# Laguna Honda Hospital

## Value Stream #2 – Discharge
## Kaizen Workshop #1 – Discharge Care Planning

## JCC Presentation

## March 13, 2018

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

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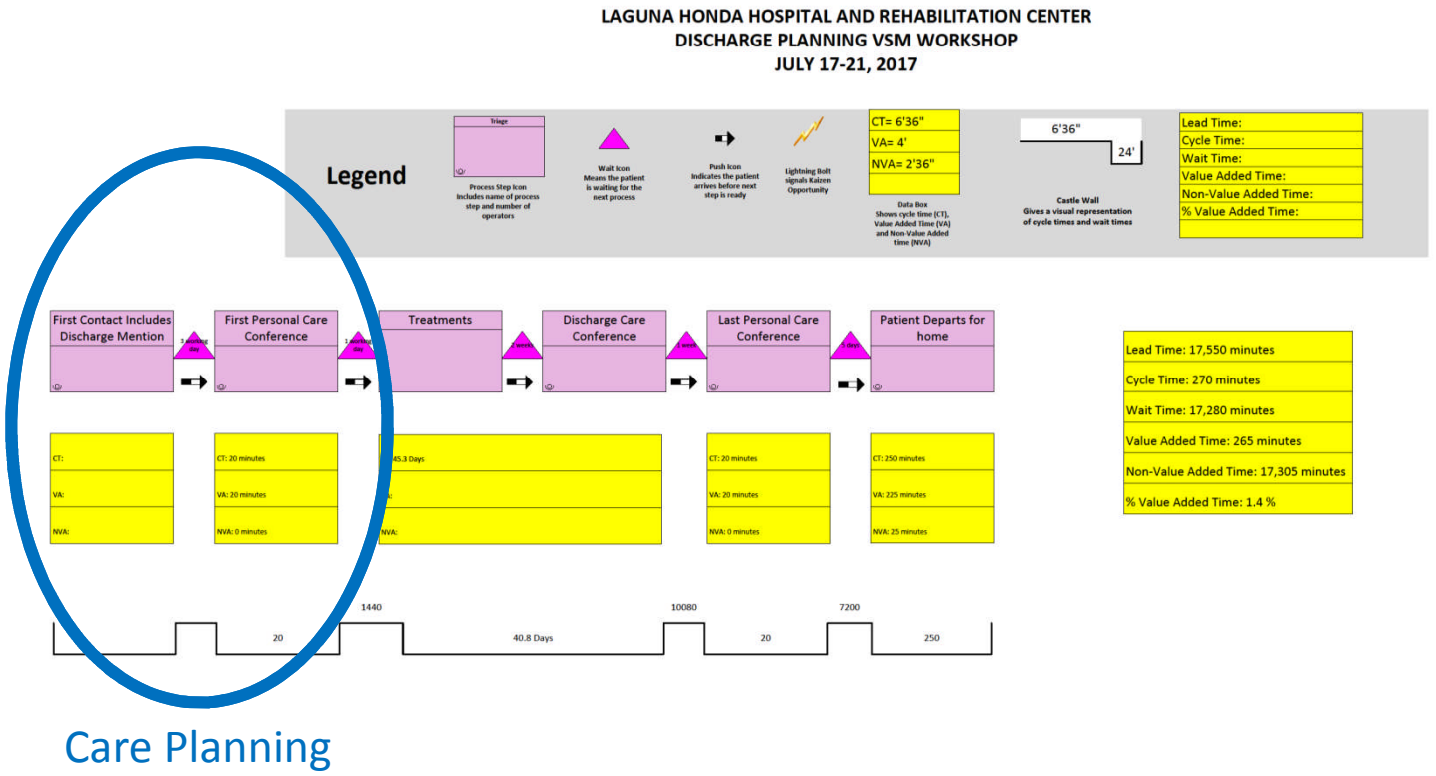
# Future State

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

This is how the value stream workshop team envisioned the improved discharge process. The care planning kaizen team focused on the time from admission through the first interdisciplinary care conference.




Care Planning



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# Value Stream A3-T

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

**A3 Title: Discharge Planning Processes (Draft)**

Team Members: Regina Gomez, Jennifer Carton-Wade, Nawzaneen Talai, Crystal Figlietti, Norman Calabia, Elizabeth Dayrit, Janet Gillen, Susan Schnider, Cindia Lok, Joanne Holland, Kris Mohler, Irin Blanco, Jacky Spencer-Davies, Deanna Chan, Kathy Lee, Toni Rucker, Oshinachi Okakpu, Luis Calderon, Olivia Thanh, Dr. Lisa Hoo, Dr. Lisa Pascual, Susan Rosen, Kyra Sikora

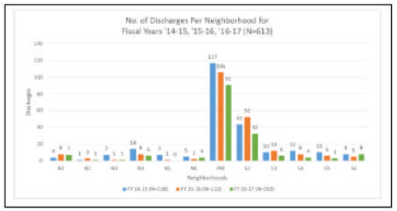
Date: 07-20-17 Version: 2
Updated: 8/23/17

**I. Background:**

Laguna Honda currently does not have the bed capacity to meet the need for post-acute care services on a consistent basis. San Franciscans that require skilled nursing services from ZSFG and other acute care settings wait for admission. Discharges from Laguna Honda to the community have decreased due to lack of residential beds, especially in medical board and care settings. Recent admissions of custodial care level patients who do not have a disposition identified have filled skilled nursing beds that could be filled by patients with skilled nursing needs. Managed Medical coverage only allows for up to 60 days of skilled nursing facility care. Medicare (MC) is proposing a change from fee for service payment to value based purchasing based on the IMPACT Act. This means that there will be a set reimbursement amount based on patient outcomes regardless of length of stay (LOS). While the greatest opportunity for bed turn over exists on two units (PMS and S2), these 2 units are also impacted because the other skilled nursing units have a growing number of custodial patients.

