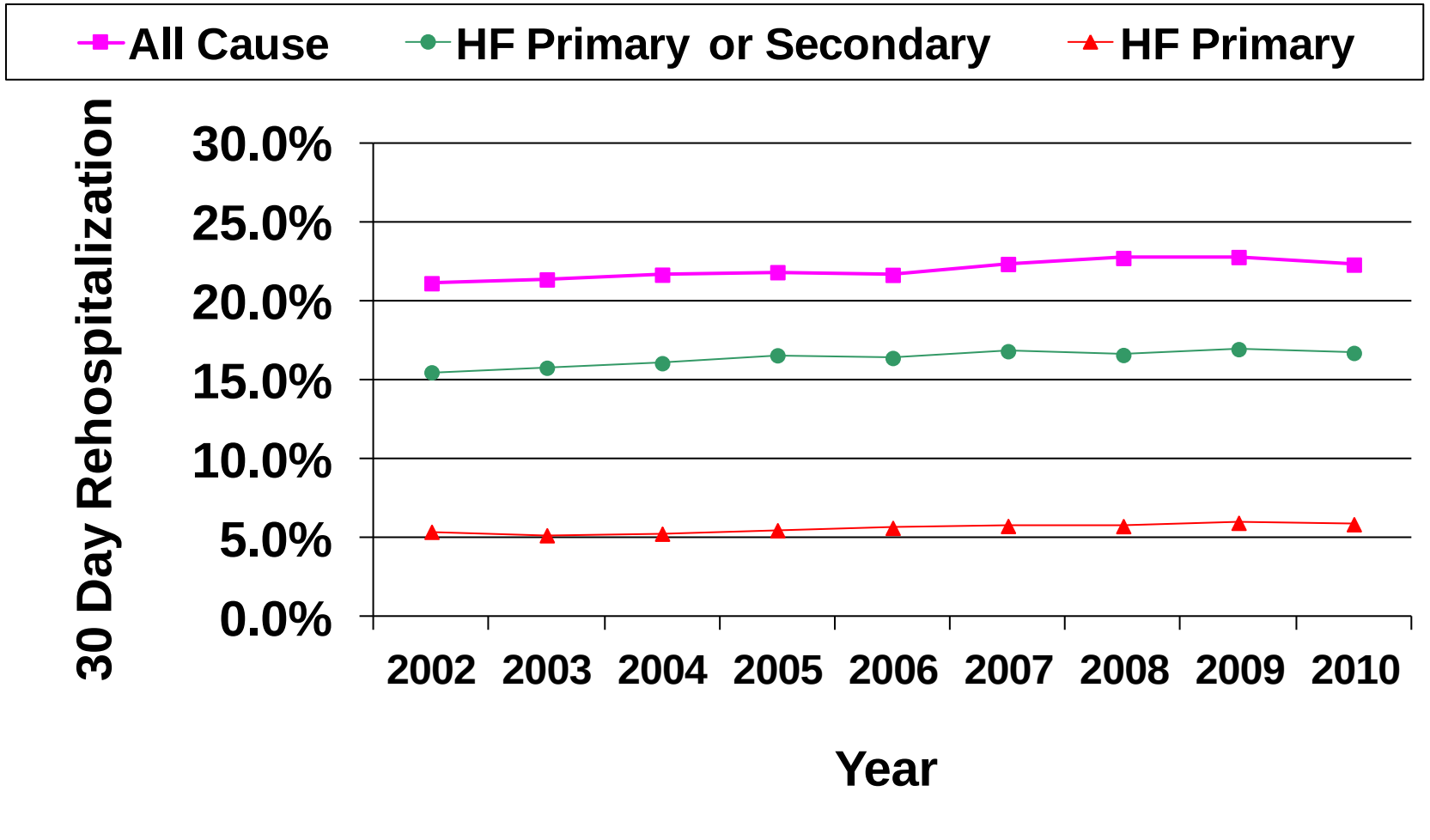
Transition of Care Practices for Heart Failure

A Comparison of VA and Non-VA Hospitals

Paul Heidenreich MD, MS

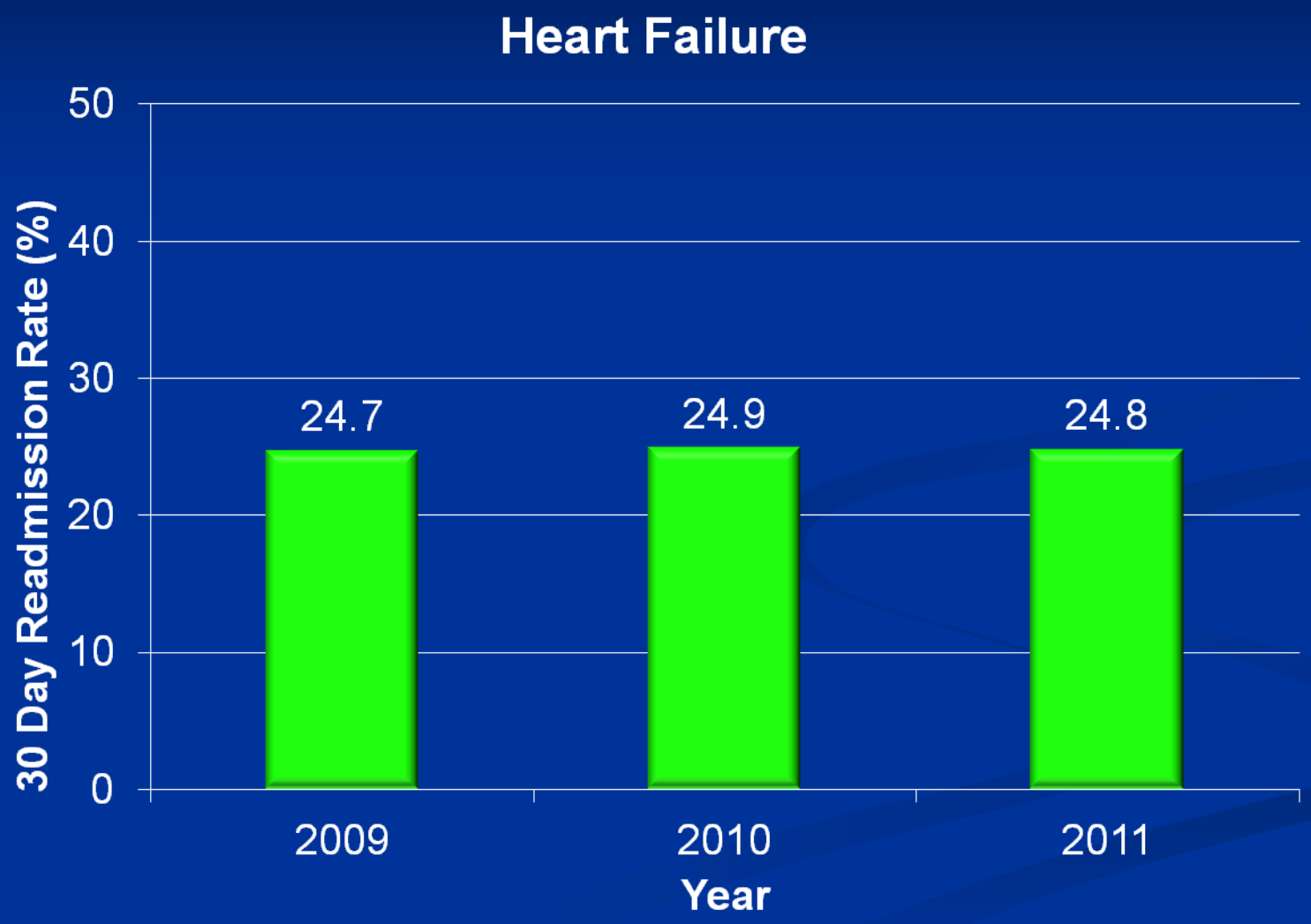
11/6/2013

VA Trends in Readmission



CHF QUERI extension of Heidenreich JACC, 2010

Recent Trends in Readmission



Hospital Compare

Hospital to Home (H2H)

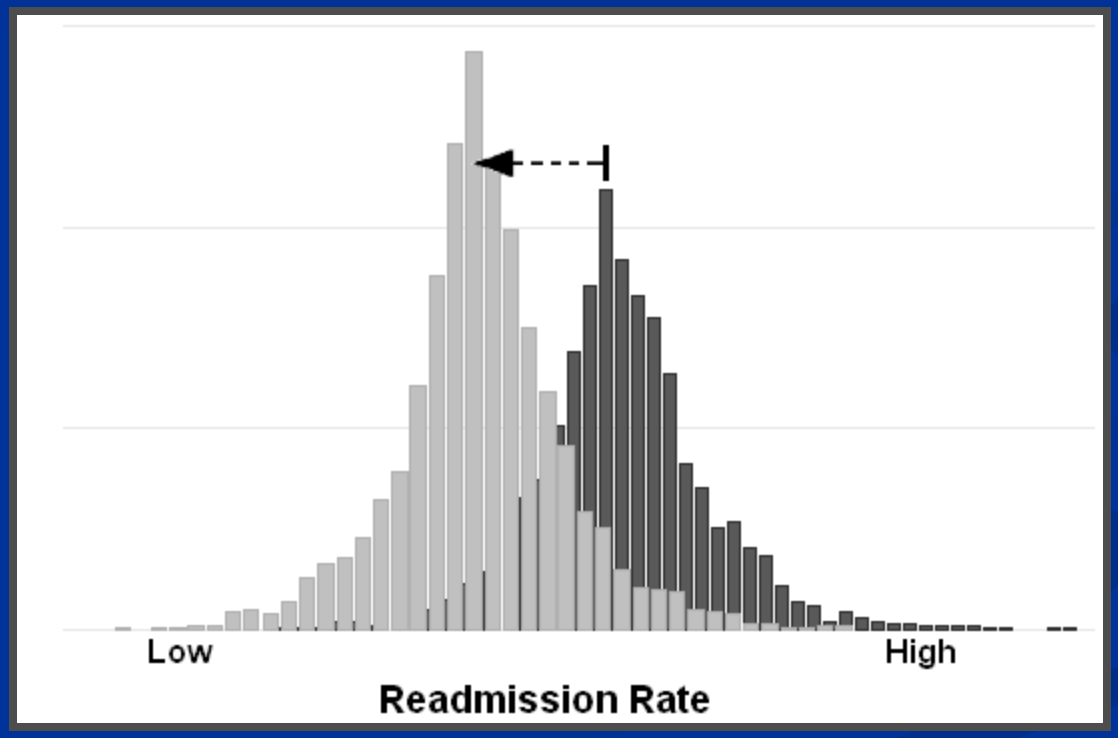
Partner: Patient Care Services

National Initiative led by:

Institute for Healthcare Improvement

American College of Cardiology

H2H Goal: Reduction in All Cause 30-Day Readmission by 20% by 12/2012



H2H 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?

