
Association of Patient-Reported Readiness for Discharge and Hospital Consumer Assessment of Health Care Providers and Systems Patient Satisfaction Scores: A Retrospective Analysis



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- BACKGROUND:** Patient-reported outcomes (PRO) have been increasingly emphasized, however, determining clinically valuable PRO has been problematic and investigation limited. This study examines the association of readiness for discharge, which has been described previously, with patient satisfaction and readmission.
- STUDY DESIGN:** Data from adult patients admitted to our institution from 2009 to 2012 who completed both the Hospital Consumer Assessment of Healthcare Providers and Systems and the Press Ganey surveys post discharge were extracted from an existing database of patients (composed of 220 patients admitted for small bowel obstruction and 98 patients with hospital stays ≥ 21 days). Using the survey question, “Did you feel ready for discharge?” (RFD), 2 groups were constructed, those RFD and those with lesser degrees of readiness (ie, less ready for discharge [LRFD]) using topbox methodology. Outcomes, readmission rates, and satisfaction were compared between RFD and LRFD groups.
- RESULTS:** Three hundred and eighteen patients met the inclusion criteria; 45% were female and 94% were Caucasian. Median age was 62.3 years (interquartile range 52.5 to 70.8 year). Median length of stay was 10 days (interquartile range 6.0 to 24.0 days) and 69.2% were admitted with small bowel obstruction. The 30-day readmission rate was 14.3% and 55% indicated they were RFD. Those RFD and LRFD had similar demographics, comorbidity scores, and rates of surgery. Those RFD had higher overall hospital satisfaction (87.3% RFD vs 62.4% LRFD; $p < 0.001$), higher physician communication scores (median 3.0 RFD vs 2.0 LRFD; $p < 0.001$), and higher nursing communication scores (median 3.0 RFD vs 2.0 LRFD, $p < 0.001$). Readmission rates were similar between the groups (11.4% RFD vs 18.2% LRFD; $p = 0.09$).
- CONCLUSIONS:** Readiness for discharge appears to be a clinically useful patient-reported metric, as those RFD have higher satisfaction with the hospital and physicians. Prospective investigation into variables affecting patient satisfaction in those LRFD is needed. (J Am Coll Surg 2015;221: 1073–1082. © 2015 by the American College of Surgeons. Published by Elsevier Inc. All rights reserved)
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During the last decade, many aspects of clinical care and medical research have been impacted by the focus on patient-centered care. This concept was given prominence

in 2001 with the publication of *Crossing the Quality Chasm* by the Institute of Medicine.¹ Therein, they defined 1 of the 6 priority areas for collective action as the provision of patient-centered care, which is customized according to the patient’s needs and values. As a consequence, there was rapid expansion in the field of patient-reported outcomes (PRO).² Patient-reported outcomes are defined as the report of the status of a patient’s health that comes directly from the patient.³ Because the impact of medical care can best be assessed by those who actually experience it, the appropriate use of PRO is central to the transformation of health care into a more patient-centered enterprise.⁴

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Abbreviations and Acronyms

ED	= emergency department
HCAHPS	= Hospital Consumer Assessment of Healthcare Providers and Systems
LOS	= length of stay
LRFD	= less ready for discharge
PRO	= patient-reported outcomes
RFD	= ready for discharge
SBO	= small bowel obstruction

Concurrent with the emphasis on the delivery of patient-centered health care, regulations requiring the use of a variety of health care quality metrics have been rapidly increasing and impacting health care delivery.⁵⁻⁷ The Affordable Care Act's establishment of the Hospital Readmissions Reduction Program is one such regulatory program, and is having profound effects on the clinical care delivered in hospital settings. Another critical regulation having significant impact is the institution of Hospital Value-Based Purchasing, which links Medicare and Medicaid reimbursement to patient satisfaction, as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.^{8,9}

One relatively understudied area at present is the relationship between patient-reported outcomes and quality metrics. The aim of this study was therefore to determine the relationship between one of the previously studied PRO (readiness for discharge) and 2 quality metrics (readmission rates and patient satisfaction).

METHODS**Patient sample**

An existing database of patients with complete patient satisfaction data was used for this study. This database was constructed from hospital records and included only patients who returned satisfaction surveys during the defined interval. This dataset of 318 patients was composed of 2 distinct subgroups and had been collected for earlier studies. It included patients admitted for small bowel obstruction (SBO) ($n = 220$ or 69.2% of the total sample) and patients with hospital stays longer than 21 days ($n = 98$ or 30.8% of the total sample). All patients with a diagnosis of SBO were included. The most recent 100 patients (98 of which were included in this sample) with hospital stays ≥ 21 days (from a larger group of 278 patients) who had detailed clinical data extracted for an earlier study were included. This resulted in a patient population that was diverse and included both medical and surgical patients. In addition, there was variety in the acuity of the hospital course, including both routine

and complex admissions, as well as emergent and elective admissions. All patients had completed both the HCAHPS and the institutional Press Ganey surveys between 2009 and 2012. For the overall group ($n = 318$), patient accrual by year was as follows: 5% ($n = 15$) in 2009; 8% ($n = 27$) in 2010; 46% ($n = 147$) in 2011; and 41% ($n = 129$) in 2012. For each subgroup, patient accrual by year followed a similar pattern. For the SBO group, accrual by year was 5% ($n = 12$) in 2009; 9% ($n = 19$) in 2010; 43% ($n = 95$) in 2011; and 43% ($n = 94$) in 2012. For patients with hospital stays longer than 21 days, the accrual was 3% ($n = 3$) in 2009; 8% ($n = 8$) in 2010; 53% ($n = 52$) in 2011; and 36% ($n = 35$) in 2012. Those who completed only one of these surveys were not included in our sample. Standard HCAHPS exclusions applied (eg, those who were aged younger than 18 years, psychiatric or rehabilitation admissions, discharge to nursing facilities, admitted as observation status, and those already surveyed within previous 90 days). At our facility, >85% of patients are eligible to be surveyed and all of those eligible are sent surveys through a third-party vendor. All patients from the database were included, with the exception of 2 patients who had missing data for the central variable—readiness for discharge. Patients had previously undergone detailed retrospective chart reviews. Variables collected included demographic (eg, age and sex), clinical (eg, comorbidities and admitting diagnosis), and structural data related to inpatient hospital admission (eg, admitting service and route of admission). Primary diagnosis was determined by clinical chart review, including review of admitting notes, daily notes, discharge summaries, imaging studies, and relevant laboratory studies. Billing records were not used for this study. The distance that patients traveled from home to the hospital facility was calculated using the patient's home address and standard mapping programs. Comorbidities were defined by the standard definitions within the Charlson Comorbidity Index scoring system.¹⁰

Surveys

Surveys were distributed as part of the processes for standard care by the institution's chosen vendor (Press Ganey). Surveys were mailed between 48 hours and 6 weeks after discharge, the standard HCAHPS recommended time frame. Mean \pm SD time in our sample between discharge and a resulted survey was 37 ± 12.1 days. Because the date that surveys are sent was not available and the resulted date included all aspects of records submission to the vendor (which is only done on a weekly basis and includes processing time), this is only an estimate of the true time period for survey completion by patients.

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