**II. Current Conditions:**

- Occupancy rate: 98-99%
- Average # of 15-20 accepted referrals on wait list
- ~ 50% all admissions have San Francisco Health Plan and Medicare
  - SFHP enrollment increase from 36K to 136K in 8 years
- Decreasing trend of discharges to the community
  - FY 14-15 = 238, FY 15-16 = 212, FY 16-17 = 151
- Below state & national averages for MC discharges of short stay patients
  - LHH – 41%, State- 56%, National – 57%
- Discharges from PMS and S2 are the greatest for FY 16-17
  - S2- 32
  - PM- 91
- Average LOS FY 16-17 to house/apartment, hotel/SRO, and shelters
  - S2 263 days
  - PM 77 days




**PROBLEM STATEMENT:**

The number of residents discharged from Laguna Honda has been declining over the past 3 fiscal years. There is a need to focus on discharge planning processes of residents who are able to return to their prior living situation where housing is not a barrier to discharge. The current discharge planning process must be evaluated for efficiency to reduce avoidable delays in length of stays.

**III. Goals & Targets:**

By end of FY 17-18,
1. Increase by 25% the number of residents (who are short stay and have a home) discharged back to the community within 60 days of admission.
2. Reduce average LOS by 30% by improving internal and external discharge planning care coordination processes and reducing wait times between processes. (Average LOS for S2 from 263 to 184 days, PM from 77 to 54 days)

**IV. Analysis:**

Our observations find the following issues contributing t

- Care planning
  - It is not clear when the resident is not
  - Lack of resident participation in disch
  - Lack of a comprehensive, interdiscipl team and resident/family
  - Discharge care plan meetings are no
- Discharge Prep
  - Home not ready upon discharge date
  - Lack of consideration for the timing, f
  - No standard work for linkage to servi
- Day of Discharge
  - There are multiple forms for discharg

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

- Care planning
  - Care Conferences will be: interdisciplinary, include the resident and/or family, use a standard electronic form that is centrally located
  - Discharge date transparency, consensus and timing
  - Early and well-established discharge process including flow and elements of day of discharge
  - Common understanding among community partners, optimize partnerships, shared education
- Discharge Prep
  - Medication training and processes need to start earlier in the resident's stay
  - Access to in-house and discharge related substance use treatment
  - Life skills: recognize challenges of home environment, assist resident in preparing for community living, and maintaining healthy lifestyle
  - Complete home evaluations sooner, prepare home environment
  - Timing of DME referral, delivery, fitting and storage
- Day of Discharge
  - Advanced preparation for day of discharge: transportation, vouchers, resident education, etc.- engage resident in the process

**VI. Plan:** Specifically how will you implement?

IMPLEMENTATION PLAN

| ACTION ITEM | RESPONSIBILITY | DUE DATE / STATUS |
|---|---|---|
| **Just do it** | | |
| A and E reminder admission is short stay | Irin B | 8/4/2017 -- Completed |
| Create script for each discipline to acknowledge short stay | Dr. Pascual/Jenn CW | 8/4/2017 -- Completed |
| Document reason resident not present in RCC note | Cindia/Jenn CW | 8/4/2017 -- Completed |
| Discussion with referring sources re: start discharge plan | Irin B | 8/4/2017 -- Completed |
| | | |
| | | |
| **Kaizen #1** Care Planning | Sponsor: W Hathaway+ J. Carton-Wade<br>POs: L. Hoo, C, Figlietti+ E. Dayrit | September 25-29, 2017 |
| **Kaizen #2** Discharge Preparation | Sponsor: Janet Gillen<br>POs: Grace Chen | Nov. 28- Dec. 2 2017 |
| **Kaizen #3** Day of Discharge | Sponsor: L. Cecconi + M. Fouts<br>POs: I. Blanco+ S. Rosen + C. Lok | January 22 – 26, 2018 |

**VII. Follow-Up:** How will you assure ongoing Plan, Do, Check, Act?
Include on Executive Visibility wall
Include on Executive and Manager Gemba rounds

- Care Conferences will be: interdisciplinary, include the resident and/or family, use a standard electronic form that is centrally located
- Discharge date transparency, consensus and timing
- Early and well-established discharge process including flow and elements of day of discharge
- ~~Common understanding among community partners, optimize partnerships, shared education~~ (determined to be out of scope)

# Kaizen #1 A3

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

**A3 Title: Short Stay Discharge Planning** **Owner:** Jennifer Carton-Wade, Wilmie Hathaway **Date** 9/28/17 **Version** 2

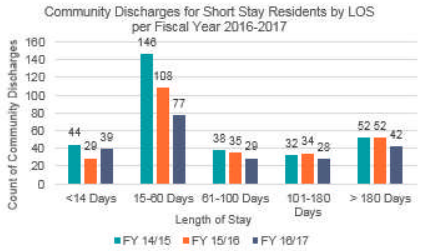
**I. Background**: What are you talking about & why?

The beginning of the resident's stay is crucial in setting the stage for collaborating to achieve an effective and timely discharge to their previous living situation. Key time points or events include:

- Admission
- Initial care conference
- Determination and notification of discharge date.
- Development and communication of the overall plan of care executed by all of the disciplines. (Currently using Form 714 as a response to DOJ requirement).

**II. Current Conditions:**

- Of the 1326 residents admitted to Laguna honda in FY 2016-17, 42% of them were coded as short stay
- Short stay residents are admitted with the hospital expectation that they are being admitted for a short (100 days or fewer) stay.
- Reimbursement from Medicare and managed MediCal doesn't cover cost. What it does has limits:
  - Medicare covers up to 100 days
  - Managed MediCal covers up to 60 days
- Many short stay residents are here longer than 100 days. (see graph)
- Long stay patients are an increasing percentage of total beds at Laguna Honda
- There are fewer SNF beds in the community (#?)




**Problem Statement**

Some short stay residents who have housing remain at Laguna Honda beyond their need for skilled nursing, contributes to a waitlist for skilled nursing beds causing a backup in the network.

