STRATEGIES TO REDUCE AVOIDABLE REHOSPITALIZATIONS AND ED VISITS

Today’s Speakers

Kathleen Glendening  M.P.H., B.S.N.,N.H.A.,RAC-CT
Corporate Director, Clinical Services, Continuing Care Management Service Network
Catholic Health East

Aysha Kuhlor  R.N., B.A.,CDONA
Director, Clinical Services, Saint Mary Home,
Vice President (NADONA)
Objectives for Today’s Presentation

- Understand practices associated with “Never” Events to reduce avoidable Rehospitalizations and ED visits
- Learn three strategies related to Complex Medicare Care Programs that reduce avoidable rehospitalizations and ED visits
- Understand two essential components of the INTERACT Program linked to reducing avoidable Rehospitalizations and ED visits
- Discover how CHE measures Rehospitalizations and ED visits and sets yearly targets
Hospital Readmissions
Why Do We Care?

- One in five Medicare-age patients are readmitted within 30 days of discharge. 50% within the first week.
- Re-admissions can be reduced by 40-50% with a systematic approach to the care transition.
- Beginning 2013, CMS will level progressive penalties for excessive readmission rates.
- Hospitals with rates higher than national average for AMI, HF, PN subject to payment penalty up to 1% for all Medicare patients.
### 30-Day Hospital Readmissions Rates – Post-Acute Care Providers

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Acute Care (LTAC)</td>
<td>10%</td>
</tr>
<tr>
<td>Impatient Rehab Facility (IRF)</td>
<td>7.2%</td>
</tr>
<tr>
<td>Skilled Nursing Facilities</td>
<td>21%</td>
</tr>
<tr>
<td>Home Health</td>
<td>29%</td>
</tr>
<tr>
<td>Med PAC Target</td>
<td>8%</td>
</tr>
</tbody>
</table>

Source: Health Dimensions Group
Federal Value Based Models

Affordable Care Act
Passed March 23, 2010

Federal Hospital Value-Based Purchasing Program

Three components:

Penalties/Rewards for performance based on:

1. Quality Reporting Scores
2. Readmission Rates
3. Hospital Acquired Conditions

Begins: October 1, 2012
HISTORY

- Lack of focus on prevention resulting in poor quality outcomes
- Poor chronic disease management
- Revolving door used to benefit the Hospitals
- Increased cost to the Medicare Program
SNF - Challenges

- Readmissions occur from not having on-site primary care clinicians,
- Post-Acute not having access to lab and x-ray studies in a timely manner,
- Competency challenges with staff recognizing changes in condition quickly, and
- Communication problems

The “new world” med-surgical Post-Acute nursing units!
Medicare is planning changes

- **The current situation**, which favors hospital transfers, is going to change.

- **Medicare is planning changes in payment** that will reward lower rates of avoidable hospitalizations.

- **Surveyors** will be examining how facilities assess and manage acute changes in status.
Opportunity

- Reduce avoidable readmissions to the hospital
- Reduce avoidable emergency room visits
- Improve patient education and compliance
- Enhance patient transitions across the continuum of care
- Reduce hospital acute care length-of-stay by transferring the delivery of this care into post-acute services
## Never Events

**CHE Target 0%**

The following four Never Events (facility acquired) should never occur:

1. Medication Errors - Resulting in ongoing monitoring and/or harm
2. Infections - Resulting in a facility outbreak
3. Falls - Resulting in major injury
4. Pressure Ulcers - Identified as High risk and facility acquired

## INTERACT II Process

**CHE Target 15.41%**

National initiative to reduce preventable readmissions through the following initiatives:

1. Education with hospitals, physicians, nurses, aides, residents and families
2. SBAR – Assessment and communication process with Physician
3. Early identification of change
4. CARE PATHS

## Complex Medical Care

Model focused on the improvement of chronic disease management:

1. CHF, COPD, AMI & Pneumonia
2. Reduces avoidable readmissions
3. Reduces avoidable emergency room visits
4. Improve patient education and compliance
5. Reduce hospital acute care length of stay
6. Enhance patient transitions across the continuum of care
NEVER EVENTS

