



# California

## CHAPTER

### ***Case Report: The CA ACC Quality Committee's goal to help our members improve the transition of their patients from the hospital to the community***

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#### **Chief Complaint: "Re-admitted to the hospital with HF and AMI"**

I am sure that the majority of our members are aware of the quality measures and patient care readmission initiatives that occur in our hospitals. However, most of may not know the history and rationale behind these efforts and how the CA ACC can help to improve the quality core measures for the management of patients with acute myocardial infarction (AMI) and heart failure (HF) leading to improved patient outcomes.

#### **History:**

In 2001 the Joint Commission (with input from clinical professionals, health care provider organizations, state hospital associations, health care consumers) announced initial core measurement areas for hospitals, which included acute myocardial infarction (AMI) and heart failure (HF). At the same time the Joint Commission worked with the Centers for Medicare & Medicaid Services (CMS) on the AMI, and HF sets that were common to both organizations. The goal was to minimize data collection efforts for these common measures and focus efforts on the use of data to improve the health care delivery process.

In order to promote high quality, patient-centered care and accountability, CMS and Hospital Quality Alliance (HQA) began publicly reporting 30-day mortality measures for acute myocardial infarction (AMI) and heart failure (HF) in June 2007 (then extended to pneumonia [PN] in June 2008). Since then CMS has expanded these publicly reported outcome measures to include 30-day readmission rates for these conditions and in-hospital complications along with mortality. The goal was to increase the transparency of hospital based care quality, provide useful information for consumers to chose venue of care, and assist hospitals in their own quality improvement efforts.

#### **Exam and Results:**

In October 2012 the Affordable Care Act added section 1886(q) to the Social Security Act established the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to inpatient prospective payment system (IPPS) hospitals with excess readmissions for the applicable conditions of AMI, HF and PN. This policy was finalized in 2013, and so as health care providers we should be more aware of federal penalties associated with the care (readmission within 30 days) of patients with a diagnosis of AMI and HF.

#### **Assessment and Plan:**

The ACC's Hospital to Home (H2H) Initiative is a resource for hospitals and cardiovascular care providers committed to improving transitions from hospital to "home" and reducing their risk of federal penalties

associated with high readmission rates. This initiative is meant to fill the gap that currently exists during this transition of care.

The ACC Hospital-to-Home (H2H) is specifically designed to help its members to better understand and anticipate transition issues that are likely to affect readmission rates. The goal of this program is to **reduce 30-day all-cause risk-standardized readmission rates for patients' discharges with HF or AMI by 20%.**

Rather than imposing and advocating specific strategies, the H2H project will provide a central clearinghouse of information and toolkits geared to improve care transitions and reduce readmission rates. The H2H program has three specific initiatives to help your center to improve their readmission quality measures:

- **See You in 7 program:** The goal of the H2H SY7 Challenge is to confirm that patients discharged with a diagnosis of HF/AMI to have a follow-up appointment scheduled for outpatient of the admitting condition and for cardiac rehab referral set within 7 days of hospital discharge.
- **Mind Your Meds:** The goal of the H2H MM Challenge is for patients with HF and MI to have clarity of understanding their discharge prescriptions and reconcile their discharge prescriptions with their previous outpatient medication list and ensure optimal medication management.
- **Signs and Symptoms:** The goal of the H2H S&S Challenge is to activate patients for earlier recognition of disease and medication adverse events and have a plan to address them as an outpatient to avoid unnecessary admissions.

Since 2013 the following has changed with regard to patient care quality measures in the community:

- Partnering with local hospitals
- Discharging patients with follow-up appointment
- Tracking percentage of patients with 7 day appointment
- Estimating risk for readmission
- Using electronic form for medical records
- Providing action plans to discharged HF patients
- Calling patient after discharge

If your institution is not doing this then it is time to get involved with the ACC H2H program.

**Follow up (Comments from our Quality Committee members):**

**Pranav M. Patel, MD, FACC (Chair, CA ACC Quality Committee):**

*"From a personal standpoint having gone through a recent and successful Joint Commission recertification for our heart failure program; and working with our administration and staff to successfully reduce our AMI and HF readmissions (and length of stay) has been made more easier with the ACC toolkits and NCDR registry information.*

*At our institution we have we have gone further and also now improved our program by forming a hospital wide Cardiology Mortality committee which reviews all cardiac related mortality and morbidity on a regular basis (with a goal to improve a quality measures). We routinely examine length of stay and readmission date for AMI and HF. We have also designed a Cardiology "documentation tool" to help our physicians and coders by encourage appropriate documentation. We have seen an improvement in our length-of stay, readmissions, complication rates and mortality numbers for HF and AMI. Such improvement can easily be attained by any institution, especially with the tools that are available from the ACC."*

**The H2H plan** can help initiate similar programs at various institutions. Eventually many facilities will adapt these programs for their own needs. The ACC provides programs to help institutions improve their hospital to home data by improving on the quality of care provided to patients. Healthcare providers do not have to come up with a new plan, but can use the ACC programs to help with tailoring a plan for their own needs. In the same respect, ACC programs can also benefit from other ideas that will strengthen our own program goals".

