Gap/Root Cause Analysis (RCA) Sample

Before completing this form, complete the Care Transitions Assessment. Identify one of the gap assessment items where the facility's response was either: (1) not implemented/no plan, (2) plan to implement/no start date set, or (3) plan to Implement/start date set. Use this gap/RCA form to get a better understanding of what factors are contributing to the gap and what steps can be taken for improvement.

Organization:	
Team Lead:	
Team Members:	
Assessment Item/Area of Focus: (refer to Care Transitions Assessment)	Your facility provides focused case management for residents at high risk for readmissions to coordinate care addressing: a) Ability to pay for medications b) Scheduling of physician follow-up visits c) Transportation to follow-up visits d) Availability of family/friends to assist resident at time of discharge

Component	Sample Activities Completed	Sample Key Findings
Data: What data specific to this gap area is available to help guide and measure this work? Supportive tools: • 7-Day Audit Chart Tool • 5 Whys • HSAG Data Report	Examples: • Analyzed HSAG's readmission report. • Analyzed data in HSAG's QIIP dashboard. • Analyzed internal report of readmissions. • Reviewed data from medical records for readmissions in the last month.	• HSAG's report shows 30% of readmissions were patients on high-risk medications. • 75% were identified as high-risk for readmissions. • 36% did not have a physician follow-up visit documented/scheduled before discharge. • 82% are prescribed take 13 or more medications • 68% of medical records indicated they were not asked about ability to pay for medications. • 79% did not have a caregiver that lived with them. • 59% has no personal way to get home and needed transportation arranged for them.
Observational work: Evaluate the current processes related to patient transitions. Supportive tools: • 5 Whys	• Observed the patient discharge process for 10 residents identified as high-risk.	• Resident education on diagnosis, treatment plan, new prescriptions, and signs and symptoms to watch out for was conducted in 15 or less minutes and during the last hour that the resident was in the facility. • 40% of the 10 observations did not incorporate teach-back and instead said, "Do you have any questions for me?" • Only one of the 10 observed discharges did the nurse ask if they had the money or

Component	Sample Activities Completed	Sample Key Findings
		transportation to get their prescriptions filled. • Staff did not consistently ensure patients could understand and comply with dietary restrictions. • There were missed opportunities to facilitate referrals to community services such as public housing, substance abuse recovery facilities, or behavioral health services.
Individual and group interviews: Understand the voices of your patients and staff. Supportive tools: • Readmission Interview Tool	• Interviewed 10 patients who readmitted back to the hospital in the last two months. • Interviewed 5 day-shift and 5 night-shift and 3 weekend nurses. • Completed 3 post-discharge follow-up phone calls.	• Nurses shared there is confusion among staff on whose responsibility it is to schedule follow-up visits. Additionally, shared education is often rushed due to competing priorities. • Patients reported they: – Have difficulty arranging follow-up appointments with their PCP after discharge. – Struggle with dietary restrictions when they return home, often due to financial reasons. • Patients are confused about discharge instructions, specifically medications. • Patients interviewed had some deficit with social support for food, meds, and/or personal care and did not fill their discharge prescriptions, preferring to continue with meds they had at home to save money or wanted to wait and review with their PCP first.
Financial review: Understand the financial impact of gap item.	• Interview Nursing Home Administrator (NHA) • Reviewed publicly reported data.	The NHA shared: • Reducing readmissions would help get additional positions approved during budget season. • Readmission penalties have reduced Medicare revenue by $375,000 over the past year. • Public reported data on Medicare Compare indicates the nursing home's data for readmissions are higher than the state and national rates.

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