- Understand practices associated with “Never” Events to reduce avoidable Rehospitalizations and ED visits
- Discover how the “Never” Event programs integrate with initiatives to reduce Rehospitalizations & ED outcomes
Partnership for Patient Goals

**Adverse Events** - By the end of 2013, *preventable hospital-acquired conditions* would *decrease by 40%* compared to 2010. Achieving this goal would mean approximately *1.8 million fewer injuries to patients*, with more than *60,000 lives saved over the next three years.*

**Help patients heal without complication.** By the end of 2013, *preventable complications during a transition* from one care setting to another would be decreased so that all hospital readmissions would be reduced by *12% compared to 2010*. Achieving this goal would mean *more than 1.6 million patients will recover from illness without suffering a preventable complication requiring Rehospitalizations within 30 days of discharge.*

Reasons Skilled Nursing Facilities Should Focus on “Never” Events

- Key referral source (Hospitals) will be penalized if the rate of readmissions from nursing homes does not improve – Referrals will decline.

- Payors will not pay for additional costs of care which will impact Skilled Nursing on Medicare side via Bundled Payments and ACOs.

- Consumers (patients/families) will become increasingly aware of providers rate of readmissions in relation to competitors – Hospital compare -> Nursing home compare.
Indictor Data Collection Form
Constructs using Evidenced-based Criteria

- **Falls** – Resident Assessment Instrument, RAI Manual & Morse Screening Tool
- **Medication Errors** – American Pharmacist Associate, APA & Victorian Consultant Pharmacist, VCP
- **Infections Outbreak** – CDC Definitions & Mc Geer’s Criteria
- **PUs** – Resident Assessment Instrument, RAI Manual & Braden Screening Tool
Never Event Results

- Facility Acquired Pressure Ulcers
- Falls with Major Injury
- Infection Cluster
- Infection Outbreak Overall
- Overall Medication Error

2011 2012 YTD

- 0.96
- 0.58
- 0.26
- 0.20
- 0.12
- 0.42
- 0.21
- 0.15
- 0.11
- 0.03
Cost Avoidance – Never Events

- **2011** - Indicator tools developed to support Never Event Dashboard
  - Indicator tools clearly defined specific areas for measurement

- **2012** - Indicator Tools revised
  - Exclusions updated to Falls Indicator tool per collaborative
    - Morse Screening tool implemented
    - Post Falls Huddle Initiated
## Cost Avoidance – Never Events

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases</th>
<th>Residents</th>
<th>Multiplier</th>
<th>Dollars Saved</th>
<th>Cases Saved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls – 2011</td>
<td>80</td>
<td>454,404</td>
<td>$9,113</td>
<td>$501,215</td>
<td>55</td>
</tr>
<tr>
<td>Falls – 2012</td>
<td>85</td>
<td>662,962</td>
<td>$9,113</td>
<td>$309,842</td>
<td>34</td>
</tr>
<tr>
<td>PU – 2011</td>
<td>244</td>
<td>454,404</td>
<td>$37,800</td>
<td>$(491,400)</td>
<td>(13)</td>
</tr>
<tr>
<td>PU – 2012</td>
<td>287</td>
<td>662,962</td>
<td>$37,800</td>
<td>$2,419,200</td>
<td>64</td>
</tr>
<tr>
<td>ICN – 2011 Cluster</td>
<td>87</td>
<td>454,404</td>
<td>$3,789</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICN – 2012 Cluster</td>
<td>103</td>
<td>662,962</td>
<td>$3,789</td>
<td>$83,556</td>
<td>22</td>
</tr>
<tr>
<td>ICN – 2011 Overall</td>
<td>127</td>
<td>454,404</td>
<td>$3,789</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICN – 2012 Overall</td>
<td>135</td>
<td>662,962</td>
<td>$3,789</td>
<td>$189,900</td>
<td>50</td>
</tr>
<tr>
<td>Med Errors 2011</td>
<td>67</td>
<td>454,404</td>
<td>$677</td>
<td>$122,537</td>
<td>181</td>
</tr>
<tr>
<td>Med Errors 2012</td>
<td>30</td>
<td>662,962</td>
<td>$677</td>
<td>$39,943</td>
<td>59</td>
</tr>
</tbody>
</table>
Cost Avoidance Sources