H2H Hospital Survey

- Conducted by Yale of non-VA hospitals
- 537 facilities (90% response rate)
  - (larger, more likely to be academic)
- Asked about QI programs, medication, follow-up/transition practices.
- Focused on 10 key hospital practices

10 Key Practices
3 for Monitoring

- QI Improvement Team for readmissions
- Monitoring 7 day appointments
- Monitoring 30 day readmission rates

Bradley, JACC 2012

10 Key Practices
3 for Medications

- Patient medication education
- Pharmacist doing reconciliation
- Pharmacist obtaining med history

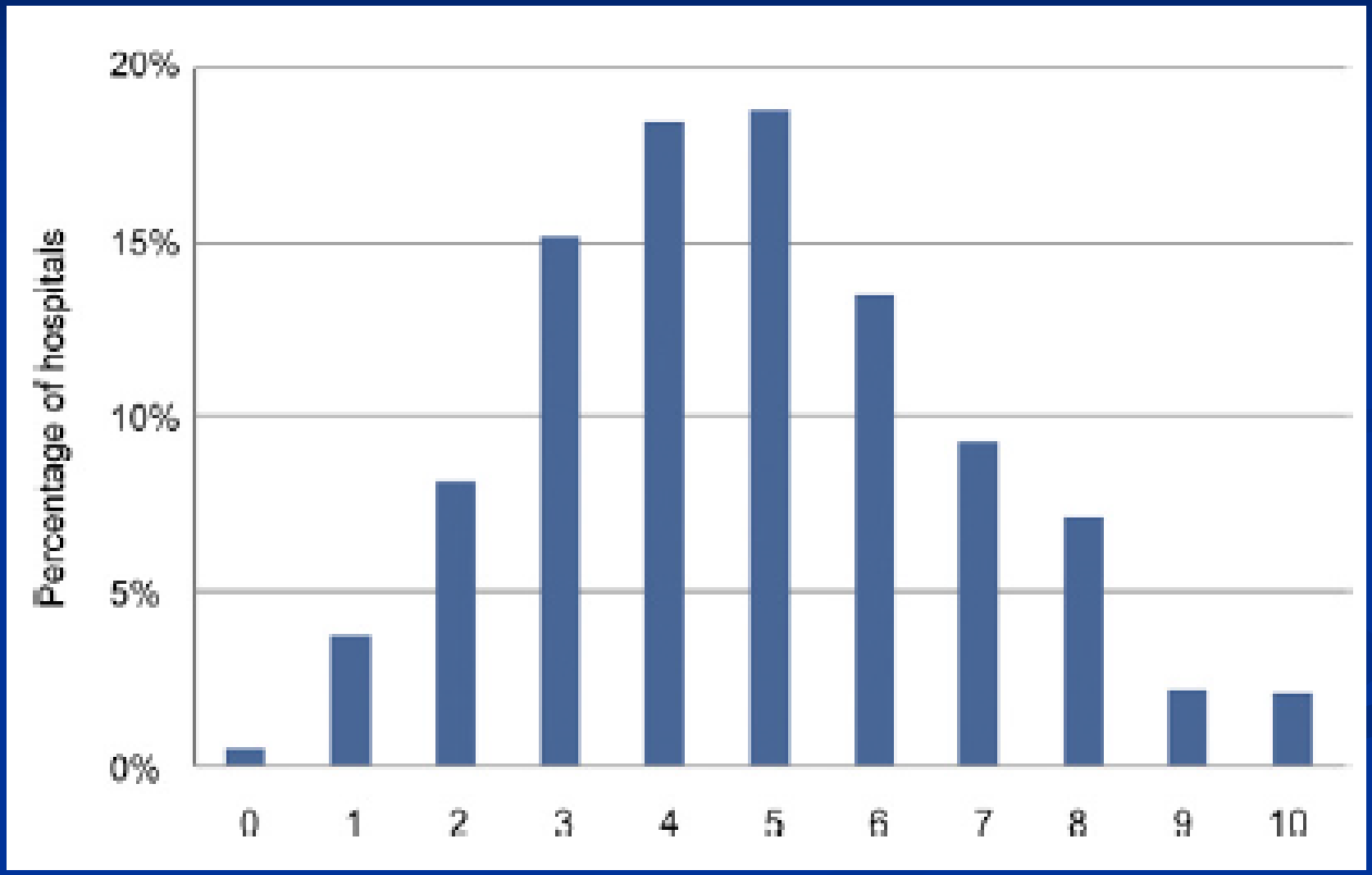
Bradley, JACC 2012

10 Key Practices
4 for Discharge and F/U

- Contact info for physician
- Appointment made before discharge
- Outpatient physician alerted
- Patient's called after discharge

