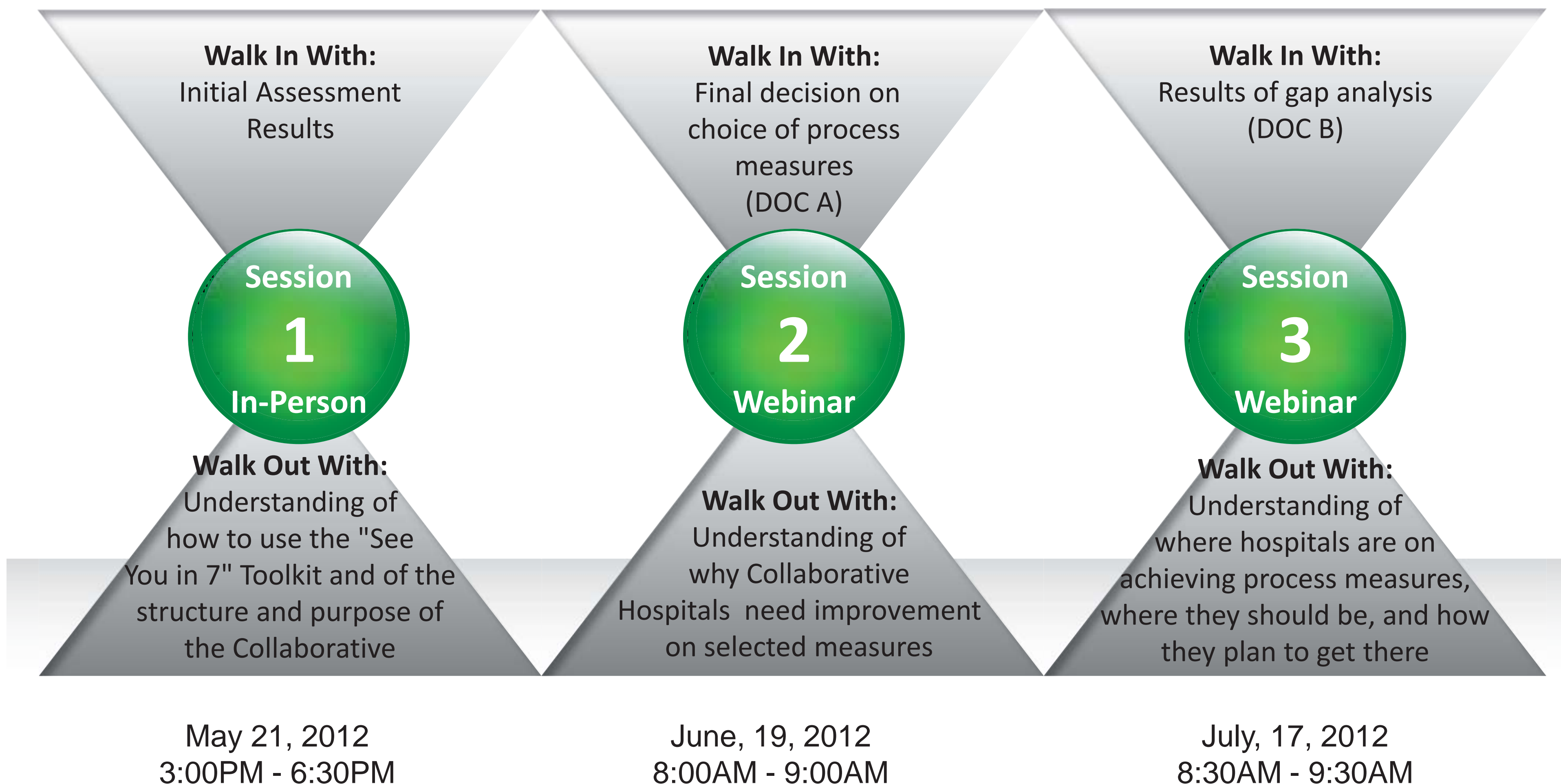
Supplementary Table 1. Structure of the Southeast Michigan "See you in 7" Collaborative