Falls - CDC

www.cdc.gov/homeandrecreationalsafety/falls/fallcost.html
$9,113 - $13,507

Pressure Ulcers

http://www.ltlmagazine.com/article/how-mds-30-can-influence-pressure-ulcer-management
$37,800

Infectious Diseases

$3,798.15

Medication Errors

$677 to $9,022
Understand two essential components of the INTERACT Program linked to reducing avoidable Rehospitalizations and ED visits.
INTERACT stands for “Interventions to Reduce Acute Care Transfers”

- It is a quality improvement program designed to improve the care of nursing home residents by:
  - Identifying situations that commonly result in transfers to the hospital and
  - Working together to manage them effectively and safely in the nursing home without transfer whenever possible
INTERACT can result in reduced hospital transfers by helping you to:

1. Prevent conditions from becoming severe enough to require hospitalization through early identification and assessment of changes in resident condition

2. Manage some conditions in the NH without transfer when this is feasible and safe

3. Improve advance care planning and the use of palliative care plans when appropriate as an alternative to hospitalization for some residents
Purpose of Tool Kit

- Aid in the early identification of a resident change of status
- Guide staff through a comprehensive resident assessment when a change has been identified
- Improve documentation around resident change in condition
- Enhance communication with other health care providers about a resident change of status
Using the INTERACT Tools
In Every Day Care

Advance Care Planning Tools

New Resident Admission
Resident Re-Assessment

Medication Reconciliation Worksheet

CNA, Other Direct Care Staff, or Family Alerts LPN/RN

Stop and Watch Early Warning Tool

Care Paths

Change in Resident Status Noted

LPN/RN Evaluation

SBAR Form and Progress Note

Acute Change in Condition File Cards

MD/NP/PA Notified

Transfer Checklist Envelope

Hospital Communication Tools

Acute Care Transfer

Transfer Data List and Sample Forms

Hospitalization Rate Tracking Tool

Quality Improvement Program

Apply learning to improve care processes and education

Quality Improvement Tool for Review of Acute Care Transfers
Communication Strategies and Tools

- Early Warning "Stop and Watch"
- SBAR/Physician/NP/PA Communication and Progress Note
- Quality Improvement Tool for Review of Acute-Care Transfers
- Acute Care Transfer Document Checklist Envelope
## Acute Care Transfer Log

You can use this tool as a worksheet for recording all acute care transfers during a month. Print more pages as needed. This tool is not necessary if you use the INTERACT Hospitalization Rate Tracking Tool, which allows you to enter the data directly into an Excel spreadsheet, and calculates rates and generates reports. A similar tracking tool is available through the Advancing Excellence Campaign in America's Nursing Homes at www.nhqualitycampaign.org.

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Month / Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table Examples

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Month / Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
New Steps

Education of the staff (Discharge Summaries)

Introduction of Interact III Tool (Interventions to Reduce Acute Care Transfers)

Assessing in-house equipment

Rounding by Physician/Clinical Staff

Monthly meeting at local hospital (meeting with SNFs, VNAs and other community organizations involved in care of heart failure population)

Culture Change for patients and families re: hospital transfers
Learn three strategies related to Complex Medicare Care programs that will reduce avoidable re-hospitalizations and ED visits.

- Target population to identify programs demographically
- Review ACH & ED visits and identify the primary causes and trends.
- Identify any clinical performance gap using the: Current State Assessment for Complex Medical Care Tool
- Review strategies employed with hospitals as partners to reduce the performance gap
Develop Clinical Care Programs:

Complex Medical Conditions:

COPD
CHF
AMI
Pneumonia
Emerging as new service line opportunity for free-standing SNFs as the healthcare delivery system continues to reconfigure service delivery to low cost / high quality services

High Strategic Significance to SNFs
Key Components of Programs Change

- Align facilities with Physicians and Managed Care Providers
- Enhance Staff Competencies, Assessment Skills and Develop Care Pathways
- Enhance Physician Coverage and Develop 24/7 Services: Lab, X-ray, Respiratory Therapy
- Enhance Communications/Follow Up for Transitions of Care / Including Family Education
Business Planning Steps to Assess Viability of CMC

