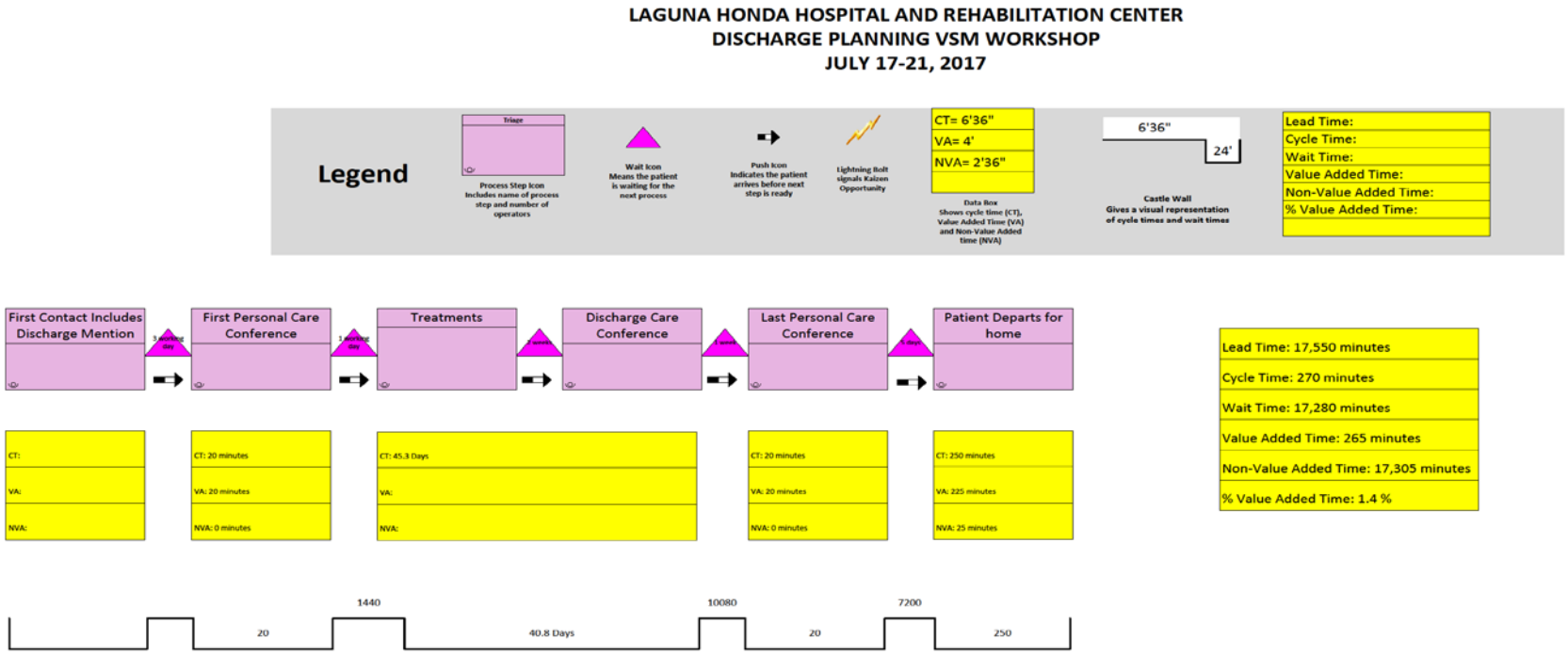
Laguna Honda Hospital

Value Stream #2 – Discharge
Kaizen Workshop #3 – Operationalizing Discharge Identification and Planning

Joint Conference Committee
July 2018

Future State

Value Stream for Discharge Planning
Kaizen #1 Discharge Care Planning
Kaizen #2 Discharge Preparation
Kaizen #3 Operationalizing Discharge Identification and Planning



Value Stream A3-T

A3 Title: Operationalizing Discharge Identification and Planning **Owner: Quoc Nguyen | Irin Blanco, Janet Gillen, Susanna Meneses**

I. Background: Laguna Honda started a Discharge VSM back in July 2017 and has since completed two Kaizen workshop: discharge care planning and discharge preparation. The third workshop looks to tie together all improvement work currently in pilot or that have been completed for short stay discharges. More specifically, the team will review the short-stay program as a whole and recommend any applicable changes as it relates to identification of short stay residents, inclusion of data into discharge huddles, and increasing awareness and understanding of applicable policy and procedure for clinical and financial staff. Successfully operationalizing short stay discharges because it will contribute to original VSM goals of increasing community reintegration for eligible residents within an appropriate length of stay.

II. Current Conditions: How Laguna Honda operationalizes short stay discharges now.

Identifying short stay residents: Patient Flow Coordinator and Director of Social Services communicates with Resident Care Team to determine best hospital service code to assign new admissions and make changes to current residents. Admissions and Eligibility will make changes in Invision/LCR. However, no formal review cadence is established and changes are based off a push, rather than pull system to the RCT.