**III. Goals & Targets:**

- Discharge date is documented by
- Short stay residents or their SDM
- Initial Resident Care Conference

**IV. Analysis:**

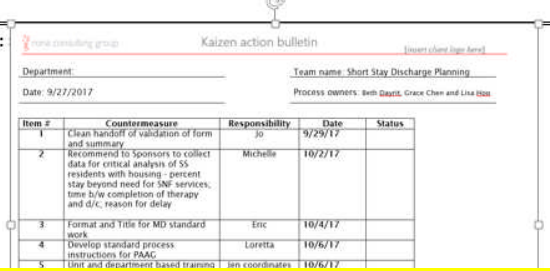
Data gathered from charts, intervie

- The meaning and implications of
- Discharge dates are not always d
- Residents are not always aware t
- Residents do not always attend the resident care conference (RCC), often because they are not invited.
- When the resident does attend they are not always encouraged to participate and some are not interested in participating.
- Documentation and discussion of discharge planning occurs in silos by discipline.
- Not all disciplines are present at care conferences.
- The initial RCC may not occur for up to 14 days after admission.
- Staff are not informed about short stay and discharge policies.
- Staff are not aware of financial implications of short stay.
- No one is in charge of discharge process.

**V. Recommendations / Proposed Countermeasures:**

| | |
|---|---|
| Communication | Create standard work for referral of short stay residents to all LHH clinic and rehab therapy that prioritizes these residents for appointments. |
| Optimization | To clarify the processes each discipline is responsible for completing prior to the initial RCC, which will be held within 7 days of admission; we developed:<br>Process at a Glance (PAAG).<br>A New RCT meeting note form |
| Education | Develop training for all RCT members emphasizing definitions and implications of short stay and new tools developed in the kaizen workshop. |

**VI. Plan:**


Kaizen action bulletin

Department:

Team name: Short Stay Discharge Planning

Date: 9/27/2017

Process owners: Beth Dayrit, Grace Chen and Lisa Hon

| Item # | Countermeasure | Responsibility | Date | Status |
|---|---|---|---|---|
| 1 | Clean handoff of validation of form and summary | Jo | 9/29/17 | |
| 2 | Recommend to Sponsors to collect data for critical analysis of SS residents with housing - percent stay beyond need for SNF services, time b/w completion of therapy and d/c, reason for delay | Michelle | 10/27/17 | |
| 3 | Format and Title for MD standard work | Eric | 10/4/17 | |
| 4 | Develop standard process instructions for PAAG | Loretta | 10/6/17 | |
| 5 | Unit and department based training | Jen coordinates | 10/6/17 | |

**90 Day Trial**

**Train and on full package for short stay residents on PMS and S2**

Some short stay residents who have housing remain at Laguna Honda beyond their need for skilled nursing, which contributes to a waitlist for skilled nursing beds causing a backup in the network.



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# Initial Target Sheet

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| Measures | | Baseline | Target |
|---|---|---|---|
| **Lead time** | Document estimated discharge date | no deadline | |
| **Lead time** | Initial RCC | </=14 days | |
| **Quality (% Defects):** | Document estimated discharge date | | 0% |
| **Quality (% Defects):** | Resident present at initial RCC | | 50% |

We did not have good baseline data for our target measures at the beginning of the workshop, so we tried to gather it during the first couple of days.



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# Interviews

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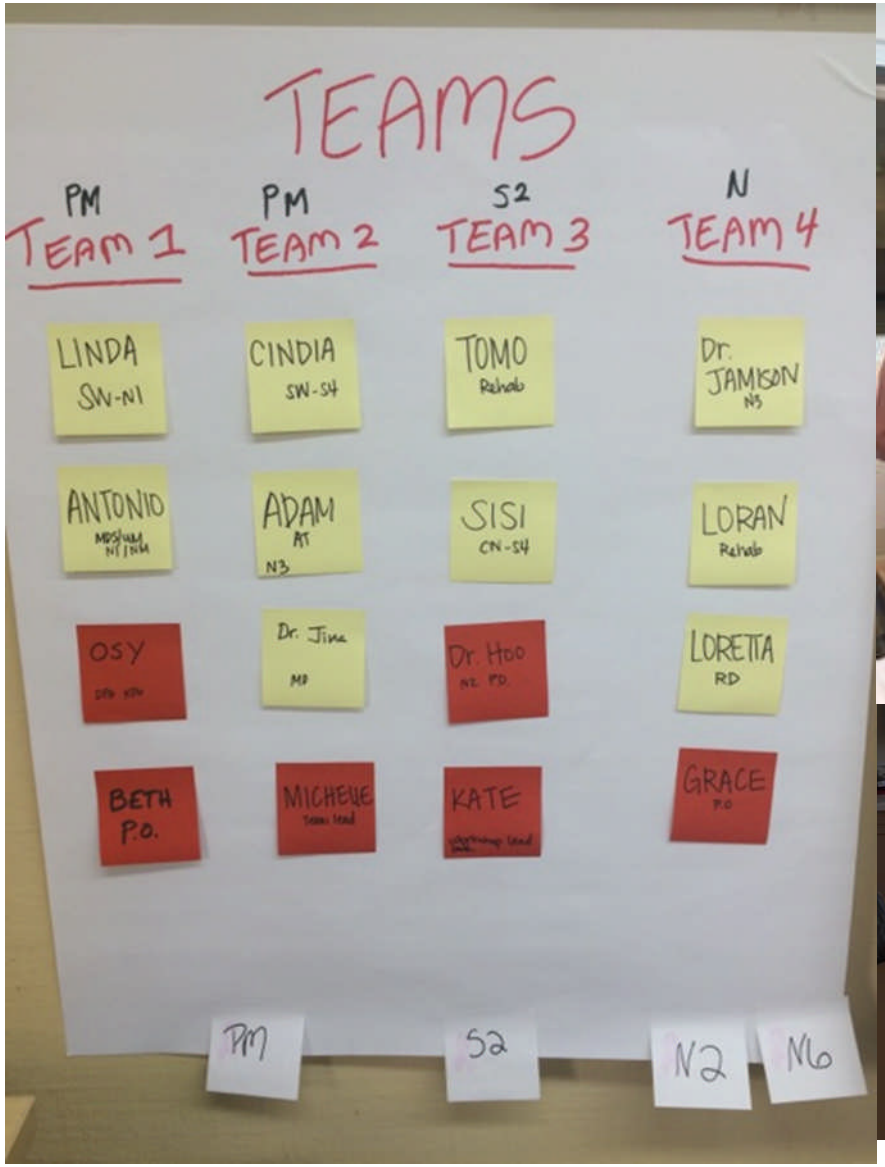