- **Conduct Market Research**
  - Hospitals will be primary referral source, which hospital is your target
  - What is the size of the market (number of CMC cases that will likely be discharged to SNF)
  - What penetration rate of market will you need to capture to break-even
  - What is current demand for ER Diversions? Will market need to be educated on ER Diversions and Physician Office Admissions?
Assess

- Organizational Readiness
  - Staffing Competencies
  - Clinical Pathways
  - Equipment
  - Contracts
  - Physician Champion
  - Financial Process Readiness
  - Case Managers at Referral Sources
Evaluate the volumes and reimbursement levels of the top 3 referral hospitals in your market.

<table>
<thead>
<tr>
<th>Complex Medical Conditions DRGs</th>
<th>Volumes and Acute Care Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Saint Francis Hosp</td>
</tr>
<tr>
<td>DRG</td>
<td>Description</td>
</tr>
<tr>
<td>293 Heart Failure</td>
<td>$ 5,588</td>
</tr>
<tr>
<td>291 Heart Failure</td>
<td>$ 14,492</td>
</tr>
<tr>
<td>292 Heart Failure</td>
<td>$ 7,792</td>
</tr>
<tr>
<td>282 AMI</td>
<td>$ 6,730</td>
</tr>
<tr>
<td>280 AMI</td>
<td>$ 15,617</td>
</tr>
<tr>
<td>281 AMI</td>
<td>$ 9,452</td>
</tr>
<tr>
<td>192 COPD</td>
<td>$ 5,614</td>
</tr>
<tr>
<td>190 COPD</td>
<td>$ 10,084</td>
</tr>
<tr>
<td>191 COPD</td>
<td>$ 7,551</td>
</tr>
<tr>
<td>193 Pneumonia</td>
<td>$ 10,888</td>
</tr>
<tr>
<td></td>
<td>Hartford Hospital</td>
</tr>
<tr>
<td>DRG</td>
<td>Description</td>
</tr>
<tr>
<td>293 Heart Failure</td>
<td>$ 5,783</td>
</tr>
<tr>
<td>291 Heart Failure</td>
<td>$ 11,695</td>
</tr>
<tr>
<td>292 Heart Failure</td>
<td>$ 8,005</td>
</tr>
<tr>
<td>282 AMI</td>
<td>$ 6,965</td>
</tr>
<tr>
<td>280 AMI</td>
<td>$ 15,542</td>
</tr>
<tr>
<td>281 AMI</td>
<td>$ 9,792</td>
</tr>
<tr>
<td>192 COPD</td>
<td>$ 5,810</td>
</tr>
<tr>
<td>190 COPD</td>
<td>$ 10,437</td>
</tr>
<tr>
<td>191 COPD</td>
<td>$ 7,815</td>
</tr>
<tr>
<td>193 Pneumonia</td>
<td>$ 11,476</td>
</tr>
<tr>
<td></td>
<td>John Dempsey</td>
</tr>
<tr>
<td>DRG</td>
<td>Description</td>
</tr>
<tr>
<td>293 Heart Failure</td>
<td>$ 7,166</td>
</tr>
<tr>
<td>291 Heart Failure</td>
<td>$ 14,492</td>
</tr>
<tr>
<td>292 Heart Failure</td>
<td>$ 9,460</td>
</tr>
<tr>
<td>282 AMI</td>
<td>$ 8,705</td>
</tr>
<tr>
<td>280 AMI</td>
<td>$ 19,259</td>
</tr>
<tr>
<td>281 AMI</td>
<td>$ 12,122</td>
</tr>
<tr>
<td>192 COPD</td>
<td>$ 7,200</td>
</tr>
<tr>
<td>190 COPD</td>
<td>$ 12,933</td>
</tr>
<tr>
<td>191 COPD</td>
<td>$ 9,652</td>
</tr>
<tr>
<td>193 Pneumonia</td>
<td>$ 14,220</td>
</tr>
</tbody>
</table>
Consider the health outcome metrics of the hospitals for each chronic disease state to determine if there is an opportunity to influence outcome.