Discharge huddles: Neighborhoods have variability when approaching discharge huddles including frequency, data and reporting used, and attendance. Short stay residents are also not equally distributed across all neighborhoods, with Pavilion Mezzanine and S2 housing the majority of short stay residents. This leads to unequal and unequitable performance when measuring length of stay for residents. Current short stay residents with length of stay greater than 100 days is 19%.

Awareness and understanding: A recent survey on clinical and financial department staff (n=72) indicates that most staff know which hospital service codes are short stay (97%+) and how long a short stay episode is as defined by policy (92%+). Staff also understand codes are changeable (94%). However, 25% of staff were not aware of who makes the changes when appropriate. Half of respondents wrongly indicated that housing can be a cause for code change.

Problem Statement: Laguna Honda is not able to effectively manage service code information and establish a sustainable short-stay program to operationalize short-stay residents discharges.

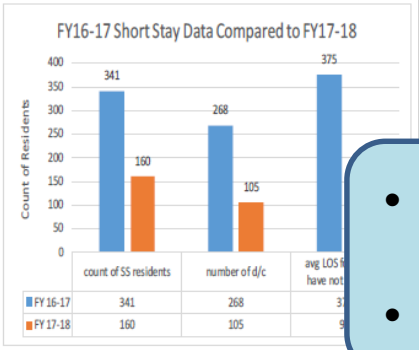
III. Goals & Targets: By end of FY 17-18
1) Decrease residents in short stay service code with length of stay greater than 100 days to less than 10%

IV. Analysis: When comparing short stay data from FY 16-17 to FY 17-18. YTD, there is cause for concern in particular trends.

1) There are less short stay residents; an indication that LHG (long term care) is more prevalent now that the current policy has excluded LIS and LHP.

2) There is a decrease in average discharges per month (22 vs. 18). When extrapolating out FY 17-18, there will be 58 less discharges than last year (210 vs. 268). This will prevent new admissions while the waitlist has grown 79% (July-January)

3) Current residents in short stay service codes (LSS, LHR, LSA and LRE) have an average length of stay close 100 days. Unless all are discharged soon, their cases will not be compliant with policy recommended days.



V. Recommendations / Proposed Countermeasures: What do you propose and why?

Discharge Huddle Worksheet that:
- Includes consolidated information to identify residents that are potentials for discharge and on track for discharge
- Allows for resident care team (RCT) members to have up-to-date information exchange at huddles and resident care conference (RCC)
- Increases transparency of the discharge process which also focuses on estimated discharge date

Discharge Huddle Guide that:
- The streamlined worksheet can be utilized at huddle to accompany the huddle guide.
- The purpose of the guide is to provide an organized structure for discharge huddles to improve efficiency.

VI. Plan: Specifically how will you implement?

Item #	Problem	Countermeasure	Owner(s)	Due Date	Status
1	Metrics are not fully developed for the new process	Create metrics	Quoc Nguyen	3/2/2018	Completed
2	New process has not been compared to LHHPP 20-09	Compare final products to Short Stay P&P	Nawz Z. Talai	3/5/2018	Completed
3	Social Services does not know about new standard work	Training of standard work for Social Services	Janet Gillen	3/7/2018	Completed
4	The RCT does not know about new standard work	Training of standard work for D/C Huddle Guide	Camille Kalu	3/7/2018	Completed
5	New process has not been simulated on the gemba	Simulation of D/C Huddle Guide	Camille Kalu	3/8/2018	Completed
6	VSM team has not come together	Meeting with Kaizen #1 and #2 Process Owners to review Discharge Planning Timeline	Irin Blanco	3/16/2018	Completed
7	SF-GetCare does not currently have the necessary fields	Make changes to SFGetCare (MDS Fields, UM Field, Worksheet in Main Menu with DC Huddle button, 2nd Day Social Worker Assessment MR703 Date, Estimated D/C Date)	Jennifer Carton-Wade	3/20/2018	Completed
8	Fields have not been utilized before	Test changes to SFGetCare	Jennifer Carton-Wade	3/20/2018	Completed
9	Staff does not currently have access to the report	SFGetCare report access for staff	Janet Gillen	3/21/2018	Completed
10	Staff does not currently use the D/C Huddle Worksheet	Education of D/C Huddle Worksheet for S6 RCT	Elaine Ignacio Camille Kalu	3/22/2018	Completed
11	New process has not been simulated on the gemba	Simulation with the S6 D/C Huddle Guide for RCT	Elaine Ignacio Camille Kalu	3/22/2018	Completed
12	MDS does not know about new standard work	Training of standard work for MDS	Susan Duong Kirstie Isana	3/23/2018	Completed
13	UM does not know about new standard work	Training of standard work for UM	Susan Duong Kirstie Isana	3/23/2018	Completed

- Utilizing current data to identify residents that are ready for discharge
- Optimizing discharge huddles

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Improvement Request

During the workshop, we aligned our improvement ideas with these requests:

- All short-stay eligible residents have hospital service codes updated using standardized requirements.
- All clinical and financial departments are educated on policy and purpose of short-stay program
- Neighborhood discharge huddles include integration of real time data
- Resident care team operationalizes short stay discharges based off of the same information and know where to access the information

