


Care Coordination Quickinar Series 3: Gap/Root Cause Analysis (RCA)

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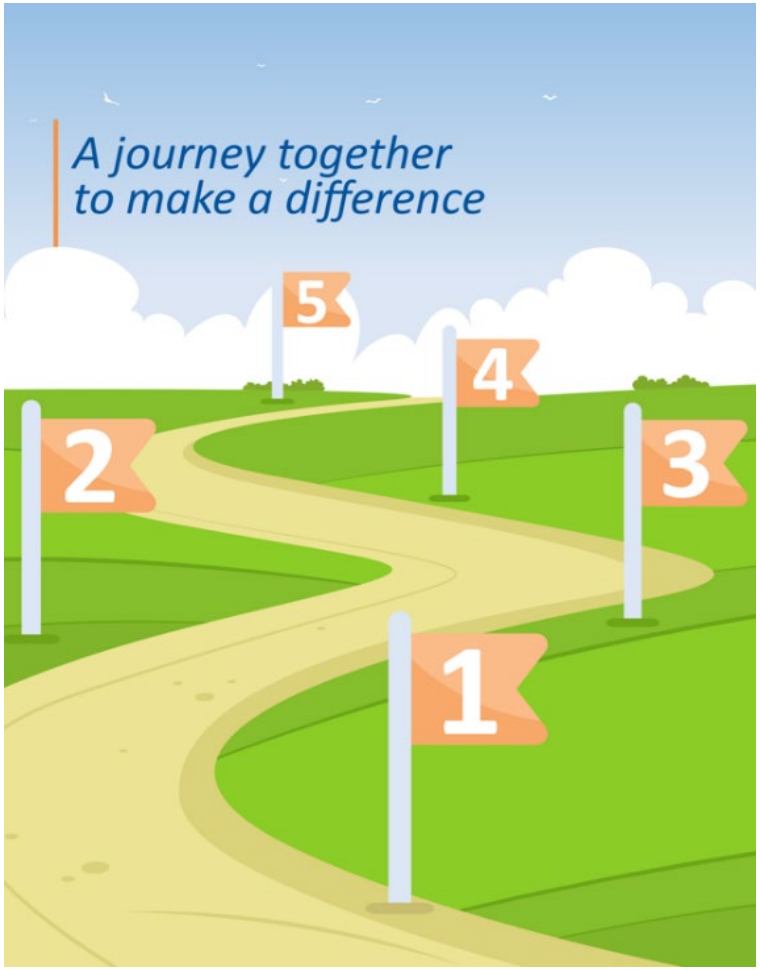
Health Services Advisory Group (HSAG)
February 15, 2022

OBJECTIVES

- Discuss and identify the components of the Gap/RCA tool.
- Identify other resource audit tools:
  - 7-day audit tool
  - Patient interview
  - 5 whys
  - HSAG data reports

2022 Care Coordination Journey

1. **Assessment:** Complete the care transition assessment and RCA to identify your program's strengths and opportunities for improvement.
2. **Strategy Selection:** Evaluate findings, review resources, and select the most appropriate strategy to address your gap.
3. **Implementation:** Develop a strategy tree and implement tactics.
4. **Monitor Results:** This is how you can determine if the strategy is working and make adjustments to your intervention accordingly.
5. **Learn:** Attend HSAG Care Coordination quickinar sessions to learn from subject matter experts.



Root Cause Analysis

Aaron Cross
Instructor, Think Reliability

Care Transitions Assessment

Care Coordination

Care coordination is a key priority for the Centers for Medicare & Medicaid (CMS) to improve quality and achieve safer and more effective care. However, gaps in care, such as poor communication and ineffective discharge processes, remain a challenge.

To address these gaps, HSAG provides evidence-based strategies, resources and training [illegible] are coordination.

Medicati[illegible]

Medication

Pharmacy-L[illegible]

Discharg[illegible]

Intensive Cas[illegible]

Social Determi[illegible]

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Care Transitions

Acute Care Provider Care Transitions Assessment

Facility Name: _____ CCN: _____ Assessment Date: _____ Completed by: _____

Work with your department leadership team to complete the following assessment. Each item relates to care transition elements that should be in place for a program to improve care transitions within your facility. This Care Transitions Implementation Assessment is supported by published evidence and best practices including, but not limited to, the Joint Commission (TJC), National Quality Forum (NQF), Project RED (Re-Engineered Discharge from the Agency for Healthcare Research and Quality [AHRQ]), Project BOOST (Better Outcomes to Optimize Safe Transitions from the Society of Hospital Medicine), and the Care Transitions Model ([CTM®] also known as the Coleman Model). Select the level of implementation status on the right for each assessment item. Once this form is complete, please go online and enter your answers.

