Reduce Preventable CAH Inpatient Readmissions

Baseline Aggregate and Peer Group Results

Corrected

Data Collection: Nov 2012
Number of cases: 223 readmission cases
Number of admissions in the period: 4256
Report date: Jan 2013

PROJECT SUMMARY

Abstract

Reducing preventable readmissions is a priority for the nation's healthcare system. Kaiser Health News reported in Aug 2012 that the national average readmission rate for Medicare patients has remained steady at 19% for several years[1]. Strategies to prevent readmissions have been developed by national quality leaders such as the Partnership for Patients, Institute for Healthcare Improvement (IHI), the Agency for Healthcare Research and Quality (AHRQ), and the Centers for Medicare and Medicaid Services (CMS).

The Patient Care and Affordable Care Act of 2010 contains provision for hospitals to collaborate nation-wide to focus on reducing preventable readmissions through the Partnership for Patients Project. The Project is implemented at the state and local level through Hospital Engagement Networks. The MT-PIN initiated this improvement study in collaboration with the MHA-HEN to reduce preventable CAH readmissions.

Participants

Seventeen PIN participating facilities submitted baseline data from 223 inpatient readmission cases which occurred between Jan 1 and June 30, 2012. Participants from all five PIN peer groups submitted baseline data for the study. Due to the small number of cases, peer groups four and five have been combined for peer benchmarking purposes.

Findings

The baseline composite score for all participating CAHs was 6.2 on a 10-point scale.

Overall, the readmission rate for participating facilities appears to be 5.2 %, substantially less than the national average for Medicare patients cited above. Nearly 11% of the patients had a discharge diagnosis of pneumonia; another 8.5% had a discharge diagnosis of heart failure. About 5% of the readmitted patients were assessed for readmission risk during the prior admission. Inpatients received written discharge instructions about 84% of the time. The instructions were fairly complete, containing the recommended elements about 70% of the time. Roughly 6% of these patients received instructions using a Teach Back method, and their medical records contained documentation of their understanding of the instructions.

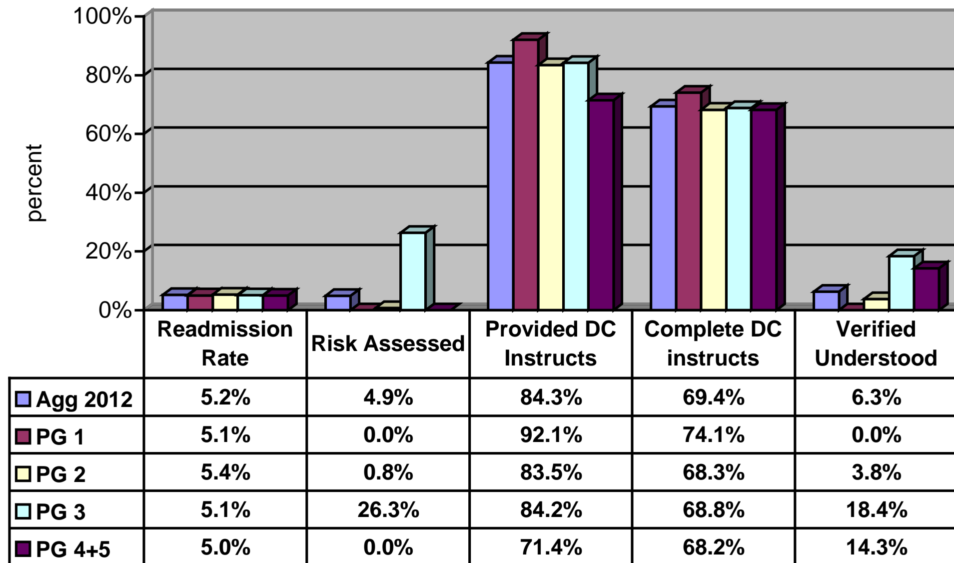
Opportunities

The following opportunities for improvement have been identified:

