2. **Early Follow-Up:** Does the patient have a follow up visit scheduled within a week of discharge and are they able to get there?
3. **Symptom Management:** Does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



H2H Will

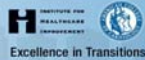
- Build a community of hospitals, health care systems, clinical practices, and strategic partners dedicated to reducing preventable hospital readmissions
- Address the challenge of creating a coordinated health care team across different settings of care
- Ensure reliable, safe and health-enhancing transitions for patients
- Leverage the expertise and experience of other organizations and partners

So that **together** we can accomplish what none of us alone can do!



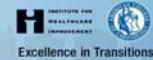
H2H Resources

- **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**



H2H Partnerships

- H2H strategic partners and supporters, such as hospital systems, state Quality Improvement Organizations, medical societies, and others are critical to success
- Strategic partners publicly support the H2H goals, recruit additional partners, and actively promote H2H to their constituents
 - Supporters contribute resources to help the initiative reach its goals



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
- Practical strategies and tools you can customize for your needs
- Recognition for your good care

The screenshot shows the H2H website interface. At the top, there are logos for H2H Hospital to Home and the Institute for Healthcare Improvement. Below the logos is a navigation menu with items like Home, Member Center, Products, Programs, Conferences, Jobs, E-Store, Links, Chapters, and Tools. A search bar is also visible. The main content area features the H2H logo and a section titled 'About H2H' which describes the initiative's goal to reduce preventable readmissions for patients recently hospitalized with a cardiovascular condition.



The H2H initiative will officially launch with a kick-off webinar on October 22nd!

To enroll or learn more about the initiative, please visit www.H2HQuality.org or email hospital2home@acc.org



Thank You

Contact Information:
www.h2hquality.org
hospital2home@acc.org



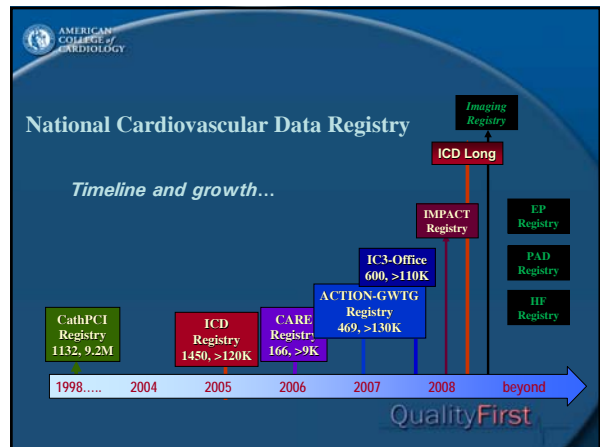
Helping Cardiovascular Professionals Learn, Advance, Heal.



IC³ Program[®]

Improving Continuous Cardiac Care

In Every Office, Right Now



Study in the Lancet

- Best practice interventions would reduce overall coronary heart disease deaths by 57%, and the difference in deaths by socioeconomic groups by 69%
- Such interventions include reduction of systolic blood pressure by 10 mmHg, of cholesterol by 2 mmol/L, and of blood glucose by 1 mmol/L in pre-diabetic people, and quitting smoking

Kivimaki et al. *Lancet* 2008;372:1648-54

The IC³ Program Goal

The IC³ Program is a national network designed to improve the quality of cardiovascular care and its delivery in the ambulatory setting

IC³ Program Aims

- ◊ Prepare clinicians to thrive in a performance-based healthcare system
- ◊ Make it easier to consistently practice evidence-based medicine
- ◊ Provide the road map & vehicle for quality improvement
- ◊ Coordinate care across sites and settings
- ◊ Connect practices in a learning community committed to patient-centered care

The goal of IC3 is to help clinicians....