Assessment Items	Not implemented/ no plan	Plan to implement/no start date set	Plan to implement/ start date set	In place less than 6 months	In place 6 months or more
A. Medication Management					
1. Your facility has a pharmacy representative verifying the patient's pre-admission (current) medication list upon admission.[i]	☐	☐	☐	☐	☐
2. For high-risk medications (anticoagulants, opioids, and diabetic agents), your facility utilizes pharmacists to educate patients, verifying patient comprehension using an evidence-based methodology.[ii]	☐	☐	☐	☐	☐
3. Your facility has a process in place to ensure patients can both access and afford prescribed medications prior to discharge (e.g., Meds-to-Beds, home delivery of meds, for affordability verification).[iii]	☐	☐	☐	☐	☐
B. Discharge Planning					
4. When patients meet high readmission-risk criteria, your facility focuses customized care coordination efforts for:[iv]					
a. Social determinants of health (e.g., financial barriers, transportation, food insecurities, social isolation, housing, safety, etc.).	☐	☐	☐	☐	☐
b. Patient-centered care planning addressing potential transitional barriers (continual process customized for each unique patient focusing on optimal outcomes while including the patient and caregivers in decision making).[v]	☐	☐	☐	☐	☐

Care Coordination Assessments

Download PDF versions:

- Acute Care Transitions Assessment
- ED Care Transitions Assessment
- SNF Care Transitions Assessment

