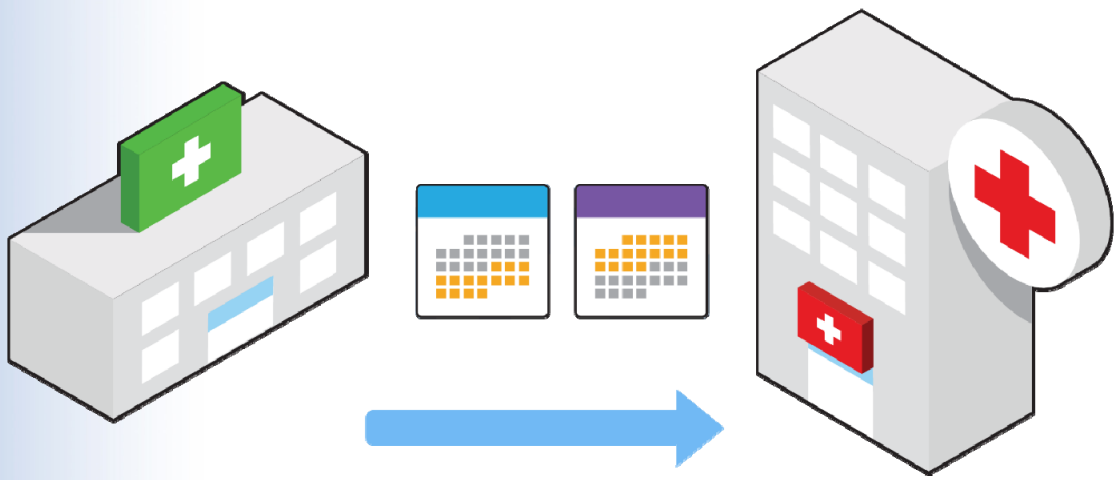
Session #:RO1

Advanced Strategies to Re-hospitalizations



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Objectives:

- Identify the various process measures involved in Re-hospitalizations
- Discuss ways to conduct Root Cause Analysis on Re-hospitalizations
- Identify strategies to avoid Re-hospitalizations
- Discuss innovative ideas experienced from participants (Lessons Learned)to reduce Re-hospitalizations

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WHY? WHY? WHY?

- Medicare Payment Advisory Commission estimates 75% of Re-hospitalizations are avoidable
- Estimated total hospital costs – up to $44 billion annually
- More than 20% Re-hospitalizations within 30 days
  - 90% are unplanned
- Re-hospitalizations rates vary from less than 10% to greater than 40%

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FY2015

- CMS is finalizing the expansion of the applicable conditions for FY2015 to include:
  - Patients admitted for an acute exacerbation of chronic obstructive pulmonary disease (COPD)
  - Patients admitted for elective total hip arthroplasty (THA) and total knee arthroplasty (TKA)

Effective Interventions to Reduce Re-hospitalizations (IHI study)

- Enhanced care and support at transitions
  - Improved discharge processes, nurse education about disease management, remote monitoring, improved communication with hospital
- Improved patient education and self-management support
- Multidisciplinary team management
  - Co-management between Ortho and Geriatric services
  - early DC planning
  - transmission of detailed DC instructions to the receiving facility
- Patient-centered planning at the end of life
  - Referral to Hospice

No single intervention was regularly associated with reduced risk of 30-day Re-hospitalization.

Hansen LO, Young RS, Hinami K, Leung A, Williams MV.Interventions to Reduce 30-Day Readmission: A systematic Review. Annuals of Internal Medicine; 2011 October: 155(8) 520-28.

Some Process Drivers for Readmissions

- Staffing challenges
- Poor communication with transition of care
- Physician services – minimal PCP involvement with transition planning
- Identity of high-risk residents
- Lack of education to disease management
- Hospital relations
- Use of Stop and Watch
- Use of SBAR
- Advance planning for end-of-life
- Lack of team approach

Some Strategies to Improve Processes Prior to Admission

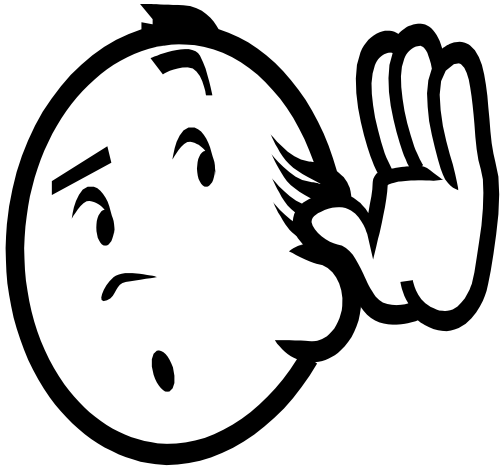
- Conducting RCA and address causal factors
- Work with hospital(s) to review obstacles and what interventions could be put into place
- Engage residents and family in DC planning
- Meet with hospital staff prior to admitting
  - meds reconciliation
  - equipment needs
  - lab results

