As pressure builds to reduce hospital readmissions throughout the country, early follow-up has been in the spotlight across the cardiovascular profession. While early follow-up is a key component in improving heart failure (HF) and acute myocardial infarction (AMI) readmission rates, most patients with these conditions are not seen by a physician within 30 days after a hospitalization.

A study published July 18 in the *Journal of the American College of Cardiology* (JACC), which found substantial variability overall in hospital practices to reduce readmissions of patients with HF or AMI. The study noted that fewer than one-third (32.1 percent) of hospitals surveyed reported keeping track of patients having follow-up appointments within seven days of discharge.

In an effort to reverse this trend, the ACC’s Hospital to Home (H2H) initiative has spent the last year challenging practitioners to better understand and tackle readmission problems, including lack of early follow-up. “See You in 7” was the first of three challenges in the H2H Challenge program. Challenge participants had access to toolkits, webinars and surveys to capture and share experiences with other participants, providing the H2H community with an online repository of strategies and tools to build on.

The ACC’s Michigan Chapter recently took the “See You in 7” challenge one step further by teaming up with the Greater Detroit Area Health Council (GDAHC) and 12 Michigan hospitals to establish the Southeast Michigan See You in 7 Hospital Collaborative. Michigan’s Quality Improvement Organization (QIO), MPRO, is also playing an integral role in the collaboration by providing data on appointments scheduled within seven days so that participating hospitals are aware of the progress made over the course of the year.

“This ACC Chapter and GDAHC partnership is a win-win-win combination,” said Joy A. Pollard, PhD, RN, ACNP-BC, a cardiology acute care nurse practitioner and Cardiac Care Liaison for the ACC Michigan Chapter. “We feel we have laid the foundation for a successful collaboration, and we look forward to reporting our results when the collaboration concludes next spring.” Visit H2HQuality.org to learn more about the H2H Challenges.
### See You in 7 Toolkit Process Measures

- Identifying heart failure patients prior to discharge
- Scheduling and documenting a follow-up visit with a cardiologist or primary care practitioner that takes place within seven days after discharge
- Providing the patient with documentation of the scheduled appointment
- Identifying and addressing barriers to keeping the appointment
- Working to ensure that the patient arrives at the appointment within seven days of discharge
- Making the discharge summary available to the follow-up health care provider

### Calculating Readmission Risk

Given the complexity of factors contributing to hospital readmissions, it is often difficult to determine readmission risk for patients with AMI, HF and pneumonia before they are discharged. In response, the Yale-New Haven Hospital Center for Outcomes Research and Evaluation (CORE) developed the CORE Readmission Risk Calculator. The calculator, which is available as an app or on the web, uses medical record data models developed for the Centers for Medicare and Medicaid Services and distributed through the H2H initiative. The custom tool then factors in a patient’s demographic and clinical characteristics to evaluate risk.

“It has been helpful to draw attention to the level of risk – we hear about high rates of readmission but it seems to surprise people still when they calculate it for a patient and actually see such a high number for the person in front of them,” said Harlan M. Krumholz, MD, SM, FACC, who led the development efforts.

The calculator has sparked innovation in hospitals across the country, and while unavoidable variables are always possible, the ability to anticipate readmissions risk opens doors to future advancements in the quality of patient care. “The indicators used in the tools are definitely the high risk markers, and when present they warrant close attention in achieving successful transitions along the continuum of care for heart failure,” said Linda L. Tavares, MS, RN, ACNP-BC, AACC, after experimenting with the tool.

For more information on the calculator, visit [H2HQuality.org](http://H2HQuality.org).