Care Coordination Quickinars

Care Coordination Toolkit

www.hsag.com/cc-resources

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Gap RCA Tool

Care Coordination Toolkit

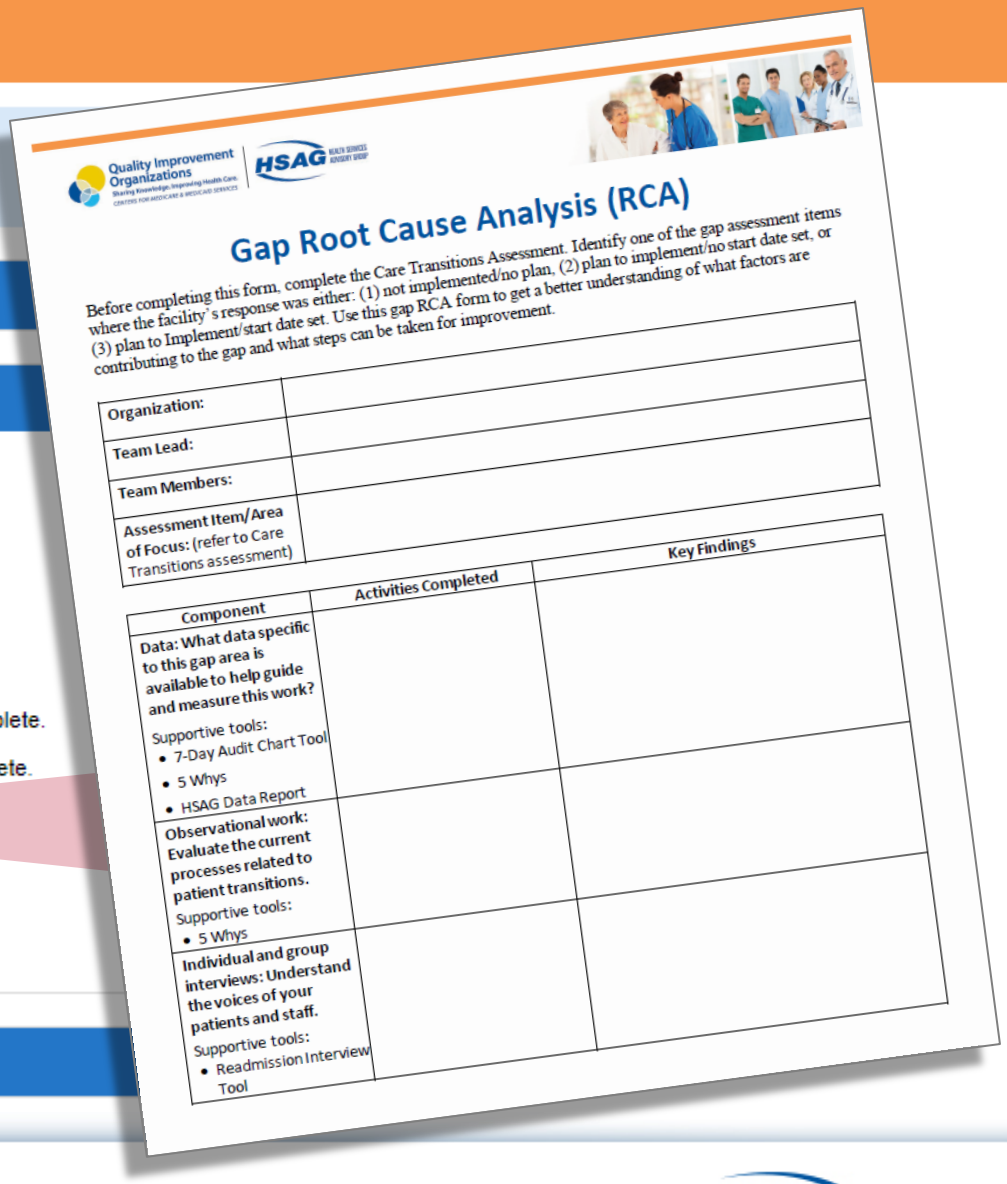
1 Journey to Success

2 Gap Analysis

About Gap Analysis

1. Five Key Areas Known to Reduce Avoidable Readmission (PDF)
2. Typical Failures in Discharge Planning (PDF)
3. Top Evidence-Based Interventions (PDF)
4. Care Transitions Assessment—Acute Care, download and complete.
   Care Transitions Assessment—Emergency Department, download and complete.
   Care Transitions Assessment—Skilled Nursing Facility, download and complete.
5. Gap Root-Cause Analysis (PDF)
   Gap Root-Cause Analysis (fillable PDF)
   Gap Root-Cause Analysis (Word document)
6. Gap Root-Cause Analysis Sample (PDF)

3 Tools to Support Gap Analysis



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Gap Root Cause Analysis (RCA)

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)	

Component	Activities Completed	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		
Observational work: Evaluate the current processes related to patient transitions. Supportive tools: • 5 Whys		
Individual and group interviews: Understand the voices of your patients and staff. Supportive tools: • Readmission Interview Tool		

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7-Day Readmission Chart Audit Tool

Care Coordination Toolkit

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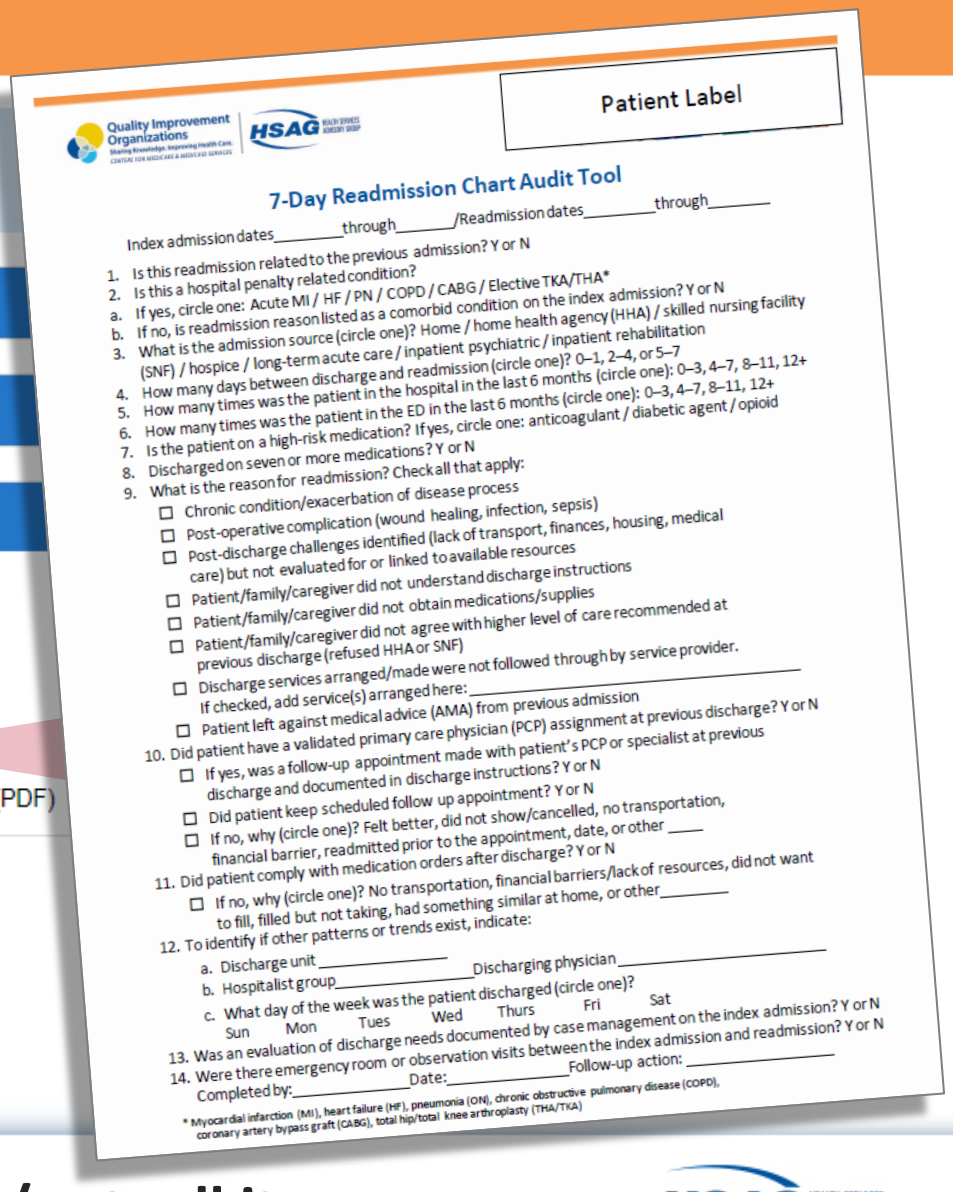
About Tools to Support Gap Analysis (PDF)