Bradley, JACC 2012

Hospitals With 10 Key Practices

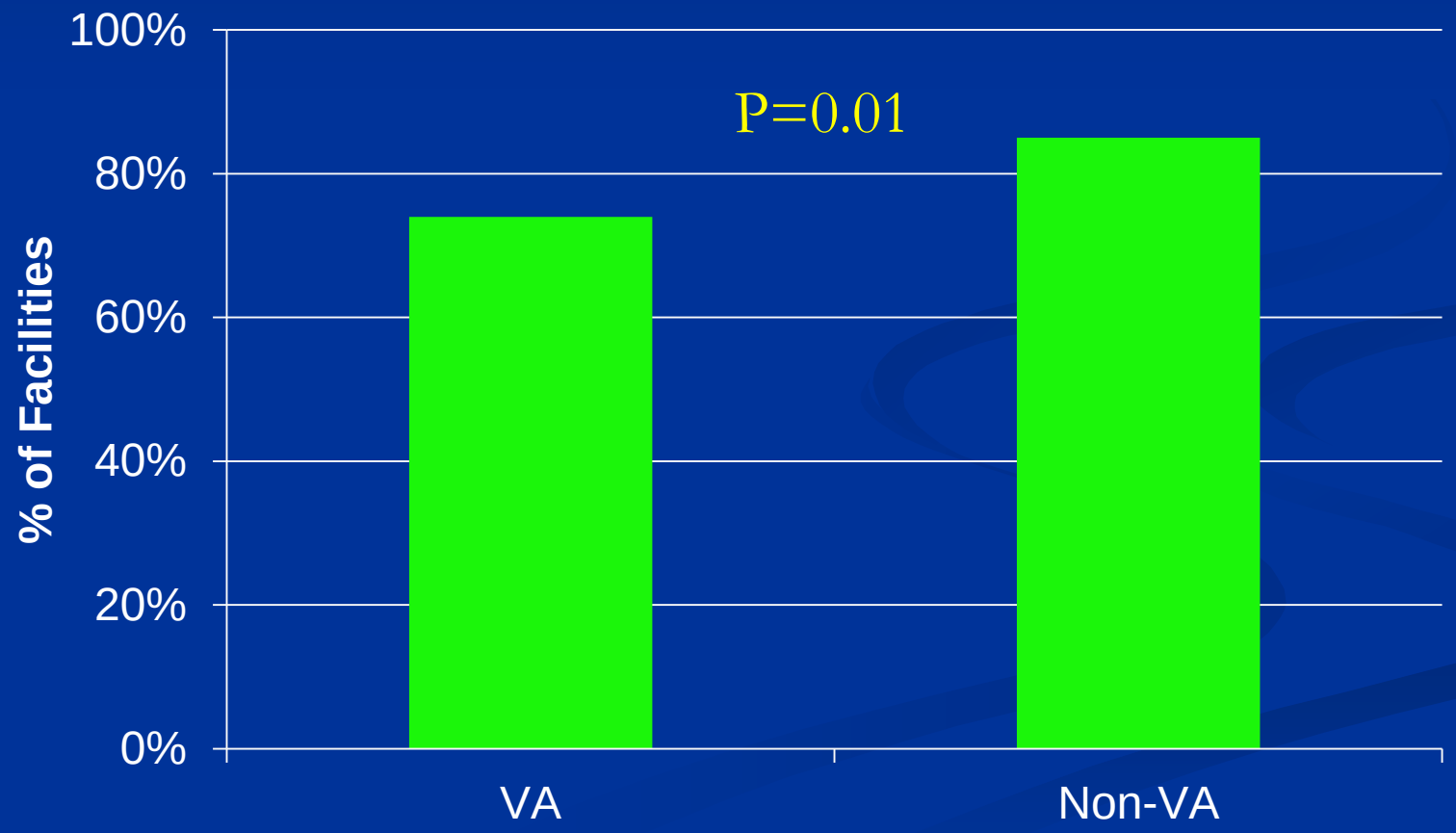


Bradley, JACC 2012

H2H VA Comparison

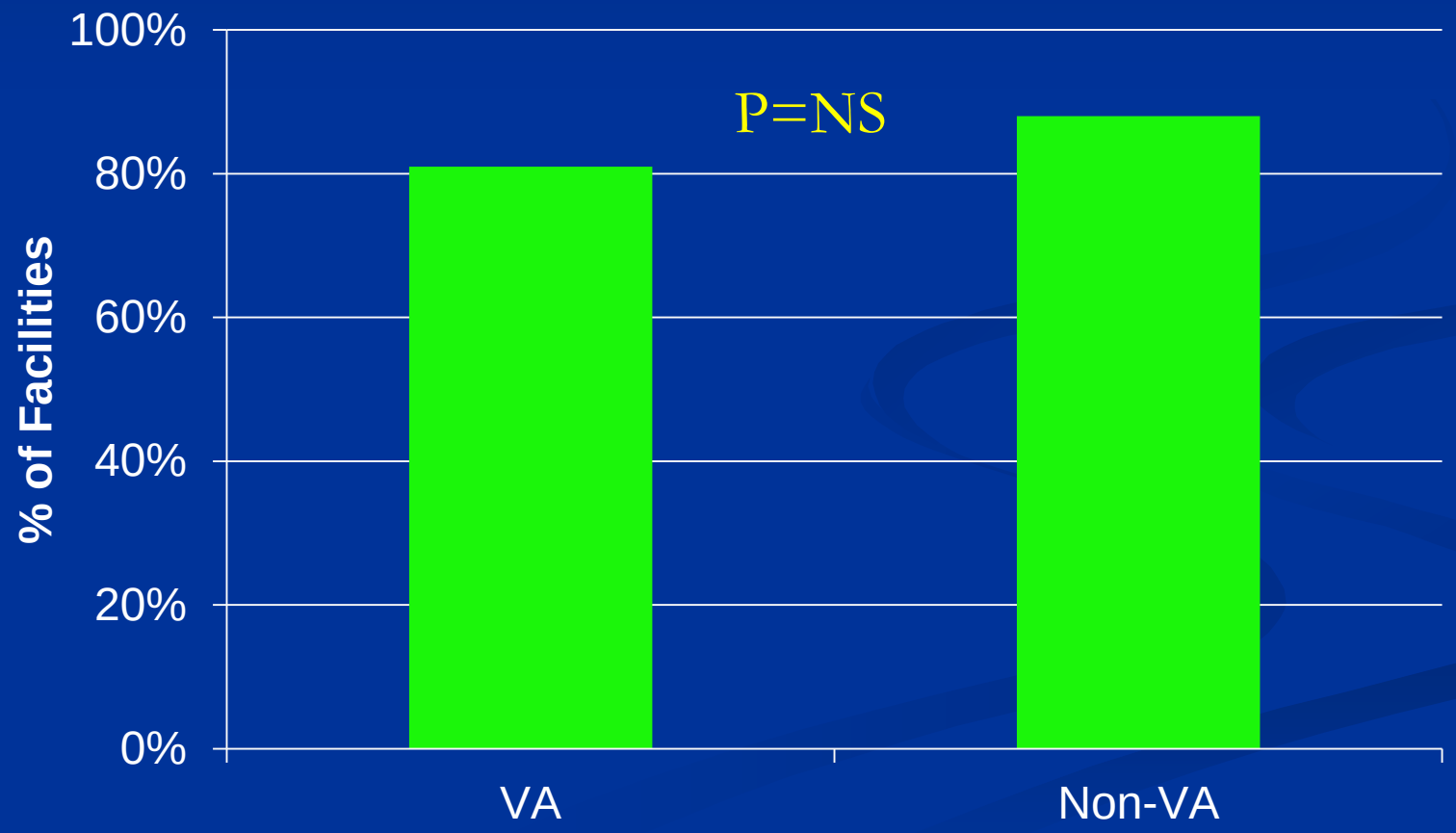
- Same survey to 80 VA facilities participating in H2H
  - (larger, more likely to be academic)
- Compared to non-VA facilities

Hospital Has A Reliable Process In Place To Identify Patients With HF At The Time They Are Admitted



CHF QUERI unpublished data

Has QI Team Devoted to HF Readmissions



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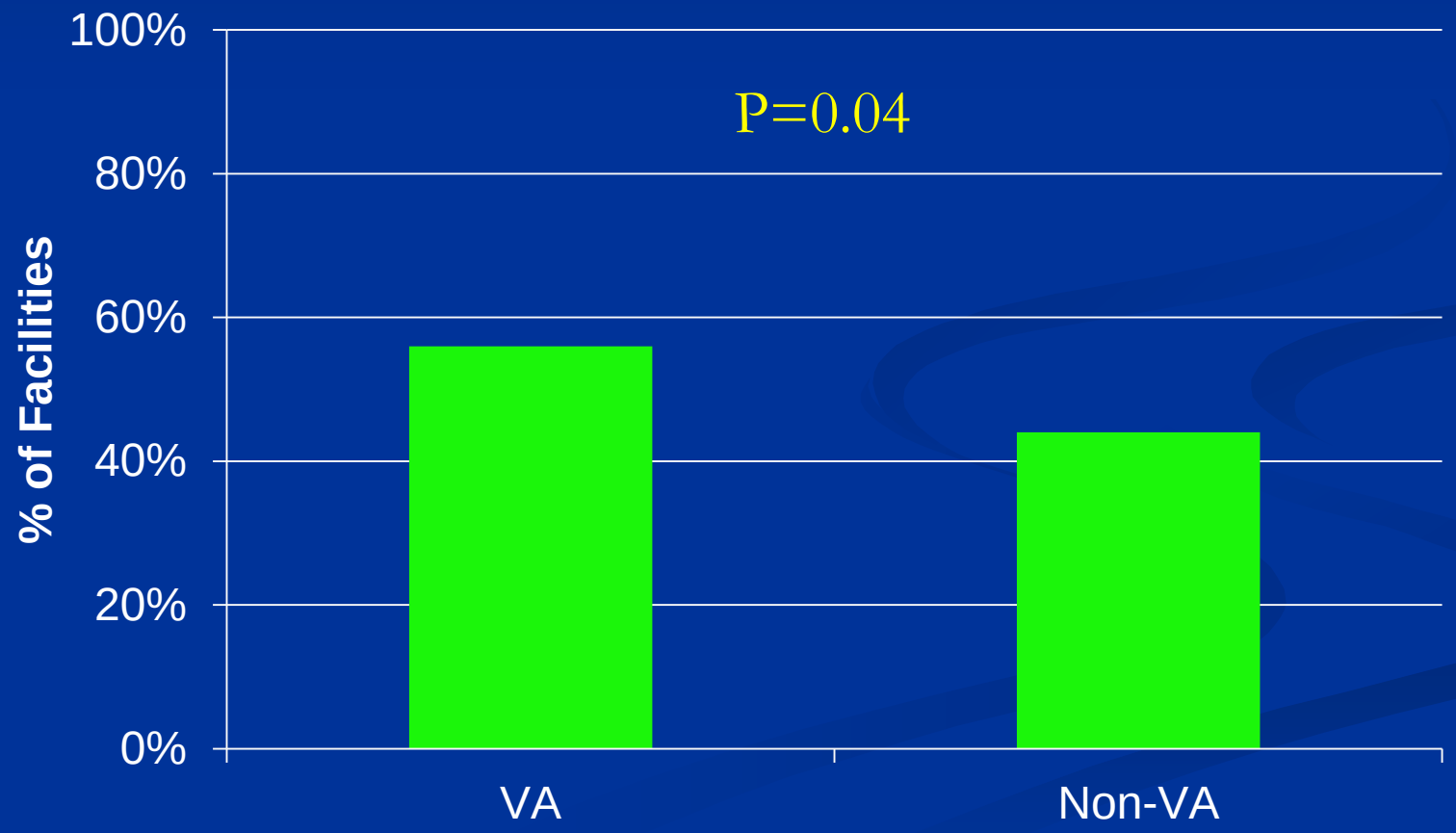
Tracks 7 day Follow-up Appointments



