ALLIANT HEALTH SOLUTIONS | HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

HQIC Patient Safety Network: Readmissions

Welcome!

- All lines are muted, so please ask your questions in Q&A
- For technical issues, chat to the 'Technical Support' Panelist
- Please be aware that this event will be recorded

We will get started shortly!

HQIC Readmissions:
Using Readmission Data to Conduct a Root Cause Analysis

Melody Brown, MSM

Sarah Irsik-Good, MHA

January 5, 2022

ALLIANT HEALTH SOLUTIONS

HQIC
Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

Making Health Care Better *Together*

COLLABORATORS:

Alabama Hospital Association
Alliant Health Solutions
Comagine Health
Georgia Hospital Association
KFMC Health Improvement Partners
Konza

Hospital Quality Improvement

Welcome from all of us!

ALABAMA HOSPITAL ASSOCIATION

ALLIANT HEALTH SOLUTIONS

Comagine Health

GHA Georgia Hospital Association

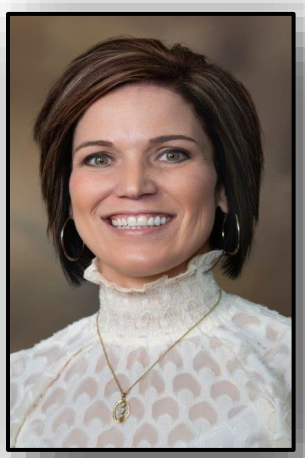
kfmc HEALTH IMPROVEMENT PARTNERS

KONZA

Readmission Co-Leads

Melody "Mel" Brown, MSM
Melody has over 40 years of healthcare experience, including varied roles at Alliant Health Solutions working on the CMS contract for the Quality Innovation Network–Quality Improvement Organization (QIN–QIO). Coaching hospitals and nursing homes on all facets of healthcare quality improvement has been her focus as the Patient Safety Manager.

Contact: Melody.Brown@AlliantHealth.org



Sarah Irsik-Good, MHA
Sarah has over 20 years of healthcare experience and has worked in nearly every healthcare delivery setting including acute care (both PPS and CAH), long term care, behavioral health, and ambulatory care. At KFMC, Sarah has managed QIN-QIO projects including both readmission reduction and care coordination projects.

Contact: sgood@kfmc.org

Learning Objectives

- **Learn Today:**
  - Identify and evaluate readmission-specific RCA tools
  - How to assess a process to determine “why” a patient is readmitted
- **Use Tomorrow:**
  - Conduct a systematic Root Cause Analysis of your hospital’s readmissions
  - Determine the most common cause(s) of readmissions for your facility and patient population

Vision

There are many characteristics and circumstances that place individual patients at a higher risk of being readmitted soon after a hospital discharge. Among the influences for re-hospitalization are specific diagnoses, co-morbidities, emotional factors, personal issues, mental health factors, older age, multiple medications and associated reactions, level of caregiver and home support, history of readmissions, financial issues and deficient living conditions.

You must first identify which influences are at play in your community/patient population before you can enhance or add interventions to address those influences.

Only then can you identify patients at high risk for readmission **PRIOR** to discharge from their index admission, and connect them with the appropriate interventions to avoid a readmission.

Recap: Sessions 1 & 2

- Conducted a deep-dive into readmission metrics, defined measurement data, improvement data and identified local sources of data

- Evaluated identified readmission data sources and learned how to identify “who is being readmitted

Root Cause Analysis

- Identifying causal factors that underline variations in outcomes (i.e. readmissions):
  - How, where, why a problem, adverse event or trend exists
  - Should focus on a process that has potential for redesign to reduce risk
  - Allows you to determine underlying causes and identify recommended changes
  - Focus on systems and processes, not individual performance

Steps to Complete a RCA

- Collect Readmission Data – look at primary 30-day readmission DRG's
- Hospital Consumer Assessment of Healthcare Providers Survey (HCAHPS) data for areas to improve related to discharge planning and medications
- Core Measure Scores
- Analyze Data
- Chart review of readmitted patients
- Readmitted patient/family interviews
- Discharge process mapping

RCA Methodology

1. Medical Record Reviews

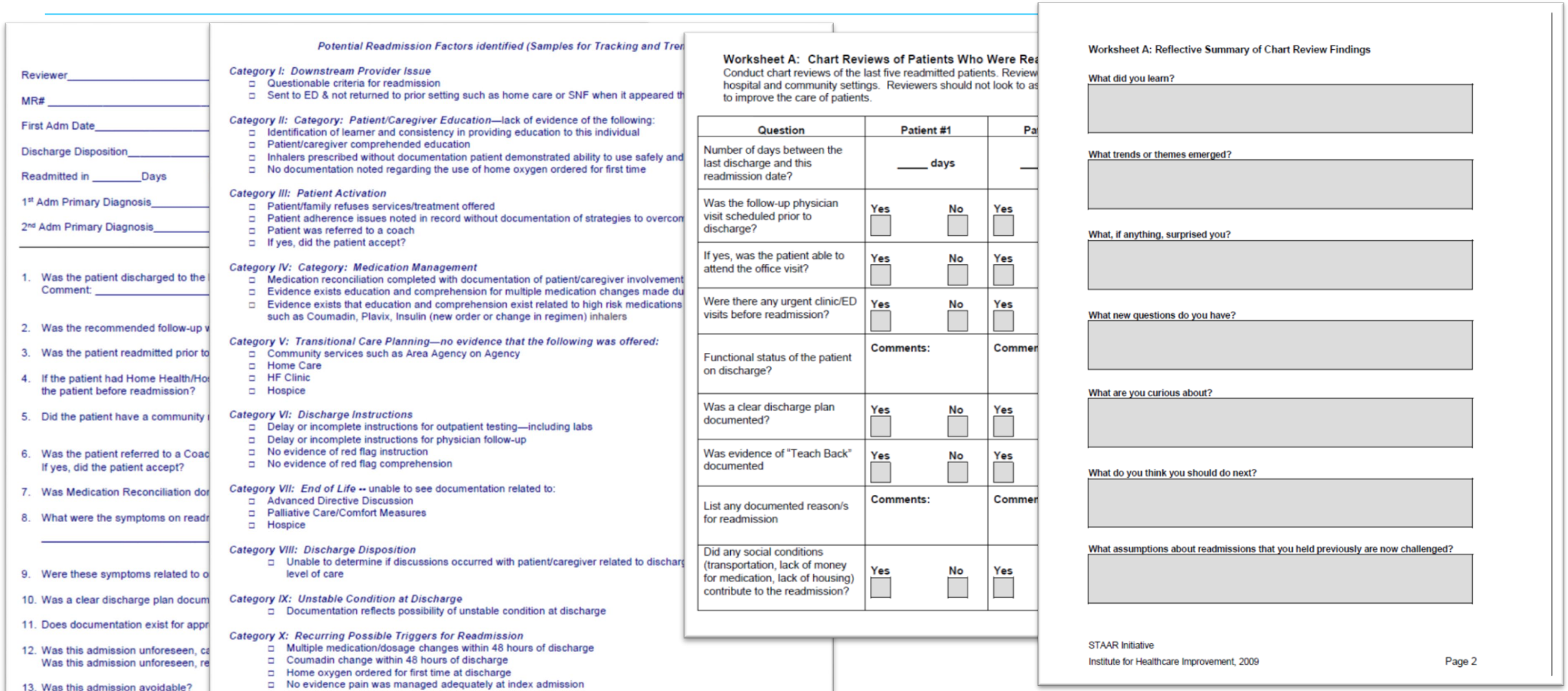
2. Interview sample of patients/family members using an interview tool