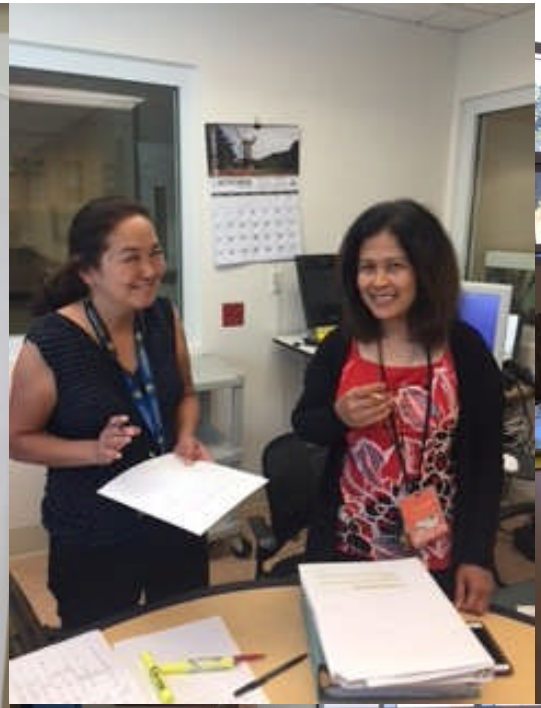

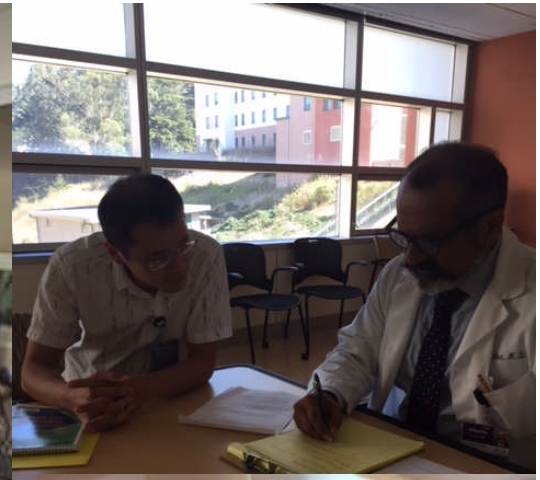

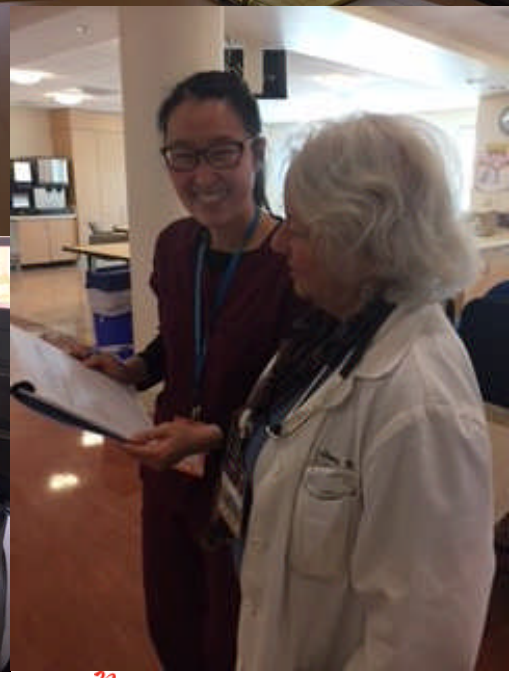

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# The Gemba: Where the work is done

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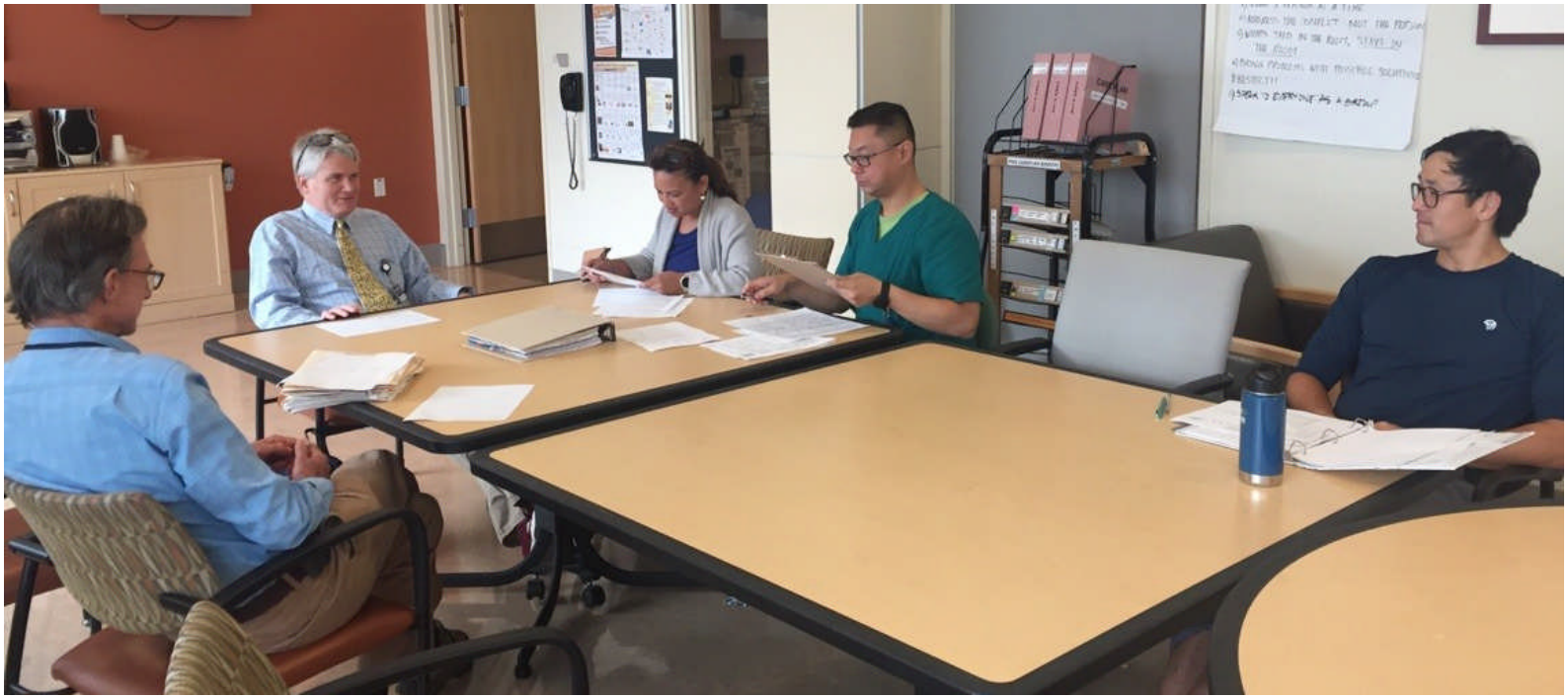

