

Introduction

Ix Insight #1: In 2006, hospitals spent more than \$30 billion on unnecessary readmissions. An Agency for Healthcare Research and Quality (AHRQ) report estimated that hospitals spent almost \$31 billion on over 4 million unnecessary readmissions.

Ix Insight #2: Almost 20% of Medicare beneficiaries are re-hospitalized within the first 30 days of hospital discharge; heart failure is a major readmission priority for the federal government.

- In 2004, there were 17.4 billion unplanned hospital readmissions.
- Heart failure is an area of particular concern with 26.9% of those discharged with heart failure readmitted within 30 days.
- More than half of those discharged with heart failure had no associated outpatient visits billed to Medicare within first 30 days of discharge.

Ix Insight #3: Reducing hospital readmissions is an important cost-control opportunity in the health care reform debate. Readmissions fit in with the priorities of the Obama administration and many congressional leaders, who want to improve cost-effectiveness by reducing:

- expensive errors
- duplication
- unnecessary procedures

Ix Insight #4: Legislative leaders are considering new payment policies to encourage more effective use of resources and to support positive patient outcomes. The current payment system financially rewards hospitals for readmissions, many of which are preventable. Potential solutions include the following approaches:

- reduced payments to hospitals with higher readmission rates
- provide bundled payments to hospitals with higher re-admission rates
- provide bundled payments to all hospitals

Hospital to Home (H2H): Excellence in Transitions

The screenshot shows the ACC website with the following content:

- Header:** "6 1949-2009 AMERICAN COLLEGE OF CARDIOLOGY" and "Helping Cardiovascular Professionals Learn. Advance. Heal." with a search bar.
- Navigation:** Home, Member Center, Products, Programs, Conferences, Jobs, E-Store, Links, Chapters, Join, Support, Heart House.
- Main Content:**
 - H2H Hospital to Home:** A large graphic with the H2H logo and the text "Excellence in Transitions".
 - About H2H:**

The Hospital to Home (H2H) is a national campaign to reduce preventable readmissions for patients recently hospitalized with a cardiovascular condition, the leading cause of hospitalization in the United States. The American College of Cardiology and the Institute of Healthcare Improvement, organizations with a successful record of improving care, are combining forces and developing partnerships to form a campaign to improve the transition of patients from inpatient to outpatient status. About one in five patients hospitalized with cardiovascular conditions are readmitted within 30 days and studies suggest that many of these readmissions can be prevented.

Building on the success of the D2B Alliance, we are developing a campaign that will improve practice. Details will emerge over the next few months, but join now by signing up your hospital and becoming part of this national effort. Your enrollment signals a commitment to be a part of improving care. We will launch officially in June, but be a part of this effort from the beginning!

To register and receive more information on the H2H initiative, [click here](#).
- Left Sidebar:** About ACC, Membership, Education, Quality and Science, Practice Management, Advocacy, Publications, Media Center, ACCOS REGISTER NOW!, Cardiosource, CardioSmart.

Ix Insight #5: Quality improvement (QI) initiatives have the potential to reduce hospital readmission rates by spreading innovation around strategies to eliminate unnecessary variation. The Hospital to Home (H2H) initiative (developed by ACC and the Institute for Health Care Improvement) aims to influence change based on these principles. H2H officially launches in the Summer of 2009 and likely will include at least 1,500 hospitals as well as many collaborating organizations, health care systems and clinical practices.

Ix Insights #6: A coherent combination of approaches and tools allow multiple stakeholders to participate with a vision to achieve the same goal – improved patient outcomes through care transitions. A community of collaborators is more likely to be able to:

- Ensure reliable, safe and health-enhancing transitions for patients
- Provide straightforward, evidence-based recommendations for improving transitions
- Disseminate customizable ideas, tools and strategies
- Provide an online forum for participant hospitals to share strategies and successes
- Leverage the expertise and experience of other organizations

Ix Insights #7: Approaches to improving health outcomes should be patient-centered.

In the process of planning the H2H initiative, patient-centered focal points naturally emerged, each of which has key Ix opportunities:

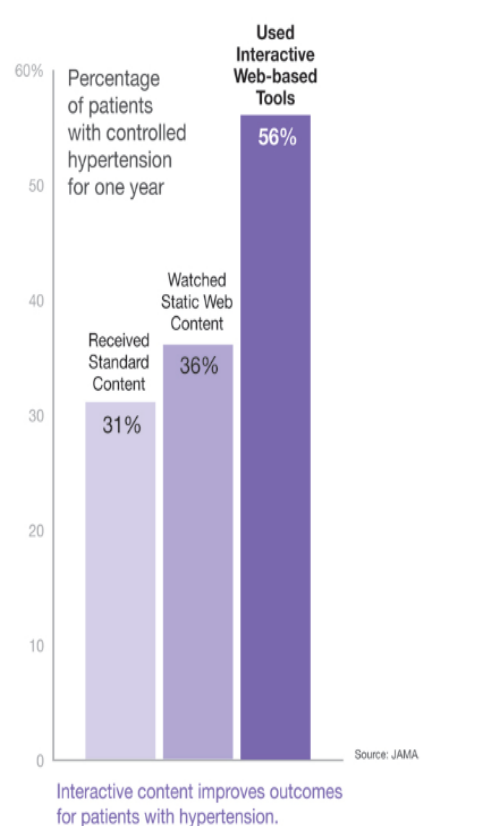
- Pre-discharge education/assessment
- Medication reconciliation
- Follow-up within specific timeframes
- Home health

Ix Insights #8: Patient-centered ideas should translate into measurable outcomes – in terms of patient understanding, self-efficacy, and access. H2H focuses on three main concepts around the patient, which are their:

- The patient's familiarity and access to their prescribed medications
- The patient's ability to schedule and travel to follow-up appointments with 1-2 weeks post-discharge
- The patient's understanding of critical health concerns and when and where to seek medical attention.