Some Strategies to Improve Processes After Admission

- Use of Stop and Watch, SBAR and Huddles
- Staffing challenges addressed
- PCP engagement
- Education of staff and competencies to disease management and early detection of signs and symptoms
- Identify high-risk residents
- Resident and family education/re-education

Group Activity: What are some of Yours?

- Form into groups
- Discuss/list what challenges you are experiencing with your readmissions process
- Select a person to present to the audience



Group Activity

- Each group discuss your experiences with re-hospitalizations and “what worked well”
- Select a scribe to capture these Lessons Learned
- Select a person to present to the audience
- Have some fun!

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What did you Learn?

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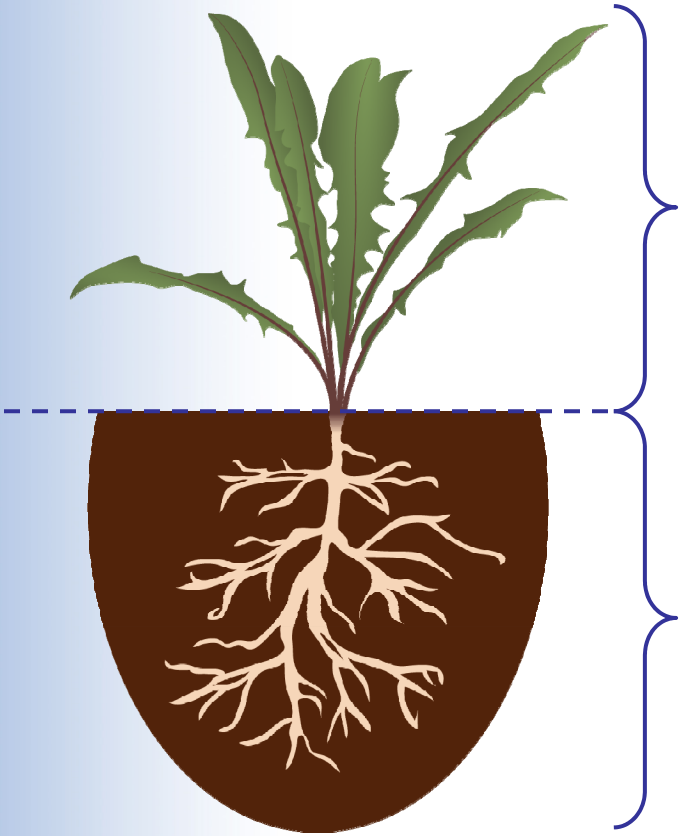
Root-Cause Analysis Basics



Symptom of problem:
THE WEED

- Above the surface
- Obvious

Underlying causes:
THE ROOT

- Below the surface
- Not obvious

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Purpose of Root-Cause Analysis

Continued

- To understand variation in process by exploring potential reasons or causal factors
- To identify opportunities that need to be changed in process

Root-Cause Analysis

- The ability and desire to continually make improvements can happen by asking:

Why?

Is there a better way to do this?

Definitions

- Root-Cause Analysis (RCA)
  - The process for identifying **basic reasons** or **causal factors** that underlie a variation in performance
  - A method of **problem solving** that tries to identify **root causes** of faults or problems
    - Wikipedia

Root-Cause Analysis (RCA)

- **Root-Cause Analysis** is a method of **problem solving** that tries to identify **root causes** of faults or problems. — Wikipedia
- Root-Cause Analysis is not a single, sharply defined methodology; there are **many different tools, processes and philosophies for performing RCA**.

Various RCA Tools

Use an Adaptable Root Cause Analysis Process

RCFA Process

Failure

- Interviews
- Protect Equipment/Parts
- Documents, Records, Diagrams
- Creative Disassembly of Parts
- Expert Investigation

Evidence and Proof

Investigation and Understanding

- Flowchart
- Fishbone Diagram
- Timeline Plots
- Distribution Histograms
- Pareto Charts
- FMEA

Analysis and Identification

- Brainstorming
- Brain Writing
- Is-Is Not Table
- Why Tree (Fault Tree Analysis)
- 5/7 Whys (and test Why Tree)

Corrective Action

- Evaluation Table
- Affinity Diagrams
- Relationship Digraph

Implementation

- Project Management

Must Have's for Root-Cause Analysis Credibility

Why?

