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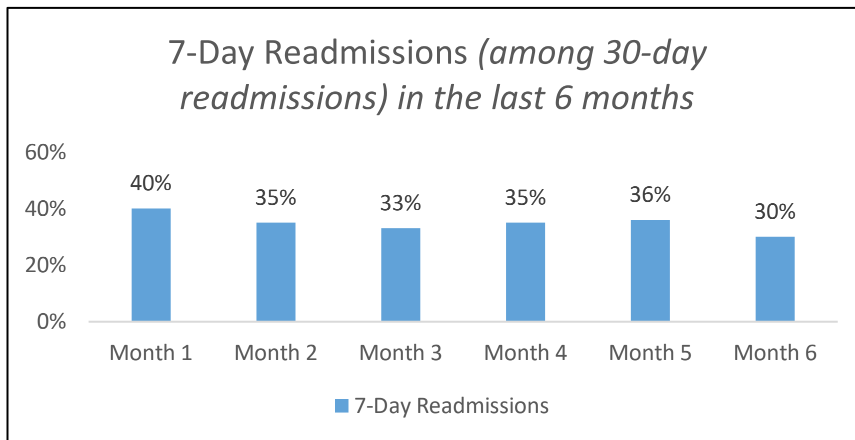
CENTERS FOR MEDICARE & MEDICAID SERVICES

HSAG HEALTH SERVICES ADVISORY GROUP

7-Day Readmission Chart Audit Tool Instructions

Background/Purpose: Readmission data show that for the last six months, of those who readmitted to the hospital in 30 days, 30 percent or more have returned to the hospital within 7 days of discharge. The purpose of this tool is to obtain insight into why a readmission within 7 days of discharge has occurred and how it could have been avoided. It will help identify patterns and trends among readmitted residents, existing gaps in the organization's current discharge processes, and opportunities for performance improvement.

7-day readmissions (among 30-day readmissions) in the last 6 months



Description: This one-page audit tool prompts staff members to review a list of factors commonly attributed to preventable hospital readmissions. The review can help you understand the kinds of barriers residents, families, and providers face during preparation of discharge to the post-transitional care period and the circumstances leading residents to return to the hospital.

Data Collection: The audit can be completed by performing a brief chart review of the first admission and the readmission, and/or through an interview of the resident, family member, or clinicians involved in the resident's care. Additional assessment can be obtained by contacting the resident's primary care provider, home health agency, or mental health provider, for example, to gain their perspective.

Implementation: Each day, identify the residents in your care who were readmitted within 7 days of their last discharge. Residents with a planned readmission are excluded from the audit. Complete the audit tool on each resident. Share these results with the interdisciplinary team, a readmission workgroup, or a readmission team.

Performance Improvement: Aggregate the results of your audits each month to identify the common trends, patterns, and themes. Review current processes surrounding the post care transitions of residents, and focus process improvement efforts that close the gaps found.

This material was prepared by Health Services Advisory Group (HSAG), a Quality Innovation Network-Quality Improvement Organization (QIN-QIO) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. QN-12SOW-XC-05122022-03

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Resident Label

7-Day Readmission Chart Audit Tool

Index admission dates_________through_______/Readmission dates_________through________

1. Is this readmission related to the previous admission? Y or N
2. What is this diagnosis for the readmission?
3. What is the admission source (circle one)? Hospital / home / home health agency (HHA) / hospice / other
4. How many days between discharge and readmission (circle one)? 0–1, 2–4, or 5–7
5. Is the resident on a high-risk medication? If yes, circle one: anticoagulant / diabetic agent / opioid
6. Discharged on seven or more medications? Y or N
7. What is the reason for readmission? Check all that apply:
   - ☐ Chronic condition/exacerbation of disease process
   - ☐ Post-operative complication (wound healing, infection, sepsis)
   - ☐ Post-discharge challenges identified (lack of transport, finances, housing, medical care) but not evaluated for or linked to available resources
   - ☐ Resident/family/caregiver did not understand discharge instructions
   - ☐ Resident/family/caregiver did not obtain medications/supplies
   - ☐ Resident/family/caregiver did not agree with higher level of care recommended at previous discharge (refused HHA)
   - ☐ Discharge services arranged/made were not followed through by service provider. If checked, add service(s) arranged here: ____
8. Did resident have a validated primary care physician (PCP) assignment at previous discharge? Y or N
   - ☐ If yes, was a follow-up appointment made with resident's PCP or specialist at previous discharge and documented in discharge instructions? Y or N
   - ☐ Did resident keep scheduled follow up appointment? Y or N
   - ☐ If no, why (circle one)? Felt better, did not show/cancelled, no transportation, financial barrier, readmitted prior to the appointment, date, or other ______
9. Did resident comply with medication orders after discharge? Y or N
   - ☐ If no, why (circle one)? No transportation, financial barriers/lack of resources, did not want to fill, filled but not taking, had something similar at home, or other____________
10. To identify if other patterns or trends exist, indicate:
    a. What day of the week was the resident discharged (circle one)?
       Sun Mon Tues Wed Thurs Fri Sat
11. Was an evaluation of discharge needs documented on the index admission? Y or N