1. 5 Whys Tool for Root-Cause Analysis (PDF fillable form)
2. 5 Whys Tool for Root-Cause Analysis—Sample (PDF)
3. 7-Day Readmission Checklist and Audit Tool and Instructions (PDF)
4. Readmission Interview with Patients, Family Members and Care Team Members (PDF)



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Patient Label

7-Day Readmission Chart Audit Tool

Index admission dates_____through_____/Readmission dates_____through_____

1. Is this readmission related to the previous admission? Y or N
2. Is this a hospital penalty related condition?
   a. If yes, circle one: Acute MI / HF / PN / COPD / CABG / Elective TKA/THA*
   b. If no, is readmission reason listed as a comorbid condition on the index admission? Y or N
3. What is the admission source (circle one)? Home / home health agency (HHA) / skilled nursing facility (SNF) / hospice / long-term acute care / inpatient psychiatric / inpatient rehabilitation
4. How many days between discharge and readmission (circle one)? 0–1, 2–4, or 5–7
5. How many times was the patient in the hospital in the last 6 months (circle one): 0–3, 4–7, 8–11, 12+
6. How many times was the patient in the ED in the last 6 months (circle one): 0–3, 4–7, 8–11, 12+
7. Is the patient on a high-risk medication? If yes, circle one: anticoagulant / diabetic agent / opioid
8. Discharged on seven or more medications? Y or N
9. What is the reason for readmission? Check all that apply:
   - ☐ Chronic condition/exacerbation of disease process
   - ☐ Post-operative complication (wound healing, infection, sepsis)
   - ☐ Post-discharge challenges identified (lack of transport, finances, housing, medical care) but not evaluated for or linked to available resources
   - ☐ Patient/family/caregiver did not understand discharge instructions
   - ☐ Patient/family/caregiver did not obtain medications/supplies
   - ☐ Patient/family/caregiver did not agree with higher level of care recommended at previous discharge (refused HHA or SNF)
   - ☐ Discharge services arranged/made were not followed through by service provider. If checked, add service(s) arranged here: _____
   - ☐ Patient left against medical advice (AMA) from previous admission
10. Did patient have a validated primary care physician (PCP) assignment at previous discharge? Y or N
    - ☐ If yes, was a follow-up appointment made with patient's PCP or specialist at previous discharge and documented in discharge instructions? Y or N
    - ☐ Did patient keep scheduled follow up appointment? Y or N
    - ☐ If no, why (circle one)? Felt better, did not show/cancelled, no transportation, financial barrier, readmitted prior to the appointment, date, or other ____
11. Did patient comply with medication orders after discharge? Y or N
    - ☐ If no, why (circle one)? No transportation, financial barriers/lack of resources, did not want to fill, filled but not taking, had something similar at home, or other_____
12. To identify if other patterns or trends exist, indicate:
    a. Discharge unit _____
    b. Hospitalist group_____Discharging physician_____
    c. What day of the week was the patient discharged (circle one)?
    Sun Mon Tues Wed Thurs Fri Sat
13. Was an evaluation of discharge needs documented by case management on the index admission? Y or N
14. Were there emergency room or observation visits between the index admission and readmission? Y or N