- Is the RCA repeatedly digging deeper by asking *why* 5 times?
- Is there participation by leaders and associates that are "closely involved" with work in the process/system with the RCA?
- Does the RCA include considerations of any relevant literature (evidence-based practice)?

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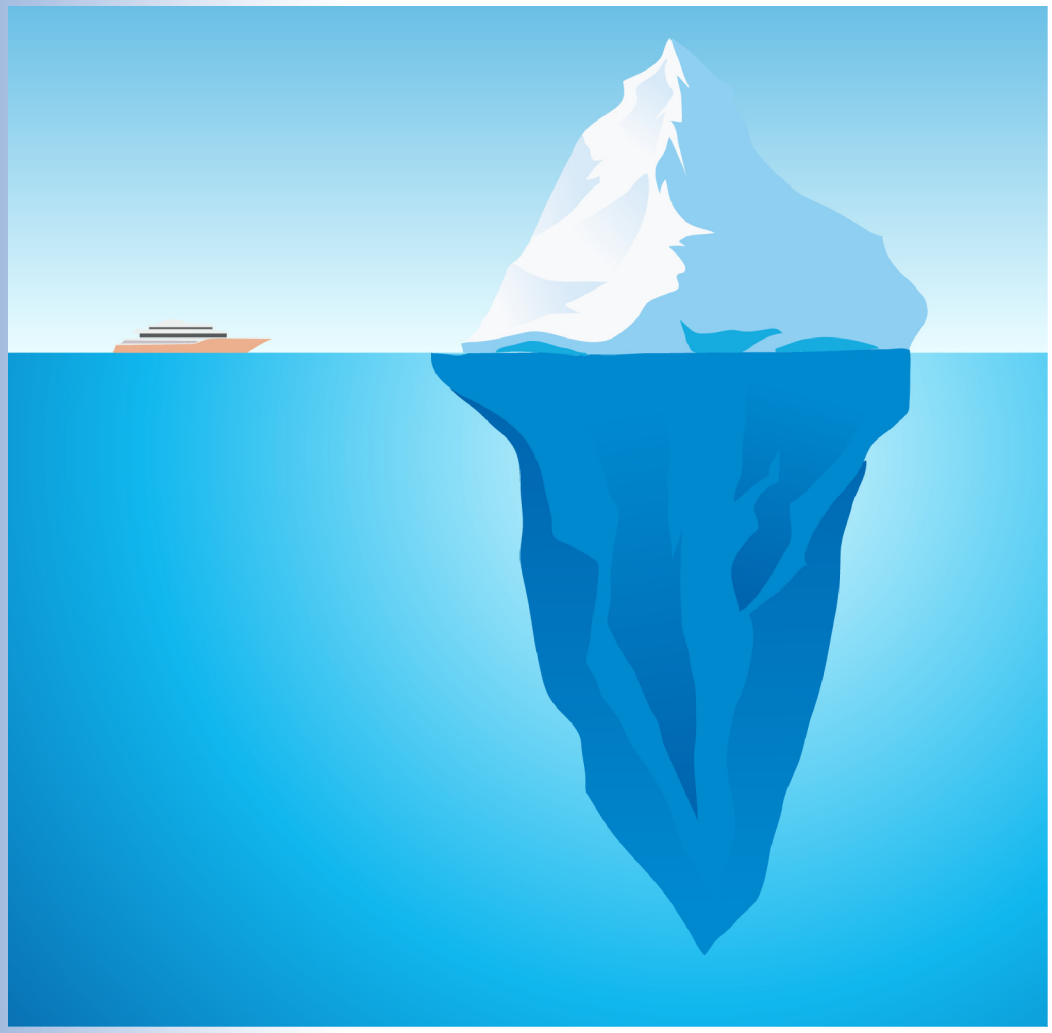

Symptom

Root Cause

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Keep Asking

- What happened?
- Why did it happen?
- What can be done to prevent it from happening again?
- Where (location) is it happening most?
- What time of day?
- What day of the week?
- What shift?
- What unit?