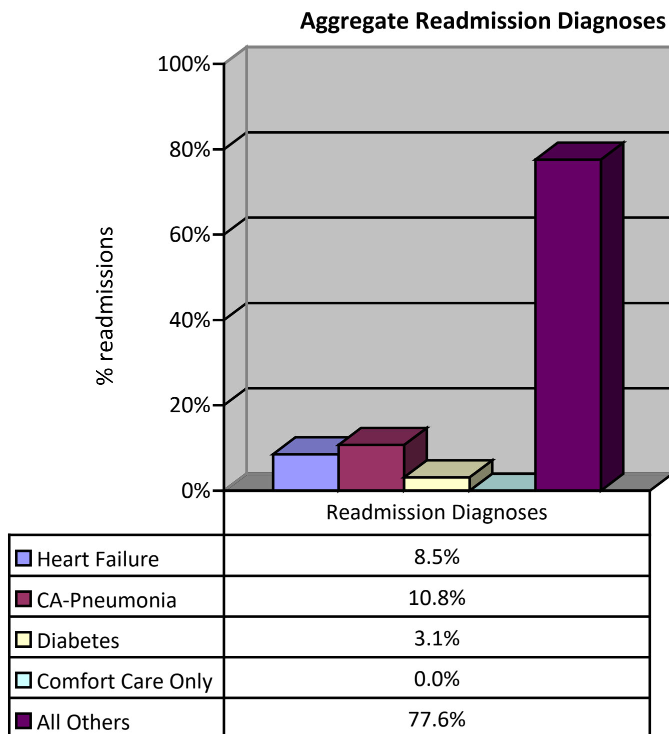
- Reduce CAH inpatient readmissions by 20%, a Project goal
- Develop and implement processes to identify patients at risk for readmission within 24 hours of admission
- Provide all patients with written discharge instructions
- Ensure all patients receive instructions about all of the Project recommended elements
- Ensure all patients being discharged home understand their discharge instructions, including medication use, prior to discharge by checking with a teach back method

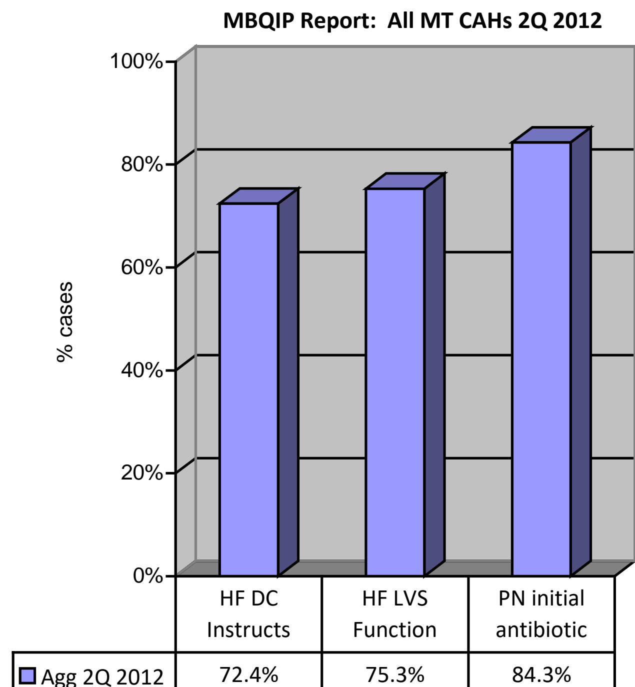
I. Baseline Composite Score: 6.2 on a 10 point scale.

The composite score is calculated using data from the four key process steps identified in the graph below.