To be a relevant program, SNF Readmissions for disease state should fall 10% below rate currently experienced.
Saint Mary Home Preparation Plan

Re-evaluate clinical competency of the staff (assessment skills, admissions assessments, etc.)

Establish relationship with hospitals

Evaluation of services provided by providers

- Labs
- X-rays
- Pharmacy Services
- Care Transitions
  - E.g. Patient from Hospital with Illeus
PLANNING FOR CMC - COPD

Identify Physician Champion for COPD Program
Develop

- Clinical Programming
  - Protocols
  - Pathways
  - Procedures
  - Training Materials
  - Policies

- Financial / Market
  - Referral Pattern
  - Case Management
  - Insurance Contracts
  - Outcome Management
  - Ancillary Service Contract Arrangements
Task Force Groups

Changes in Internal Educational Practices

- Competency tests
- Protocols / Assessments / Policies
- Education with Hospitals
- Partner with Acute Care
- Interact II Tool
- 5 Why Analysis - Root Cause Analysis
Acquire Equipment

Equipment Needs
1. Crash Cart
2. AED
3. Pulse oximetry machines
4. EKG Machine
5. Blood Pressure machines and stethoscopes
6. Oxygen and suction equipment
7. Patient scale
8. Cardiac chairs
9. Bariatric equipment
10. Other standard equipment and supplies
Develop Clinical Program

Assess and Measure Clinical Readiness

- **Collaborate** with acute care leaders to reduce avoidable ED visits and readmissions
- **Assess** current state/readiness for Complex Medical Program
  - Where will the unit be located and how many beds
  - Medical Director for sub acute care
  - Program Director – CRNP with specialty in cardiac services responsible for overall program operations
  - Unit Manager to oversee nursing operations
  - Assess current staffing levels and ability to transition staff to sub acute care – critical RN positions must be filled to achieve and plan staffing for sub acute care
**Develop Clinical Program**

- **Implement Staffing Levels and Training**

- **Staffing Productivity and Mix**
  - NNHPD at 5.0 for Transitional Care Unit,
  - Increase of RN staff and include experience and expertise in medical surgical nursing at a minimum

- **Identify educator**
  - contract or hire if necessary
  - must be experienced with:
    - critical care nursing and assessment skills training
    - Able to develop core curriculum
    - Train on Staff competencies in cardiac and pulmonary care, physical assessment skills training, critical thinking skills, training, IV therapy, other high level clinical services.

- **Ongoing training for all staff to ensure optimum competency level and all new employees must complete the program as part of orientation.**
Complex Medical Care

- Early Recognition and response to individual needs
- Reduce development of contributory risk factors
- Reduce incidence of avoidable complications
- Increase coordination of care with providers
In 2012, the Skilled Nursing Council expanded the dashboard to include the collection of four complex medical diagnoses:

- AMI – Acute Myocardial Infarction
- CHF – Congenital Heart Failure
- COPD – Chronic Obstructive Pulmonary Disease
- Pneumonia
Rehospitalizations & ED Visits

- Learn how CHE measures Rehospitalizations and ED visits and sets yearly targets.

- Understand how all three processes: “Never” Events, CMC programs and the INTERACT process are related to reduce avoidable Rehospitalizations and ED visits.
Construct:

\[
\frac{\text{# of Emergency Visits in the Month}}{\text{Within 30 Days Discharge from the Hospital}} \times 1000 \times \text{Resident days for the month}
\]
Acute Care Readmissions W/I 30 Days

Construct:

Total # of Residents Who Were Readmitted to Acute Care Hospital
Within 30 days Admission to the NF
_________________________ X 100
All Admissions from the Hospital Within 30 days
Hospital Value-Based Purchasing Program

- Readmission Rates
  - Reduce Medicare hospital payments to hospitals that have higher than expected readmission rates
    - Began: October 1, 2012
    - Based on 30 day readmission rates following heart attack, heart failure and pneumonia
Providers Will Be Held Accountable for Readmissions