Michigan
CHAPTER

Southeast Michigan "See You in 7" Hospital Collaborative: What to Expect

Focus	Methods/Tools	Meetings
Pre-Implementation May - July	ACC Online Initial Assessment; ACC "See You in 7" Toolkit; Selection of "See You in 7" Process Measures; Analysis of where hospital is, where it should be, and how to get there	Kickoff Meeting; 2 Conference Calls/Webinars
Test Intervention Aug - Jan	Plan for Improvement; Pre-Implementation Data Submission; Collaborative hospitals to share best practices, barriers; Quarterly Progress Reports	2 Quarterly Meetings; 4 Conference Calls/Webinars
Evaluation Feb - April	Data collected will be evaluated; Lessons learned to be shared; Quarterly Progress Report Post-Implementation Data Submission	2 Conference Calls/Webinars; 1 Quarterly Meeting

Pre-Implementation Phase: Selecting "See You in 7" Process Measures and Performing Gap Analysis



May 21, 2012
3:00PM - 6:30PM

June, 19, 2012
8:00AM - 9:00AM

July, 17, 2012
8:30AM - 9:30AM

Due Date: 6/8/2012 **DOC A**

Southeast Michigan "See You in 7" Hospital Collaborative: Selected Process Measures

Please fill out this form and e-mail it to [redacted] Program Manager of Cost Quality, at [redacted] *by June 8, 2012.* The Process Measure cells have been filled in for your convenience. Please delete the rows containing Process Measures you are not selecting as a focus for the Collaborative.

Selected Process Measure	Why your hospital chose this Process Measure	Barriers to improvement encountered previously
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 7 days after discharge	*Example:* Currently, we tell the patient/family to schedule an appointment when they get home. Appointment should be made before the patient leaves the hospital, and details should be reviewed with the patient prior to discharge.	*Example:* Previous efforts at making the appt. prior to discharge were difficult, because follow-up appointments were not available within 7 days.
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 7 days of discharge	*Example:* We aren't currently doing any follow-up and substantial opportunity exists for improvement	*Example:* N/A
Making the discharge summary available to the follow-up health care provider		