Resident Care Conference



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# Wastes

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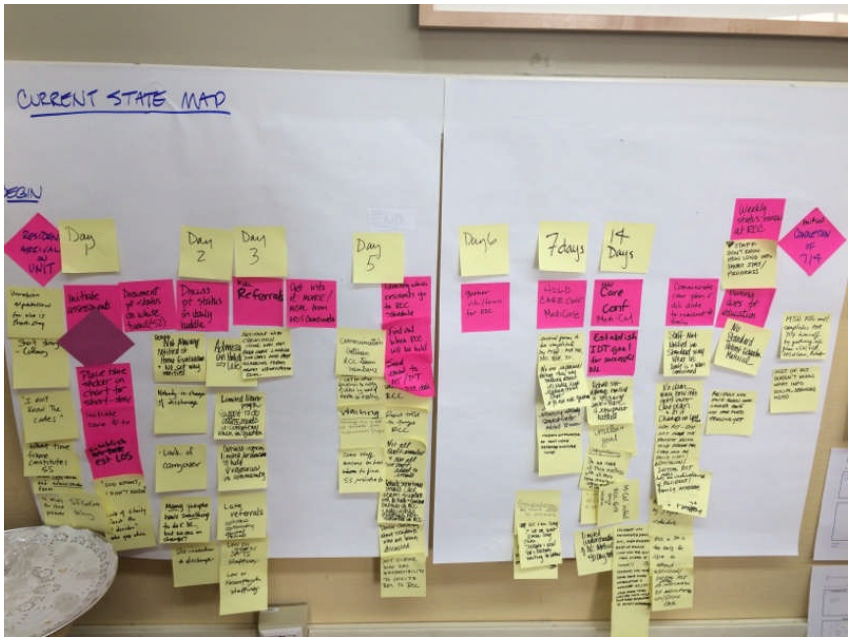


- Resident does not know about RCC
- No one knows who is in charge of determining discharge date
- Units use a variety of forms



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# Grouping of Ideas by Category

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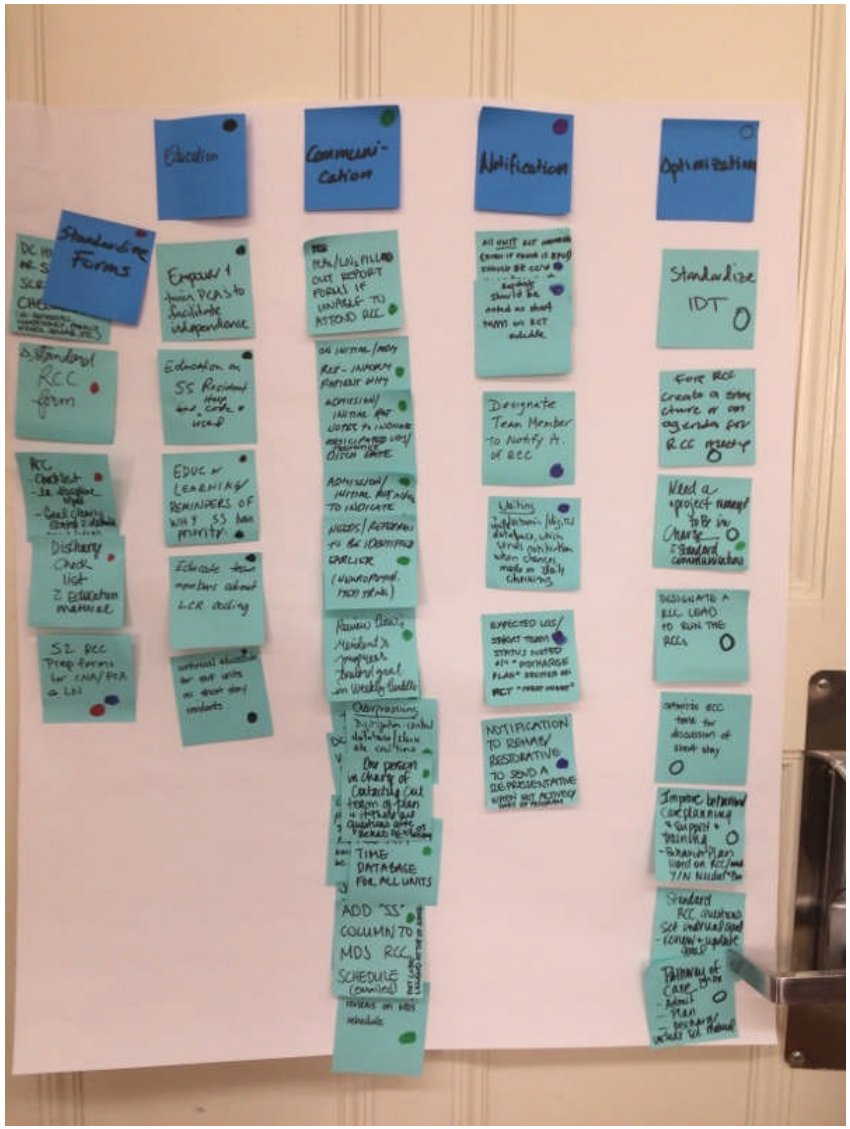