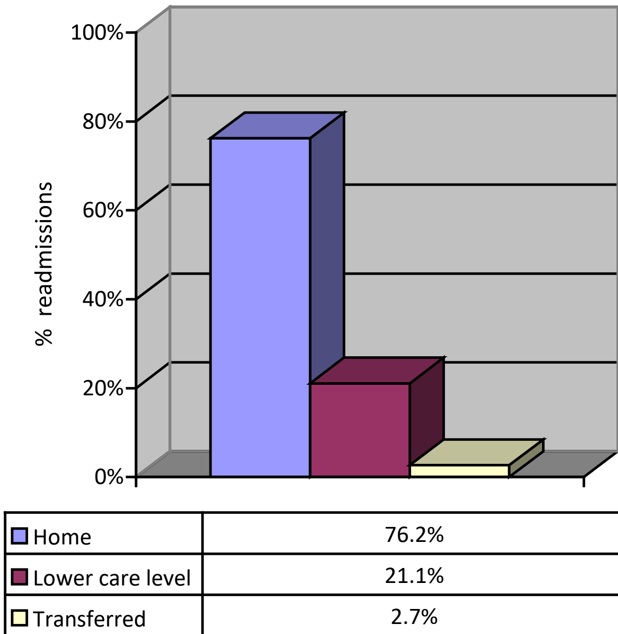


II. Participating CAH Patients At-Risk for Readmission

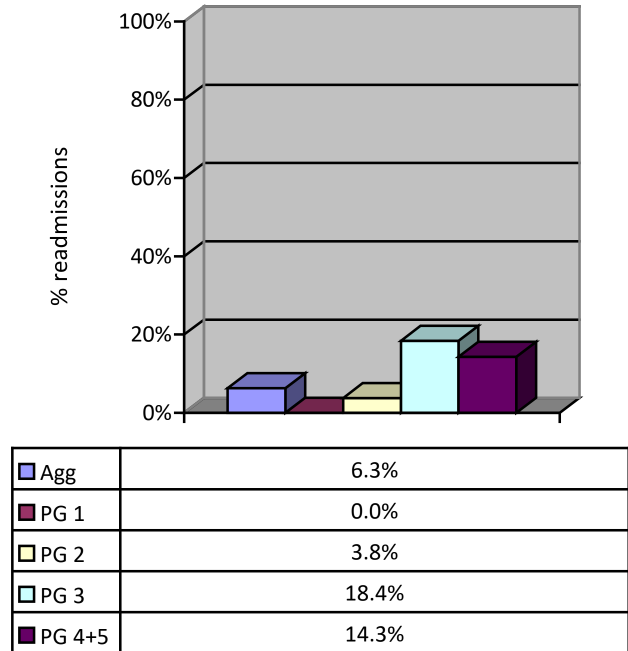




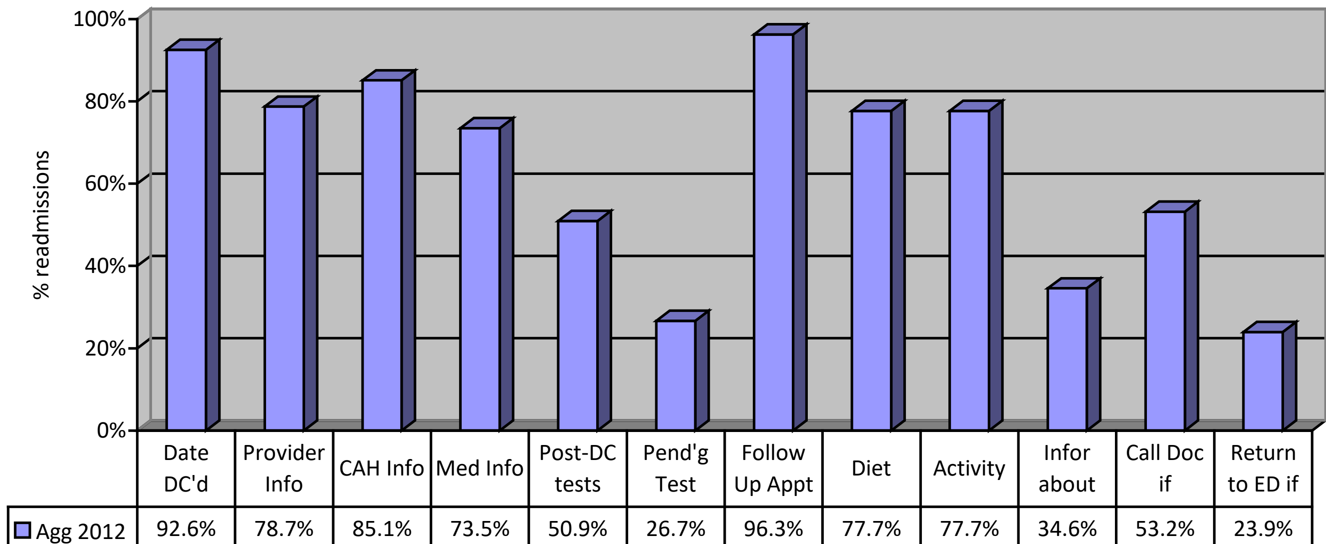
III. Patient Preparation for Discharge



Home	76.2%
Lower care level	21.1%
Transferred	2.7%



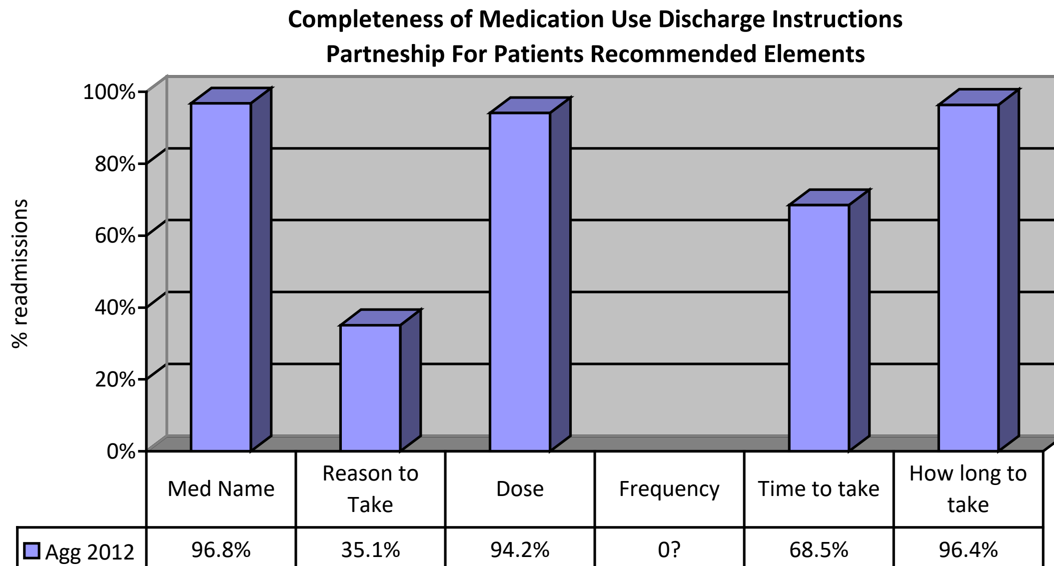
Agg	6.3%
PG 1	0.0%
PG 2	3.8%
PG 3	18.4%
PG 4+5	14.3%



