Using Root Cause Analysis to Reduce All-Cause Readmissions

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Test Your Problem Solving Skills

If you had two U.S. coins totaling 55 cents and one of the coins was NOT a nickel, what are the two coins?

Can a man living in Milwaukee, Wisconsin be buried west of the Mississippi?
What is Root Cause Analysis (RCA)?

• The process used to identify the origin of a problem
• Uses a specific set of tools to determine:
  – What happened?
  – Why it happened?
  – How to prevent it from happening again
Root Cause Analysis Basics

Symptom of the problem.
“The Weed”
Above the surface

The Underlying Causes
“The Root”
Below the surface

The word root, in root cause analysis, refers to the underlying causes, not the one cause.
What Root Cause Analysis is NOT

Used to blame any one person or group
Pulling the RCA Community Team Together

• The RCA team is;
  – Cross-setting
  – Multidisciplinary
  – Inclusive of staff directly involved if possible
  – Includes Physicians
  – Has support of leadership

  Everyone on the team is EQUAL

• Everyone leaves their badge outside of the room
A Readmission happens....
—now what?
Purpose of the Root Cause Analysis

• Identify the “root” cause of readmissions at your hospital/facility/agency.
• Identify patterns of readmissions specific to your community and its providers.
• Use RCA results to guide and target criteria and intervention selection.
Variety of Root Cause Analysis Tools

- Patient/family interviews
- Care coordinator interviews
- Medical record reviews
- Process mapping
- Cause-and-effect diagrams
- “5 Whys”
Patient/Family Interviews

- Semi-structured telephone or face-to-face interviews with readmitted patients
- Helps identify opportunities for improvement from the patient’s perspective
Care Coordinator Interviews

- Conduct individual and/or group interviews with care coordinators.
- Identify patterns, trends, and opportunities for improvement from the staff perspective.
- Formulate groups across settings or within provider teams, organizations, or specialties.
Medical Record Reviews

• Review randomly sampled hospital discharges and 30-day readmissions.

• Common finding:
  – Patient education is completed and documented, but patients need more in-depth understanding to self-manage their conditions.
• Clarify specific roles and contributions of those involved.
• Observe discharge and admission processes directly, interview process owners, map the processes.
• Elicit staff and community partner perceptions about where communication issues and gaps may occur.
Cause-and-Effect Diagram (Fishbone Diagram)

- Visually illustrates potential causes of high readmissions
“5 Whys”

• Start asking why readmissions occur and record the answer.

• If the answer does not directly identify the root cause of your readmissions problem, ask why again and record the answer.

• Continue this process until your team agrees the problem’s root cause has been identified.
Why are so many Medicare beneficiaries with heart failure being readmitted to our hospital?

Because they do not understand or remember the red flags related to their condition after discharge.

Why do they not understand the red flags?

They do not have the correct documentation or reminder systems in place.
“5 Whys” Example (cont’d)

Why do they not have the proper documentation or reminders?

They did not receive a Personal Health Record (PHR) or red flag magnet with documentation of these red flags upon discharge.

Why did they not receive the PHR or magnet?

Distribution of these materials is not part of the current discharge process.
Using RCA to Drive Intervention Selection - Example

RCA Technique: Interview for all patients during one month who are currently in hospital for a 30-day readmission

Key Findings: (1) Patients did not understand/did not correctly take medications
(2) Patient condition worsened; unsure of what to do, called 911 or came to ED

Intervention Selection: Care Transitions Intervention (CTI)

Intervention directly addresses root cause identified

Intervention improves patient activation and engagement—addresses four pillars (personal health record, red flags, medication management, and follow-up)
“To address this mistake we must use root-cause analysis. I’ll begin by saying it’s not my fault.”
Results from Previous Care Transition RCAs

• RCAs revealed remarkably consistent results
• Patients experienced readmissions because of:
  – Unmanaged worsening of their conditions
  – Inadequate medication reconciliation
  – Lack of patient/family education
  – Returning to emergency departments instead of accessing a different type of medical service
Three Basic System Gaps

• Lack of engagement or activation of patients and families
• Lack of standard processes among providers for transitioning patients
• Ineffective or unreliable sharing of relevant clinical information
RCA Conclusion

• Many evidence-based interventions directed at one or more of these gaps, but require cooperative activity by more than one provider.

• All communities must build cross-setting or multi-provider relationships to deploy, measure, and revise implementation strategies.
Community building is the necessary groundwork to enable improvement.
“May I be excused? My brain is full.”
Thank You

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