Completed by:_____________________Date:_____________Follow-up action: ____________________________

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7-Day Readmission Analysis Worksheet

Instructions

Review 10 resident readmissions that occurred within 7 days of discharge. Consider the following:

- What patterns are you seeing?
- Were there trends in the residents' diagnoses?
- Is resident education documented throughout the hospitalization?
- Were the residents on high-risk medications?

Things to Consider

- What additional data are needed to be more specific to the population the intervention will target?
- What data are being collected and how (e.g., data from pharmacy department for high-risk med use, staff feedback, resident interviews, etc.)?
- By when do you need the additional data?

Create Data Visuals to Report the Data

Data can be displayed using various methods.

- Visual information can help a team focus on the causes that will have the greatest impact if solved.
- Information should be displayed in an easy-to-interpret visual format.
- Status of information can quickly be determined as moving in a positive or negative direction.
- Trends and patterns can be identified easily.

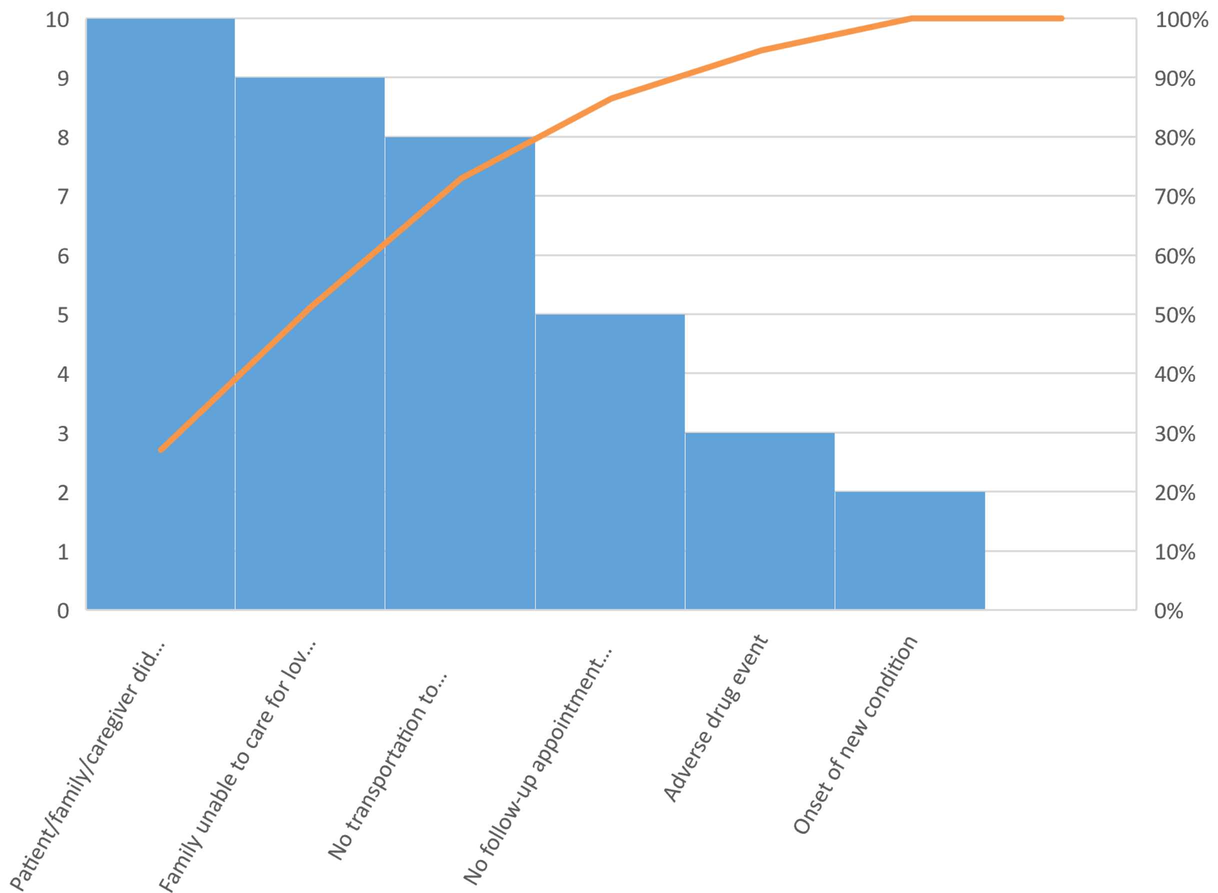
On the following page are three examples of easy-to-use charts. These charts can provide the team with information to use in the improvement planning process.