	Date DC'd	Provider Info	CAH Info	Med Info	Post-DC tests	Pend'g Test	Follow Up Appt	Diet	Activity	Infor about	Call Doc if	Return to ED if
Agg 2012	92.6%	78.7%	85.1%	73.5%	50.9%	26.7%	96.3%	77.7%	77.7%	34.6%	53.2%	23.9%

IV. Medication Use Discharge Instructions

Additional opportunities have been identified to improve CAH patient safety through the medication system, focusing in this study on the discharge education process within that system in collaboration with the discharge care and planning processes:



- Ensure the medication instructions for each medication include the reason why the patient is to take it
- Ensure the medication instructions for each medication include what time of day to it
- Among the cases submitted, no record was abstracted showing the frequency, ie, how often, the patient should take the medication. This information is most likely included in the dose information. The study will need to verify with participants that this is correct.

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[1] *Medicare To Penalize 2,217 Hospitals For Excess Readmissions*; Rua, Jordan; Kaiser Health News, Aug 2012; http://www.kaiserhealthnews.org/stories/2012/august/13/medicare-hospitals-readmissions-penalties.asp

Reduce Preventable CAH Inpatient Readmissions

Aggregate and Peer Group Final Report

Data Collection: Nov 2012; June 2013
Number of cases: 223 and 182 readmission cases, respectively
Number of admissions in the period: 4256; 3711
Report date: Jan 2013; July 2013

PROJECT SUMMARY

Abstract

Reducing preventable readmissions is a priority for the nation's healthcare system. Kaiser Health News reported in Aug 2012 that the national average readmission rate for Medicare patients has remained steady at 19% for several years[1]. Strategies to prevent readmissions have been developed by national quality leaders such as the Partnership for Patients, Institute for Healthcare Improvement (IHI), the Agency for Healthcare Research and Quality (AHRQ), and the Centers for Medicare and Medicaid Services (CMS).

The Patient Care and Affordable Care Act of 2010 contains provisions for hospitals to collaborate nation-wide to focus on reducing preventable readmissions through the Partnership for Patients Project. The Project is implemented at the state and local level through Hospital Engagement Networks. The MT-PIN initiated this improvement study in collaboration with the MHA-HEN to reduce preventable CAH readmissions.

Participants

Seventeen PIN participating facilities submitted baseline and remeasurement data for inpatient readmission cases which occurred between Jan 1, 2012 and June 30, 2013. Participants from all five PIN peer groups submitted baseline data for the study. For the final report, peer groups one and two, and peer groups three, four and five were combined for peer benchmarking purposes due to the distribution of facilities submitting data.

Findings

The composite score for all participating CAHs increased from 6.2 at baseline to 7.3 at re-measurement, using a 10-point scale.

- The preventable readmission rate of participating facilities decreased from 5.2% to 4.5%, achieving the project goal of reducing preventable readmissions by more than 20%.
- Assessing patients for readmission risk increased modestly, from 4.9% to 17.0%.
- Completeness of discharge instructions improved from 69% complete to 81%.
- Use of a teach-back method for giving patient discharge education increased from 6.3% to 27.5%.
- Heart failure and pneumonia readmission rates were relatively consistent from baseline to re-measurement.
- Diabetes and comfort care patients do not appear to add significantly to MT CAH readmission rates.