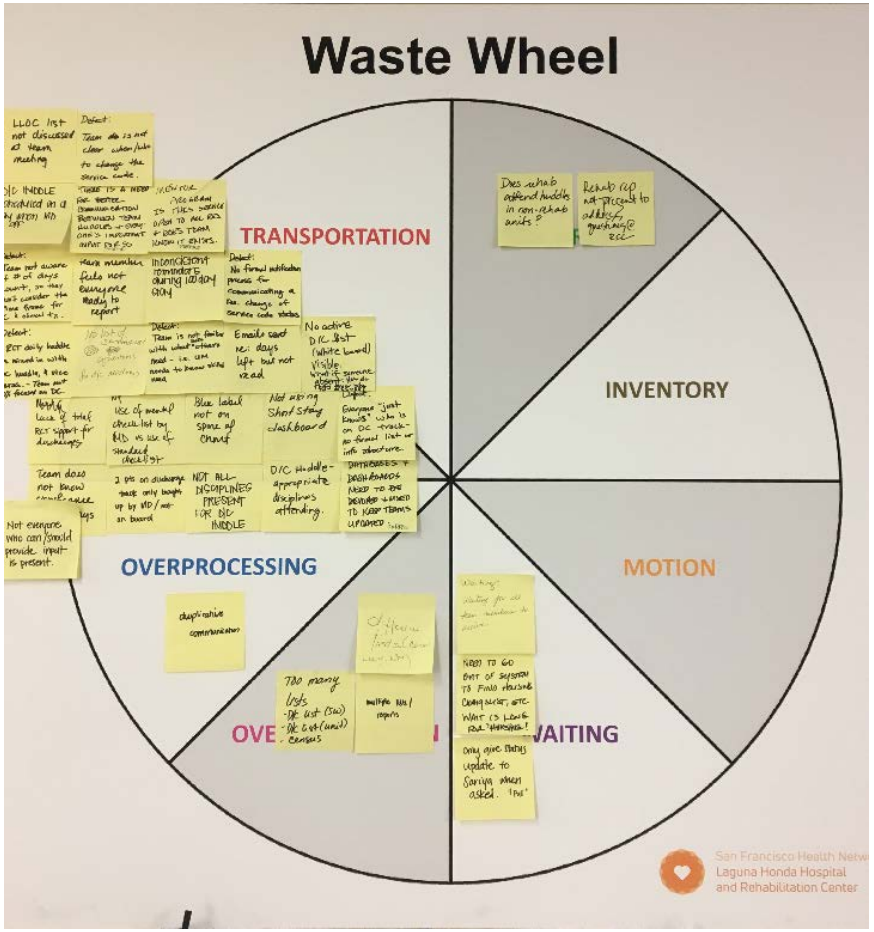
Workshop Targets

Target	Baseline
Reduce discharge huddle cycle time per resident	10-19 min
Consolidating multiple lists into a user friendly format	3 lists
Criteria for discharge is objective and standardized for Community Reintegration Performance Improvement Team	No

