Using Root Cause Analysis to Determine Why Readmissions are High

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Presentation Objectives

• Identify at least three elements to include in root cause analysis (RCA)
• Identify internal data sources for use during RCA (e.g. EMR, business applications)
• Develop a process for gathering patient/family and physician perceptions regarding causes for readmissions
• Develop project plan for completion of a hospital-specific RCA

Background Information

• CMS estimates avoidable re-hospitalization costs for Medicare to be $12 billion/annually
• CHF, AMI, and Pneumonia are the first target diagnoses
• Effective FY 2012, hospitals will receive payment reductions for avoidable re-hospitalizations
• In the future, physicians will receive payment reductions for avoidable re-hospitalizations (starting with bundling demonstration projects)
• COPD, diabetes, and renal failure likely the next
• Note: Readmission vs. re-hospitalization
CMS Demonstration Project

- For hospitals in top (or bottom) 25 percentile for re-hospitalization, $$ available for demonstration project
- Hospital specific data (percentile) available at Community Based Care Transition Program
- This site also includes all other needed information
- Must partner with a qualified Community-Based Organization (CBO) e.g. Partners in Care Foundation

Key Requirements

- Cover Letter
- CCTP Program Applicant Cover Sheet
- Executive Summary
- Strategy and Implementation Plan
- Organizational Structure and Capabilities
- Previous Experience
- Budget Proposal
- Supplemental Materials
- 30 double-spaced pages or less in at least a 12 font

Root Cause Analysis

What RCA methods do you feel would elicit the most useful information for your hospital?
Root Cause Analysis

Most Critical Part of Application and Most Crucial to Local Hospital Efforts to Reduce Readmissions

• Community Demographic Analysis
• Data Analysis
• Patient/Family Interviews
• Medical Record Review
• Physician Focus Groups
• Literature Search
• Analysis of Current Processes & Gap Analysis

Community Demographic Analysis

• Who do you serve?
• What is unique about your population?
• What health risks are known in your population?
• What are the resources in your community to help address the issue?
• With whom can you partner?

Data Analysis

• You need to know what is available to you in your organization...
• Core measure application – what else can your system give you?
• Do you have financial systems that can help?
• Do you have EMR?
Question:
The most discharges occur on which day of the week?

Examples of Data Analysis Tools:

Examples of Data Analysis Tools
Patient/Family Interviews

• Ask why they think they had to come back to hospital
• Ask what they think could have avoided readmission
• Collect information about:
  - Did they see/contact their doctor before coming to ED about their symptoms?
  - Did they miss any medications?
  - What diet have they been following?
  - What did they do when symptoms started?
  - Was there a post discharge f/u MD appointment?
    If so, when and was the MD seen in office post discharge?

Medical Record Review

• Condition at discharge
• Symptoms/issues for readmission
• Discharge plan (case management)
• Medication reconciliation
• Discharge instructions - including was there an indicated timeframe for MD F/U post d/c
• Other info

Physician Focus Groups

• Set up multiple breakfast meetings
• Invited high general volume admitters, those with high readmission volume and those with low volume of readmissions
• Shared what we were trying to accomplish
• Asked what they thought would prevent readmissions
• Shared what we knew from other activities
Literature Search

• Good news - lots out there
• Bad news - lots out there
• Some helpful sites:
  Society of Hospital Medicine | Quality Initiatives for Hospitalized Patient Care
  Avoid Readmissions Through Collaboration - Page – Resources
  Project RED (Re-Engineered Discharge) - A Randomized Controlled Trial at Boston Medical Center
  IHI Home Page

Analysis of Current Process and Gap Analysis

• Flow chart process and look for gaps based on what you have learned
• Use staff conducting the process
• Look for literature cues to fill gaps in process
Some of What We Learned About Our Patients Who Experienced Readmission

- 64% of patients were discharged to home after index admission
- 35% readmitted within 7 days; most within 4 days
- Most common discharge day was Friday
- Most discharge instructions indicated to see MD in 1 to 2 weeks
- Most did not see provider before readmission
- Most stated they took medications as ordered (cannot validate)
- Families reluctant to DC patients to a SNF on the first DC; usually agreed to short term SNF placement by the 3rd re-hospitalization
Other Plans

• Work with our high volume skilled nursing facilities to provide resources for early identification and management of symptoms
  — INTERACT II - Interventions to Reduce Acute Care Transfers
• Next, work with high volume home health agencies
• Work with HSAG and participate in Learning and Action Network

Summary

To reduce readmissions, you need:
• A clear understanding of your population and influencing factors for readmissions
• A clear understanding of your current processes
• To develop processes to address “gaps” in your current processes

Questions???

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