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)	Facility manages super-utilizers (four admissions in one year or six emergency department visits within one year) using a customized case management approach that individualizes patient-centered care coordination plans

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 hospital specific readmission report. • Analyzed data in HSAG's QIIP dashboard. • Analyzed internal report of hospital readmissions and emergency room visits. • Reviewed data from medical records for super-utilizers in the last month.	• HSAG's report shows super-utilizers (SUs) account for 23% of admissions, 17% of emergency department (ED) visits, and 20% of observations stays. • 75% of SUs were identified as high-risk for readmissions. • 36% of SUs did not have a physician follow-up visit documented/scheduled before discharge. • 82% of SUs are prescribed take 13 or more medications. • 68% of SU medical records indicated they were not visited by a pharmacist while being treated at the facility. • 79% of SUs 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 in-patient discharge process for 10 patients identified as high-risk. • Observed the emergency-department discharge process for 10 patients.	• Patient 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 patient was hospitalized. • 40% of the 20 observations did not incorporate Teach-Back and instead said, "Do you have any questions for me?" • Only one of the 20 observed discharges did the

Component	Sample Activities Completed	Sample Key Findings
		nurse ask if they had the money or 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 have been in the ED 7 times in the last month. • 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 complete medication reconciliation. Additionally, shared education is often rushed due to patients being eager to leave the hospital or a full lobby and patients needing to be seen. • Patients reported they: – have difficulty arranging follow-up appointments with their primary care physician (PCP) after discharge. – struggle with dietary restrictions when they return home, often due to financial reasons. • Patients are confused about discharge instructions, specifically medications. • In the ED, patients interviewed had some deficit with social support for food, meds, and/or personal care and didn't 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 Chief Financial Officer (CFO). • Reviewed publicly reported data.	The CFO shared: • Over the past year, SUs have cost the hospital more than 2 million dollars. • Reducing visits among SUs would help get additional positions and care coordination program expansion plans 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 hospital's data for unplanned hospital visits are higher than the state and national rates for most conditions.

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