The Gemba: Where the Work is Done

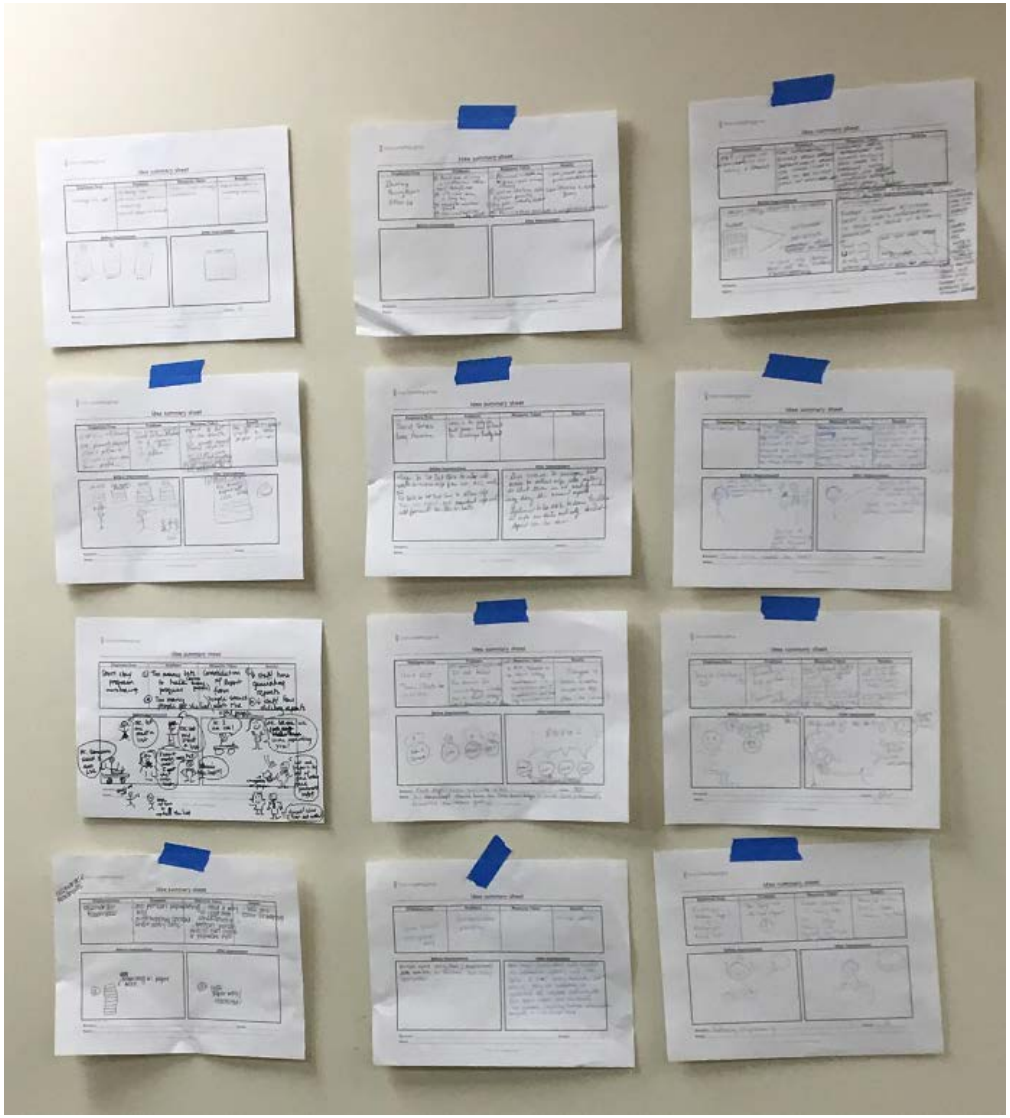
Discharge huddle

Wastes



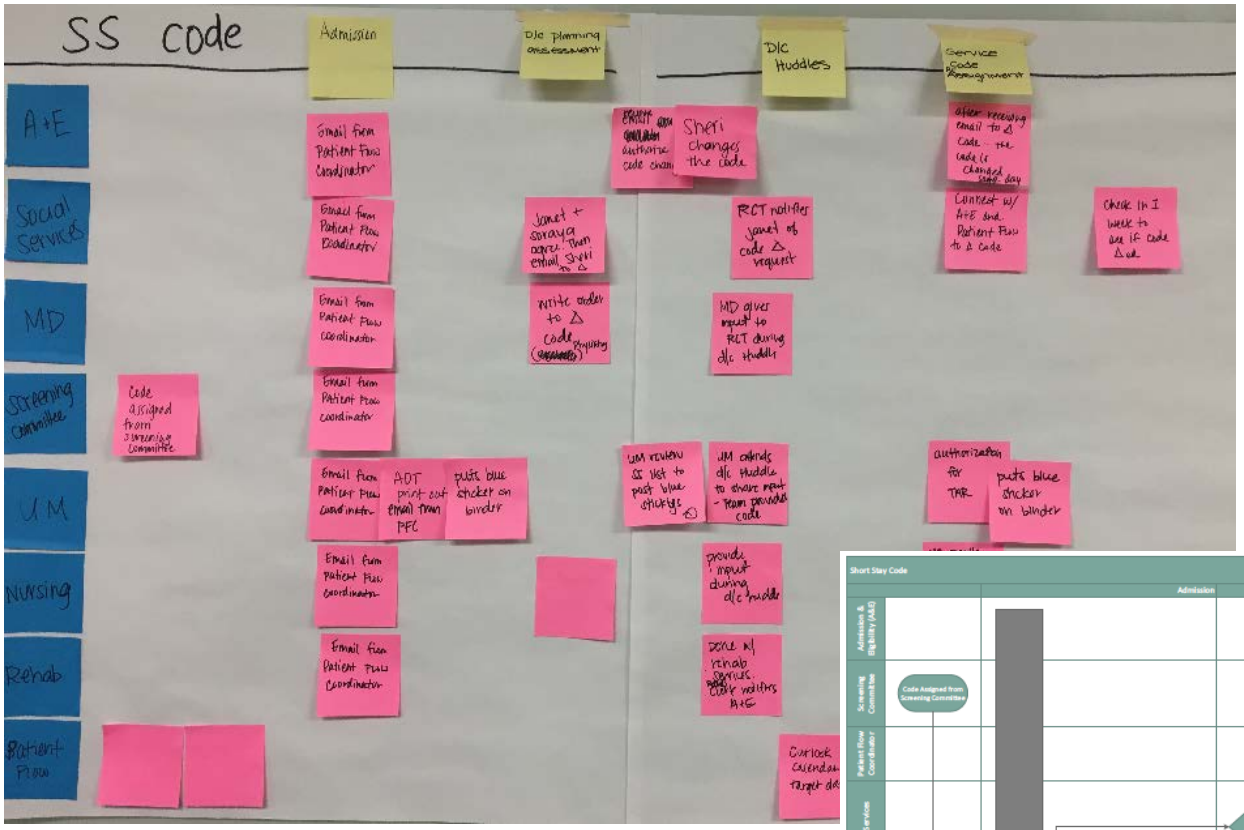
- Overprocessing of multiple reports for discharge information.
- No standard format for discharge huddles can lead to information gaps.