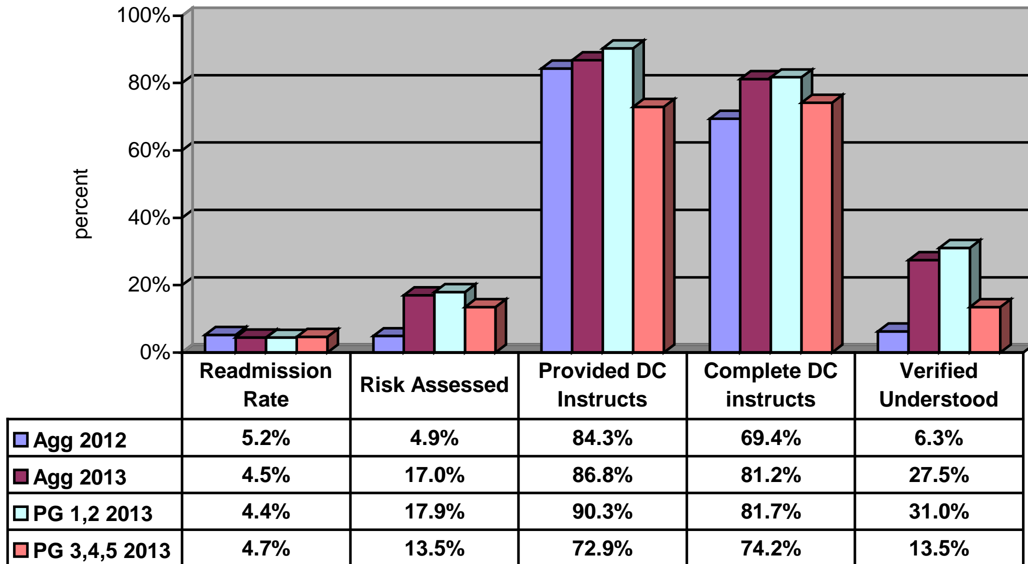
Opportunities

The following opportunities for ongoing improvement have been identified:

- Develop and implement processes to identify all patients at risk for readmission within 24 hours of admission.
- Ensure all patients receive written discharge instructions and that they are complete.
- Ensure all patients being discharged home understand their discharge instructions, including medication use prior to discharge by using a teach back discharge education method.

I. Composite Score: 7.3 on a 10 point scale in 2013.

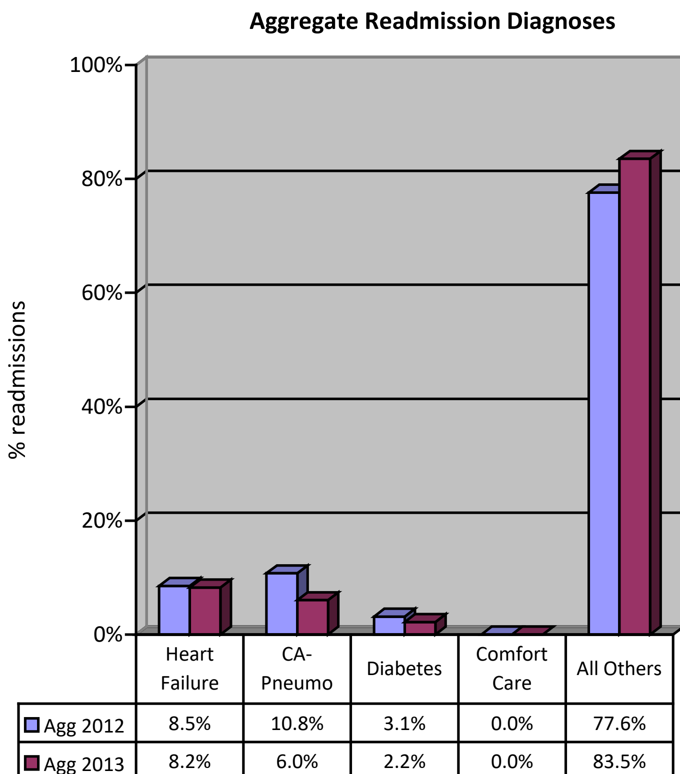
The composite score is calculated using data from the four key process steps identified in the graph below.



	Readmission Rate	Risk Assessed	Provided DC Instructs	Complete DC instructs	Verified Understood
Agg 2012	5.2%	4.9%	84.3%	69.4%	6.3%
Agg 2013	4.5%	17.0%	86.8%	81.2%	27.5%
PG 1,2 2013	4.4%	17.9%	90.3%	81.7%	31.0%
PG 3,4,5 2013	4.7%	13.5%	72.9%	74.2%	13.5%

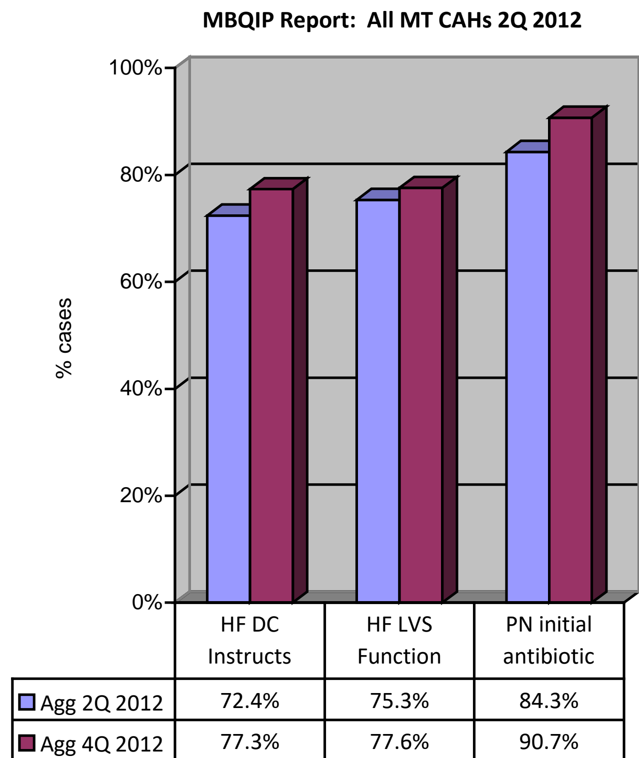
II. Participating CAH Patients At-Risk for Readmission

