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Preventable Readmissions Phase 1 Workbook Tutorial

Hi, welcome to the New York State Partnership for Patients Preventable Readmissions tutorial. My name is Kelly Donahue, and I am one of the project managers for the New York State Partnership for Patients.

During this tutorial we are going to walk through a data aggregation tool that has been developed to assist hospitals in analyzing patients with high risk factors for readmission that has been identified on the pilot phase 1 tracking sheet. The data aggregation tool is going to be complementary to the patient tracking tool that you see on your screen right now and that you are currently using to identify those patients at risk for readmission and how you can mitigate those risk factors. This is also going to help you take a look at any trends in your readmissions to the pilot unit and identify some areas for improvement.

So you will see page one of the tracking sheet here, and this is page two, where you can identify risk factor categories and the risk factors identified. If you have any questions as you are listening to the tutorial, please feel free to reach out to your project manager. And at this time I would like to turn it over to Robert O'Neal to walk you through the actual data aggregation tool.

Hi everyone, I am going to walk you through our data aggregation tool today. What you are looking at here is where you will answer the aggregate patient data that you have been collecting on your paper patient data tracker. So there are two tabs on this workbook, as you see below, it says "data entry and readmission report," we are currently on the data entry tab, this is where you will enter all the data that will feed into automatically generate your readmission reports.

So, this top table here corresponds directly with the paper patient tracker, the top section where you have checkboxes. So before, and I should mention, this tool is not meant to be used to record individual patients, instead you will record individual patient information on your paper tracking sheets, you may then choose to aggregate this information and enter the totals for each period for which you track patients into this tool.

Before you start to enter any information into this tool, you will first want to go through all of your paper sheets and total them up. This first row here shows the total number of patients tracked. So you will want to go through and count all of your tracking sheets for that period, add them up and enter that here. It is very important that you do enter it here, because this particular row feeds into just about every chart on the report.

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Below that row, you will enter the period in which the first risk assessment was completed for each patient. So you total the number of patients for which the first risk assessment was completed within 24 hours, within 48 hours, et cetera. And you enter the data in the corresponding cell for each period. It is important to note that these cells should each be less than or equal to the total number of patients tracked in the first cell of that column. They should also ideally add up to the total number of patients tracked that you entered for that period.

So below this section, you would enter the number of patients for which a patient caregiver was identified. And below that you enter the number of patients and each patient location prior to admission or transfer to the pilot that you are tracking. So again, you will enter the number of patients who are transferred or admitted from the ED, Critical Care, Home, Skilled Nursing Facility, et cetera. And again, these should ideally add up to the total number of patients tracked in that period.

And this is important to note as well, that right now we have a generic period one, period two, period three, et cetera category up on top, you can change this however you would like. For example, you could put January, February, and so on, and that will copy down throughout all of the tables. For now we will keep it at period one and period two.

So that's the fires table that you will enter, the second and the rest of the sheet deals with the risk factor categories. So we won't be tracking the individual risk factors that you recorded, we will be tracking the risk factor categories. And these will be listed in the first column of your pace and tracker sheet, there's also a list of all the categories and the corresponding risk factors identified on the second page of your patient tracker paper sheet.

So the first thing that you want to do is enter your first risk factor category and to do this you click in the box and then you click, there's a little dropdown arrow to the bottom right side, you click on that and then you can select any of the eight risk factor categories that we have listed on your paper sheets. Now if you have your own custom risk factor category, you can just leave it blank, click in the box and enter your risk factor category name. And it will appear at the top of the table here. But for now, I'll leave it at (inaudible).

Now for this risk factor category, you are going to enter the total number of patients with risk factors in that risk factor category. So for example, you may have a patient that has multiple risk factors in a single risk factory category. For example, if a patient was alone, lacked caregiver support and requires assistance for activities of daily living, these are three risk factors in the psycho-social barriers category. So that patient should only be counted, say we select psycho-social barriers, that patient should only be counted once here.

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So below that, and again this is an important number to enter as this will – many charts on the report rely on this number. The categories below are optional. So these rows represent the disciplines responsible for addressing the risk category that you selected. Again these are -- all four of these rows have a dropdown box with potential disciplines, you can either select the discipline or as above you can leave it blank and type in something else.

Below that, you will enter the number of patients for which timely referrals were made to the responsible discipline for all risk factors in this risk factor category. So again if there are multiple risk factors that the patient has within this risk factor category, timely referrals would have to have been made to the responsible discipline for all of these risk factors in order for the patient to be counted in this cell. If only two out of three referrals were made, for two out of three of the risk factors, you wouldn't record the patient here.

And the same is true for the next row, which indicates that all risk factors in this risk factor category were addressed as planned. Again, all of the risk factors in the risk factor category for that particular patient would have to have been addressed as planned in order to enter the patient, or to count the patient in this period. And this table repeats eight times, you can enter eight different risk factor categories and they will all be charted on the readmissions report which I will be moving to now.

To reach the readmissions report, you click on the second tab here at the bottom of the screen, it shows readmissions report. Now at the top of the report it will show the number of patients that you have been tracking thus far and the number of periods that have been recorded. I just entered dummy data here, so for ten patients and just period one. The first table shows the percentage of patients in each time period in which their first risk assessment was completed. This chart sort automatically, in this case 40% of patients had their first risk assessment completed within 48 hours and that is the largest proportion of patients, so that is automatically generated, goes to the top.

Below that, it shows the percentage of patients that were transferred or admitted from each location that you entered in the data entry page. Again this sorts automatically and I should note here, that the skilled nursing facility category and other both have 0% of patients, that's because I entered zero for each of those, had I left other blank, it disappears. And that goes for all of these charts. Below this chart, we show the percentage of patients for whom a caregiver was identified.

And then the next section, which the apprentice will be on a separate page that shows the risk factor categories. So this first chart show the percentage of all patients tracked that have risk factors in each risk factor category that you have identified on the data entry page. In this case medications is the most common risk factor category. And I should note that if you want to

remove a risk factor category you can go back to the data entry page, click on the category that you would like to remove go to the dropdown box, click on the blank and it will remove the category. See medications is no longer listed.

So after this chart, we show the percentage of patients for whom a timely referral was made to the responsible discipline for all risk factors in the risk factory category. And this is calculated a little differently than the chart above, so for example, if a patient is in – this is the number of patients for whom a timely referral is made to a responsible discipline for all risk factors in the risk factor category over the number of patients that had a risk factor in the psycho-social barriers category. And the same is true for the final table here which show the percentage of patients for whom all risk factors and the risk factor category were addressed as planned.

So that is the report, we hope that this is useful and helpful to you in your tracking of your patients and if you have any questions whatsoever, please contact your Partnership for Patients project manager and we will be happy to assist you. Thank you.