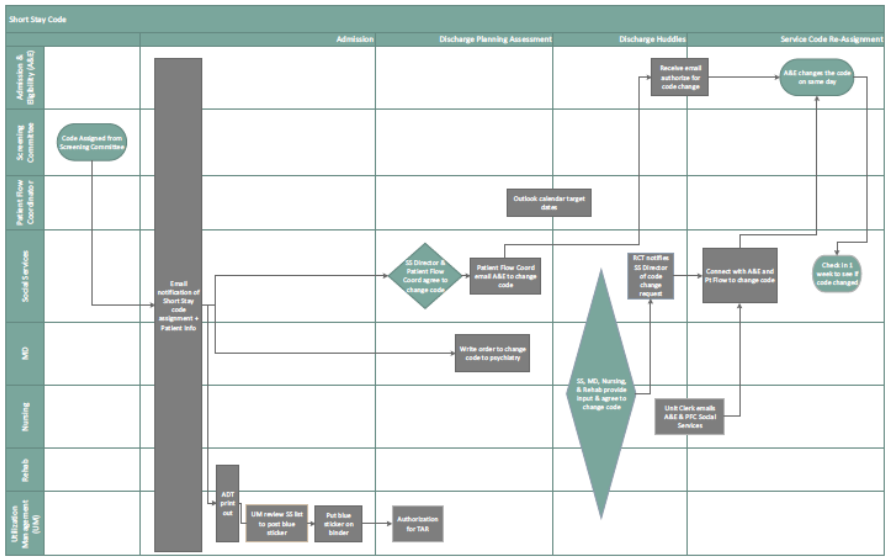
Grouping Ideas by Category



- Simplification of reports used for discharge.
- Streamline the discharge huddle.

Mapping the Current Process





Process for identifying residents ready for discharge

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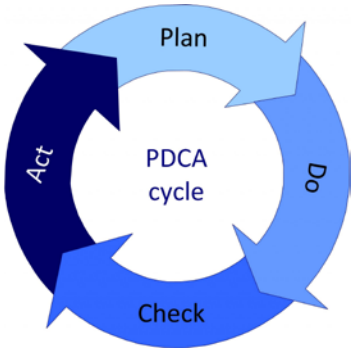
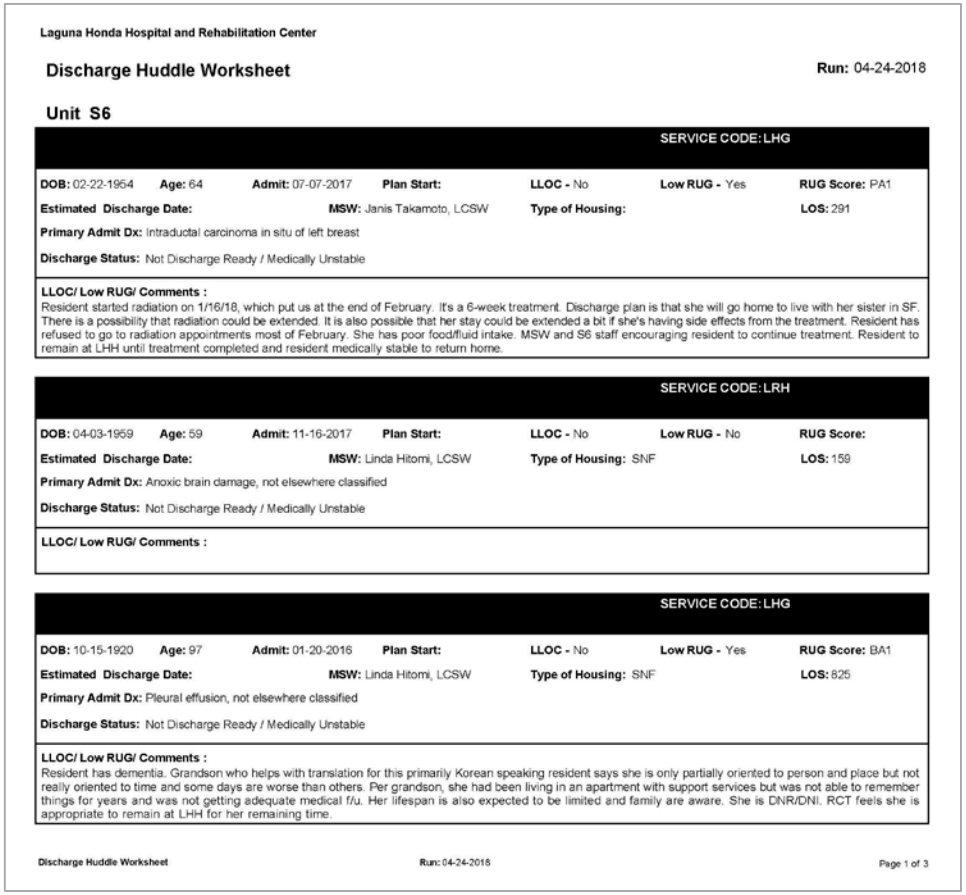
Experiments: Plan