**Sandeep Krishnan, MD (Fellow, Cedars Sinai):**

*"The H2H program is a great idea to give healthcare providers across the state and country tools they can use regardless of the type*

of system they work in to help them lower readmission rates for their patients with CHF and AMI. In my personal experience both during residency and fellowship I have found that my patients with the highest risk for readmission were those who are taking so many medications that they could not keep them all straight. One technique that I have employed is asking their family members to bring every single medication bottle the patient has at home into the hospital at some point during the admission (including herbal, OTC, supplements). Every time or at least every other time I have done this I have found that patients have two of the similar kinds of medications at home because they got them from two different physicians neither of whom knew that the patient was already taking one of the meds in that class. Unfortunately, I feel that this occurs more than any of us are aware. One way we could incorporate this into the H2H program is encouraging hospitals pharmacists or nursing staff to become involved in the process of medication reconciliation on discharge. Another point as part of the **"See you in 7 challenge"** is that we should try to get the patients who are being discharged within the next 24-48 hours an appointment before they even leave the hospital".

**Ajit Raisinghani, MD, FACC (UCSD Medical Center):**

*"One of the factors that we have found to be important in reducing the readmission of heart failure patients here at UCSD is working closely with nursing homes or rehabs where these patients have often been discharged. We have found it important to work closely with a few and if possible provide some training so that patients are not simply sent back to the ER at the first sign of any heart failure symptoms."*

**Jin Kyung Kim, MD, PhD, FACC (UC Irvine)**

**See You in 7 program;** *"At UCI is already doing a close post-hospital follow up with an post-discharge appointment within 7 working days for the patient to be seen at any of the cardiology ambulatory sites. Opening the clinic slots to other general cardiologists and NPs who may not be the patient's regular care provider but who is qualified to quickly check the clinical status of these patients and do the med reconciliation at these post-hospital f/u will likely to reduce the 30-day readmission rate. In addition, if the patient cannot make the clinic appointment, we also do a telephone call to follow up".*

**Mind Your Meds program:** *"All our ancillary clinic staff (Nurses and MAs) are performing med reconciliation at every visit with good results".*

**Signs and Symptoms:** *"At UCI, there are several mechanism to help patients recognize early warning signs - these include the post-hospital f/u phone calls, HF NP rounding WHILE the patient is hospitalized and education that occurs during these rounds, and simple hand-outs explaining the symptoms and signs that the patients can pay attention to and provide a guideline as to what they can do at home. I find these work very well. I would like to add that a consideration to an implantable PA monitoring device such as CardioMEMS should be given to qualifying patients, as we are doing at UCI".*

**Amit Bahig, MD (Fellow, UC Irvine):**

*"In my experience, patient education and medication reconciliation are critical in reducing hospital readmissions. By removing redundant and potentially harmful medications and highlighting the necessary ones, this exercise tends to enhance patients' feeling of control over their medications. Also, I find compartmentalizing medications by their effects on organ systems helps focus the emphasis on those that will help them stay out of the hospital. Finally, I find that patient counseling has a much greater impact when administered in the presence of family/friends. Requesting them to be present on discharge day or clinic visit has helped me in my experience".*

**Normal Lepore, MD, FACC (Cedars Sinai, President, Southern California Governor, CA ACC):**

*"All great ideas. In my experience, a big gap in the hand off of care from inpatient to outpatient has been an accurate list of medications that is provided to the outpatient treating cardiologists and PCP. This leads to a lot of confusion and medicine errors as not every hospital formulary carries the same exact drugs as the patient may be taking as outpatient. So for instance, a patient may be taking olmesartan as outpatient but given valsartan on discharge then when patient arrives to out patient visit is taking both. Lots of confusion here at this transition point that can be better handled then it is. Also, best to have our protocols/guidelines to not just take into consideration the official ACC/AHA guidelines but also introduce new treatments...that have been introduced into the marketplace."*

What are your thoughts? Please let us know:

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