3. Process Assessment
   - Direct observation
   - Interviews with Staff
   - Process Mapping

Readmission Record Audit Tools

- Consistent audit tool recommended
- Prompts clinical or quality staff to review a list of factors commonly attributed to preventable hospital readmissions
- Categorize the results for aggregate analysis each month in order to identify common trends, patterns and themes

Medical Record Audit Tools



Reviewer_____

MR# _____

First Adm Date_____

Discharge Disposition_____

Readmitted in _____Days

1st Adm Primary Diagnosis_____

2nd Adm Primary Diagnosis_____

1. Was the patient discharged to the
   Comment: _____
2. Was the recommended follow-up
3. Was the patient readmitted prior to
4. If the patient had Home Health/Ho
   the patient before readmission?
5. Did the patient have a community
6. Was the patient referred to a Coac
   If yes, did the patient accept?
7. Was Medication Reconciliation do
8. What were the symptoms on readm
   _____
9. Were these symptoms related to o
10. Was a clear discharge plan docum
11. Does documentation exist for appr
12. Was this admission unforeseen, ca
    Was this admission unforeseen, re
13. Was this admission avoidable?
    Comment: _____

Potential Readmission Factors identified (Samples for Tracking and Tren

Category I: Downstream Provider Issue
- ☐ Questionable criteria for readmission
- ☐ Sent to ED & not returned to prior setting such as home care or SNF when it appeared th

Category II: Category: Patient/Caregiver Education—lack of evidence of the following:
- ☐ Identification of learner and consistency in providing education to this individual
- ☐ Patient/caregiver comprehended education
- ☐ Inhalers prescribed without documentation patient demonstrated ability to use safely and
- ☐ No documentation noted regarding the use of home oxygen ordered for first time

Category III: Patient Activation
- ☐ Patient/family refuses services/treatment offered
- ☐ Patient adherence issues noted in record without documentation of strategies to overcon
- ☐ Patient was referred to a coach
- ☐ If yes, did the patient accept?

Category IV: Category: Medication Management
- ☐ Medication reconciliation completed with documentation of patient/caregiver involvement
- ☐ Evidence exists education and comprehension for multiple medication changes made du
- ☐ Evidence exists that education and comprehension exist related to high risk medications such as Coumadin, Plavix, Insulin (new order or change in regimen) inhalers

Category V: Transitional Care Planning—no evidence that the following was offered:
- ☐ Community services such as Area Agency on Agency
- ☐ Home Care
- ☐ HF Clinic
- ☐ Hospice

Category VI: Discharge Instructions
- ☐ Delay or incomplete instructions for outpatient testing—including labs
- ☐ Delay or incomplete instructions for physician follow-up
- ☐ No evidence of red flag instruction
- ☐ No evidence of red flag comprehension

Category VII: End of Life -- unable to see documentation related to:
- ☐ Advanced Directive Discussion
- ☐ Palliative Care/Comfort Measures
- ☐ Hospice

Category VIII: Discharge Disposition
- ☐ Unable to determine if discussions occurred with patient/caregiver related to dischar level of care

Category IX: Unstable Condition at Discharge
- ☐ Documentation reflects possibility of unstable condition at discharge

Category X: Recurring Possible Triggers for Readmission
- ☐ Multiple medication/dosage changes within 48 hours of discharge
- ☐ Coumadin change within 48 hours of discharge
- ☐ Home oxygen ordered for first time at discharge
- ☐ No evidence pain was managed adequately at index admission

Worksheet A: Chart Reviews of Patients Who Were Rea

Conduct chart reviews of the last five readmitted patients. Review hospital and community settings. Reviewers should not look to as to improve the care of patients.

Question	Patient #1	Pa
Number of days between the last discharge and this readmission date?	____ days	___
Was the follow-up physician visit scheduled prior to discharge?	Yes ☐ No ☐	Yes
If yes, was the patient able to attend the office visit?	Yes ☐ No ☐	Yes
Were there any urgent clinic/ED visits before readmission?	Yes ☐ No ☐	Yes
Functional status of the patient on discharge?	Comments:	Commer
Was a clear discharge plan documented?	Yes ☐ No ☐	Yes
Was evidence of "Teach Back" documented	Yes ☐ No ☐	Yes
List any documented reason/s for readmission	Comments:	Commer
Did any social conditions (transportation, lack of money for medication, lack of housing) contribute to the readmission?	Yes ☐ No ☐	Yes

Worksheet A: Reflective Summary of Chart Review Findings

What did you learn?

What trends or themes emerged?

What, if anything, surprised you?

What new questions do you have?

What are you curious about?

What do you think you should do next?

What assumptions about readmissions that you held previously are now challenged?

STAAR Initiative
Institute for Healthcare Improvement, 2009 Page 2

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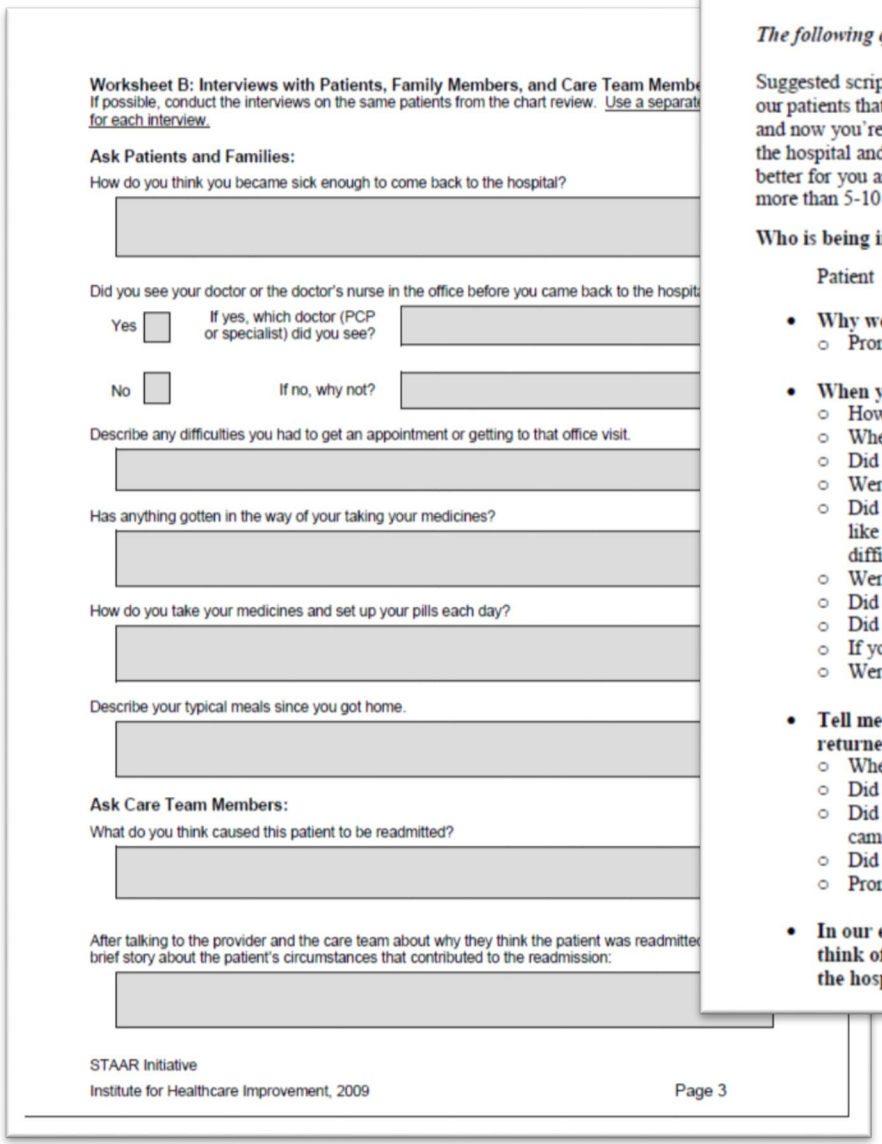
Patient/Family Interview Tools



Worksheet B: Interviews with Patients, Family Members, and Care Team Membe
If possible, conduct the interviews on the same patients from the chart review. Use a separat
for each interview.