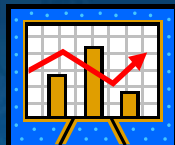
Documentation
P4P
Certification
Electronic Record
....
Guideline-based
Patient care

survive



...improve quality of care delivery and optimize patient outcomes

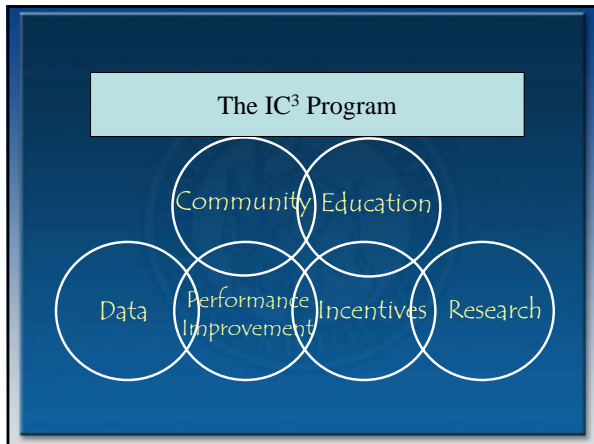
Variation in Care
Gaps in Care
Poor Care Coordination



What is it?



Office-based CV QI program that helps clinicians thrive in a performance-based reimbursement system through the systematic practice, timely reporting, and continuous improvement of quality



Community Building

The IC3 national network of practices dedicated to high quality CV care.
Interactive communication.
Best practices.

Education

Educational programming.
Clinical guideline updates.
Selection of EHR vendors.
Billing and coding.

Data Collection

Office-based registry.
Collect and use patient care data more effectively.
Coordinate care.
Benchmarking.
Demonstrate quality of care.

Outpatient Performance Measures

CAD, Afib, HTN,
 Heart failure,
 Diabetes, Rehab

ACC/AHA
 PCPI
 PQRI
 NQF

Performance Improvement

Practice assessment.
QI tools.
Decision support

Quality Improvement 

- Customized practice needs
- Practice workflow
- Transactional quality
- Incentives

Recognition and Rewards

*Recognition.
Maintenance of
Certification
Payers.
Malpractice
tipping points*



Research

*New insights on care delivery.
Impact of program.
Practice-Based
Research Network.*

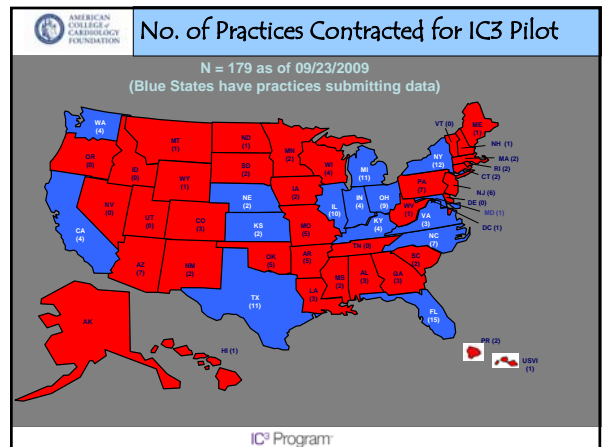


IC3 Program Package

- Practice Readiness Assessment
- Series of Webinars
- Guideline Derivatives
- Periodic newsletter
- Practice Certificate
- Data submission to payers

IC3 Program Package

- EMR selection, Maintenance of Certification, Team-based Care
- Workflow design tips
- Medication adherence aids
- Community access for best practice sharing and problem-solving
- Liability reduction



IC³ Program Paper DCF

Data Collection and Export Methods

1. Data collection using **Paper Form** and Data export using **EFAX**
2. Data collection using your **EMR** and Data Export using **SI Solution**
3. Data collection using your **EMR** and Data Export using your **EMR**

Phases of System Integration Solution

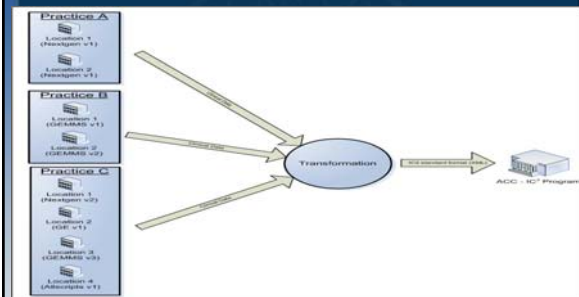
Phase 1 – Collect whatever exists

- SI Solution installation
- EMR mapping (iterative, most time consuming)
- Text extract and test reports for 1 provider (1/1/08 thru current day data)
- First extract and reports for all providers, all location (1/1/08 thru current day data)
- Sign-off on EMR mapping
- Monthly extracts containing 3 rolling months of data
- Quarterly reports