Discouraging Unnecessary Readmission by Engaging Patients

Ix Insight #9: Patient education results in better health outcomes. According to another 2008 JAMA study, patients using interactive web-based education tools were almost twice as likely to have their condition under control after one year.

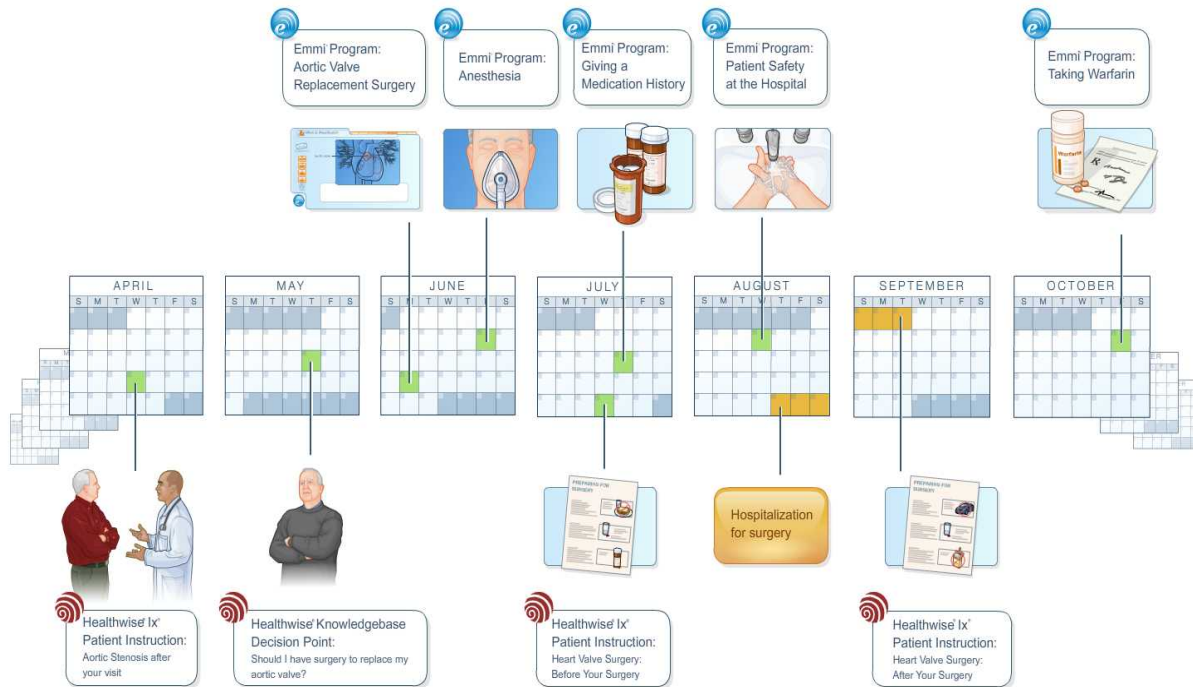


Ix Insight #9: Patient education and engagement is possible, and likely enhanced through multimedia programs. Emmi and Healthwise build on both of their areas of expertise – communications and a health knowledge database – to engage consumers in the ongoing process of learning about and maintaining their health. The importance of timing, which is a critical component of health information is illustrated below.

Ix Insight #10: By providing patients and families with information targeted to the appropriate moment in care, we can enhance health outcomes and reduce hospital readmissions. After discharge, several time-sensitive opportunities to promote health can be supported by Ix interventions at specific points along the care continuum, including:

- self-care
- self-triage (knowing when to seek medical attention)
- self-management of chronic illness (knowing how and why medication works)
- decision support

The diagram below illustrates the continuum of care after hospital discharge. The patient is engaged in a series of standardized, high quality conversations to encourage a safe transition home.



IxCenter Resources

To read about a **Reengineered Hospital Discharge Program**, see the May 2009 Ix Research Briefing, located in the member portal:

<http://www.informationtherapy.org/members/research.cfm>

For the PowerPoint presentation, visit the IxInsights section of the member portal:

<http://www.ixcenter.org/members/insights.cfm> and click on “PowerPoint Presentation” for IxInsights #45.

Additional Resources

Stephen F. Jencks et al. 2009. Rehospitalizations Among Patients in the Medicare Fee-for-Service Program. *New England Journal of Medicine*, 360, 1418-28.

Beverly B. Green et al. 2008. Effectiveness of Home Blood Pressure Monitoring, Web Communication, and Pharmacist Care on Hypertension Control. *Journal of the American Medical Association*, 299(24), 2857-67.

For more information, and to enroll in the H2H national quality initiative, please go to:

www.acc.org/h2h/enrollment. You can also email hospital2home@acc.org

Emmi + Healthwise demo available at:

http://www.emmisolutions.com/emmi_plus_healthwise

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