- Education
- Notification
- Communication
- Optimization



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# Root Cause Analysis: 5 Whys

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Why is there no estimated discharge date?
No one thinks they have to make the determination.
Why?
Everyone thinks it is someone else's job.
Why?
Most disciplines think the social worker is in charge of discharge. SW thinks the doctor needs to determine length of stay.
Why?
**No one is in charge!**

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# Experiments

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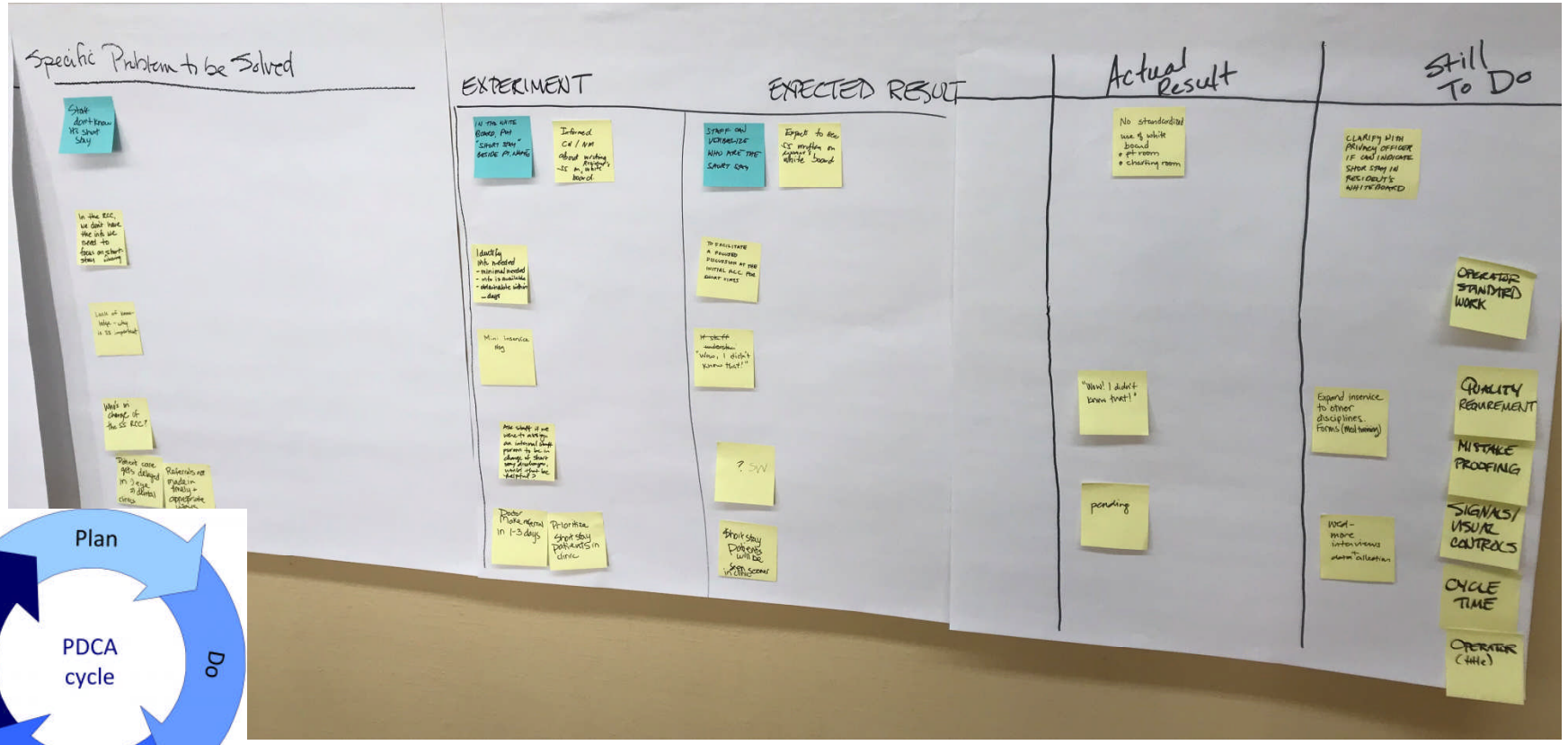
| Problem | Experiment | Expected Result | Actual Result | Still to Do |
|---|---|---|---|---|