Ask Patients and Families:

How do you think you became sick enough to come back to the hospital?

Did you see your doctor or the doctor's nurse in the office before you came back to the hospit

Yes ☐ If yes, which doctor (PCP or specialist) did you see?

No ☐ If no, why not?

Describe any difficulties you had to get an appointment or getting to that office visit.

Has anything gotten in the way of your taking your medicines?

How do you take your medicines and set up your pills each day?

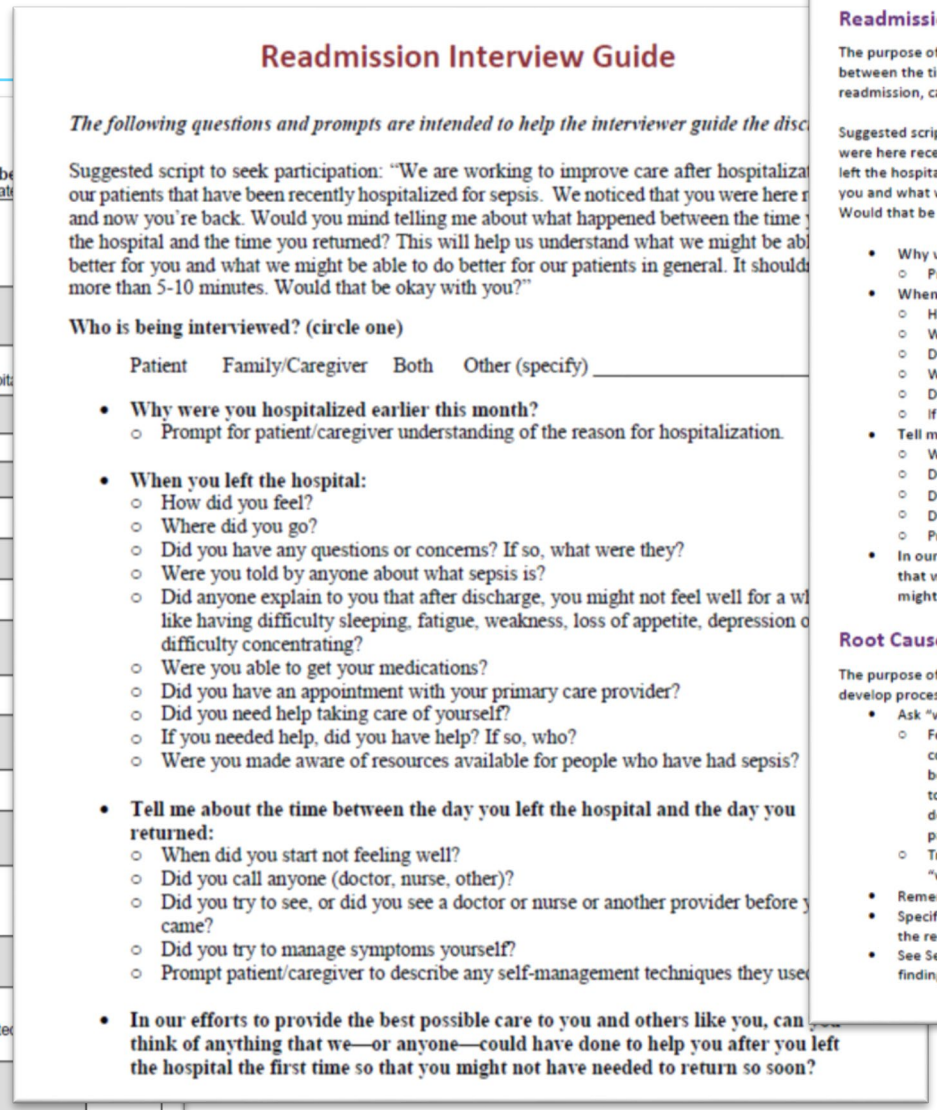
Describe your typical meals since you got home.

Ask Care Team Members:

What do you think caused this patient to be readmitted?

After talking to the provider and the care team about why they think the patient was readmitte
brief story about the patient's circumstances that contributed to the readmission:

STAAR Initiative
Institute for Healthcare Improvement, 2009 Page 3



Readmission Interview Guide

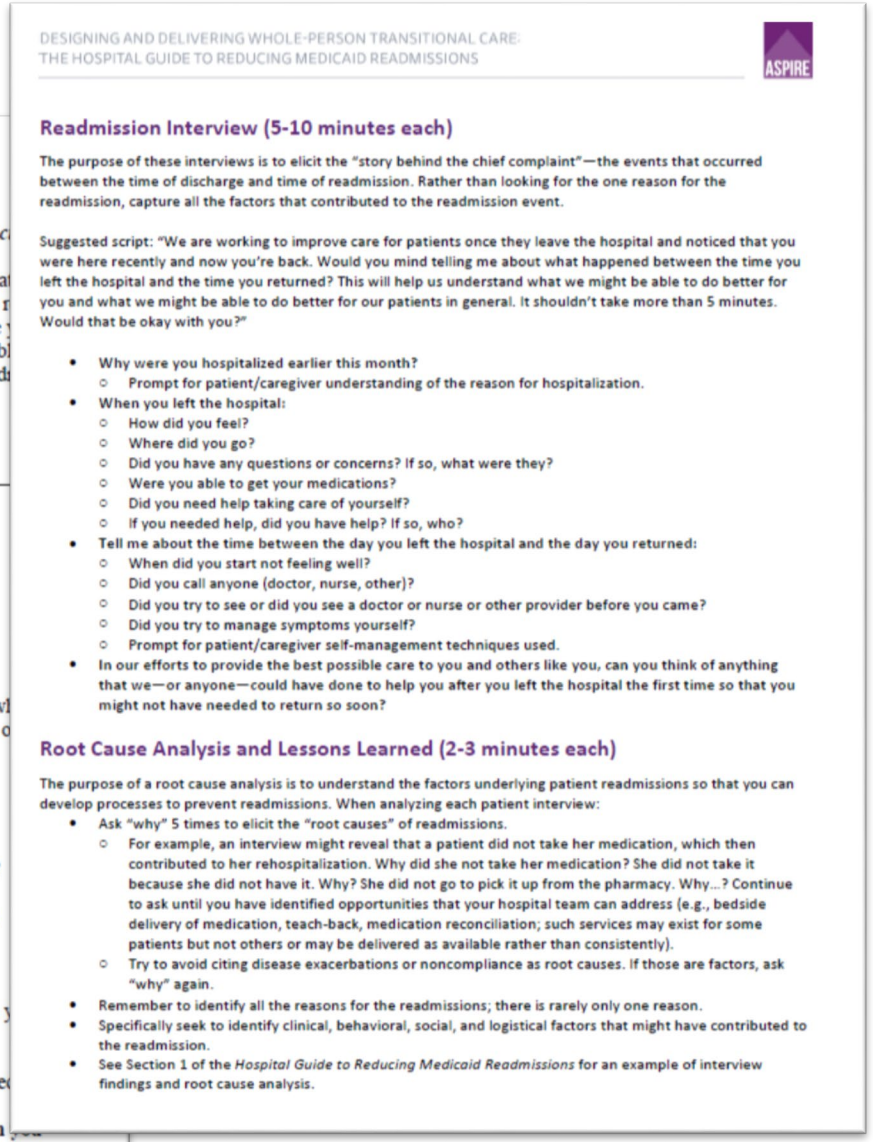
The following questions and prompts are intended to help the interviewer guide the disc

Suggested script to seek participation: "We are working to improve care after hospitaliza
our patients that have been recently hospitalized for sepsis. We noticed that you were here r
and now you're back. Would you mind telling me about what happened between the time
the hospital and the time you returned? This will help us understand what we might be abl
better for you and what we might be able to do better for our patients in general. It should
more than 5-10 minutes. Would that be okay with you?"