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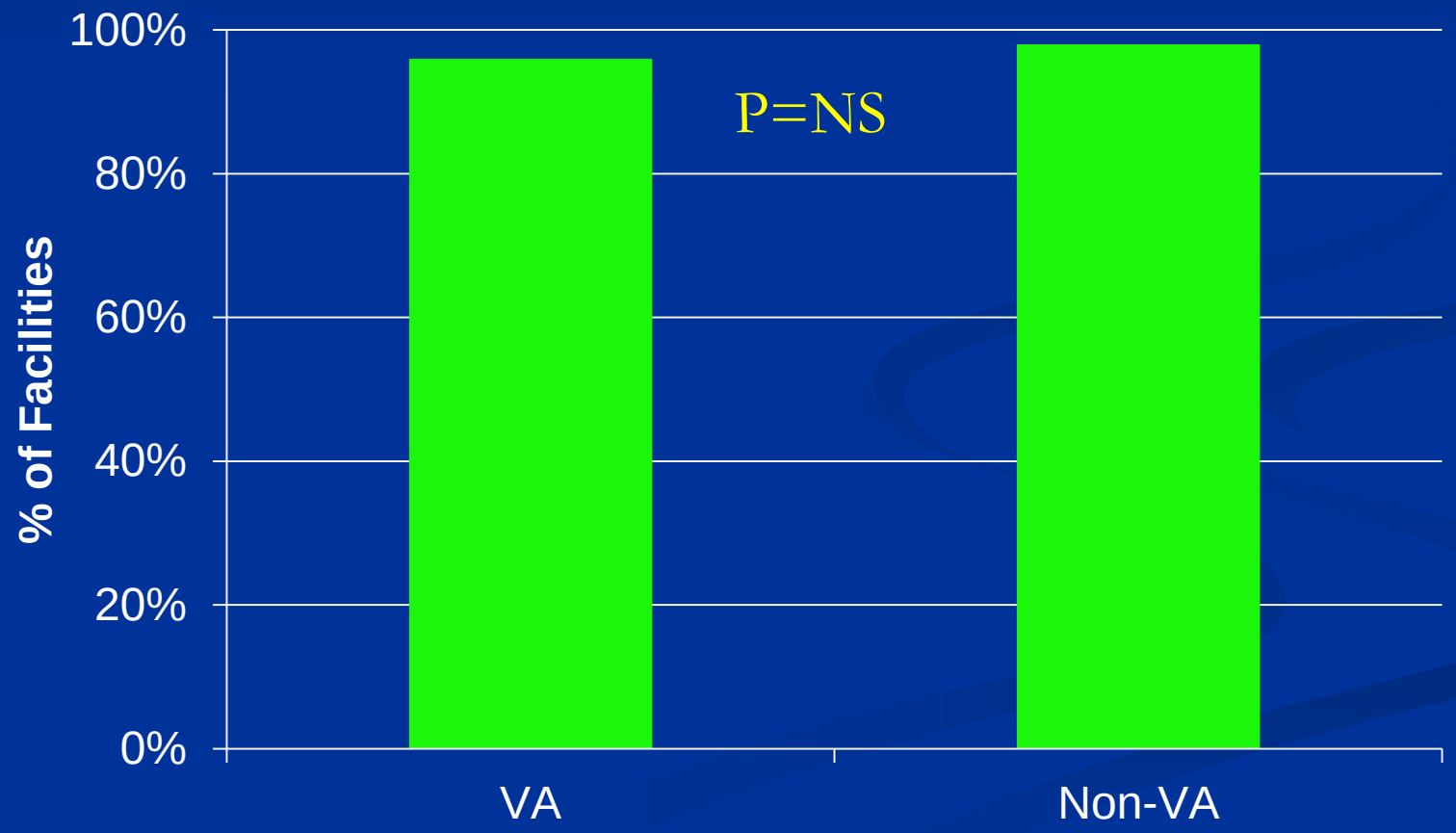
Tracks 30-Day Readmission Rates



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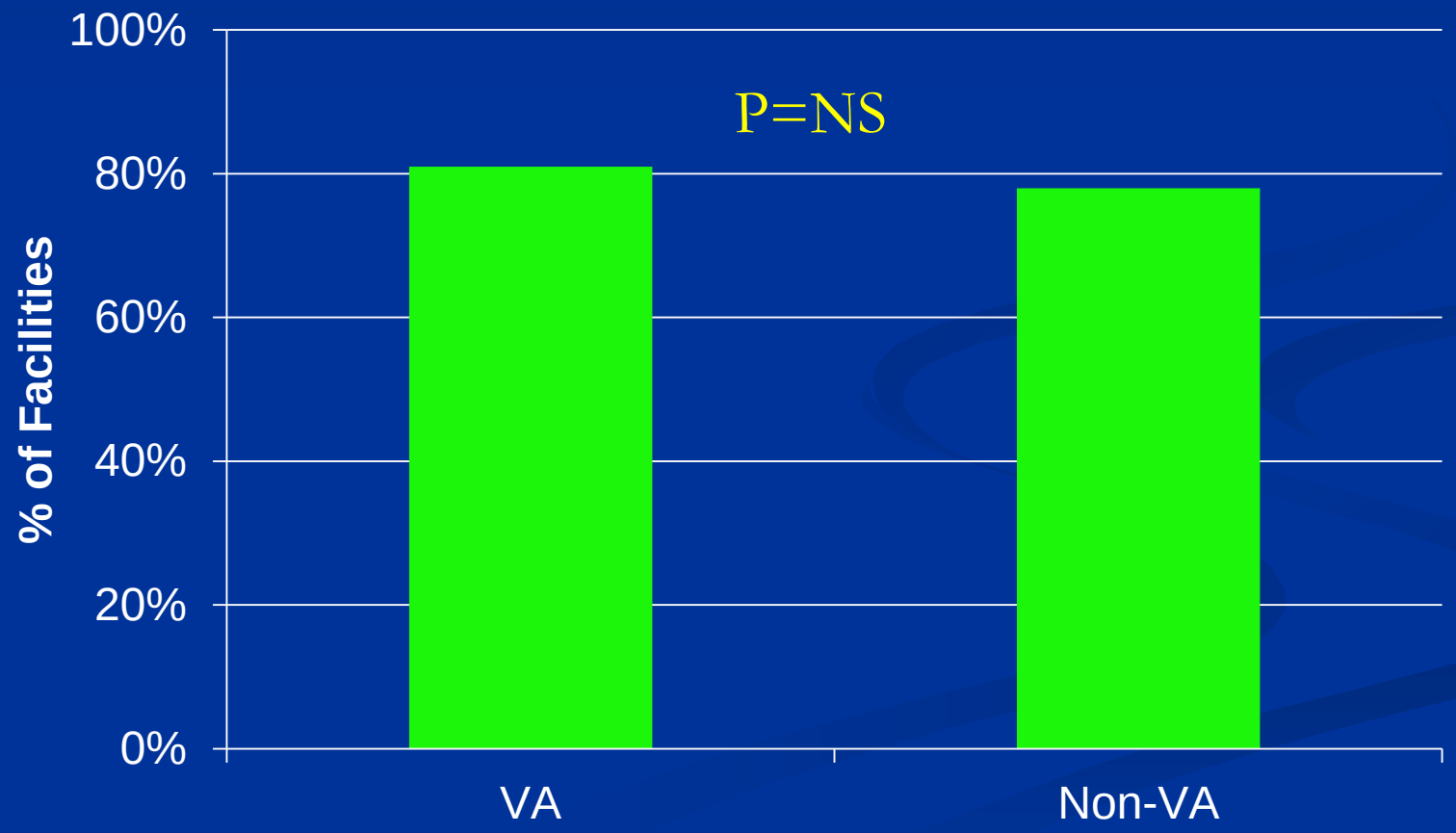
Patients Receive Detailed Medication Education



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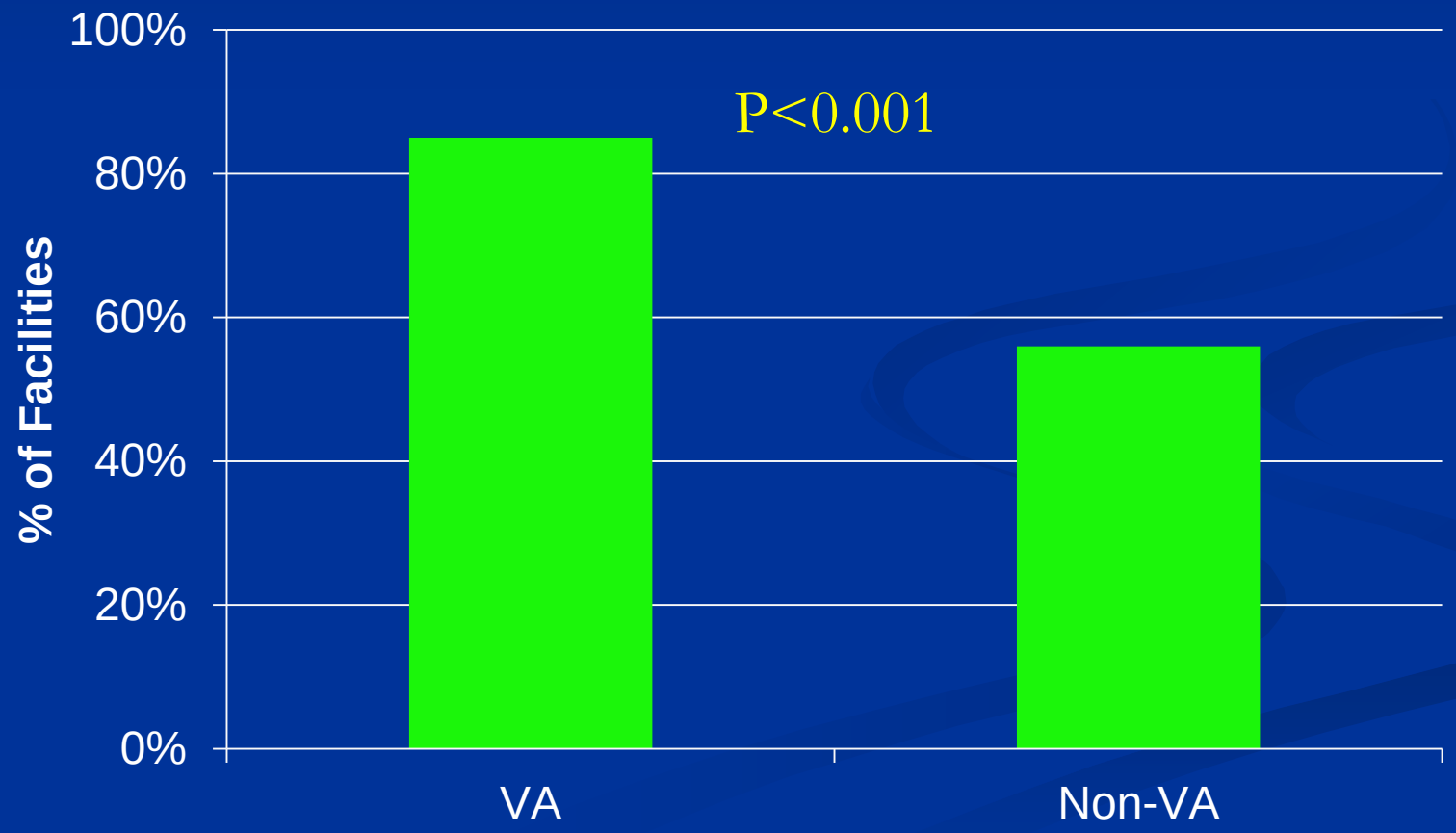
Pharmacist Involved in Taking Medication History