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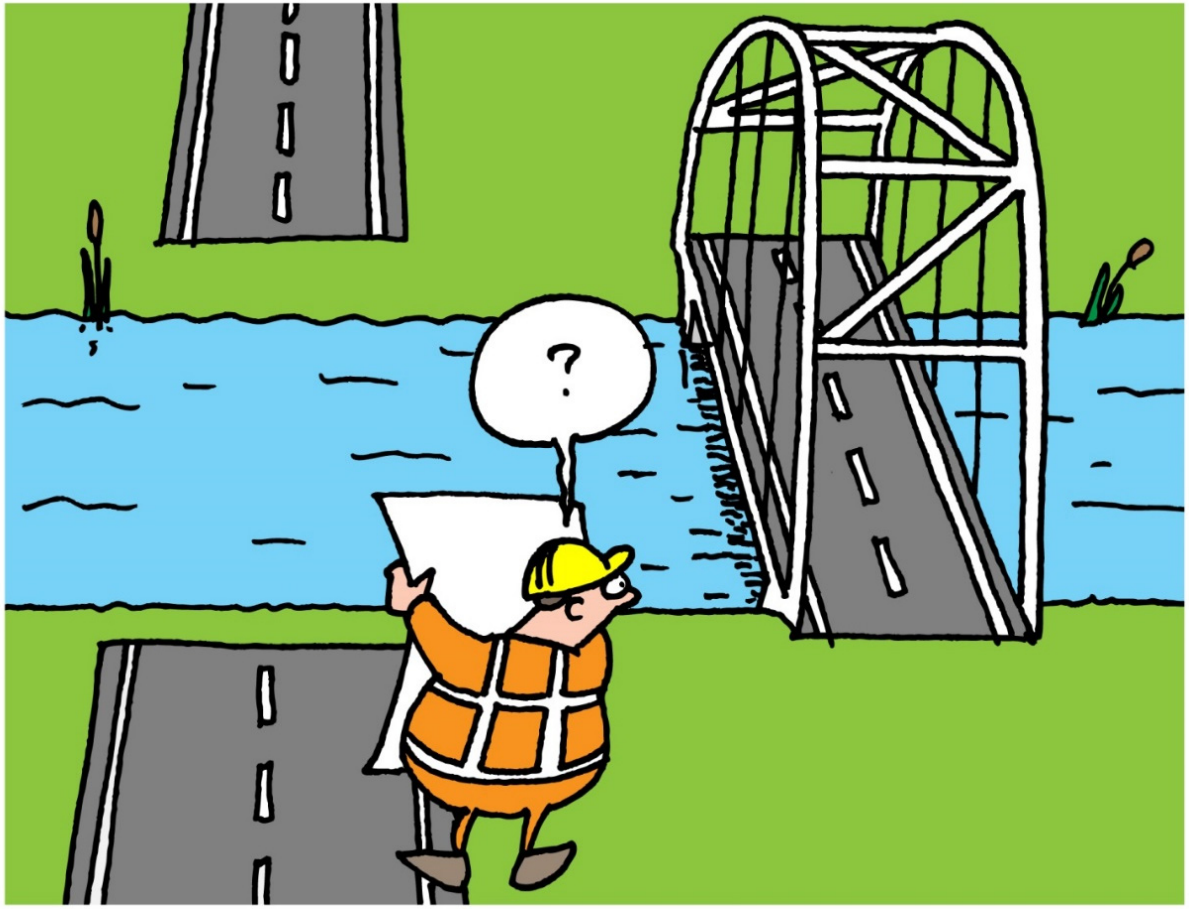
If you don’t involve the user…

you will develop the wrong system system.

— Brian Joiner



Group Activity

- Each group discuss your challenges with re-hospitalizations and perform RCA
- Develop a list of ways to improve process/challenges
- Select a person to present to the audience
- Have some fun!

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Case Study Group One

Mrs. M Black was admitted to the facility on August 13, 2013 and is an 85 year old morbidly obese female and her medical diagnoses include: osteoarthritis, lumbago, diabetes without complications, chronic obstruction pulmonary disease, unspecified essential hypertension, atrial fibrillation, chronic kidney disease, esophageal reflux, history of venous thrombosis embolism. She was admitted to the hospital on 08/08/2013 with complaints of severe abdominal pain associated with alternating bouts of diarrhea and constipation.

Resident (M. Black) is alert and oriented with intermittent confusion. She requires total assistance with transfers and bed mobility and rides a scooter throughout the facility.