Due Date: 7/6/2012 **DOC B**

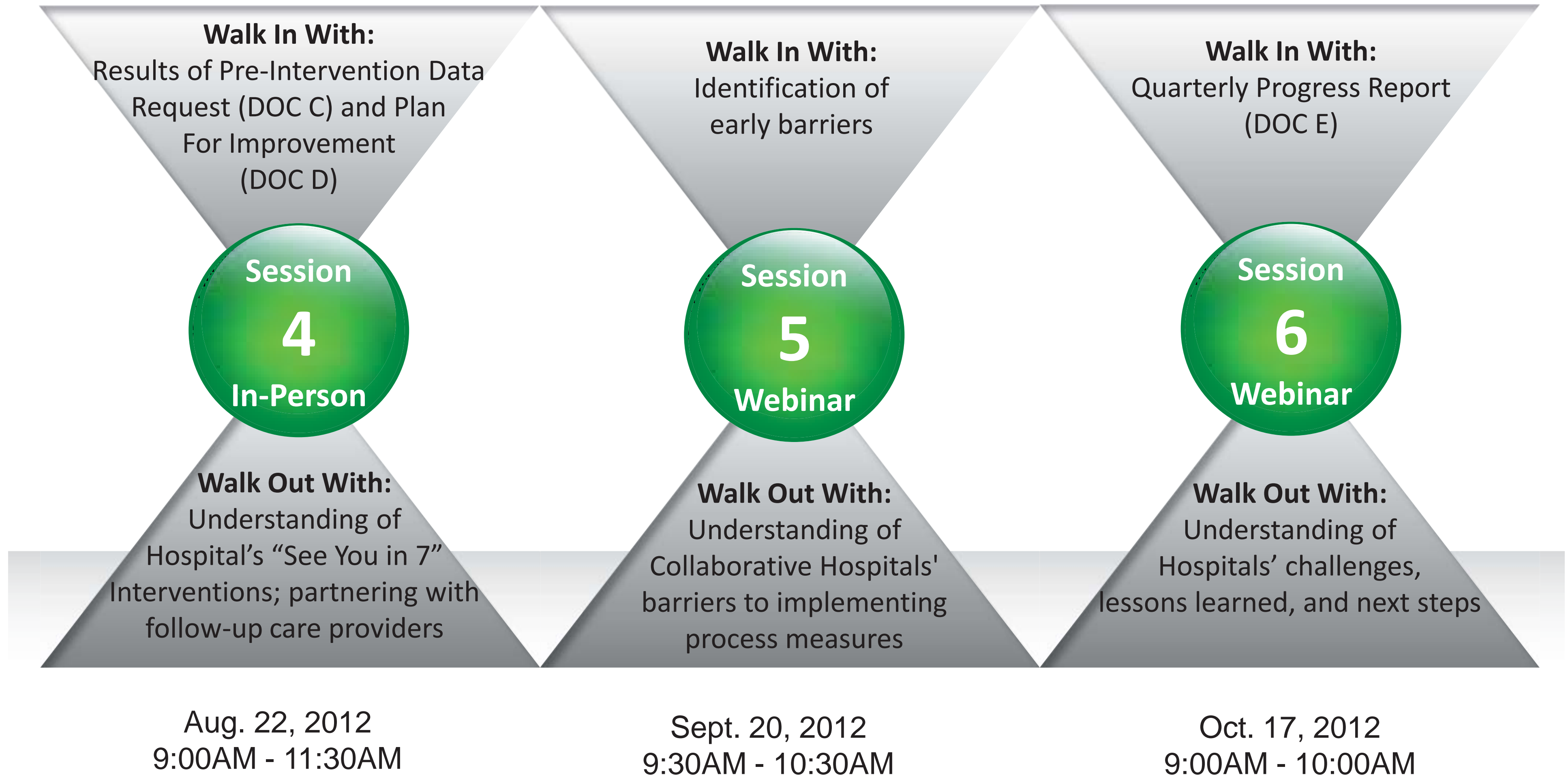
Southeast Michigan "See You in 7" Hospital Collaborative: Gap Analysis

Please fill out this form and e-mail it to [redacted] Program Manager of Cost Quality, at [redacted] ***by July 6, 2012.*** The Process Measure cells have been filled in for your convenience. Please delete the rows containing Process Measures you did not select as a focus for the Collaborative.