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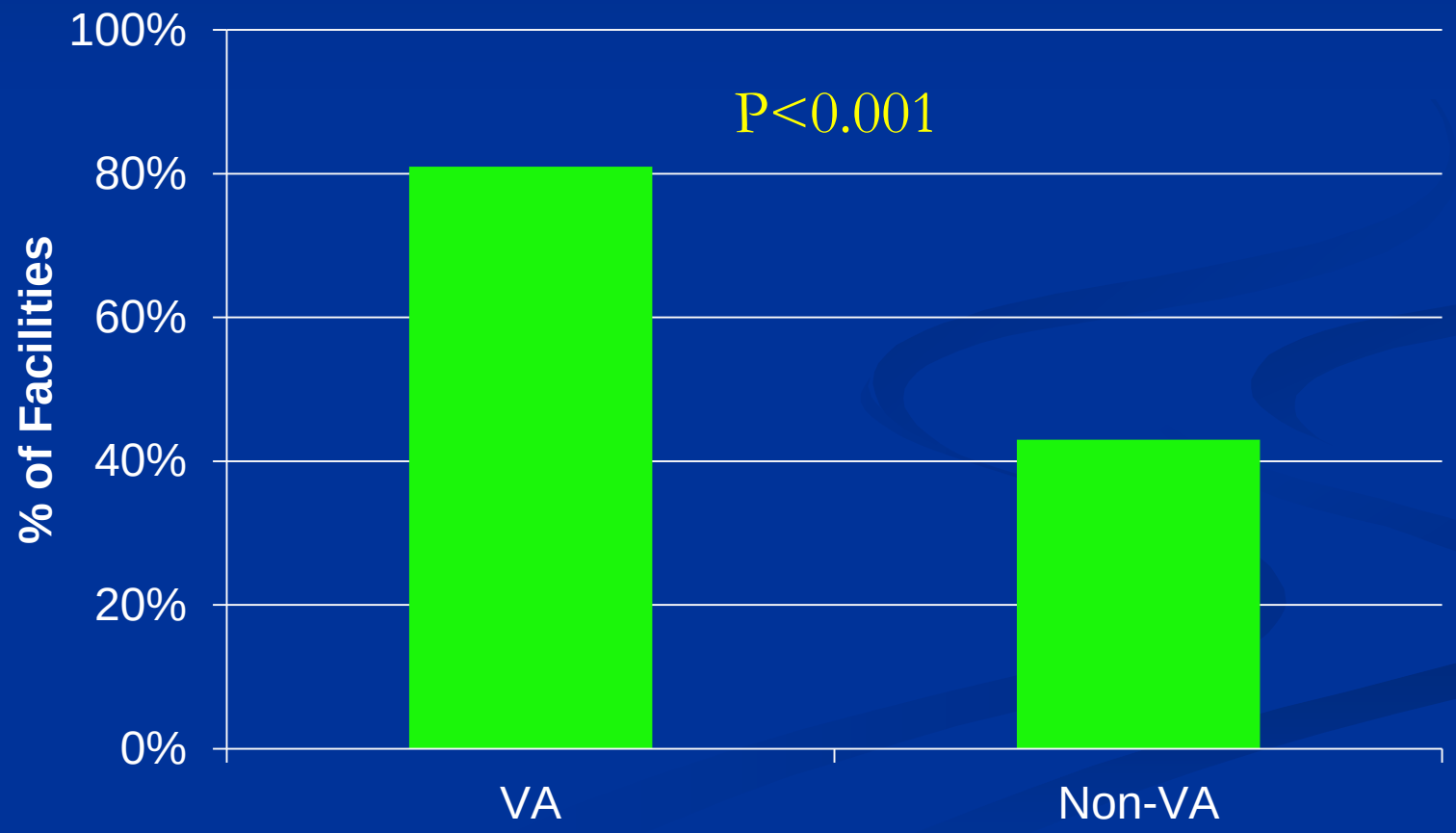
Pharmacist Involved in Medication Reconciliation



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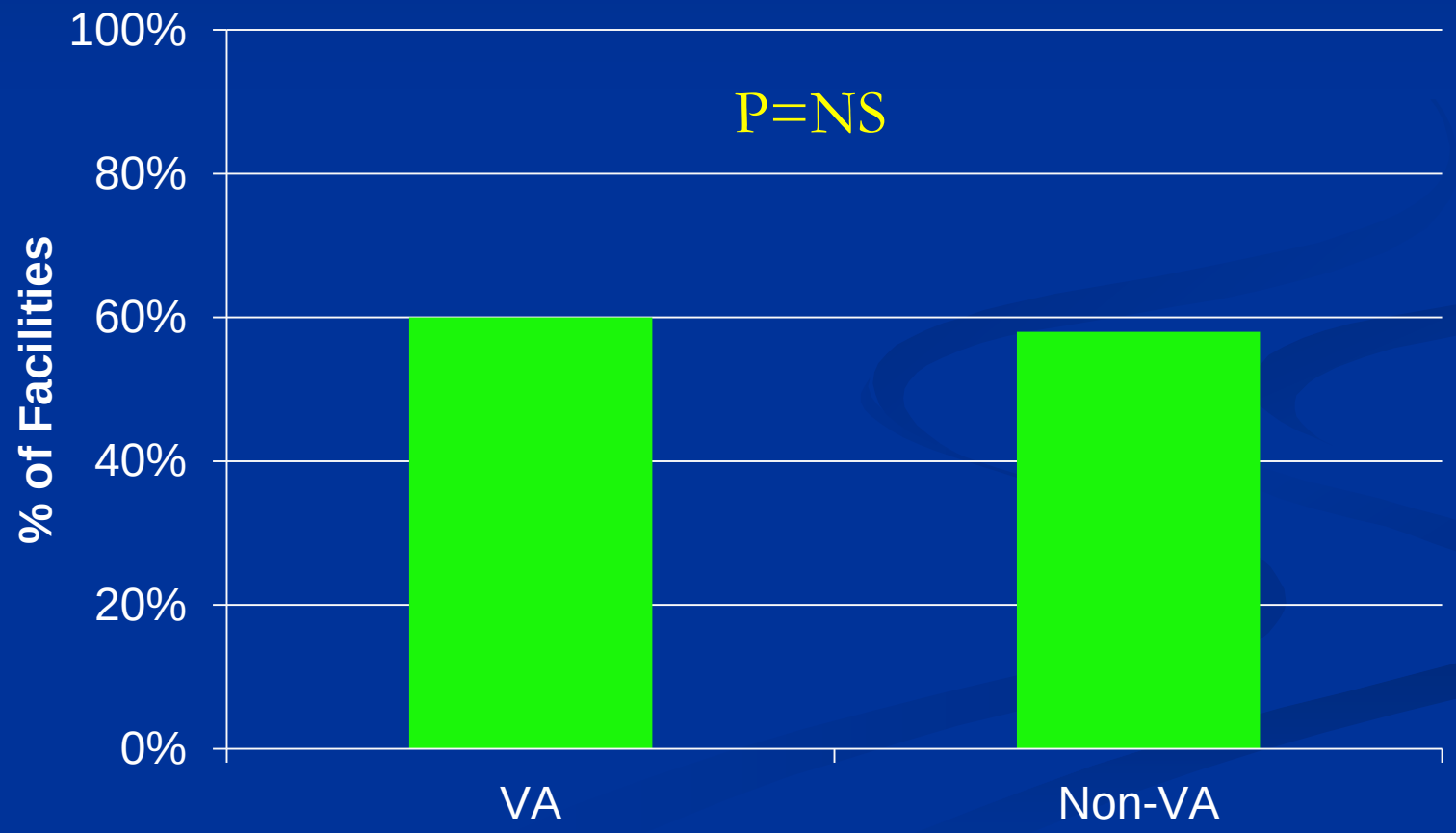
Emergency Plan to Contact Provider