Who is being interviewed? (circle one)

Patient Family/Caregiver Both Other (specify) _____

- **Why were you hospitalized earlier this month?**
  - Prompt for patient/caregiver understanding of the reason for hospitalization.
- **When you left the hospital:**
  - How did you feel?
  - Where did you go?
  - Did you have any questions or concerns? If so, what were they?
  - Were you told by anyone about what sepsis is?
  - Did anyone explain to you that after discharge, you might not feel well for a wh
    like having difficulty sleeping, fatigue, weakness, loss of appetite, depression o
    difficulty concentrating?
  - Were you able to get your medications?
  - Did you have an appointment with your primary care provider?
  - Did you need help taking care of yourself?
  - If you needed help, did you have help? If so, who?
  - Were you made aware of resources available for people who have had sepsis?
- **Tell me about the time between the day you left the hospital and the day you returned:**
  - When did you start not feeling well?
  - Did you call anyone (doctor, nurse, other)?
  - Did you try to see, or did you see a doctor or nurse or another provider before y
    came?
  - Did you try to manage symptoms yourself?
  - Prompt patient/caregiver to describe any self-management techniques they use
- **In our efforts to provide the best possible care to you and others like you, can**
  think of anything that we—or anyone—could have done to help you after you left
  the hospital the first time so that you might not have needed to return so soon?



DESIGNING AND DELIVERING WHOLE-PERSON TRANSITIONAL CARE:
THE HOSPITAL GUIDE TO REDUCING MEDICAID READMISSIONS

ASPIRE

Readmission Interview (5-10 minutes each)

The purpose of these interviews is to elicit the "story behind the chief complaint"—the events that occurred between the time of discharge and time of readmission. Rather than looking for the one reason for the readmission, capture all the factors that contributed to the readmission event.

Suggested script: "We are working to improve care for patients once they leave the hospital and 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 minutes. Would that be okay with you?"

- Why were you hospitalized earlier this month?
  - Prompt for patient/caregiver understanding of the reason for hospitalization.
- When you left the hospital:
  - How did you feel?
  - Where did you go?
  - Did you have any questions or concerns? If so, what were they?
  - Were you able to get your medications?
  - Did you need help taking care of yourself?
  - If you needed help, did you have help? If so, who?
- Tell me about the time between the day you left the hospital and the day you returned:
  - When did you start not feeling well?
  - Did you call anyone (doctor, nurse, other)?
  - Did you try to see or did you see a doctor or nurse or other provider before you came?
  - Did you try to manage symptoms yourself?
  - Prompt for patient/caregiver self-management techniques used.
- In our efforts to provide the best possible care to you and others like you, can you think of anything that we—or anyone—could have done to help you after you left the hospital the first time so that you might not have needed to return so soon?

Root Cause Analysis and Lessons Learned (2-3 minutes each)

The purpose of a root cause analysis is to understand the factors underlying patient readmissions so that you can develop processes to prevent readmissions. When analyzing each patient interview:

- Ask "why" 5 times to elicit the "root causes" of readmissions.
  - For example, an interview might reveal that a patient did not take her medication, which then contributed to her rehospitalization. Why did she not take her medication? She did not take it because she did not have it. Why? She did not go to pick it up from the pharmacy. Why…? Continue to ask until you have identified opportunities that your hospital team can address (e.g., bedside delivery of medication, teach-back, medication reconciliation; such services may exist for some patients but not others or may be delivered as available rather than consistently).
  - Try to avoid citing disease exacerbations or noncompliance as root causes. If those are factors, ask "why" again.
- Remember to identify all the reasons for the readmissions; there is rarely only one reason.
- Specifically seek to identify clinical, behavioral, social, and logistical factors that might have contributed to the readmission.
- See Section 1 of the *Hospital Guide to Reducing Medicaid Readmissions* for an example of interview findings and root cause analysis.