Selected Process Measure	Where is your hospital in terms of achieving this process measure?	Where should your hospital be in terms of achieving this process measure?	What interventions will your hospital implement in order to reach these aims? (a more detailed description of interventions to be filled out prior to the second quarterly meeting)
Identifying heart failure patients prior to discharge	Nothing right now, only if we cath tem in nurse rounding Once diagnosis is entered, there is an alert if core measures aren't met	All HF or potential HF patients are recognized and tracked during the hospitalization to make sure we are implementing interventions	Review list of cases in core measures to determine if HF team was aware of the patients. Are there trends? Same unit? EMR alerts can be added, PRM can page HF coordinator Identify during rounds
Scheduling and documenting a follow-up visit with a cardiologist or primary care practitioner that takes place within 7 days after discharge	We tell the patient/family to schedule an appointment when they get home. We don't know if they make the appt, and we don't know if they attend the appt.	Patients should have an appointment scheduled prior to discharge, this will avoid the dilemma of appt slots not being available. Work with large PCp or HF clinic to arrange for time slot and to recognize importance of seeing patient.	Determine if aiming for : • 3 or 7 days • appt with Cardiologist, PCP, or both • who, what, when re: appt • how will we keep track of the patients info
Providing the patient with documentation of the scheduled appointment	It is included in the discharge summary	The appointment and info about the appt should be more obvious. Patients need to be more aware	Develop special appointment card; info gets lost in large discharge document Call patient to remind them of the appt.
Identifying and addressing barriers to keeping the appointment	Really not sure	Ideally, knowing possible barriers prior to discharge and working at reversing the barriers	Prior to discharge, when scheduling the appointment, assess and problem solve for barriers (ride, no one to go with pt, competing appts, too tired or sick, etc)
Working to ensure that the patient arrives at the appointment within 7 days of discharge	We aren't currently doing any follow-up	Measure to determine compliance with appt and identify barriers	Audit via f/u phone call to patient to be conducted after the scheduled appt. And/Or Partner with cardiology office to track no show rates and call those patients
Making the discharge summary available to the follow-up health care provider	Since going to [redacted] discharge summary is poorly organized, physicians may do a lot of cutting and pasting, the discharge summary is not user-friendly for anyone	Clear, concise, priority driven, serve as a handoff, discharge summary should be available prior to the appointment	Physician lead team has reorganized summary, retrained staff, created new expectations re: content & format, will audit summaries, and have a hot line for feedback

SAMPLE

Testing Intervention Phase: Implementing Interventions Related to Selected Process Measures



Aug. 22, 2012
9:00AM - 11:30AM

Sept. 20, 2012
9:30AM - 10:30AM

Oct. 17, 2012
9:00AM - 10:00AM

Due Date: 8/10/2012 and 4/5/2013

DOC C

Southeast Michigan "See You in 7" Hospital Collaborative Data Request

Please complete the data request for the relevant time period and e-mail it to [redacted]
by **Aug. 10, 2012** for the pre-intervention data and by **April 5, 2013** for the post-intervention data.

	Process Measure	**Metric**	**May - July (Pre-Intervention**	**Feb. - April (Post-Intervention)**
	N/A - Denominator	# of heart failure patients	30	30
1	Identify all heart failure patients prior to discharge	# of heart failure patients identified prior to discharge		
2	Scheduling and documenting a follow-up visit with a cardiologist or primary care practitioner that takes place within 7 days	Prior to discharge, # of heart failure patients with a scheduled follow-up visit with a cardiologist or PCP. This visit must be scheduled to take place within 7 days of discharge.		
3	Providing patient with documentation of the scheduled appointment	# of heart failure patients given documentation of the scheduled appointment prior to discharge		
4	Identifying and addressing barriers to keeping the appointment	# of patients with which any potential barriers to keeping the follow-up appointment were identified and addressed prior to discharge		
5	Working to ensure that patient arrives at appointment within 7 days of discharge	# of patients who arrived at appointment within 7 days of discharge		

Due Date: 8/10/2012

DOC D

"See You in 7" Hospital Collaborative
Plan for Improvement
[Enter Hospital Name]

Process Measure #2	Barriers
Schedule and document a follow-up visit with a cardiologist or primary care practitioner that takes place within 7 days	

Strategies	Action steps	Target Date	Responsible Person
Example: Identify hospital staff responsible for making follow-up phone calls; provide staff with follow-up script outline	*Example:* Hold initial meeting with staff responsible for making follow-up phone calls to explain initiative, provide staff with script, and discuss strategies for compiling data on the number of heart failure patients who have a follow-up visit scheduled within 7 days of discharge. Hold meetings monthly to address questions/concerns.	*Example:* 8/27/2012	*Example:* [redacted] System Performance Improvement Leader, "See You in 7" Project Lead

Due 10/5/2012 **DOC E**

Please fill out this form and e-mail it to [redacted] Program Manager of Cost Quality, at [redacted] ***by October 5, 2012.***

"See You in 7" Hospital Collaborative
Quarterly Progress Report

Hospital Name: ____

Project Leader:____

Reporting Period: Aug. 22 – Oct. 5, 2012

Instructions: For each process measure your hospital is implementing as part of the "See You in 7" Hospital Collaborative, please fill in the information below.

