scan™

PLAN ALL-CAUSE READMISSIONS

5-Star Best Practices ★★★★★

Seeing patients within 7 days of discharge is one of the best interventions to avoid readmissions. When you care for patients correctly, readmission rates fall, performance on quality measures improves and savings are realized as byproducts.

What to review with your patients and their caregivers post discharge:

- Explain discharge instructions and ask patients to repeat them back to you to confirm understanding.
- Reconcile discharge medications in the discharge instructions with the outpatient medication list. Medication errors often lead to readmissions.

What to tell your patients and their caregivers:

- Instruct them on when to call their physicians, when and how to take their medications and when and where to access care. Provide a phone number(s) to call if they have any post-discharge issues.
- Inform patients where to go for urgent/emergent/post-operative care and which outpatient facilities are available. Provide contact information; include addresses, maps and phone numbers.

What to ask your patients and their caregivers:

- Do they have family or friends who can help with their care?
- Do they have the transportation they need to pick up their prescriptions or get to follow-up appointments or a medical facility if they need urgent care?
- Do they need additional help to care for themselves at home?
- Are their homes safe? Are there stairs? Are there items on the floor that could cause them to trip and fall? Can they walk easily throughout their homes?

What your office can do:

Set up procedures for your office staff to:

- See patients within 7 days of being discharged. Patient engagement must occur within 30 days of discharge.
- Request patients' discharge summaries from their hospitals prior to the appointment or call patients to remind them to bring the discharge papers when they visit you.
- Ensure that patients receive delivery of critical durable medical equipment and patients and caregivers know how to use it.

Medical Group Guidelines

What Is Measured: Risk-adjusted percentage of senior patients discharged from hospital stays who were readmitted to a hospital within 30 days.

How It Is Measured: The percentage of acute inpatient stays during the measurement year that was followed by an unplanned acute readmission for any diagnosis within 30 days for patients 65 years of age and older. The formula includes an adjustment to control for difference in the case mix of patients across different populations.

To calculate the observed rate and expected rate for the population, the following formulas are used:

- **Numerator/metric = Observed Rate:** The number of acute readmissions divided by the number of eligible acute admissions equals percentage of actual readmissions.
- **Denominator = Expected Rate:** The average of the expected probability of readmission for each admission based on the acuity of the patients' conditions.
- **National Average Observed Value:**

$$\text{PCR} = \frac{\text{Percentage of actual readmissions}}{\text{Expected probability of readmissions}} \times \text{National average observed value}$$

What the Medical Group Can Do:

Establish a care transition program that will support the following:

- Review the hospital discharge summaries and see that all diagnoses are documented and submitted through encounters.
- Follow up with provider offices to ensure that patients have been seen within seven days of discharge.
- Emphasize importance of providers to maintain a "lifeline" with patients after discharge.
- Assist provider offices via IT to improve quality, integrate care and ease patients' transition.
- Encourage provider offices to maintain frequent communications across the whole care team.
- Provide case management planning to assist and identify high-risk patients through a risk assessment tool.
- Partner with high volume contracted facilities to share data, including discharge summaries and best practices at the time of discharge, to ensure the information flows to the provider of care.
- Develop process for transmitting discharge summaries to physicians' offices in advance of the appointment.
- Align efforts of hospitals and community providers to ease transitions across the care settings.
- Initiate discharge planning on day of admission.