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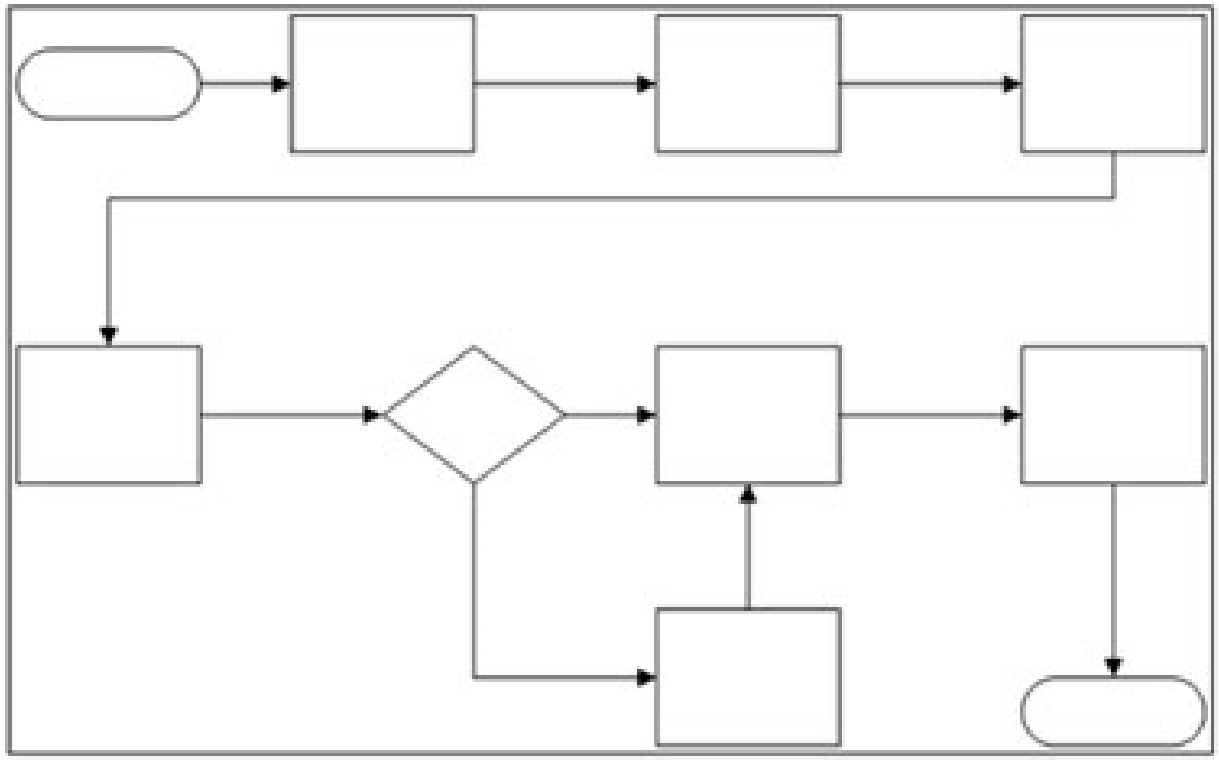
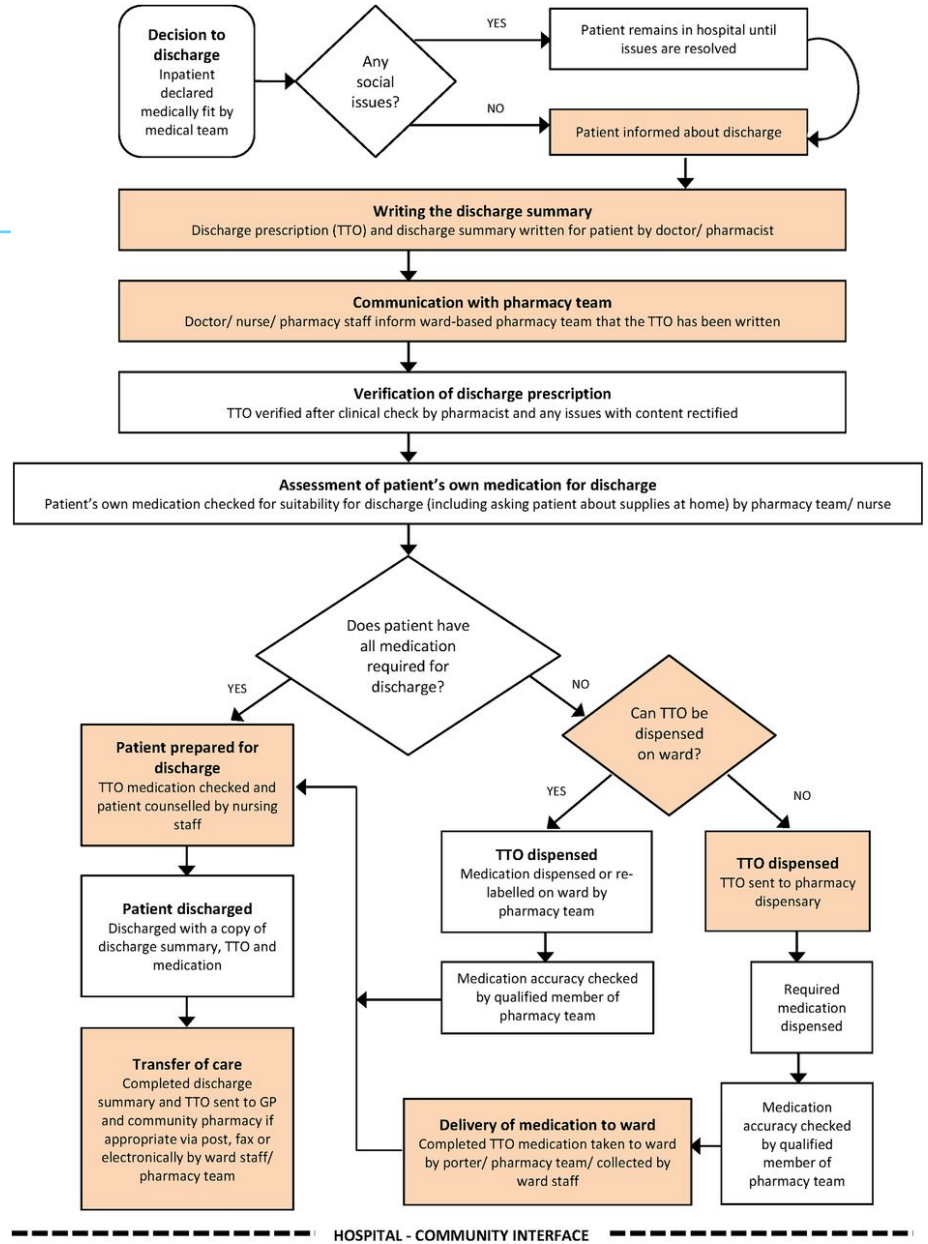
Process Assessment Tools

- Process Mapping
- 5 Why's
- Cause-and-Effect Diagram
- Fault Tree Analysis
- Value Stream Mapping

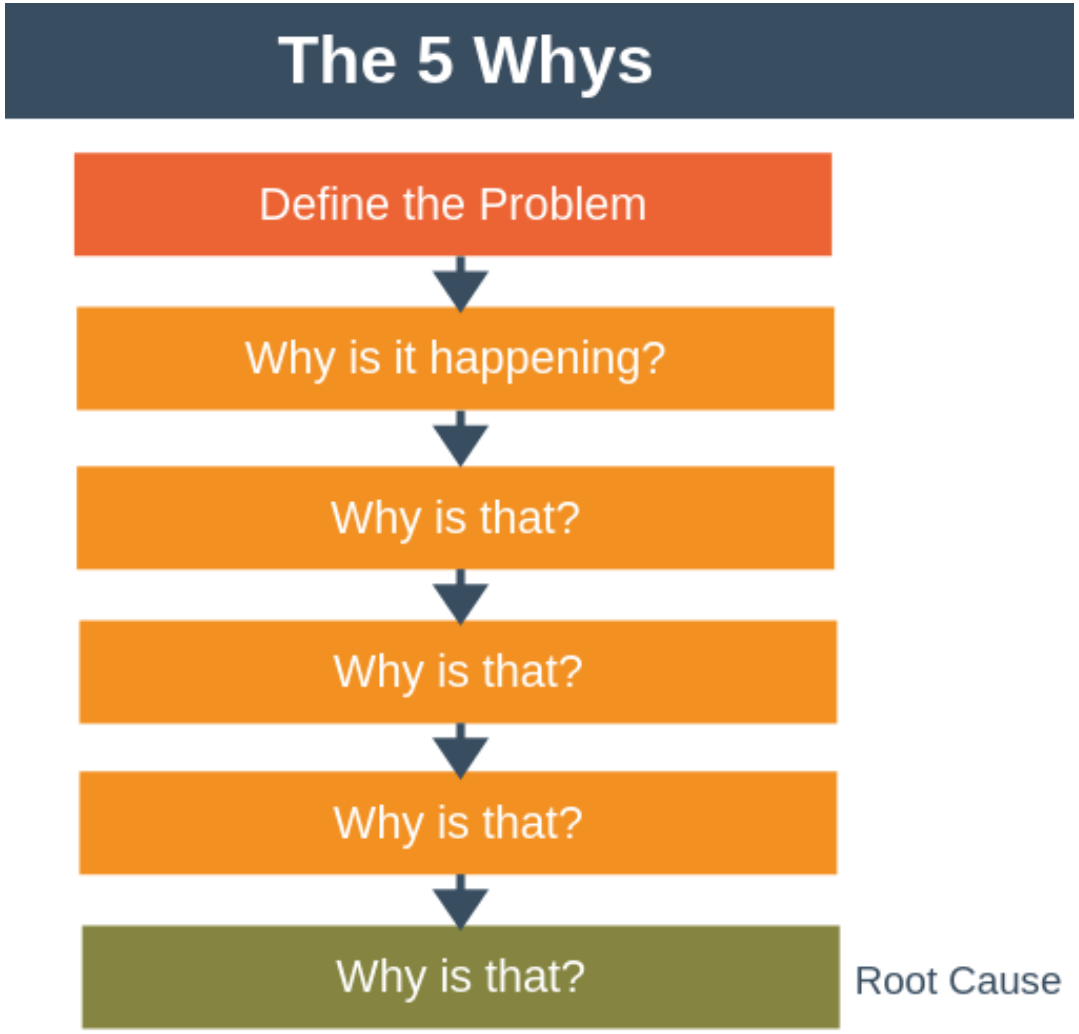
Process Mapping



https://www.google.com/url?sa=i&url=https%3A%2F%2Fejhp.bmj.com%2Fcontent%2F24%2F5%2F278&psig=AOvVaw2K6p7Xkt98AtZJqru5Q5SZ&ust=1641326478092000&source=images&cd=vfe&ved=0CAsQjRxqFwoTCJjW28GzlvUCFQAAAAAdAAAAABAD