Section 1:

Process Measure #1: Identify all heart failure patients prior to discharge

A: Progress (Describe the strategies undertaken over the last 3 months to achieve this process measure and the dates you implemented these strategies; please include successful and unsuccessful strategies)

Strategies	Go Live Date
Example: 1 to 2 dedicated staff review patients' charts daily for any "triggers" and flag the chart (triggers: admission diagnosis codes for HF, shortness of breath, swelling, edema, fluid overload; Secondary diagnosis codes for HF, shortness of breath; history of HF; Abnormal BNP or NT-proBNP levels; treatment with IV diuretics within the last 24 hours; chest X-ray showing HF or pulmonary edema)	***Example:*** 8/27/2012

Testing Intervention Assessing Progress and Restructuring Interventions Phase

Session 7 In-Person
Nov. 13, 2012
8:30AM - 11:00AM

Session 8 Webinar
Dec. 13, 2012
8:00AM - 9:00AM

Quarterly Progress Report (DOC F)
Session 9 Webinar
Jan. 17, 2013
9:30AM - 10:30AM

Evaluation: Successes and Lessons Learned

Session 10 Webinar
Feb. 14, 2012
9:30AM - 10:30AM

Post-Intervention Data Request (DOC C)
Session 11 Webinar
March 14, 2013
10:00AM - 11:00AM

Quarterly Progress Report (DOC G)
Session 12 In-Person
April 17, 2013
8:30AM - 11:00AM

Supplementary Table 2

30- day Readmission Risk-Standardization Factors (May 1, 2011 through April 30, 2012)												
Variable	CH				NPH				Matched NPH			
Age (years)	76.5±12.3				75.6±12.4				76.0±12.5			
	No		Yes		No		Yes		No		Yes	
	N	%	N	%	N	%	N	%	N	%	N	%
Gender(Male,Female)	15474	57.86	11270	42.14	52122	55.49	41806	44.51	15399	56.93	11650	43.07
CABG	26538	99.23	206	0.77	93192	99.22	736	0.78	26841	99.23	208	0.77
Diabetes	14313	53.52	12431	46.48	50183	53.43	43745	46.57	14426	53.33	12623	46.67
Disorders of fluid/electrolyte/acid-base	15355	57.41	11389	42.59	56833	60.51	37095	39.49	15610	57.71	11439	42.29
Iron deficiency	14051	52.54	12693	47.46	53762	57.24	40166	42.76	13380	49.47	13669	50.53
Cardio-respiratory failure or shock	20623	77.11	6121	22.89	74706	79.54	19222	20.46	21889	80.92	5160	19.08