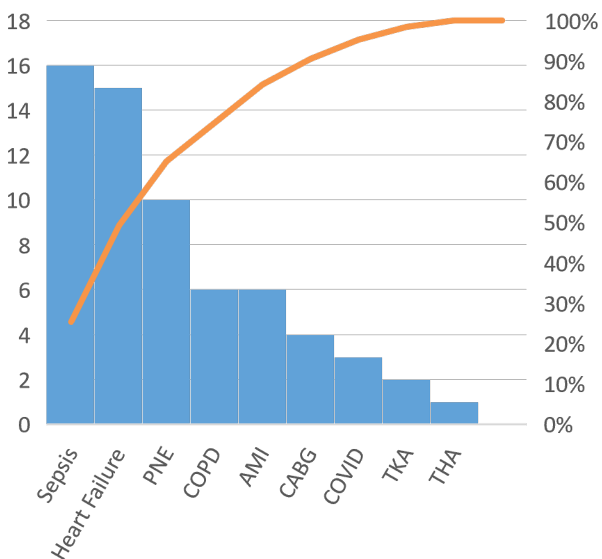
Pareto Chart

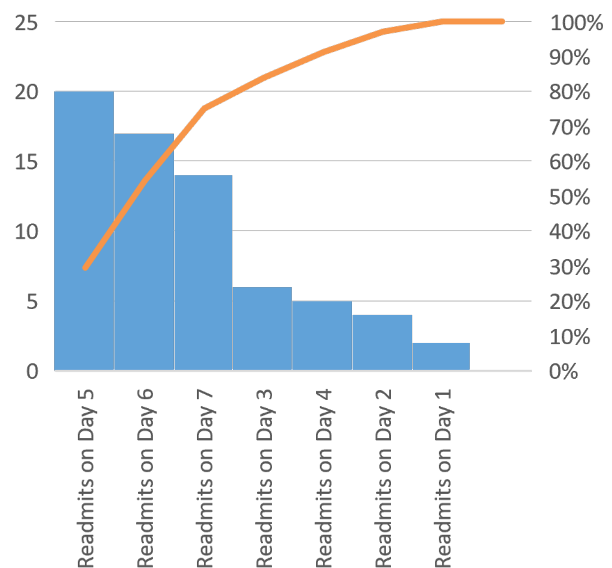
List problem categories on the horizontal axis and frequencies on the vertical axis.

3 Easy Steps to Create a Pareto Chart

1. Gather data and insert into Excel.
2. Use the "sort" feature to order your values from largest to smallest (not essential if you have Excel 2016).
3. Highlight category and counts> Insert Chart > Histogram> Pareto.


Audit of 10 7-Day Readmissions
10
9
8
7
6
5
4
3
2
1
0
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Patient/family/caregiver did...
Family unable to care for lov...
No transportation to...
No follow-up appointment...
Adverse drug event
Onset of new condition


Main Diagnosis for Readmission within 7 Days
18
16
14
12
10
8
6
4
2
0
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Sepsis
Heart Failure
PNE
COPD
AMI
CABG
COVID
TKA
THA


Number of Readmissions within 7 Days of Discharge
25
20
15
10
5
0
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Readmits on Day 5
Readmits on Day 6
Readmits on Day 7
Readmits on Day 3
Readmits on Day 4
Readmits on Day 2
Readmits on Day 1