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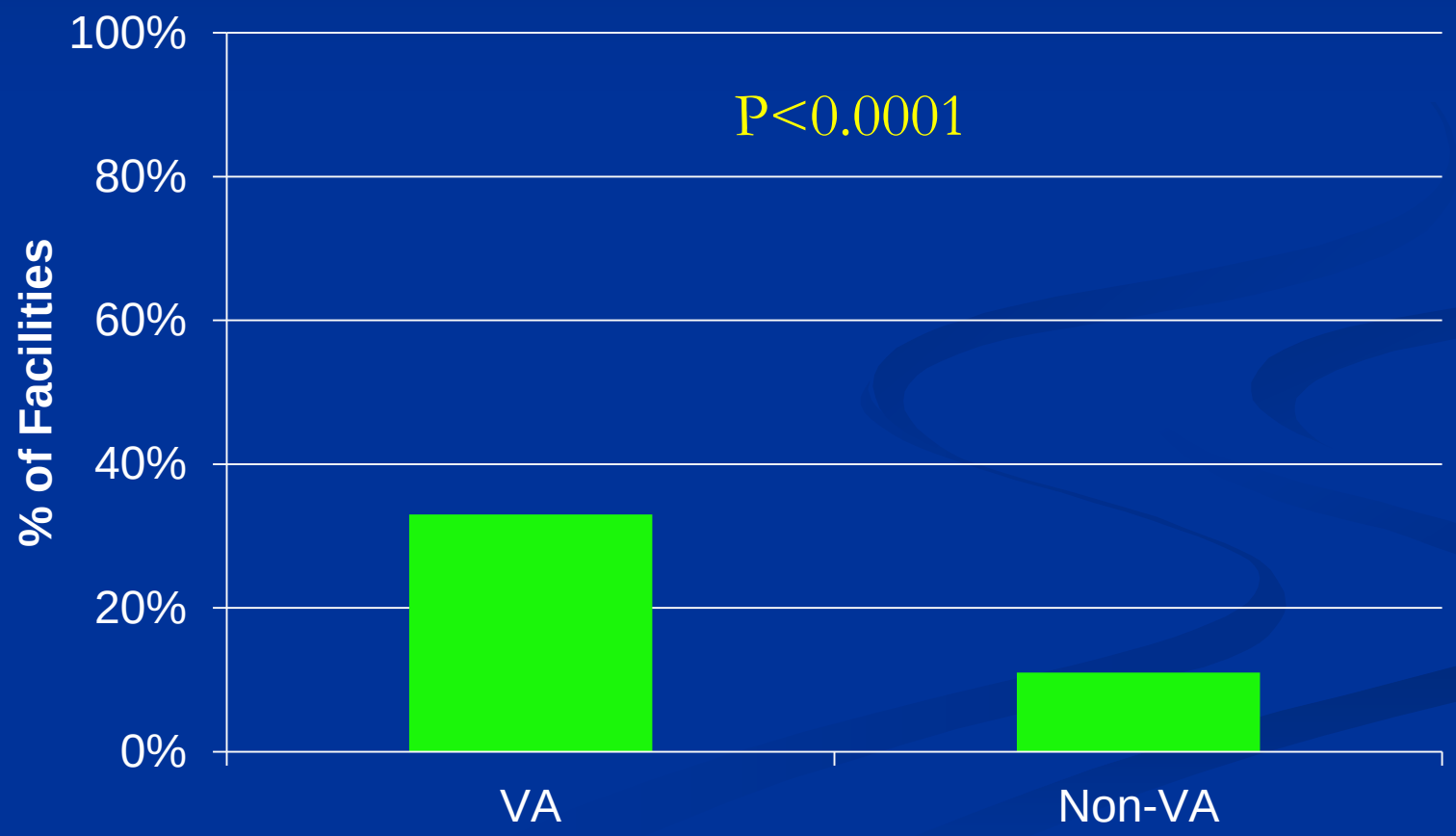
Outpatient Follow-Up Arranged at Time of Discharge (Always)



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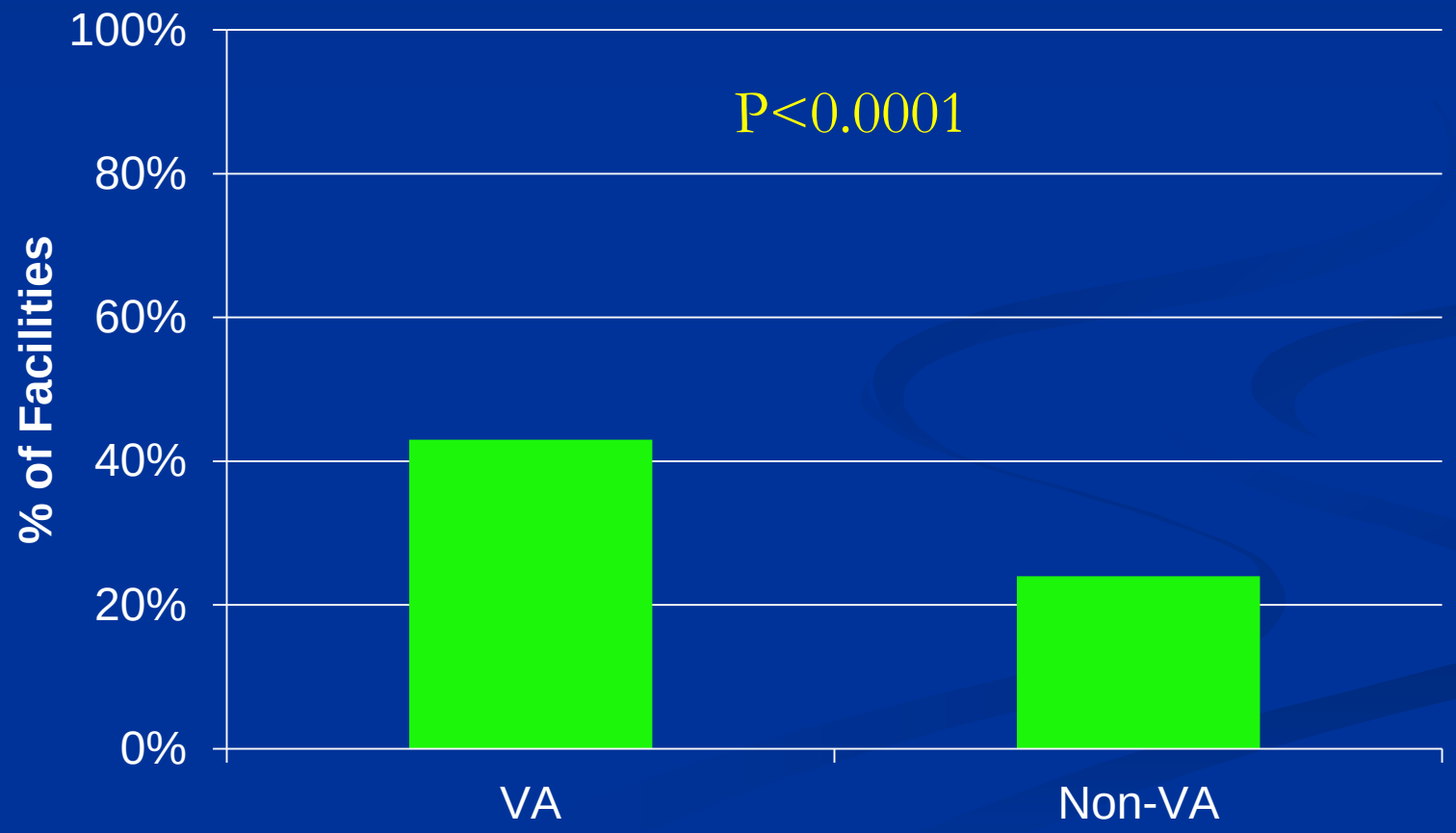
Summary Sent to Outpatient Provider (Always)



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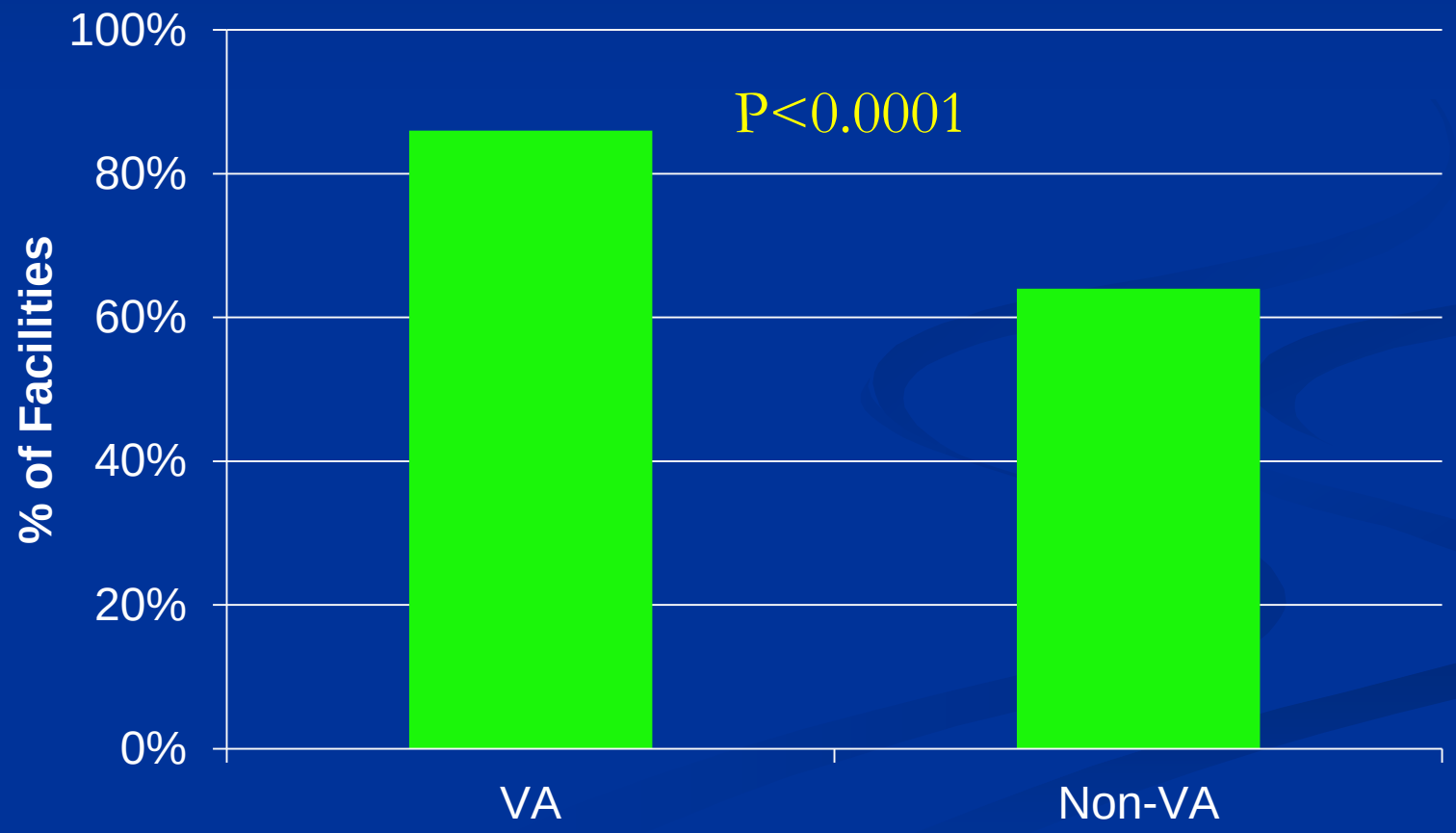
Post-Discharge Call to Patient