5 Why's



https://www.lifehack.org/820207/5-whys

Problem: *Patients with COPD and CHF are being readmitted to hospital*

Why? *Patients are being readmitted because they are experiencing shortness of breath and feeling unwell and are uncertain how to manage these symptoms.*

Why? *They choose to come to the hospital as it is the last place they received medical intervention and education, and believe that is the only place where they can continue to receive support.*

Why? *Because they are unaware of other alternatives.*

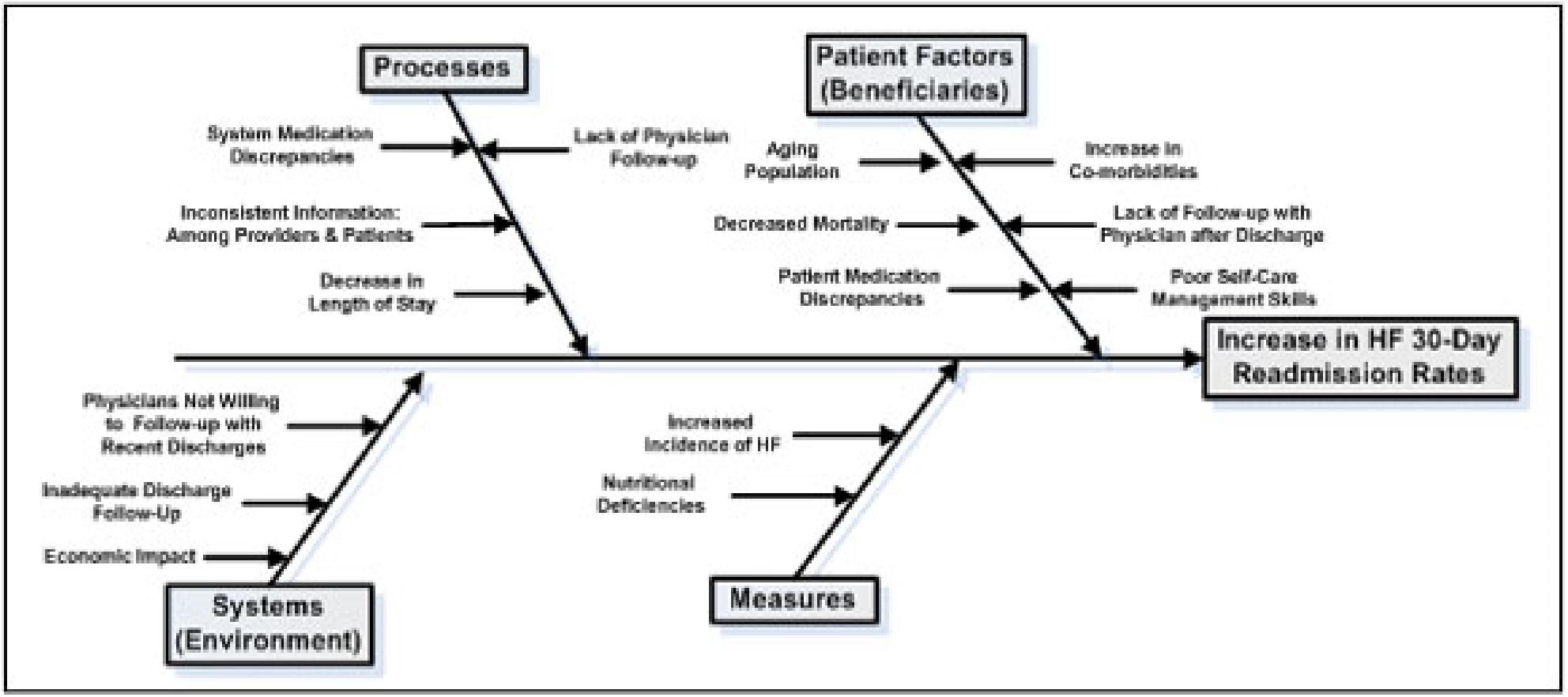
Why? *Patients were not informed about self-management strategies, and there was no warm hand-off to home care and primary care.*

Why? *There was no standardized discharge process that included patients' primary care provider and caregivers to support them*

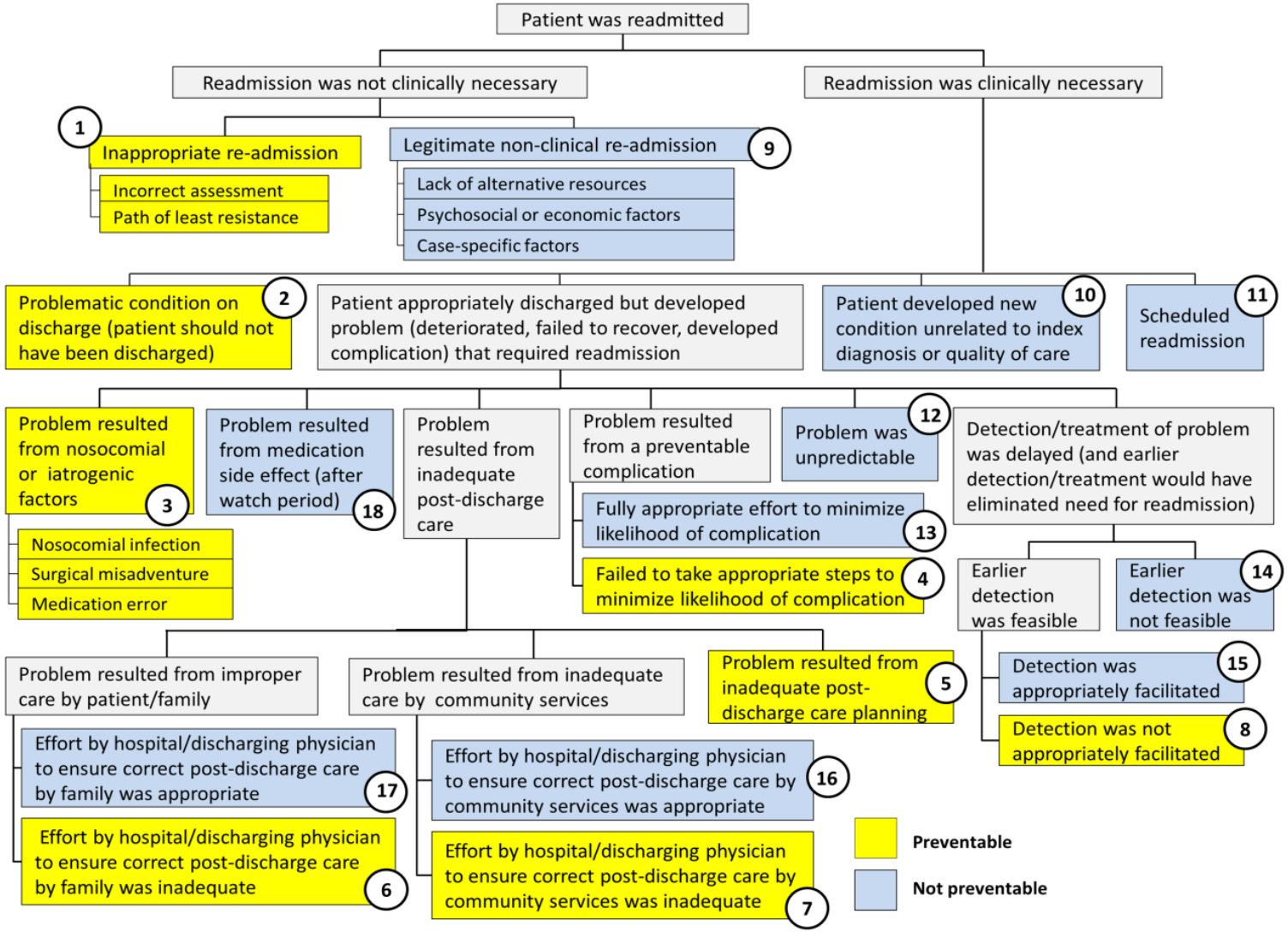
Solution: *Hold care conferences with patients and their care providers (including the most responsible physician at the hospital, primary care provider, and home and community care) prior to discharge that outline the post-discharge plan. Patients will be provided with a personalized action plan and education booklet that will be used to educate patients pre- and post-hospital discharge. All providers will be educated using the same materials.*

https://quorum.hqontario.ca/en/Home/Posts/Improving-transitions-in-care-Part-2-Understanding-the-problem-through-a-case-study-3