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# Failing Forward

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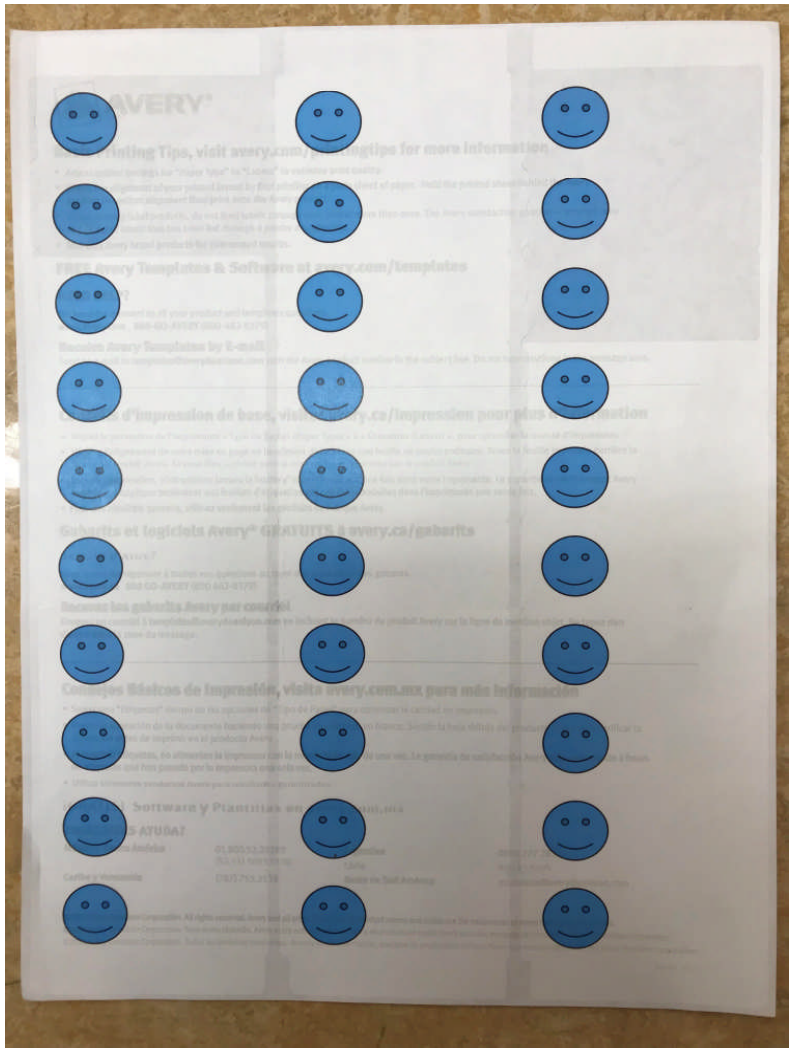

- Not all of our experiments were successful in getting us toward our goals.
- We kept trying…!



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# Work Product: Short Stay RCT Meeting Note

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Laguna Honda Hospital and Rehabilitation Center
375 Laguna Honda Blvd.,
San Francisco, CA 94116

**Interdisciplinary Team Meeting Note**

☐ **Short Stay**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Meeting Type: (check one) | | Initial (~day 7) | | Readmission | | Quarterly | Special Review |
| | | Admission (~day 14) | | Significant Change | | Annual | Relocation |

**Resident/Representative Attendance:**

Resident: Representative:

If resident or representative did not attend, indicate reason:

Estimated Length of Stay:

Resident agrees with Plan of Care: ☐ Yes ☐ No

| Team Attendance | Signature | Title | Signature | Title |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Meeting Summary:**

**DATE:** **TIME:**

Medical Condition:

Advance Directives/Code Status/MCI/AWOL:

Decision Making Capacity:

| | | | |
|---|---|---|---|
| ☐ Full Code | ☐ DNR | ☐ DNI | ☐ Code Status Discussion Pending |

Consult:

| | | |
|---|---|---|
| ☐ Dental | ☐ Vision | ☐ Podiatry |
| ☐ Rehab: ☐ PT / ☐ OT / ☐ ST/SLP / ☐ Vocational | | |
| ☐ Psych/Neuro Psych | | |
| ☐ STARS: ☐ Accept / ☐ Decline | | |
| ☐ Other Specialty: | | |

**NURSING**

ADL Functions/Restorative:

Dressing/Grooming:

Mobility/Ambulation:

| | | |
|---|---|---|
| Toileting: | Bladder: | Bowel: |

☐ Bowel and Bladder Program

Transfer:

Eating:

Mood and Behavior:

We revised an IDT form to be used for all short stay residents:

- Estimated discharge date
- Resident signature
- Comprehensive care plan



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# Work Product: Short Stay Initial Care Conference PAAG

San Francisco Health Network
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**Short Stay Initial Care Conference**
Process Owner: Nurse Manager

≤ 7 Day

| | Assessment | Medical Records | Referrals | Invitation to RCC | ADLs & Restorative Program | Diet & Nutrition | Activities | Equipment & Supplies | Housing & Living Conditions | Discharge Training Needs |
|---|---|---|---|---|---|---|---|---|---|---|
| MD DO | ✓ | ✓ H&P, Adv Dir | ✓ Order | | ✓ Order | ✓ Order | | | | |
| LNs | ✓ | ✓ MAR, TAR, WAR, BMR | ✓ Determine need, F/U | | ✓ Care plans, front card | | | ✓ Determine need(s) | ✓ | ✓ Medication & tx |
| PCA CNA | | ✓ DNCR | | ✓ Remind resident | ✓ Encourage independence | | | | | |
| PT OT ST | ✓ If referred | | | | ✓ Recommendation (s) | | | ✓ | | ✓ ADLs & equipment use |
| SW | ✓ | | ✓ Determine need | ✓ Invite resident & family/SDM | | | | ✓ | ✓ Housing, community providers and social support | ✓ Determine needs |
| AT | ✓ | | | | | | ✓ Enhance & maintain ADLs function | | ✓ Potential community resources | |
| RD | ✓ | | | | | ✓ Recommendation (s) | | | ✓ Food access, preparation and cooking | ✓ Ability to understand d/c education |
| MDS | ✓ | | | ✓ Schedule mtg, email RCC with short stay coding | | | | | | |

This process-at-a-glance (PAAG) provides a visual representation of the processes that must be completed prior to the initial RCC, which must be held within 7 days of admission for short stay residents.