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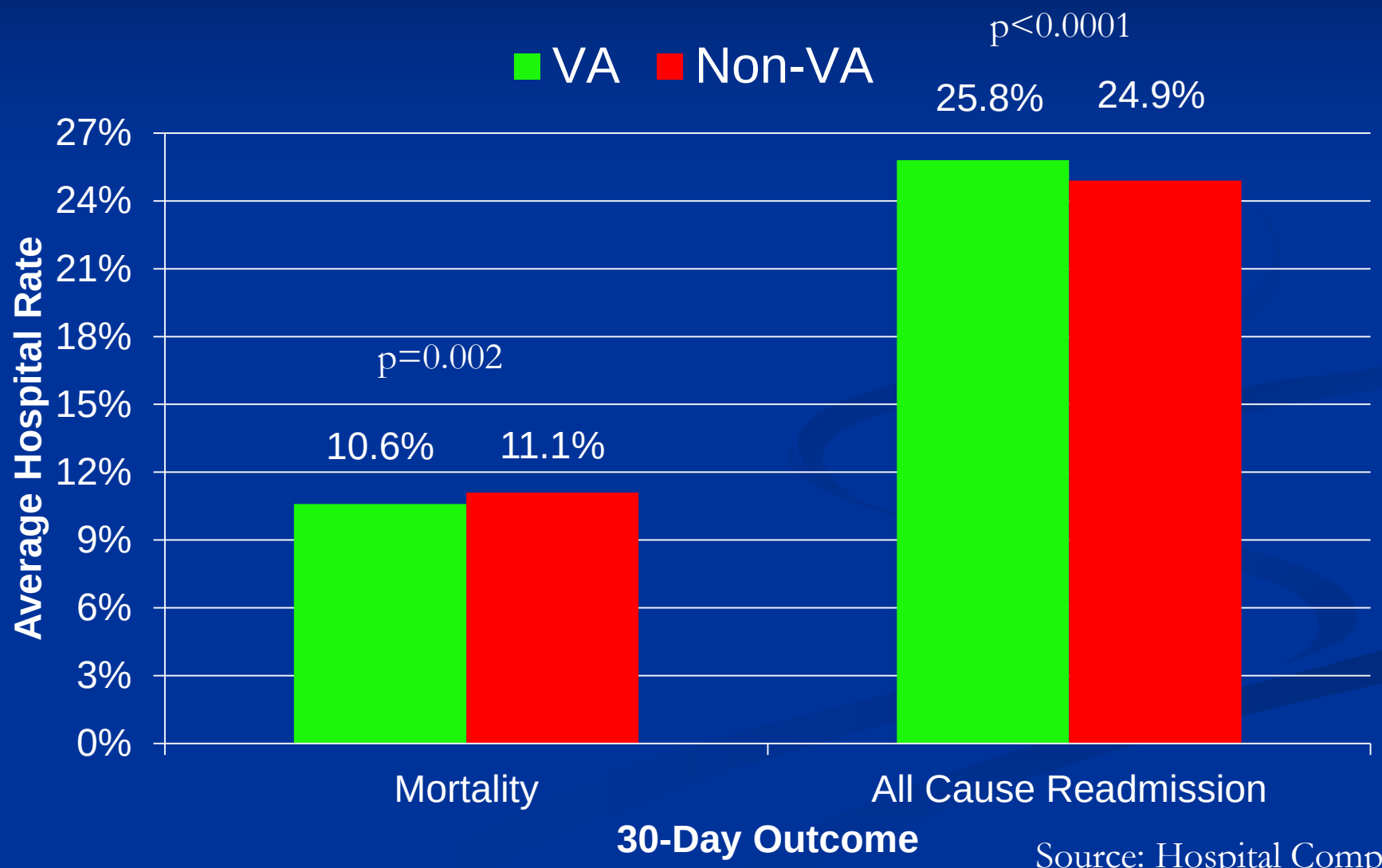
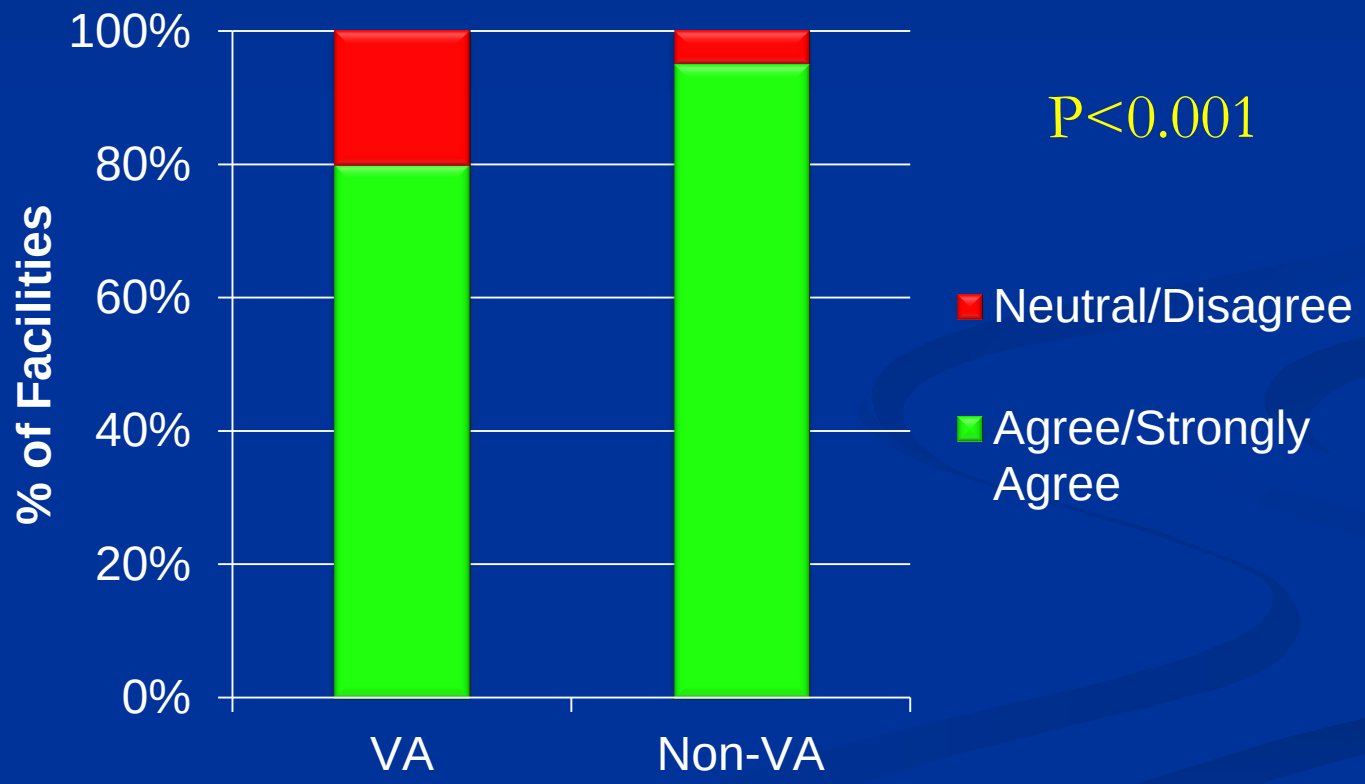
Outcome 2012: Mortality Better, Readmission Worse than Medicare



Source: Hospital Compare

Hospital Has Reducing Preventable Readmissions As A Written Objective?



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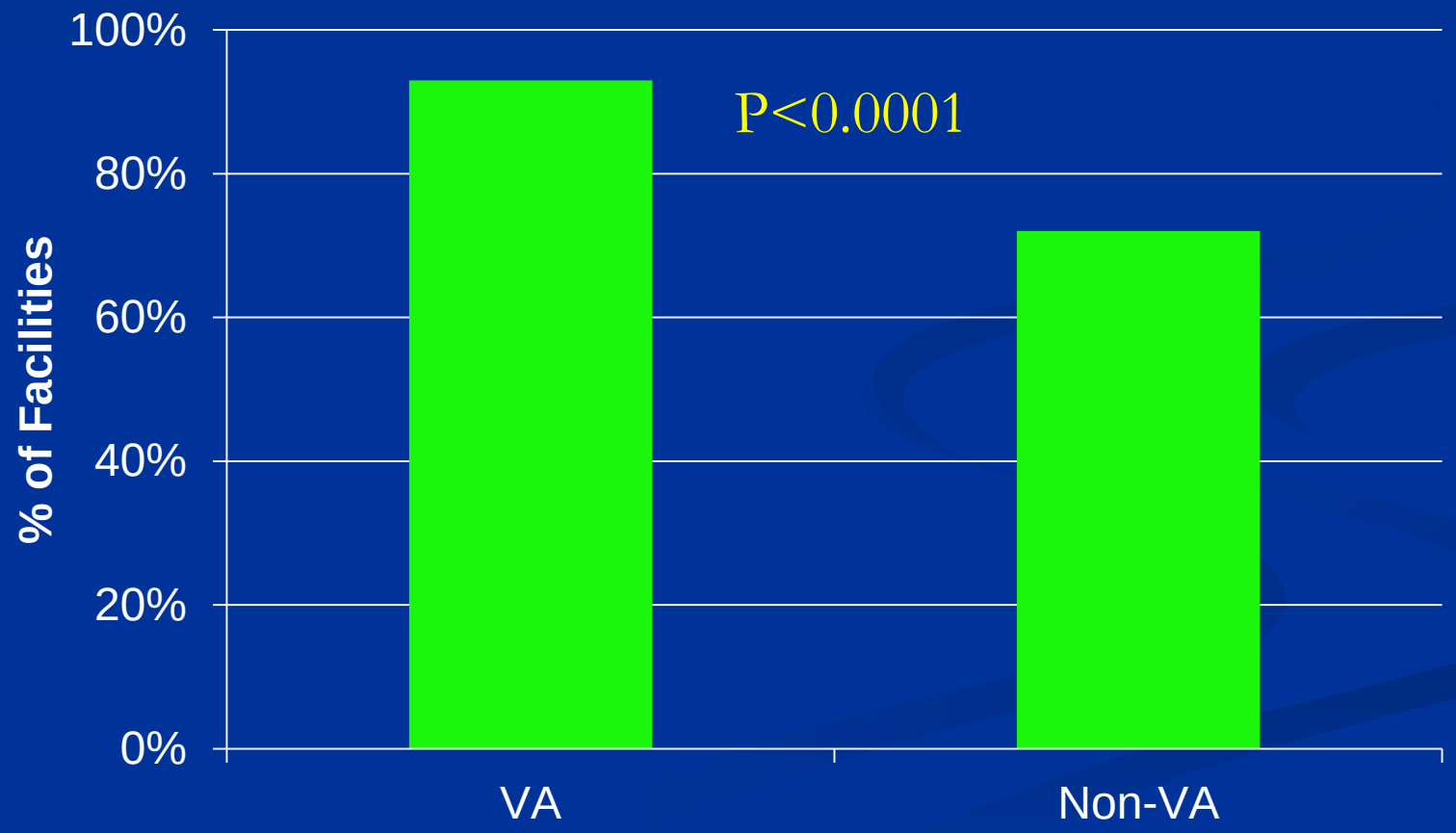
Use Telemonitoring for Some Patients



