PACE Performance on Post-Discharge Primary Care Evaluations from Jan-Jun 2012

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INTRODUCTION

• Who am I?
  • Physician Assistant student – Towson/CCBC Essex, MD

• What am I doing?
  • PCLP-NMF/GE Scholar
  • PACE Performance on Post-Discharge Primary Care Evaluations from Jan - Jun 2012
What is PACE?

• Program of All-Inclusive Care for the Elderly
• Comprehensive medical, health, and social services that integrate acute and long-term care.
• Patients 55 years of age or older living in the community and requiring nursing home care.
• Strict regulation and auditing from CMS, CDHCS, Health Dep.

“PACE organization should use organizational data to identify and improve areas of poor performance. The PACE organization must take actions that result in improvements in its performance in all types of care”

1
According to the Medicare Payment Advisory Commission, avoidable hospital readmissions cost Medicare $12 billion a year\textsuperscript{2}

The average costs for readmissions is 30-40% higher than the average cost of acute hospital admissions\textsuperscript{3}

According to Department of Health and Human Services the Obama administration and Congress have both named the reduction of readmissions as a target area for health reform\textsuperscript{3}

Moore et al. determined that 49% of patients experience at least one medical error that is related to transitional care between inpatient and outpatient settings\textsuperscript{4}

There is evidence in the medical literature that patients scheduled or who have seen a primary care provider (PCP) for post-hospital follow-up are less likely to be readmitted\textsuperscript{5,6}
OBJECTIVES

• To determine performance for a 72-hour window between discharge and PCP.
• To determine hospital diagnosis follow up by PCP.
• To assess clinical data from Altamed in light of the current national data.
• To participate in Altamed’s vision of leading community health services by contributing to the continuous evaluation of performance set at PACE
METHODS

- Retrospective randomized chart review study
METHODS (cont...)

- End Points
  - Time between discharge and PCP evaluation.
  - ER diagnosis followed up by PCP.
  - Early hospital readmission (30 days).

- Statistical Analysis
  - Fisher’s exact test between:
    - 72-hr window rate and re-admission rate
    - Hospital diagnosis follow-up and re-admission rate
    - 72-hr window rate and diagnosis f/u
## RESULTS

### 30-DAY READMISSION RATES

<table>
<thead>
<tr>
<th></th>
<th>Based on number of admissions</th>
<th>Based on one admission per patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission rate</td>
<td>24.1%</td>
<td>15.8%</td>
</tr>
<tr>
<td>Patients seen within 72h</td>
<td>43.1%</td>
<td>40.6%</td>
</tr>
<tr>
<td>Visits where Dx. was addressed</td>
<td>82.7%</td>
<td>81.3%</td>
</tr>
</tbody>
</table>

California and U.S. data was retrieved from the Dartmouth Atlas of Health Care (Goodman et al. 2011). AHCRQ study on Chronic condition data was obtained from Podulka et al. (2008).
RESULTS

Median: 4
Average: 5.3 ± 0.61
72 HOUR TIME WINDOW

<table>
<thead>
<tr>
<th>Admission based</th>
<th>Readmitted</th>
<th>Not readmitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 72 hours</td>
<td>44%</td>
<td>20</td>
</tr>
<tr>
<td>&gt; 72 hours</td>
<td>56%</td>
<td>23</td>
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<table>
<thead>
<tr>
<th>Patient based</th>
<th>Readmitted</th>
<th>Not readmitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 72 hours</td>
<td>40%</td>
<td>2</td>
</tr>
<tr>
<td>&gt; 72 hours</td>
<td>60%</td>
<td>5</td>
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</table>

P value = 0.54

P value = 0.68
## DIAGNOSIS ADDRESSED

<table>
<thead>
<tr>
<th>Admission based</th>
<th>Readmitted</th>
<th>Not readmitted</th>
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</thead>
<tbody>
<tr>
<td>Dx discussed</td>
<td>10</td>
<td>38</td>
</tr>
<tr>
<td>Not discussed</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>Dx discussed</strong></td>
<td><strong>84%</strong></td>
<td><strong>Not discussed</strong></td>
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<tr>
<td><strong>Not discussed</strong></td>
<td><strong>16%</strong></td>
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**P value = 0.2**

<table>
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</thead>
<tbody>
<tr>
<td>Dx discussed</td>
<td>4</td>
<td>29</td>
</tr>
<tr>
<td>Not discussed</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td><strong>Dx discussed</strong></td>
<td><strong>82%</strong></td>
<td><strong>Not discussed</strong></td>
</tr>
<tr>
<td><strong>Not discussed</strong></td>
<td><strong>18%</strong></td>
<td><strong>5</strong></td>
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</table>

**P value = 0.27**
DIAGNOSIS ADDRESSED AND 72 HOUR TIME WINDOW

P value = 0.02
DISCUSSION

- Readmission data is consistent with result from regional and national centers.

- Implications of the 72h window.

- Challenges to addressing the diagnosis in the first visit.

- Limitation of the study: sample size, EHR data collection/ time constraints.
CONCLUSIONS

There is an opportunity to improve the 72-h window performance

Ongoing project...

Future ideas: relative readmission rates
ACKNOWLEDGEMENTS

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THANK YOU!
REFERENCES

3. Measuring Hospital Readmission as an Outcome for Care Management Programs. DMAA: The Care Continuum Alliance Forum 2009. San Diego, CA