Aggregate Readmission Diagnoses



	Heart Failure	CA-Pneumo	Diabetes	Comfort Care	All Others
Agg 2012	8.5%	10.8%	3.1%	0.0%	77.6%
Agg 2013	8.2%	6.0%	2.2%	0.0%	83.5%

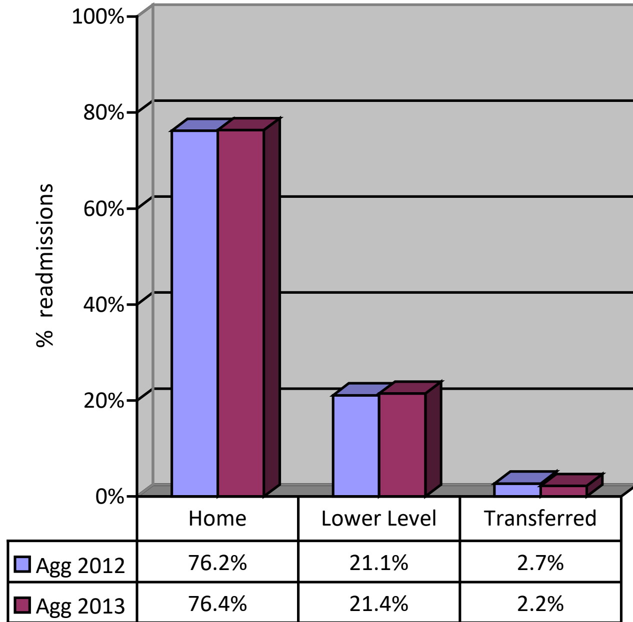
MBQIP Report: All MT CAHs 2Q 2012



	HF DC Instructs	HF LVS Function	PN initial antibiotic
Agg 2Q 2012	72.4%	75.3%	84.3%
Agg 4Q 2012	77.3%	77.6%	90.7%