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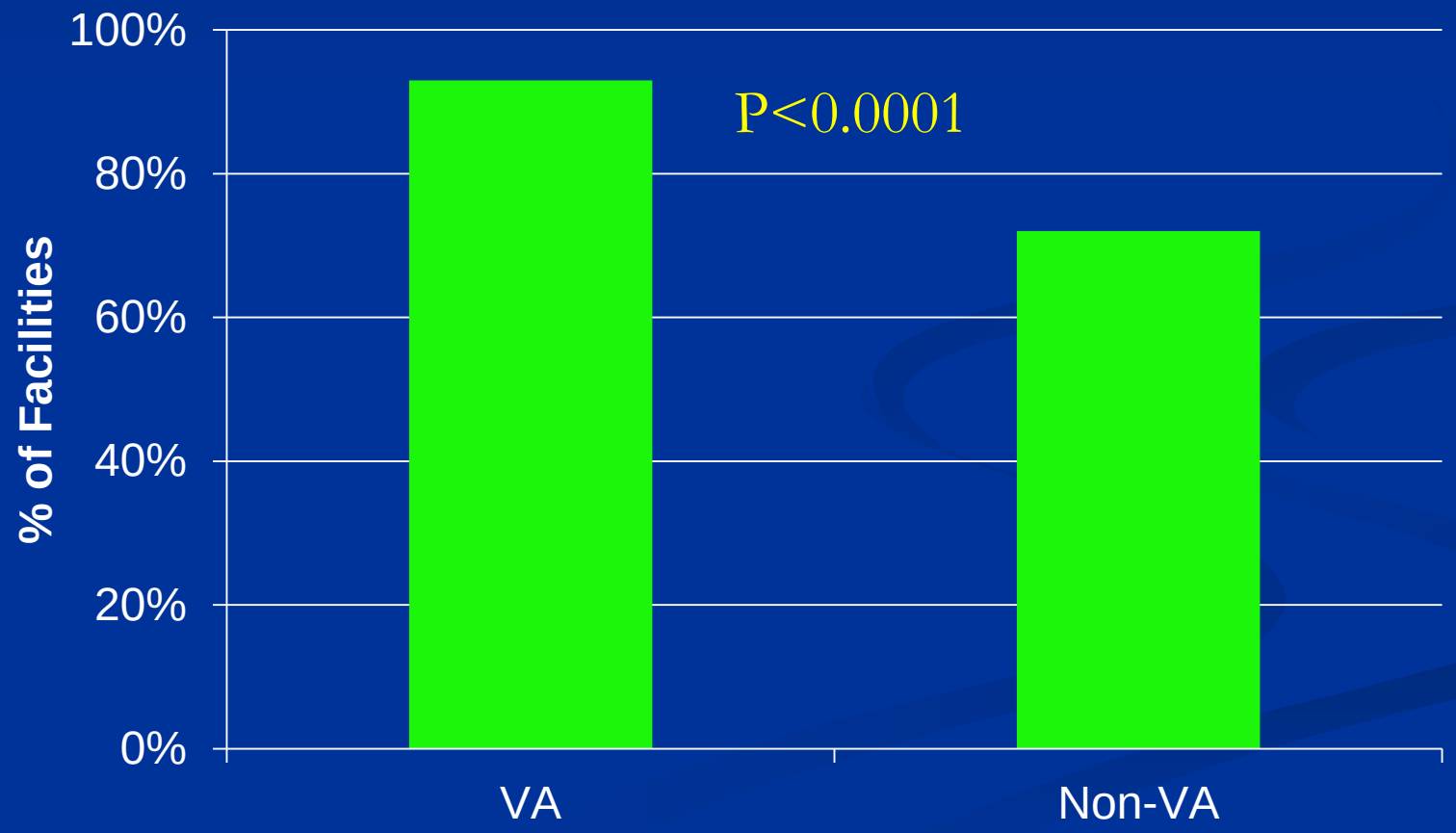
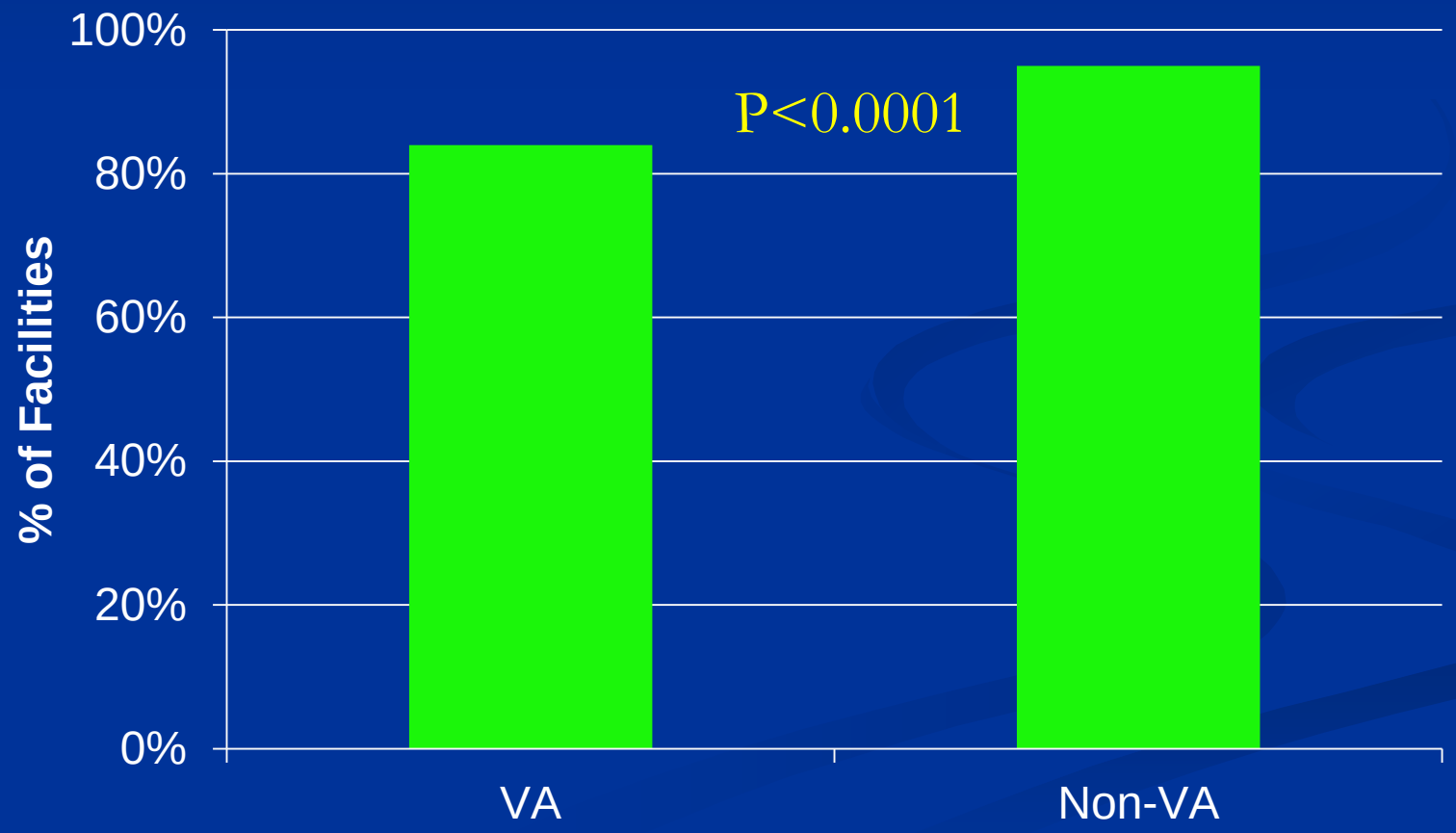
Use Disease Management for Some Patients



CHF QUERI unpublished data

Use Rehab for Some Patients



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Summary

- VA H2H hospital enrollees have overall better transition of care process of care using the 10 key activities compared to non-VA H2H enrollees.
  - Computerized medical record
  - Pharmacy involvement
- Exceptions
  - Fewer QI teams for HF
  - Less cardiac rehab (not a key activity)