Phase 2 – Collect missing information

Phase 3 – Real-time reporting

System Integration Strategy



Systems Integrations Solution Requirements

Practice Requirements:

- Must be an IC³ Program Participant
- Must have signed and submitted the IC³ Program Data Collection Agreement
- Must be using an EMR
- Must have EMR SME staff (must know how to use your EMR)
- 4 to 8 weeks of staff time for EMR mapping (approximately 5 hrs per week)

Observations from System Integration Strategy Beta Installations

- Takes 4-8 weeks (for first two practices of an EMR) for mapping initial EMR Data Elements to IC³ Program Data Elements – Iterative
- Approximately 5-10 hours per week from the staff to help in mapping and review mapping and test reports
- For subsequent practices, time is expected to be less
- Need to make sure we can discretely map/identify the following:
 - Chief Complaint visits versus miscellaneous visits
 - Medicare FFS patient visits (if participating in PQRI)
 - Lab values and dates
 - Cardiac Events and dates
 - Stent information (if applicable)
 - Medications and contraindications
 - Insurance Information
 - Plan of Care Information
 - Angina Symptoms Assessment
 - Comorbidities
- Do not expect much hands-on time from the staff after the solution is operational

Theoretical

- Streamline/integrate the process so as to have no impact patient on flow
- Minimize the time we touch the form
- Never backtrack to get data...always work forward with continuous flow
- Auto populate the form
- Auto submission to ACC

Operational

- Pick your best team to help you (young, flexible, less set in their ways)
- Brainstorm with staff/IT as you teach them...their input is invaluable
- Plan on multiple iterations with rapid deadlines...do trial runs, do not be afraid to change your system, engage the non MD's in the process
- Pick a go live date and start even if data collection seems crappy

Practical

- Print the IC³ form with the demographics and insurance before the patient visit
- Nurse/MA adds vitals, questions patient and reviews meds
- Provider does the visit and "checks the boxes"
- Form goes to transcription and is entered
- At 30 days, lab and EF are imported and the form is faxed to ACC and placed in chart

Lessons Learned

- ◊ Practices are unique cultures
 - Multiple methods of data collection
 - Mechanisms to build community
 - Strategy: Readiness assessment
- ◊ Strong physician champions are critical
 - Practices need support in identifying them
 - Strategy: Share ways to identify and nurture
- ◊ Organizational issues are the crux
 - Workflow redesign
 - Comparative feedback report interpretation
 - Strategy: Provide education and tools

....and More Lessons

- ◊ It takes a village of strong strategic partners
 - MedAxiom
 - Spirit of Women
 - Strategy: Seek and nurture
- ◊ Create incentives for participation
 - Rewards and recognition
 - Strategy: Pursue payer pilots; Leverage Data
- ◊ Data Quality... Takes center stage
 - Strategy: Work with EMR sites, audit data collection process; eternal vigilance!

2009 PQRI Updates

CMS authorized a 2% bonus payment for 2009 PQRI.

CMS has informed us that ACC is recognized as a registry option for 2009 PQRI for 9 measures.

Two Reporting Periods Options: ACC will be submitting for both the 1/1/09-12/31/09 and 7/1/09-12/31/09 reporting periods. Physicians can take advantage of one or both options through IC3 Program participation.

Physicians can reports via multiple mechanisms- claims or registry; individual measures or measure groups: CMS will use the most advantageous submission(s) (i.e., that meet the reporting requirements for the longest reporting period) to determine the 2% bonus.

CMS will be reporting the names of physicians who successfully report for 2009 PQRI on their provider directory website available to the public (this information wont appear until late 2010).

Contact Information

To learn more, visit the IC³ Program Website at

www.continuouscardicare.org

If you have questions, contact us at 800-257-4737