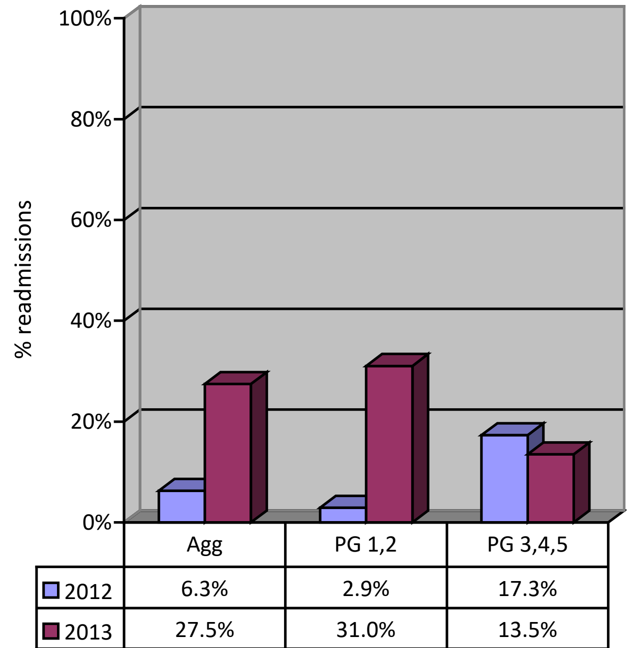
III. Patient Preparation for Discharge

Discharge Location, Previous Admission



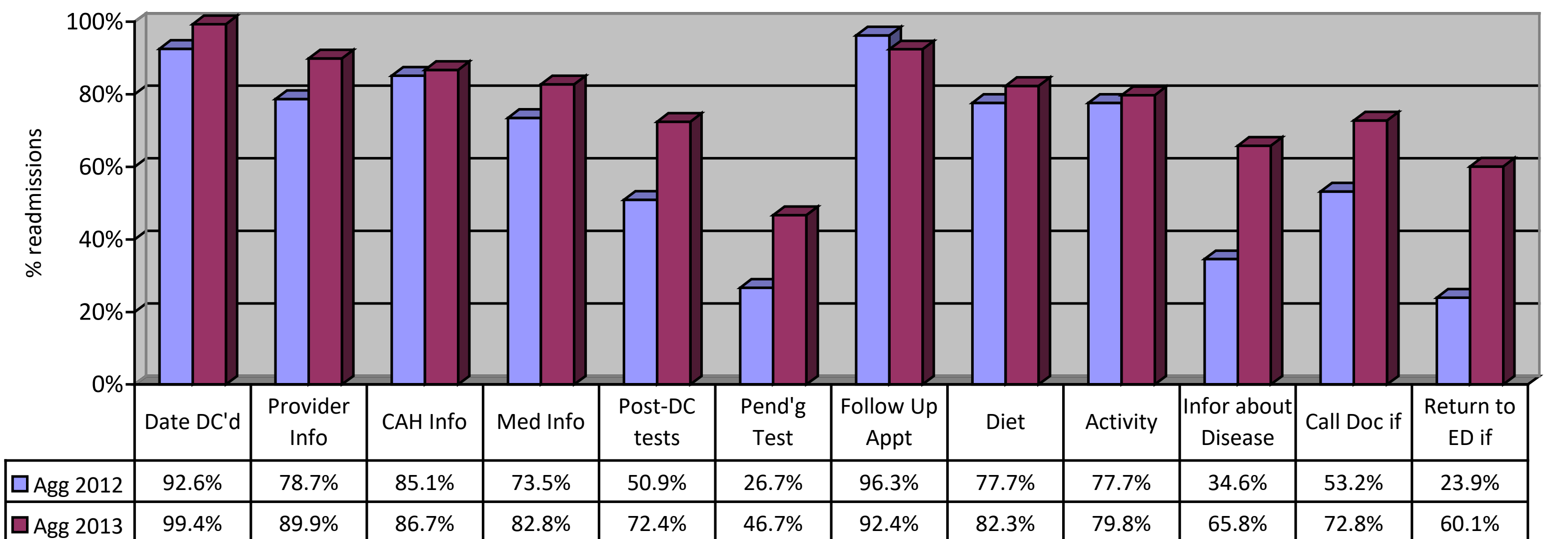
	Home	Lower Level	Transferred
Agg 2012	76.2%	21.1%	2.7%
Agg 2013	76.4%	21.4%	2.2%

Discharge Ed - Teach Back Method



	Agg	PG 1,2	PG 3,4,5
2012	6.3%	2.9%	17.3%
2013	27.5%	31.0%	13.5%

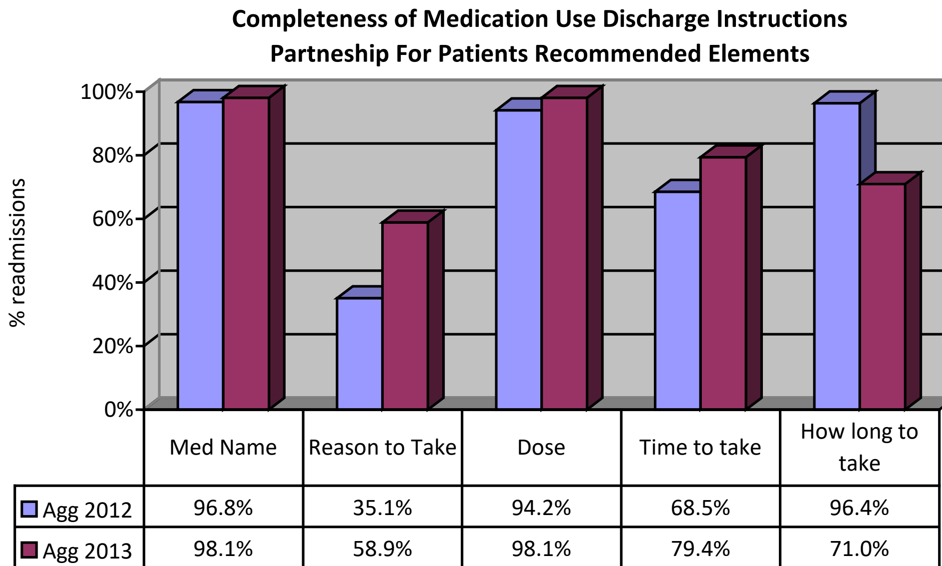
Completeness of Discharge Instructions- Partneship For Patients Recommended Elements



	Date DC'd	Provider Info	CAH Info	Med Info	Post-DC tests	Pend'g Test	Follow Up Appt	Diet	Activity	Infor about Disease	Call Doc if	Return to ED if
Agg 2012	92.6%	78.7%	85.1%	73.5%	50.9%	26.7%	96.3%	77.7%	77.7%	34.6%	53.2%	23.9%
Agg 2013	99.4%	89.9%	86.7%	82.8%	72.4%	46.7%	92.4%	82.3%	79.8%	65.8%	72.8%	60.1%

IV. Medication Use Discharge Instructions

Ongoing opportunities to improve CAH patient safety through the medication system are shown below:



	Med Name	Reason to Take	Dose	Time to take	How long to take
Agg 2012	96.8%	35.1%	94.2%	68.5%	96.4%
Agg 2013	98.1%	58.9%	98.1%	79.4%	71.0%

- Instruct all patients concerning why it is prescribed;
- Instruct all patients what time of day to tale each medication
- Tell all patients how long to take each medication

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[1] *Medicare To Penalize 2,217 Hospitals For Excess Readmissions*; Rua, Jordan; Kaiser Health News, Aug 2012; http://www.kaiserhealthnews.org/stories/2012/august/13/medicare-hospitals-readmissions-penalties.asp

Reduce Preventable Inpatient Re-Admissions Data Tool - Baseline Collection

Use this tool for abstracting records for the baseline data collection period, Jan 2012 – Jun 2012.