Vascular or circulatory disease	18705	69.94	8039	30.06	65100	69.31	28828	30.69	17811	65.85	9238	34.15
COPD	15064	56.33	11680	43.67	54360	57.87	39568	42.13	15379	56.86	11670	43.14
Pneumonia	22216	83.07	4528	16.93	76507	81.45	17421	18.55	22796	84.28	4253	15.72
Renal failure	12416	46.43	14328	53.57	44384	47.25	49544	52.75	11991	44.33	15058	55.67
Other urinary tract disorders	24840	92.88	1904	7.12	87873	93.55	6055	6.45	25066	92.67	1983	7.33
Decubitus ulcer or chronic skin ulcer	24505	91.63	2239	8.37	86754	92.36	7174	7.64	24783	91.62	2266	8.38
Other gastrointestinal disorders	16586	62.02	10158	37.98	57603	61.33	36325	38.67	15869	58.67	11180	41.33
Acute coronary syndrome	24648	92.16	2096	7.84	84252	89.70	9676	10.3	24058	88.94	2991	11.06
Valvular or rheumatic heart disease	21977	82.18	4767	17.82	78818	83.91	15110	16.09	23114	85.45	3935	14.55
Arrhythmias	13009	48.64	13735	51.36	47772	50.86	46156	49.14	13518	49.98	13531	50.02
Asthma	25968	97.10	776	2.90	90982	96.86	2946	3.14	26082	96.43	967	3.57
Peptic ulce	24813	92.78	1931	7.22	87287	92.93	6641	7.07	24915	92.11	2134	7.89
Cancer	24554	91.81	2190	8.19	87022	92.65	6906	7.35	24915	92.11	2134	7.89
Substance abuse/psychosis	23908	89.40	2836	10.60	82447	87.78	11481	12.22	23804	88.00	3245	12.00
Major psychiatric disorders	25507	95.37	1237	4.63	89967	95.78	3961	4.22	25901	95.76	1148	4.24
ESRD_dialysis	24975	93.39	1769	6.61	88487	94.21	5441	5.79	25291	93.50	1758	6.50
Hematological	26174	97.87	570	2.13	92455	98.43	1473	1.57	26549	98.15	500	1.85
Nephritis	26123	97.68	621	2.32	91187	97.08	2741	2.92	26181	96.79	868	3.21
Liver or biliary disease	25619	95.79	1125	4.21	89659	95.46	4269	4.54	25835	95.51	1214	4.49
Metastatic cancer or acute leukemia	26145	97.76	599	2.24	92201	98.16	1727	1.84	26492	97.94	557	2.06
Stroke	26191	97.93	553	2.07	91767	97.70	2161	2.3	26457	97.81	592	2.19
Dementia	23485	87.81	3259	12.19	83608	89.01	10320	10.99	23780	87.91	3269	12.09
Coronary atherosclerosis or angina	10290	38.48	16454	61.52	37810	40.25	56118	59.75	10008	37.00	17041	63.00
Other or unspecified heart disease	26043	97.38	701	2.62	90790	96.66	3138	3.34	26180	96.79	869	3.21