Completed by:_____Date:_____Follow-up action: _____

* Myocardial infarction (MI), heart failure (HF), pneumonia (ON), chronic obstructive pulmonary disease (COPD), coronary artery bypass graft (CABG), total hip/total knee arthroplasty (THA/TKA)

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5 Whys Worksheet

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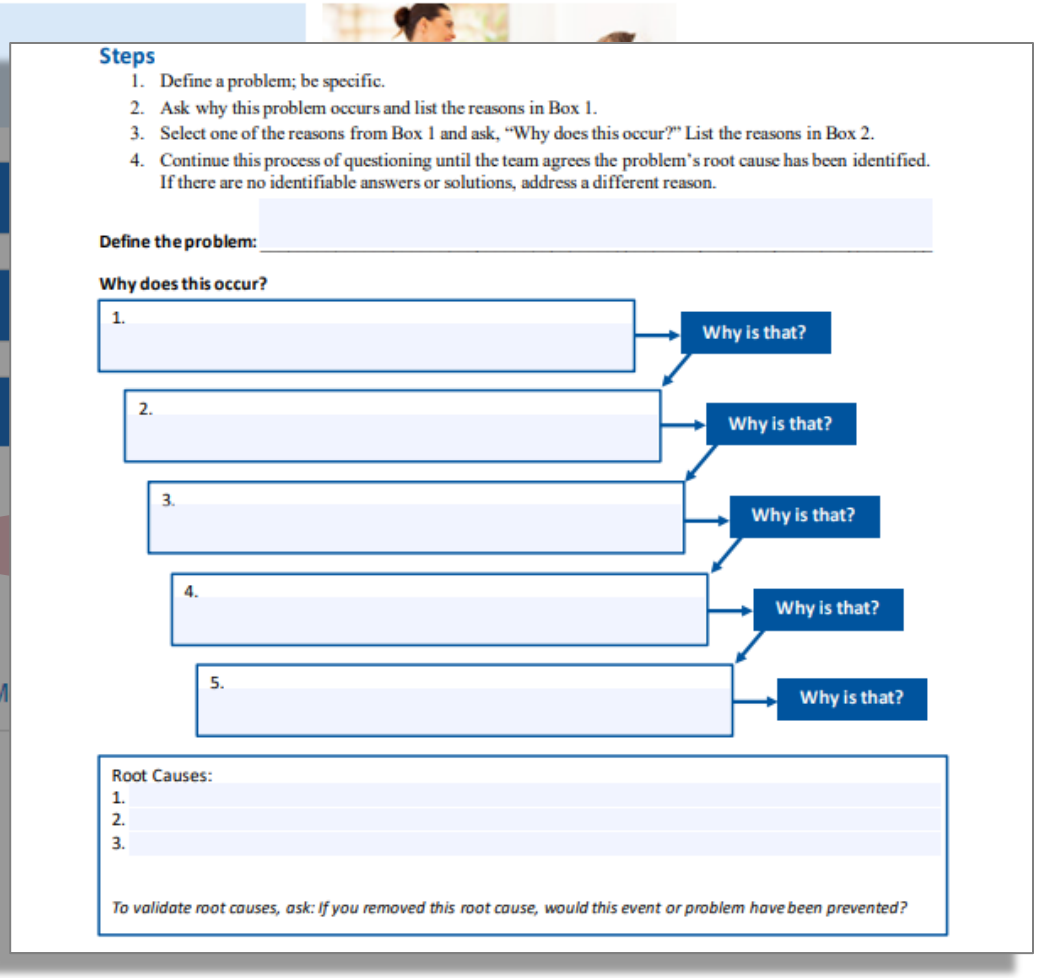

Steps

1. Define a problem; be specific.
2. Ask why this problem occurs and list the reasons in Box 1.
3. Select one of the reasons from Box 1 and ask, "Why does this occur?" List the reasons in Box 2.
4. Continue this process of questioning until the team agrees the problem's root cause has been identified. If there are no identifiable answers or solutions, address a different reason.

Define the problem: _____

Why does this occur?

1. → Why is that?
2. → Why is that?
3. → Why is that?
4. → Why is that?
5. → Why is that?