- 18% of all Rehospitalizations occur within 30 days of acute care discharge.
- These rehospitalizations accounts for $15 Billion in additional healthcare expenditures.
- It is estimated that 76% of these Rehospitalizations are avoidable and could result in savings of $12 Billion.
- CMS – BUNDLED & Value-Based Models.
Preparation for Bundled Payments – Outcomes Matter / Financial Focus is Cost Reduction

New payments models present both a risk and benefit to SNFs

- Potential for Increased Volumes
- Financial Risk of Poor Outcomes

<table>
<thead>
<tr>
<th>Payment Arrangement</th>
<th>Fee for Service Covers</th>
<th>Covers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Bundling</td>
<td>Charges, Pt Days, Admits, Physician, Post Acute Care, All Other</td>
<td>n/a</td>
</tr>
<tr>
<td>Bundled Payment</td>
<td>Admits, All Other</td>
<td>Charges, Pt Days, Physician Payment, Post-Acute</td>
</tr>
<tr>
<td>Value-based payment</td>
<td>n/a</td>
<td>Based on performance – CMS controls process</td>
</tr>
</tbody>
</table>
CMS’ Transformation of Healthcare delivery ACO

FROM
- Fragmented Care
- Volume-based payments
- Treating patients
- Payer-driven managed care

TO
- Coordinated/Integrated care
- Value-based payments
- Caring for a population
- Provider-driven accountable care
Population Management

- **Examples of high risk criteria:**
  - High ER usage
  - Multiple admits
  - Chronic Disease out of control
  - Discharge follow-up
  - Polypharmacy
  - MD/Nurse/Receptionist just know
A collection tool was created to capture the revenue and costs of care:

- RUG day payments
- Pharmacy, lab, x-ray, and supply costs
- Therapy minutes and costs
- Facility daily cost
## Initial Results

<table>
<thead>
<tr>
<th>Consolidated</th>
<th>2011</th>
<th>2012</th>
<th>Revenue</th>
<th>Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI</td>
<td>15</td>
<td>178</td>
<td>$77,241</td>
<td>$10,551</td>
</tr>
<tr>
<td>CHF</td>
<td>32</td>
<td>670</td>
<td>$308,930</td>
<td>$58,980</td>
</tr>
<tr>
<td>COPD</td>
<td>14</td>
<td>278</td>
<td>$128,230</td>
<td>$11,326</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>36</td>
<td>735</td>
<td>$342,792</td>
<td>$39,813</td>
</tr>
<tr>
<td>TOTALS</td>
<td>97</td>
<td>1861</td>
<td>$857,193</td>
<td>$120,671</td>
</tr>
</tbody>
</table>

Overall 14% margin from the 8 programs
Readmissions Model

Patient & Caregiver(s) Families

Palliative Care

Hospital Discharge

Admitted to SNF

Risk Identified

INTERACT

Never Events

Complex Medical Conditions

Chronic Conditions

Med Surg Units - SNF’s
8 Ways to Reduce Readmissions
Evidence-Based Strategies

- Risk Assessment
- Teach Self-Management
- BUNDLES
- INTERACT Process
- “Never” Events
- Complex Medical Care
- Integrate with Hospitals, Home Health, Hospice and Palliative Care
- Dashboard & Targets
- Intensive Analysis
- Post D/C Support
- Avoid Readmissions in ED
Transparency - Reporting

- Advancing Clinical Transformation Steering Committee (ACT)
- Skilled Nursing Council - Learning opportunities - both successes and challenges shared
- Quality Boards - System and Community Level
Conclusion

- **Strong leadership** committed to high quality services and positive clinical outcomes
- **Shared vision** among all members of the interdisciplinary team
- **Routine measurement** of the quality, cost and outcomes of care
- **Emphasis on person-centered care** that is coordinated among caregivers and integrated with specialized care delivery
- **Evidence based guidelines**, policies, procedures and protocols integrated into performance measurement and clinical decision making
- **Information technology** that supports and facilitates performance measurement and provides decision support for clinical care
- **Organized quality improvement** and service excellence activities
Questions ???


www.ohioacc.org/sitebuildercontent/sitebuilderfiles/h2h.pdf