Cause-and-Effect Diagram

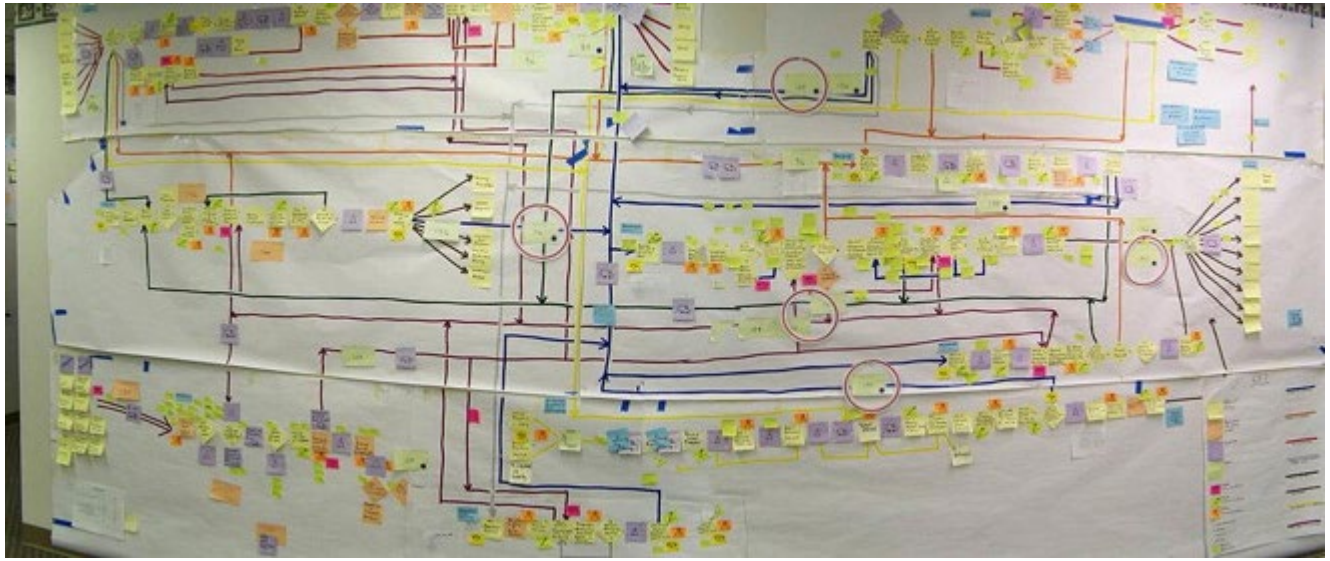


Fault Tree Analysis

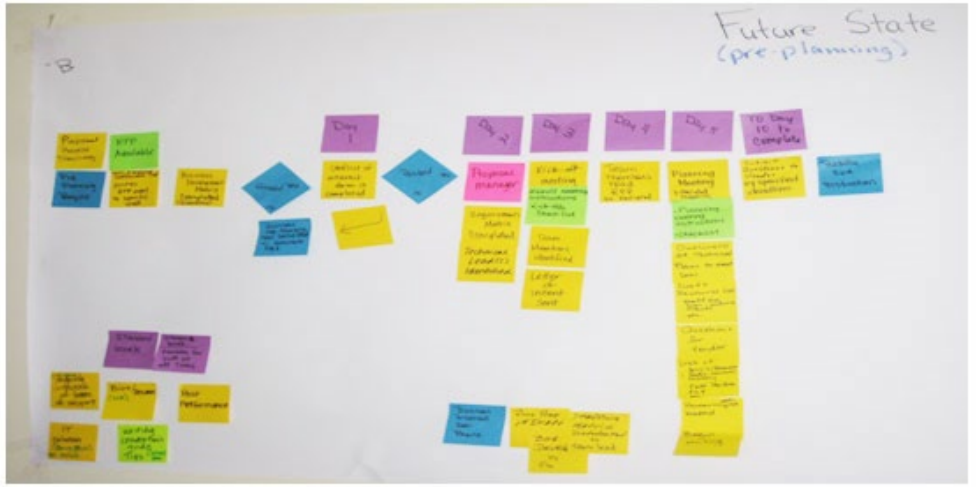


https://www.journalofhospitalmedicine.com/jhospmed/article/127946/readmission-analysis-using-fault-tree

Value Stream Mapping



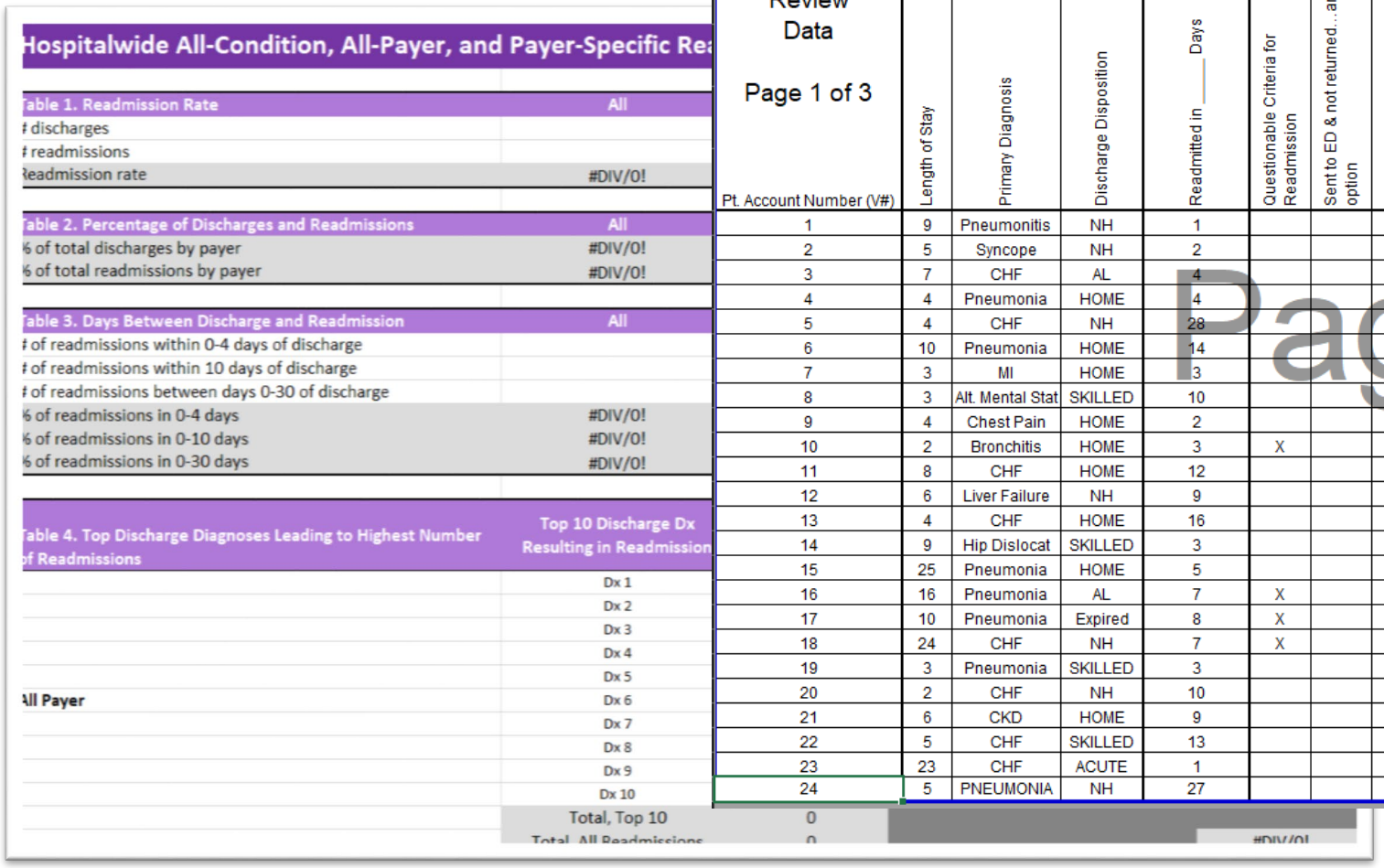
https://www.mayoclinicproceedings.org/article/S0025-6196(12)00938-X/fulltext