Other psychiatric disorders	23797	88.98	2947	11.02	86388	91.97	7540	8.03	24706	91.34	2343	8.66
Hemiplegia/paraplegia/functional disabil	24687	92.31	2057	7.69	87255	92.90	6673	7.1	24953	92.25	2096	7.75
Fibrosis of lung	26043	97.38	701	2.62	90746	96.61	3182	3.39	26077	96.41	972	3.59
Protein-calorie malnutrition	24350	91.05	2394	8.95	87164	92.80	6764	7.2	24766	91.56	2283	8.44
Depression	23158	86.59	3586	13.41	80433	85.63	13495	14.37	23495	86.86	3554	13.14

Supplementary Table 2b

30- day Readmission Risk-Standardization Factors (May 1, 2012 through April 30, 2013)												
Variable	**CH**				**NPH**				**Matched NPH**			
Age (years)	76.4±12.2				75.5±12.4				76.1±12.4			
	No		**Yes**		**No**		**Yes**		**No**		**Yes**	
	N	%	**N**	%	**N**	%	**N**	%	**N**	%	**N**	%
Gender(Male,Female)	14145	56.92	10704	43.08	50854	55.08	41467	44.92	14557	56.62	11152	43.38
CABG	24654	99.22	195	0.78	91588	99.21	733	0.79	25528	99.30	181	0.70
Diabetes	13106	52.74	11743	47.26	49231	53.33	43090	46.67	13761	53.53	11948	46.47
Disorders of fluid/electrolyte/acid-base	13696	55.12	11153	44.88	55016	59.59	37305	40.41	14899	57.95	10810	42.05
Iron deficiency	12825	51.61	12024	48.39	52007	56.33	40314	43.67	13008	50.60	12701	49.40
Cardio-respiratory failure or shock	18198	73.23	6651	26.77	71222	77.15	21099	22.85	20518	79.81	5191	20.19
Vascular or circulatory disease	17343	69.79	7506	30.21	63489	68.77	28832	31.23	17316	67.35	8393	32.65
COPD	14026	56.44	10823	43.56	53279	57.71	39042	42.29	14747	57.36	10962	42.64
Pneumonia	20603	82.91	4246	17.09	74480	80.68	17841	19.32	21448	83.43	4261	16.57
Renal failure	11138	44.82	13711	55.18	42496	46.03	49825	53.97	11481	44.66	14228	55.34
Other urinary tract disorders	23069	92.84	1780	7.16	86647	93.85	5674	6.15	23979	93.27	1730	6.73
Decubitus ulcer or chronic skin ulcer	22689	91.31	2160	8.69	85203	92.29	7118	7.71	23576	91.70	2133	8.30
Other gastrointestinal disorders	14936	60.11	9913	39.89	55307	59.91	37014	40.09	15167	58.99	10542	41.01
Acute coronary syndrome	22761	91.60	2088	8.40	82757	89.64	9564	10.36	22857	88.91	2852	11.09
Valvular or rheumatic heart disease	20309	81.73	4540	18.27	76784	83.17	15537	16.83	21907	85.21	3802	14.79
Arrhythmias	11636	46.83	13213	53.17	45892	49.71	46429	50.29	12692	49.37	13017	50.63
Asthma	24201	97.39	648	2.61	89172	96.59	3149	3.41	24738	96.22	971	3.78
Peptic ulce	22911	92.20	1938	7.80	85579	92.70	6742	7.3	23737	92.33	1972	7.67
Cancer	22896	92.14	1953	7.86	85383	92.48	6938	7.52	23640	91.95	2069	8.05
Substance abuse/psychosis	21866	88.00	2983	12.00	80441	87.13	11880	12.87	22681	88.22	3028	11.78
Major psychiatric disorders	23675	95.28	1174	4.72	88432	95.79	3889	4.21	24683	96.01	1026	3.99
ESRD_dialysis	23080	92.88	1769	7.12	86894	94.12	5427	5.88	24191	94.10	1518	5.90
Hematological	24483	98.53	366	1.47	91384	98.99	937	1.01	25411	98.84	298	1.16

Nephritis	24272	97.68	577	2.32	89488	96.93	2833	3.07	24908	96.88	801	3.12
Liver or biliary disease	23723	95.47	1126	4.53	87960	95.28	4361	4.72	24563	95.54	1146	4.46
Metastatic cancer or acute leukemia	24337	97.94	512	2.06	90545	98.08	1776	1.92	25195	98.00	514	2.00
Stroke	24289	97.75	560	2.25	90152	97.65	2169	2.35	25128	97.74	581	2.26
Dementia	23119	93.04	1730	6.96	85632	92.75	6689	7.25	23964	93.21	1745	6.79
Coronary atherosclerosis or angina	9547	38.42	15302	61.58	37325	40.43	54996	59.57	9861	38.36	15848	61.64
Other or unspecified heart disease	24057	96.81	792	3.19	89248	96.67	3073	3.33	24943	97.02	766	2.98
Other psychiatric disorders	21729	87.44	3120	12.56	82525	89.39	9796	10.61	23142	90.02	2567	9.98
Hemiplegia/paraplegia/functional disabil	22769	91.63	2080	8.37	85381	92.48	6940	7.52	23704	92.20	2005	7.80
Fibrosis of lung	24147	97.17	702	2.83	89181	96.60	3140	3.4	24873	96.75	836	3.25
Protein-calorie malnutrition	22358	89.98	2491	10.02	85654	92.78	6667	7.22	23582	91.73	2127	8.27
Depression	21480	86.44	3369	13.56	78747	85.30	13574	14.7	22343	86.91	3366	13.09