On August 29th, 2014, Mrs. Black complained with chest and right arm pain, but stated she did not need to go to the hospital as the pain was not that severe. Vital signs were taken and were as follows; temperature 98.6, heart rate 94, respirations 26, blood pressure 130/68 and oxygen saturation of 96% on room air. Further assessment revealed increased anxiety, a hacky nonproductive cough and complaints of heartburn. MD notified and orders received to administer doxycycline 100mg by mouth twice daily for 7 days and Mucinex 600mg by mouth twice daily for 7 days. Orders processed, faxed to the pharmacy and implemented within 3 hours of receiving the orders.

Documentation related to the change in condition continued throughout every shift with coughing continuing but slight improvement noted. Resident did not show signs and/or symptoms of adverse reactions related to antibiotic therapy and denied pain to chest and/or arm.

On September 1, 2014 at 10:30 am, resident complained with chest pain and requested to go to the emergency room. Vital signs were 99.4, 60, 24, 120/60 and 02 saturation 93% on room air. Lung sounds were clear and there was no obvious shortness of breath noted. MD notified and orders received to send resident to the emergency room.

September 1, 2014 at 5:00 pm, the hospital called to state resident was ready to return to the facility. She returned to the facility with the following diagnosis, COPD exacerbation and urinary tract infection. Resident received albuterol nebulizer treatments, Tylenol, Solumedrol and Macrobid while at the hospital. She returned to the facility with orders for Albuterol nebulizer treatments, prednisone 20mg tab, 2 tablets by mouth daily for 10 days and Macrobid 100mg daily for 10 days.

Case Study Two

Resident #1 is an 82 year old white male who was admitted to the facility on 10/08/2014 with diagnoses of: CVA w/ Wallenberg syndrome, migraines, GERD, prostate CA, right posterior subarachnoid subdural bleed, C3 vertebral fracture, fall history, and DVT risk among others. He spent approximately 5 weeks in a Rehab facility prior to coming to Sunny USA. He was on a puree diet with Honey thick liquids on admission and had a PEG tube in place that was not in use. He showed no s/s of aspiration on admission. Nurses notes reflected no distress, compliant with his meals and use of thickened liquids. He was receiving ST, OT and PT. He was making good progress here in the facility. He was receiving no narcotics or psychoactive medications. His pain was managed with Salon pas patches. His DVT prevention was ASA. He had baseline labs on 10/09/2014 that showed his WBC within normal limits at 8.9. He did have an incident on 10/25 where he was stung by a bee sitting out on the front porch with his family. (He had no allergy to bee stings). First aid was provided immediately. MD was notified with an antihistamine prn order received. No respiratory distress noted, only site reaction to sting and itching. Benadryl was given by the nurse. The resident showed no s/s until evening of 10/27/2014 at approximately 8pm. The resident c/o of chills with a temperature of 100.2. O2 saturation on room air was 92%, and a pulse 90 which was extremely high for him (he is normally in 58-70 range).

Resident had some coughing and increasing congestion. MD was called with orders received for a stat CXR and a urinalysis and C&S was ordered. The resident was medicated for elevated temp. Orders received for nebulizer as well. At 10:00 PM. The resident's O2 saturation was 73-80% while receiving O2 at 2L/minute. Nebulizer treatments were given as ordered. The resident's temperature was up to 102.9. Pulse and respirations were increased. The resident began vomiting. Orders received for Zofran and Tylenol which were given. Respiratory distress continued and resident was sent out via 911 at 11 PM.

Pertinent information: Labs routine at 14 days post admission showed WBC while still WNLs was increasing. (8.9 increased to 10.3). Potential indicator of infection brewing. PA was provided with report and made no changes in his plan. He was placed on the dashboard at the time of the bee sting and monitored x 72hrs with no unusual symptoms. Nurses notes well written to doc same. Stat CXR on 10/27 was negative and UA showed WBCs TNTC.

This resident's returned to the facility on November 5, 2014. The resident's hospital admission diagnosis upon returning to the facility was sepsis, respiratory failure with aspiration and severe dysphagia. He had a UTI. His CXR in the ER was neg. He was treated with ABTs. He is also currently NPO and receives nutrition via PEG.

Some New Strategies to Improve Processes After Admission

- Disease management for infections, pneumonia, CHF, falls with fractures
- Medication Reconciliation-check Beers criteria
- Incorporate therapists and therapy
- Coordination of care with multidisciplinary team (PCP, Nursing, Therapy, Dietary, Social Services)
- Lab, Imaging, Cardiac monitoring, Telemedicine

Questions and Answers

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Thank you!

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