Root Causes:
1.
2.
3.

To validate root causes, ask: If you removed this root cause, would this event or problem have been prevented?

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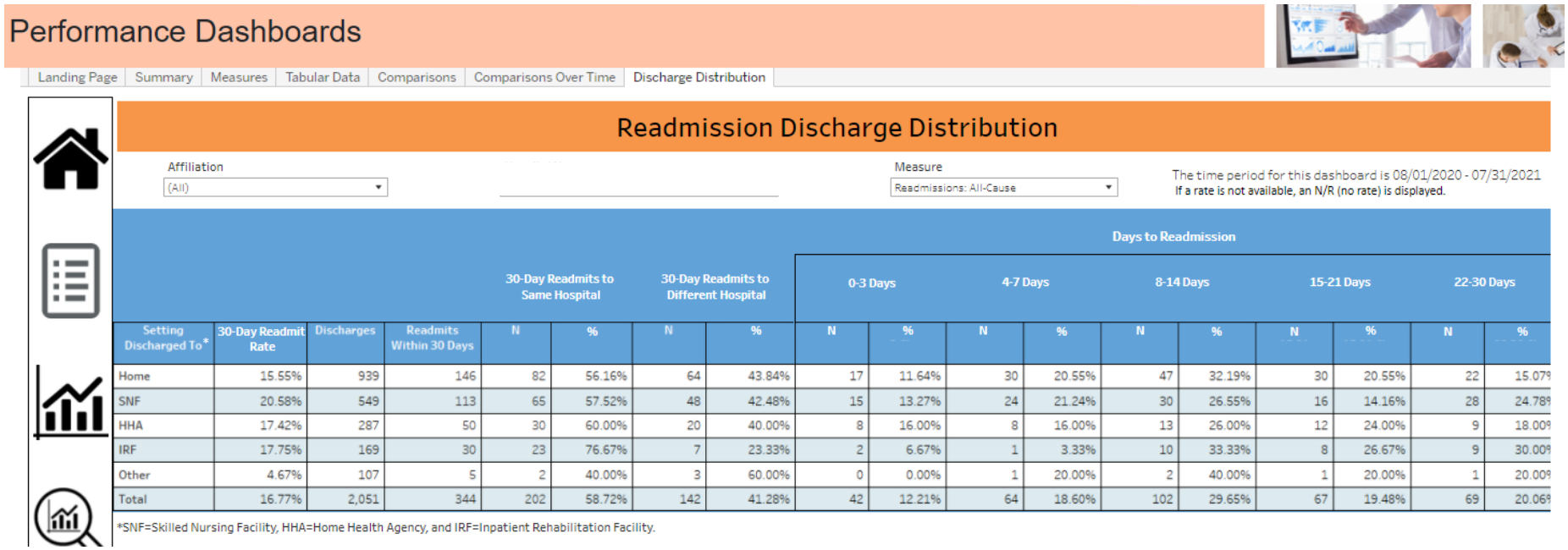
HSAG Data Reports

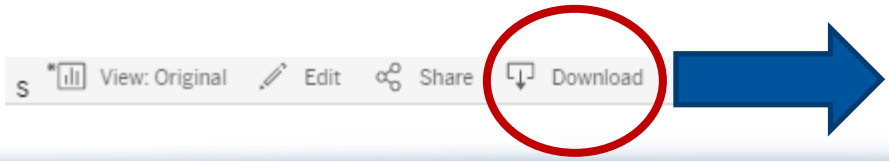


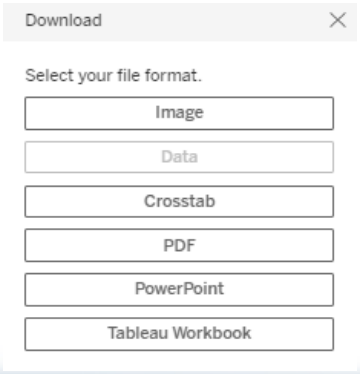
Setting Discharged To*	30-Day Readmit Rate	Discharges	Readmits Within 30 Days	30-Day Readmits to Same Hospital N	30-Day Readmits to Same Hospital %	30-Day Readmits to Different Hospital N	30-Day Readmits to Different Hospital %	Days to Readmission 0-3 Days N	0-3 Days %	4-7 Days N	4-7 Days %	8-14 Days N	8-14 Days %	15-21 Days N	15-21 Days %	22-30 Days N	22-30 Days %
Home	15.55%	939	146	82	56.16%	64	43.84%	17	11.64%	30	20.55%	47	32.19%	30	20.55%	22	15.07%
SNF	20.58%	549	113	65	57.52%	48	42.48%	15	13.27%	24	21.24%	30	26.55%	16	14.16%	28	24.78%
HHA	17.42%	287	50	30	60.00%	20	40.00%	8	16.00%	8	16.00%	13	26.00%	12	24.00%	9	18.00%
IRF	17.75%	169	30	23	76.67%	7	23.33%	2	6.67%	1	3.33%	10	33.33%	8	26.67%	9	30.00%
Other	4.67%	107	5	2	40.00%	3	60.00%	0	0.00%	1	20.00%	2	40.00%	1	20.00%	1	20.00%
Total	16.77%	2,051	344	202	58.72%	142	41.28%	42	12.21%	64	18.60%	102	29.65%	67	19.48%	69	20.06%