Cases to Include: ***For facilities with less than or equal to 30 cases***: all inpatients returning as an unplanned acute care readmission to the same facility within 30 days of last date of acute care discharge.

For facilities with greater than 30 cases: abstract a random sample of no more than 30 cases of all inpatients returning as an unplanned acute care readmission to the same facility within 30 days of last date of discharge.

Cases to Exclude: All ED, AMA and observation patients; newborns and OB readmissions that end in delivery (ie, prior false labor); hospice patients; outpatients; same day surgery patients.

Facility Name: ________________________________ Case Number: ____________________

Facility Contact: _______________________________

SECTION ONE: EVERYONE ANSWER QUESTIONS 1 - 3

1. Date of re-admission (mm/dd/yy): ______ - ______ - ______

2. Date of discharge for the previous inpatient stay: ______ - ______ - _____

3. Number of days from previous discharge to this readmission: _______ days

*** Count the day after discharge date as day one, and the admission date for the current admission as the last day. If more than 30 days, stop now- this is not a qualifying re-admission.***

SECTION TWO: OPTIONAL; FOR PARTICIPANTS WANTING DRILL-DOWN DATA

Abstract the information for questions 4 through 7 from the Previous Admission Record

4. Discharge Diagnosis of previous discharge:
   - ☐ a. heart failure
   - ☐ b. community-acquired pneumonia
   - ☐ c. diabetes
   - ☐ d. comfort care only
   - ☐ e. all other primary diagnoses; Code (optional; for facility info only): _______

5. Discharge Location previous admission (check one):

   ☐ home ☐ to lower level of care ☐ transferred *to* another acute care hospital

6. Was this patient's risk for re-admission assessed within 24 hrs of the admission?

   ☐ Yes ☐ No

7. Was this patient provided with **any** written, printed or electronic instructions about his/her post-discharge care?

☐ Yes; complete the following table ☐ No (skip to question 8)

The patient's discharge instructions as documented in the medical record of the previous admission includes the following elements:	Yes	No	NA
a. date of discharge			
b. name and contact information for physician			
c. name and contact info for the facility or post-discharge phone contact			
d. all information about medications the patient should continue to take at home, including:			
name of medication			
reason for taking it			
dose			
frequency			
time of day or when to take it, if applicable			
how long to take it, if applicable			
e. any post-discharge diagnostic tests ordered, if applicable			
f. pending test results, if applicable			
g. follow up appointments scheduled by the facility, or to be scheduled by the patient if the patient must make the appointment(s).			
h. other orders related to patient's self-care, including: diet			
activity			
i. information about the patient's disease or condition			
j. signs and symptoms that warrant a phone call to physician			
k. signs and symptoms that warrant a visit to the ED			

8. Is there evidence in this medical record that the patient received discharge education using a method that confirms patient understanding of the teaching, such as return verbalization, demonstration, the Teach-Back or Show-Me methods?

☐ Yes ☐ No

SECTION TWO, continued: OPTIONAL; FOR PARTICIPANTS WANTING DRILL-DOWN DATA

Abstract the information for questions 8 through 11 from the <u>Re-Admission Record</u>

9. Patient admitted from:

☐ home ☐ home health ☐ assisted living ☐ long term care
☐ swing bed ☐ transferred to CAH *from* another acute care hospital

10. Discharge Diagnosis of the readmission
- ☐ a. heart failure
- ☐ b. community-acquired pneumonia
- ☐ c. diabetes
- ☐ d. comfort care only
- ☐ e. all other primary diagnoses; Code (optional; for facility info only): _______

11. Discharge Location for the readmission (check one):

☐ home ☐ to lower level of care ☐ transferred to another acute care hospital
☐ deceased

Reduce Preventable Inpatient Re-Admissions Data Tool - Baseline Collection

Due Date: no later than Nov 30, 2012. ***Submit no more than 30 total cases!***

Email and Mail Submissions to: **Clint Taranik** **clint@mtha.org**
MHA, Inc.
PO Box 5119
Helena, MT 59604-5119

Send Fax Submissions to: **Attn: Clint** **1-406-443-3894**

Contact for questions: **Kathy Wilcox** **kathy@mtha.org** **1.406.461.6486**

Note: This study has been developed using Partnership For Patients guidelines.