Problem	Purpose of workshop improvement idea
There are too many lists and overprocessing of information	Consolidate and customize information from the source (SF-GetCare) into one report that is user-friendly
Discharge huddles are unorganized with information gaps	To provide an organized structure for discharge huddle to improve efficiency



Proposed Change #1: Discharge Huddle Worksheet

- Consolidated report includes information to identify residents that are potentials for discharge and on-track for discharge.
- Allows for resident care team (RCT) members to have up-to-date information exchange at huddles and resident care conference (RCC).
- Increases transparency of the discharge process which also focuses on estimated discharge date.



Laguna Honda Hospital and Rehabilitation Center

Discharge Huddle Worksheet **Run:** 04-24-2018

Unit S6

SERVICE CODE: LHG

DOB: 02-22-1954 **Age:** 64 **Admit:** 07-07-2017 **Plan Start:** **LLOC -** No **Low RUG -** Yes **RUG Score:** PA1
Estimated Discharge Date: **MSW:** Janis Takamoto, LCSW **Type of Housing:** **LOS:** 291
Primary Admit Dx: Intraductal carcinoma in situ of left breast
Discharge Status: Not Discharge Ready / Medically Unstable

LLOC/ Low RUG/ Comments :
Resident started radiation on 1/16/18, which put us at the end of February. It's a 6-week treatment. Discharge plan is that she will go home to live with her sister in SF. There is a possibility that radiation could be extended. It is also possible that her stay could be extended a bit if she's having side effects from the treatment. Resident has refused to go to radiation appointments most of February. She has poor food/fluid intake. MSW and S6 staff encouraging resident to continue treatment. Resident to remain at LHH until treatment completed and resident medically stable to return home.

SERVICE CODE: LRH

DOB: 04-03-1959 **Age:** 59 **Admit:** 11-16-2017 **Plan Start:** **LLOC -** No **Low RUG -** No **RUG Score:**
Estimated Discharge Date: **MSW:** Linda Hitomi, LCSW **Type of Housing:** SNF **LOS:** 159
Primary Admit Dx: Anoxic brain damage, not elsewhere classified
Discharge Status: Not Discharge Ready / Medically Unstable

LLOC/ Low RUG/ Comments :

SERVICE CODE: LHG

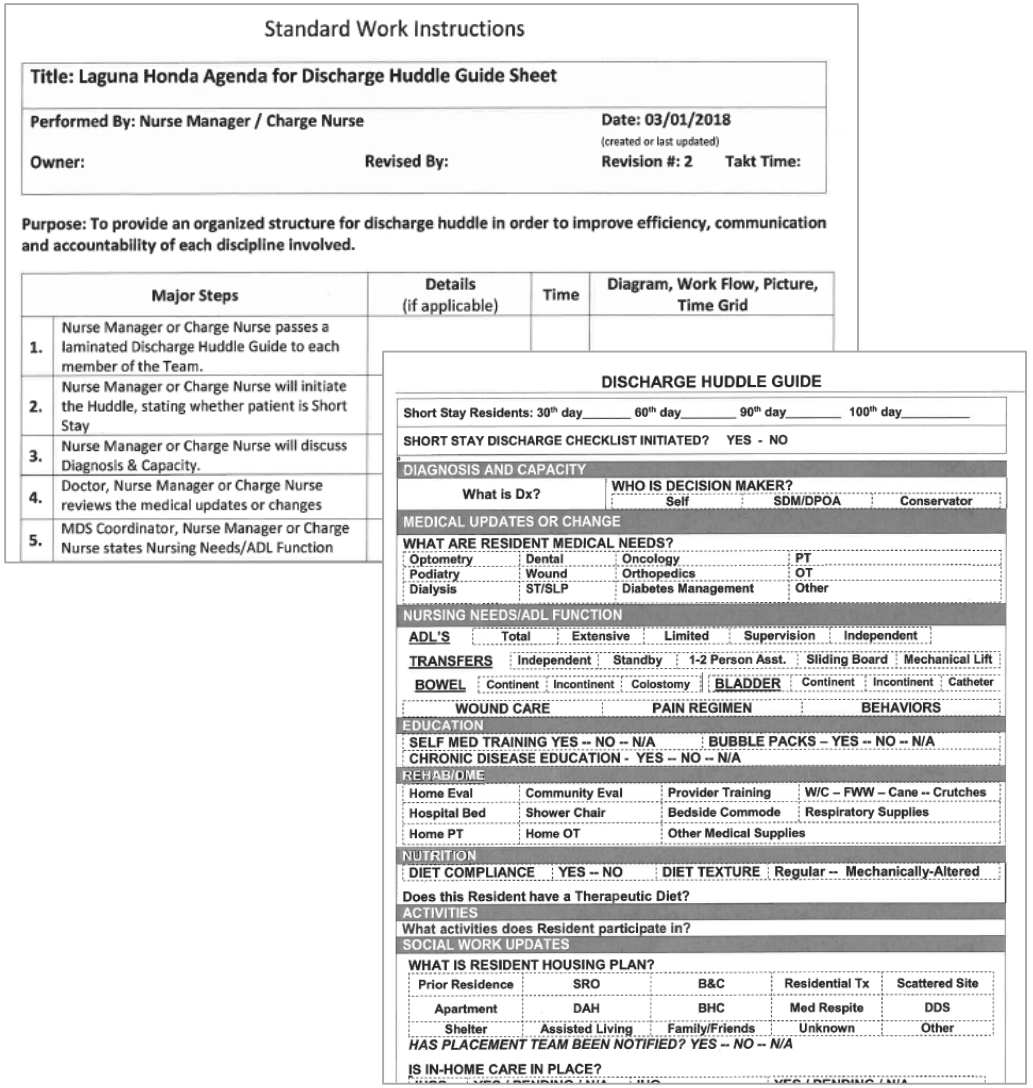
DOB: 10-15-1920 **Age:** 97 **Admit:** 01-20-2016 **Plan Start:** **LLOC -** No **Low RUG -** Yes **RUG Score:** BA1
Estimated Discharge Date: **MSW:** Linda Hitomi, LCSW **Type of Housing:** SNF **LOS:** 825
Primary Admit Dx: Pleural effusion, not elsewhere classified
Discharge Status: Not Discharge Ready / Medically Unstable