*SNF=Skilled Nursing Facility, HHA=Home Health Agency, and IRF=Inpatient Rehabilitation Facility.

Steps to download your reports:

1) Select download
2) Select file format





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Readmission Interview Tool

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About Tools to Support Gap Analysis (PDF)

1. 5 Whys Tool for Root-Cause Analysis (PDF)

   5 Whys Tool for Root-Cause Analysis *(PDF fillable form, coming soon)*

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Readmission Interview Tool

Suggested script to seek participation

"We are working to improve care after hospitalization for our patients that have been recently hospitalized. We noticed that you were here recently and now you're back. Would you mind telling me about what happened between the time you left the hospital and the time you returned? This will help us understand what we might be able to do better for you and what we might be able to do better for our patients in general. It shouldn't take more than 5 to 10 minutes. Would that be okay with you?"

Patient Name (optional): _____

Readmission: __/__/____ Index Admission: __/__/____ Last Discharge: __/__/____

Responses provided by (check all that apply): ☐Patient ☐Caregiver ☐Other: _____

What prompted you to return to the hospital?

My return to the hospital was:

☐Unexpected. ☐Expected.

☐Caused by a new medical problem. ☐Related to what I was treated for during my last hospital stay.

Comments:

Tell me about your prior discharge arrangements.	**Notes**
Where you discharged home? ☐Yes ☐No	
What arrangements were made for you prior to discharge? ☐Home healthcare Date of first home healthcare visit following discharge: __/__/____ ☐Nursing home ☐Rehabilitation ☐Hospice ☐Personal care ☐Transportation ☐Medication assistance ☐Home delivered meals ☐Homemaking/errand services ☐Medical equipment (e.g., oxygen, walker, etc.) ☐Other: _____	
How did these arrangements meet your needs? ☐Needs not met ☐Somewhat met ☐Needs met ☐Too much	

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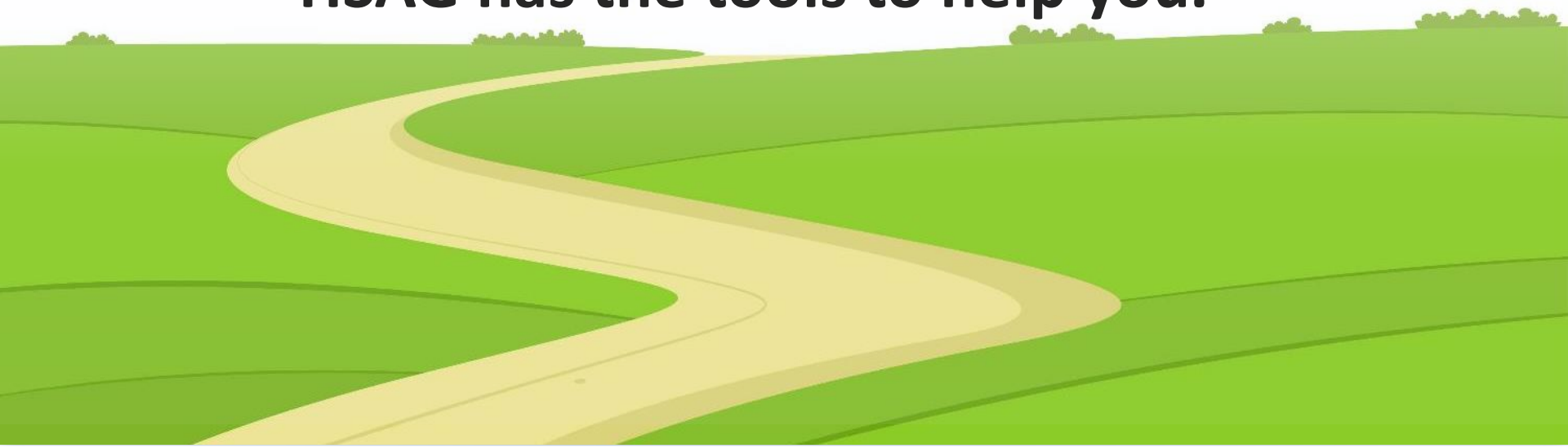
Continuing the Care Coordination Journey

