Identifying Determinants of Preventable Readmissions through Interdisciplinary RCA Reviews in Collaboration with Home Care Partner

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Aim

To identify root causes of readmissions and determine opportunities to optimize care transition processes.

Description

- The target population for RCA review is patients with penalty diagnoses receiving homecare that have a subsequent ED visit/readmission within 30 days of discharge.
- The interdisciplinary reviews are performed in collaboration with the discharge team and our preferred homecare partner, with participation from both leadership and clinical teams. Participants developed a joint case review tool to determine if the ED visit/ readmission could have been avoided through improved care transitions.
- Findings are collected and observed for trends over time. Based on learnings, performance improvement strategies are launched in order to reduce future incidence of potentially avoidable readmissions.

Project Design

- The MSH began the RCA readmissions review process in 2016, as a measure to mitigate readmission rates. A joint RCA tool was developed in collaboration with the Home Care Partner which will allow for comprehensive discussions and investigations of each readmission.
- The RCA tool is to be completed by both organizations prior to meeting in order to ensure a meaningful exchange of information on each readmission guided by a comprehensive understanding of the case.
- The tool includes questions such as:

HOME CARE PARTNER SITUATION QUESTIONS:
Summary of HOME CARE PARTNER episode leading up to time of readmission and/or ED visit:
1. What was the clinical presentation of the patient at the last 2 home visits prior to readmission? (symptoms present)
2. Did HOME CARE PARTNER take note of any clinical change in the patient status?
3. What interventions were done by HOME CARE PARTNER to prevent exacerbation of symptoms/social issues that lead to readmission?
4. Did patient have Hospital discharge summary at time of HOME CARE PARTNER SOC? Did field RN review discharge instructions with patient? Did it include list of medications? Did it include scheduled follow-up appointments? Did it include contact information on inpatient and outpatient providers?
5. Was patient educated at SOB on medication management, symptom management, escalation plan if exacerbation occurs and HOME CARE PARTNER Hotline number to call?

HOME CARE PARTNER ASSESSMENT QUESTIONS:
1. What were patient's documented goals of care (HOME CARE PARTNER vs MSH)?
2. How involved was a caregiver in patient's care during HOME CARE PARTNER admission? What education did he/she received
3. Has patient had numerous visits to any hospital ED with or without admission? If yes, number of visits?
4. If patient admitted/ED visit for fluid overload with weight gain, what were the weight trends documented by HOME CARE PARTNER RN? Last weight? Did patient have a scale in the home? If not, was one ordered?
5. Was Telehealth service indicated for this patient? If yes, did patient receive Telehealth service? If Telehealth was indicated but not provided, indicate reason.
6. Did patient receive Advance Care Planning by HOME CARE PARTNER? Did it change the trajectory of the patient?

CARE TRANSITIONS CONSIDERATION QUESTIONS:
1. Did patient have goals of care discussion documented on initial hospitalization? Did it change the trajectory of the patient?
2. Did patient meet criteria for referral to Hospice and Palliative Care?
3. Did patient have follow up appointment scheduled within 7 days after hospital discharge? If no, within 14 days? Did patient attend follow up appointment within this timeframe? If no, what was the reason patient did not attend?
4. Did patient have history of non-compliance with medications or barriers to receiving medications? Was CVS Meds to Beds utilized?

- The findings from each RCA performed are shared back with the service lines involved , as well as the Home Care partner leadership, who are thereafter responsible of addressing the identified gaps.

Actions

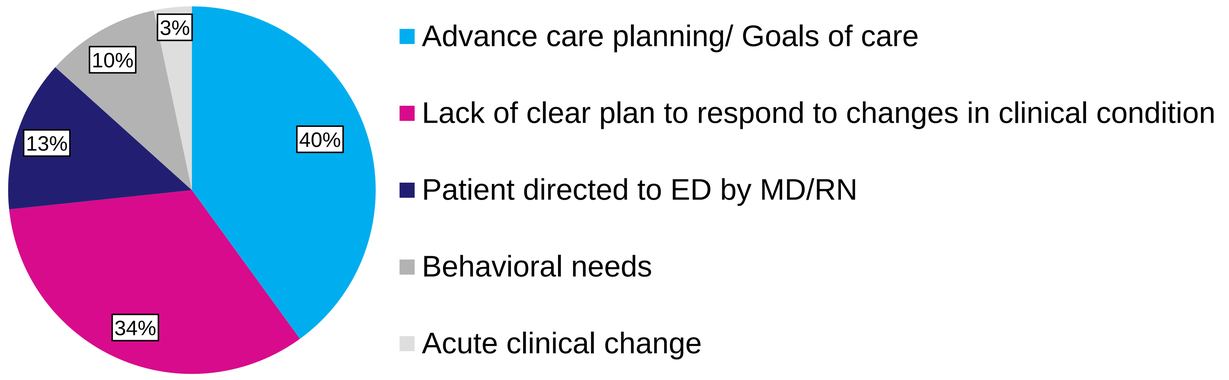
An interdisciplinary collaborative was formed and together developed and implemented a standardized review process to assess contributing factors of readmissions. Learnings from every case are shared with service line leadership for further examination of findings and to launch sustainable corresponding internal process improvement initiatives.

Results

106 readmissions were reviewed to date, revealing the following opportunities to enhance:

- Expand the MSH/Home Care Partner RN-RN warm hand-off to all units
- Launch bi-directional educational trainings across continuum of care between partnering organizations
- Create process to share MSH discharge summary with the field visiting RN
- Develop standardized processes for escalation of patient issues identified by Home Care Partner RN in the field to appropriate MD

Drivers for readmission/ED use:

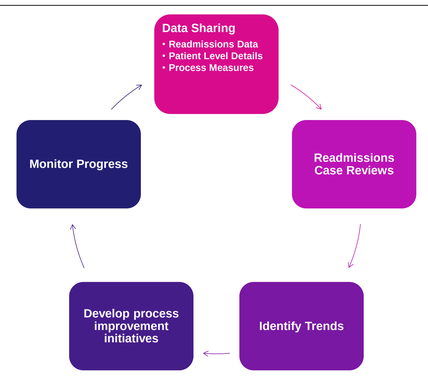


Performance improvement initiatives launched to date:

- Created service line specific escalation plans for patients with post-acute needs
- Obtained Advanced Care Planning tab view for Home Care Intake RN to improve awareness of patients goals of care discussions and advanced directives
- Launched hospital-wide Home Care in-services to provide MSH care teams with an opportunity to learn more about the post-discharge services available to MSH patients discharged to home. Topics included:
  - Home Care 101
  - Home Hospice
  - Get Home Safe Program

Interdisciplinary Team

- The interdisciplinary team involved in the joint review process consists of nursing, social work, discharging provider, case management and service line leadership from both organizations.
- Field staff from the Home Care partner are also present for the RCA reviews.



Lessons Learned

- An accountability structure must be present to monitor performance metrics and to collaborate with front line providers to improve adherence with established care transitioning processes.
- Participation in the system design and ownership of the outcomes results in greater acceptance of the collaborative initiatives and increased involvement.
- The review process requires full transparency between organizations in order to successfully identify drivers for readmission.
- Integration of the front-line care team allows for meaningful review of the cases, and engages the team to participate in corresponding PI work.