LLOC/ Low RUG/ Comments :
Resident has dementia. Grandson who helps with translation for this primarily Korean speaking resident says she is only partially oriented to person and place but not really oriented to time and some days are worse than others. Per grandson, she had been living in an apartment with support services but was not able to remember things for years and was not getting adequate medical f/u. Her lifespan is also expected to be limited and family are aware. She is DNR/DNI. RCT feels she is appropriate to remain at LHH for her remaining time.

Discharge Huddle Worksheet Run: 04-24-2018 Page 1 of 3

Proposed Change #2: Discharge Huddle Guide

- The streamlined worksheet can be utilized at huddle to accompany the huddle guide.
- The purpose of the guide is to provide an organized structure for discharge huddles to improve efficiency.



Standard Work Instructions

Title: Laguna Honda Agenda for Discharge Huddle Guide Sheet

Performed By: Nurse Manager / Charge Nurse **Date: 03/01/2018** (created or last updated)

Owner: **Revised By:** **Revision #: 2** **Takt Time:**

Purpose: To provide an organized structure for discharge huddle in order to improve efficiency, communication and accountability of each discipline involved.

	Major Steps	Details (if applicable)	Time	Diagram, Work Flow, Picture, Time Grid
1.	Nurse Manager or Charge Nurse passes a laminated Discharge Huddle Guide to each member of the Team.			
2.	Nurse Manager or Charge Nurse will initiate the Huddle, stating whether patient is Short Stay			
3.	Nurse Manager or Charge Nurse will discuss Diagnosis & Capacity.			
4.	Doctor, Nurse Manager or Charge Nurse reviews the medical updates or changes			
5.	MDS Coordinator, Nurse Manager or Charge Nurse states Nursing Needs/ADL Function			

DISCHARGE HUDDLE GUIDE

Short Stay Residents: 30th day_____ 60th day_____ 90th day_____ 100th day_____

SHORT STAY DISCHARGE CHECKLIST INITIATED? YES - NO

DIAGNOSIS AND CAPACITY

What is Dx? | WHO IS DECISION MAKER? | Self | SDM/DPOA | Conservator

MEDICAL UPDATES OR CHANGE

WHAT ARE RESIDENT MEDICAL NEEDS?

Optometry	Dental	Oncology	PT
Podiatry	Wound	Orthopedics	OT
Dialysis	ST/SLP	Diabetes Management	Other

NURSING NEEDS/ADL FUNCTION

ADL'S | Total | Extensive | Limited | Supervision | Independent

TRANSFERS | Independent | Standby | 1-2 Person Asst. | Sliding Board | Mechanical Lift

BOWEL | Continent | Incontinent | Colostomy | BLADDER | Continent | Incontinent | Catheter

WOUND CARE | PAIN REGIMEN | BEHAVIORS

EDUCATION

SELF MED TRAINING YES -- NO -- N/A | BUBBLE PACKS -- YES -- NO -- N/A

CHRONIC DISEASE EDUCATION - YES -- NO -- N/A

REHAB/DME

Home Eval	Community Eval	Provider Training	W/C -- FWW -- Cane -- Crutches
Hospital Bed	Shower Chair	Bedside Commode	Respiratory Supplies
Home PT	Home OT	Other Medical Supplies	

NUTRITION

DIET COMPLIANCE | YES -- NO | DIET TEXTURE | Regular -- Mechanically-Altered

Does this Resident have a Therapeutic Diet?

ACTIVITIES

What activities does Resident participate in?

SOCIAL WORK UPDATES

WHAT IS RESIDENT HOUSING PLAN?