Tracking and Trending

- Drives the development of your Action/Implementation Plan
- Understanding readmission patterns is critical to designing effective readmission reduction strategies
- Tracking and trending readmission data will highlight high-leverage opportunities to reduce readmissions

Tracking and Trending Tools



Hospitalwide All-Condition, All-Payer, and Payer-Specific Re
Table 1. Readmission Rate — All
discharges
readmissions
Readmission rate — #DIV/0!
Table 2. Percentage of Discharges and Readmissions — All
% of total discharges by payer — #DIV/0!
% of total readmissions by payer — #DIV/0!
Table 3. Days Between Discharge and Readmission — All
# of readmissions within 0-4 days of discharge
# of readmissions within 10 days of discharge
# of readmissions between days 0-30 of discharge
% of readmissions in 0-4 days — #DIV/0!
% of readmissions in 0-10 days — #DIV/0!
% of readmissions in 0-30 days — #DIV/0!

Table 4. Top Discharge Diagnoses Leading to Highest Number of Readmissions	Top 10 Discharge Dx Resulting in Readmission	
All Payer	Dx 1	
	Dx 2	
	Dx 3	
	Dx 4	
	Dx 5	
	Dx 6	
	Dx 7	
	Dx 8	
	Dx 9	
	Dx 10	
	Total, Top 10	0
	Total, All Readmissions	0

Hospital Readmission Review Data

Page 1 of 3

Pt. Account Number (V#)	Index Admission Information: Length of Stay	Primary Diagnosis	Discharge Disposition	Readmission Information: Readmitted in ____ Days	Category I: Downstream Provider Issue: Questionable Criteria for Readmission	Sent to ED & not returned…an option	Treatment Compliance	Category II: Patient/Caregiver Education: Identification of learning…this individual	Patient/Caregiver comprehended education	Inhalers prescribed without…and correctly	No documentation… ordered for first time	Category III: Patient Activation: Patient/family refuses services/treatment offered	Patient adherence… strageies to overcome them	Patient was referred to a coach	If yes, did the patient accept?	Category IV: Medication Management: Medication reconciliation …patient/caregiver involved	Evidence exists…during hospitalization	Evidence exists…(new order or change in regimen)inhalers
1	9	Pneumonitis	NH	1														
2	5	Syncope	NH	2														
3	7	CHF	AL	4					X									
4	4	Pneumonia	HOME	4														
5	4	CHF	NH	28														
6	10	Pneumonia	HOME	14								X						
7	3	MI	HOME	3								X						
8	3	Alt. Mental Stat	SKILLED	10														
9	4	Chest Pain	HOME	2														
10	2	Bronchitis	HOME	3	X													
11	8	CHF	HOME	12									X					
12	6	Liver Failure	NH	9								X						
13	4	CHF	HOME	16								X						
14	9	Hip Dislocat	SKILLED	3														
15	25	Pneumonia	HOME	5														
16	16	Pneumonia	AL	7	X													
17	10	Pneumonia	Expired	8	X													
18	24	CHF	NH	7	X													
19	3	Pneumonia	SKILLED	3								X						
20	2	CHF	NH	10			X											
21	6	CKD	HOME	9								X						
22	5	CHF	SKILLED	13														
23	23	CHF	ACUTE	1									X					
24	5	PNEUMONIA	NH	27			X											

Goal

1. Replicate the data locally.
2. Use the data to identify the causes of readmissions or the populations most likely to be readmitted (Root Cause Analysis).
3. Use data to drive intervention selection.
4. Use data to measure the success of intervention implementation.
5. Adjust approach based on remeasurement data (PDSA Cycles).

Step 2: Using the data to identify and track the causes of readmission

Readmission Series

Session 1: Deep Dive into Data Access

√ November 3, 2021

Session 2: Identify/Validate Local Readmission Data Sources

√December 1, 2021

Session 3: Using Readmission Data to Conduct a Root Cause Analysis

Session 4: Intervention Exploration (Part 1)

Session 5: Intervention Exploration (Part 2)

Session 6: Remeasurement & Next Steps

Resources

Medical Record Audit Tools:

KFMC Developed Tool

KFMC MR Audit Tool

IHI Developed Tool

IHI MR Audit Tool

Patient/Family Interview Tools:

AHRQ Tool

AHRQ Interview Tool

IHI Developed Tool

IHI Interview Tool

Medical Record Audit Tools:

KFMC Tracking Tool

AHRQ Tracking Tool

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Key Takeaways

- **Learn Today:**
  - Identify and evaluate readmission-specific RCA tools
  - How to assess a process to determine “why” a patient is readmitted

- **Use Tomorrow:**
  - Conduct a systematic Root Cause Analysis of your hospital’s readmissions
  - Determine the most common cause(s) of readmissions for your facility and patient population

Questions?

Email us at HospitalQuality@allianthealth.org or call us 678-527-3681.

Closing Survey

Help Us Help You!

- Please turn your attention to the poll that has appeared in the lower right-hand side of your screen.
- Completion of this survey will help us ensure our topics cater to your needs.

HQIC Goals

Behavioral Health Outcomes & Opioid Misuse

- ✓ Promote opioid best practices
- ✓ Decrease high dose opioid prescribing and opioid adverse events in all settings
- ✓ Increase access to behavioral health services

Patient Safety

- ✓ Reduce risky medication combinations
- ✓ Reduce adverse drug events
- ✓ Reduce *C. diff* in all settings

Quality of Care Transitions

- ✓ Convene community coalitions
- ✓ Identify and promote optical care for super utilizers
- ✓ Reduce community-based adverse drug events

Upcoming Events

February 2, 2022
2PM EST
(Occurring the first Wednesday of each month)

HQIC Patient Safety Network
Intervention Exploration (Part 1)

Melody Brown and Sarah Irsik-Good

www.quality.allianthealth.org

Making Health Care Better *Together*

COLLABORATORS:

Alabama Hospital Association
Alliant Health Solutions
Comagine Health
Georgia Hospital Association
KFMC Health Improvement Partners
Konza

Hospital Quality Improvement

@alliantqio

@AlliantQIO

Alliant Health Solutions

AlliantQIO

Thank you for joining us!
How did we do today?

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