- An RCA is the next tool (following the assessment) required to identify and prioritize opportunities for improvement.
- Now the team should map the goals, strategies, tactics, and tasks to achieve the improvement.

HSAG has the tools to help you.



Our Next Care Coordination Quickinar

Strategy Tree Development and Implementation

Tuesday, March 1, 2022 | 11 a.m. PT

bit.ly/cc-quickinars

Strategy Tree Sample

Goal: By the end of Quarter 4 of 2022, reduce readmissions among super-utilizers from the 28 percent baseline rate to 23 percent.

Strategy: Implement teach-back training and ensure the use of teach-back for super-utilizers.

Tactics	Tasks	Who and When	Resources Needed
1. Provide education to RN and CM staff regarding identification of super-utilizer patients.	A. Develop education on super utilizers. B. Provide education at an all-staff meeting. C. Provide research related to super utilizers and readmissions.	A. Sally— 9/30 B. Joe—10/16 C. Mary—10/15	• Characteristics of Super Utilizer PowerPoint
2. Develop and implement teach-back training.	A. Create training materials (agenda, slides, handouts, role play scenarios, evaluation, etc.). B. Schedule training dates/times. C. Print flyers and create messaging to promote training to staff.	A. Mark—10/10 B. Mary—9/25 C. Brenda—9/30	• Teach-back training slides • Teach-back starter sentences and pocket guides • Plain language handout • Health Services Advisory Group (HSAG) teach-back flyers
3. Observe three staff members per shift providing discharge education.	A. Identify observation tool. B. Assign a CM and RN to observe 3 staff members per shift. C. Collect TB observations and evaluate key findings.	• Sally—10/10 • Joe—10/20 • Mary—10/30	• HSAG teach-back competency check list
4. Conduct monthly trending of super utilizers in the emergency department.	A. Perform weekly audits. B. Make follow-up calls to patients to evaluate patient understanding.	A. Sally—COB Friday every week B. Brenda—11/15	

Care Coordination Quickinar Series

Care Coordination During a Pandemic
Tuesday, January 18, 2022 | 11:00–11:30 a.m. PT

Care Transitions Assessment Overview
Tuesday, February 1, 2022 | 11:00–11:30 a.m. PT

Gap Root-Cause Analysis (RCA)
Tuesday, February 15, 2022 | 11:00–11:30 a.m. PT

Strategy Tree Development and Implementation
Tuesday, March 1, 2022 | 11:00–11:30 a.m. PT

Readmission Super Utilizers
Tuesday, March 15, 2022 | 11:00–11:30 a.m. PT

Hot Spotting and Resources
Tuesday, April 5, 2022 | 11:00–11:30 a.m. PT

Measuring Progress | QIIP Performance Dashboard
Tuesday, April 19, 2022 | 11:00–11:30 a.m. PT

The Role of Health Equity in Care Coordination
Tuesday, May 3, 2022 | 11:00–11:30 a.m. PT

The Impact of Health Literacy
Tuesday, June 7, 2022 | 11:00–11:30 a.m. PT

Teach-Back: A Strategy to Impact Health Literacy
Tuesday, July 5, 2022 | 11:00–11:30 a.m. PT

Community Collaboration Meetings
Tuesday, August 2, 2022 | 11:00–11:30 a.m. PT

REGISTER NOW! More info at: https://www.hsag.com/cc-quickinars

To Do's by the Next Quickinar (March 1, 2022)

1. Complete the care transitions assessment (if you haven't already).
2. Identify 1–2 gaps in your completed assessment you want to focus on.
3. Complete an RCA to identify factors contributing to gaps.

Please Take 5 Seconds and Let Us Know

We want this call to be meaningful to you, so we need your input.

At the end of the webinar, you will be asked **one question** to determine if this call equipped your organization to begin implementing care coordination practices.

Thank you!

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Sharing Knowledge. Improving Health Care.
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