Prior Residence	SRO	B&C	Residential Tx	Scattered Site
Apartment	DAH	BHC	Med Respite	DDS
Shelter	Assisted Living	Family/Friends	Unknown	Other

HAS PLACEMENT TEAM BEEN NOTIFIED? YES -- NO -- N/A

IS IN-HOME CARE IN PLACE?

Map the Future Process

Discharge Planning Timeline

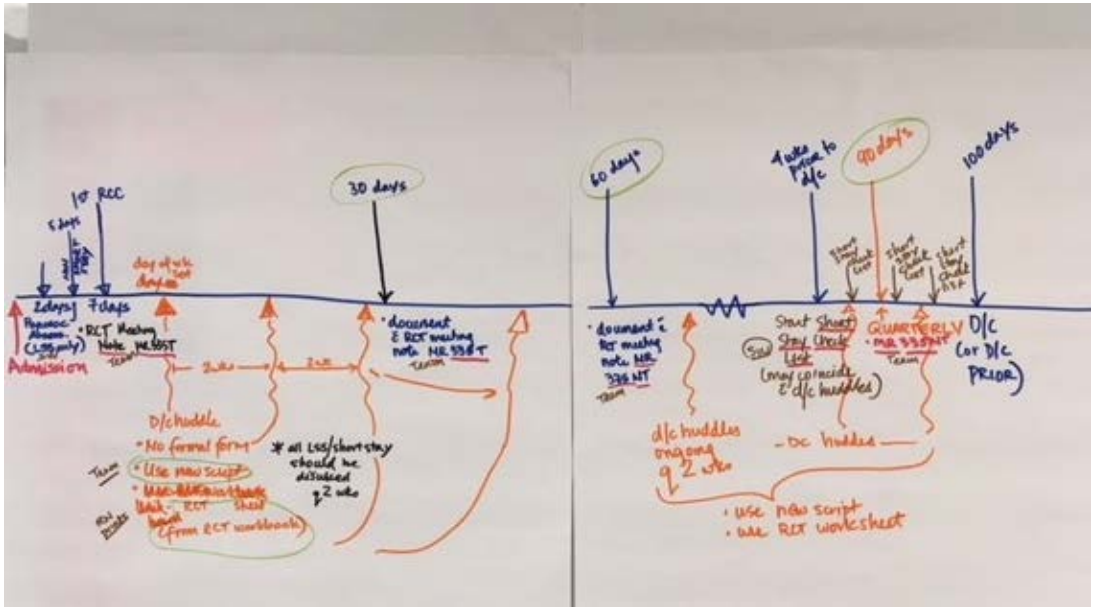
	Admission	2 Days	5 Days	7 Days	2nd Wk	4th Wk	30 Days	6th Wk	8th Wk	60 Days	10th Wk	4 wks Prior to D/C	12th Wk	90 Days	14th Wk	100 Days/Discharge
D/C Huddles					✓	✓		✓	✓		✓		✓		✓	
Task	Start	Complete Psychosocial Assessment (SS residents)	Complete Psychosocial Assessment (non-SS residents)	1st RCC			RCT Meeting Notes			RCT Meeting Notes				RCT Meeting Notes		Discharge
Form/Tool				• RCT Note: MR335T • SFGetCare SW: 711 D/C Assessment • SFGetCare SW: 705 D/C Plan	• D/C Huddle Work-sheet • D/C Huddle Guide	• D/C Huddle Work-sheet • D/C Huddle Guide	• RCT Note: MR335T • SFGetCare SW: 711 D/C Assessment • SFGetCare SW: 705 D/C Plan	• D/C Huddle Work-sheet • D/C Huddle Guide	• D/C Huddle Work-sheet • D/C Huddle Guide	• RCT Note: MR335T • SFGetCare SW: 711 D/C Assessment • SFGetCare SW: 705 D/C Plan	• D/C Huddle Work-sheet • D/C Huddle Guide	Initiate D/C Checklist	• D/C Huddle Work-sheet • D/C Huddle Guide • Ensure D/C Checklist is being completed	• RCT Note: MR335T • SFGetCare SW: 711 D/C Assessment • SFGetCare SW: 705 D/C Plan	• D/C Huddle Work-sheet • D/C Huddle Guide • Ensure D/C Checklist is being completed	

KEY:

D/C=Discharge
RCT=Resident Care Team
SS=Short Stay
SW=Social Work

Discharge Planning Timeline

- Meetings
- Tools and Forms



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Workshop Outcome

Target	Baseline	Outcome
Reduce discharge huddle cycle time per resident	10-19 min	2-5 min
Consolidating multiple lists into a user friendly format	3 lists	1 report
Criteria for discharge is objective and standardized for Community Reintegration Performance Improvement Team	No	Yes

Lean Principles Applied to the Discharge Process

Set-up Reduction:

identifying residents ready for discharge and prep-time for huddles

Sequencing:

reports ready for use in discharge huddles

Resources:

consolidated report reduces time spent processing multiple reports

Standardized:

discharge huddles and social services notes in SF-GetCare

Team

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

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