# Work Product: Short Stay Referral Process

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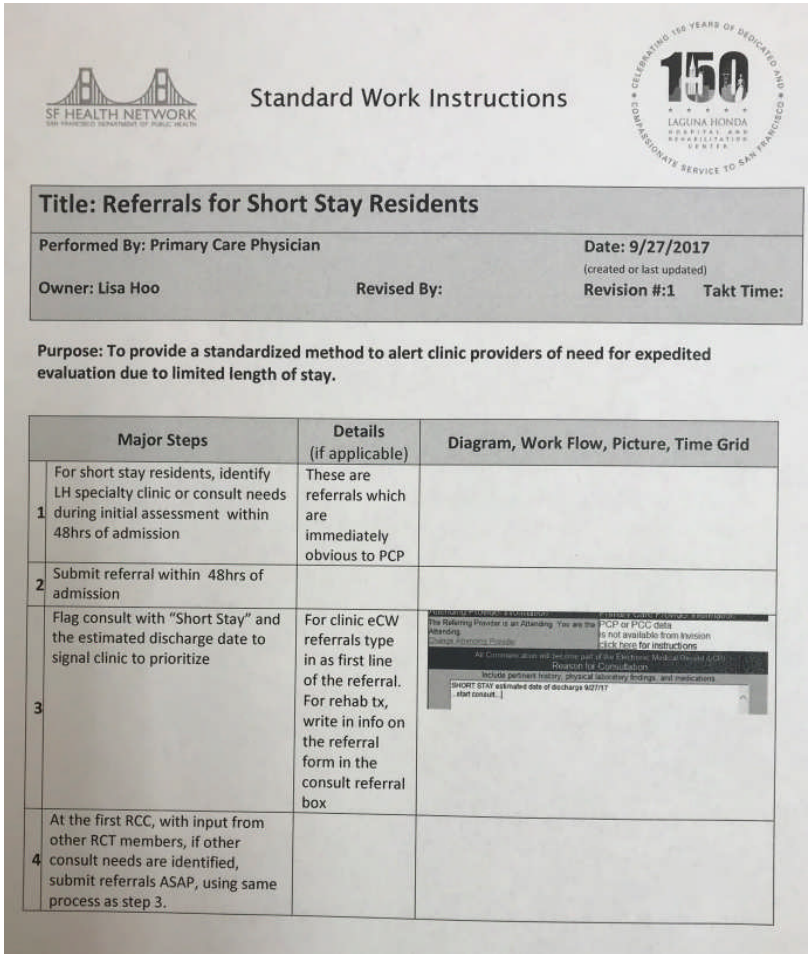

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Standard Work Instructions

LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER

**Title: Referrals for Short Stay Residents**

**Performed By: Primary Care Physician** **Date: 9/27/2017** (created or last updated)

**Owner: Lisa Hoo** **Revised By:** **Revision #:1** **Takt Time:**

**Purpose: To provide a standardized method to alert clinic providers of need for expedited evaluation due to limited length of stay.**

| | Major Steps | Details (if applicable) | Diagram, Work Flow, Picture, Time Grid |
|---|---|---|---|
| 1 | For short stay residents, identify LH specialty clinic or consult needs during initial assessment within 48hrs of admission | These are referrals which are immediately obvious to PCP | |
| 2 | Submit referral within 48hrs of admission | | |
| 3 | Flag consult with "Short Stay" and the estimated discharge date to signal clinic to prioritize | For clinic eCW referrals type in as first line of the referral. For rehab tx, write in info on the referral form in the consult referral box | |
| 4 | At the first RCC, with input from other RCT members, if other consult needs are identified, submit referrals ASAP, using same process as step 3. | | |

- Standard Work Instructions were developed for physicians to make early referrals for short stay residents.
- This process will flag the clinic to prioritize short stay residents in appointment scheduling



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# Work Product: Educational Program

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## What is Short Stay?

Residents that are expected to discharge within **100 days**.

Short stay residents can be identified by their codes:

| LSS | LSA | LRH | LRE | LHP |
|---|---|---|---|---|
| • Short Stay | • Positive Care | • Rehab | • Respite | • Palliative |

Short stay residents have a blue sticker on chart spine.


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## Why is Short Stay Important?

**Goal:** discharge the resident to the lowest appropriate level of care and promote the highest level of independence.

**Fiscal responsibility:** The resident will be covered for up to two months and then another reimbursement source may need to be identified, which is a lengthy process.

**Successful discharges:** affect our hospital quality measures and decrease wait list times for new admissions.

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# Kaizen Action Bulletin

San Francisco Health Network
Laguna Honda Hospital
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| Item # | Countermeasure | Responsibility | Date | Status |
|---|---|---|---|---|
| 1 | Clean handoff of validation of form and summary | Jo | 9/29/17 | Done. |
| 2 | Recommend to Sponsors to collect data for critical analysis of SS residents with housing - percent stay beyond need for SNF services; time b/w completion of therapy and d/c; reason for delay | Michelle | 10/2/17 | Done. Meeting invite sent by Michelle on 10/06/17. |
| 3 | Format and Title for MD standard work | Eric | 10/4/17 | Done. Dr. Hoo to work on what will be the Title. |
| 4 | Develop standard process instructions for PAAG | Loretta | 10/13/17 | Done. 9/30/27 |
| 5 | Unit and department based training on new RCT meeting form, observe use and be available for support. | Jen coordinates with Adam, Cindia and Loran | 10/13/17 | Training completed, Friday, 10/27/17 and PM & S2 will be implement/ piloted on Monday, 10/30/17.<br>Nurse Manager/Units will email KZ team for updates |
| 6 | Determine how to use RCT documentation form without requiring duplicate documentation during pilot. | Jen | 10/12/17 | Done.<br>10/13- consider fillable pdf vs handwritten |
| 7 | Notify team of form approval | Jen | 10/13/17 | Done. 10/10/17 |
| 8 | Initiate implementation of trial and spread plan | Grace coordinates with | 10/16/17 | Grace to coordinate with Leanne and Valerie (Nursing Ed). Units |

# Final 1-2-3 Target Sheet

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| Measures | | Source | Baseline (Sept?) | Target | 60 Days Month of Nov | 90 Days Month of Dec | Month of Jan |
|---|---|---|---|---|---|---|---|
| **Lead time:** The average length of days from admission to the Initial Resident Care Conference | | chart reviews | ≤14 days | ≤ 7 days | 5.9 | 5.9 | 6.9 |
| **Quality (% Defects):** The date of expected discharge is not documented in the chart at the end of the initial care conference | Numerator (# defects): | chart reviews | 6 | | 6 | 8 | 1 |
| | Denominator (sample size): | | 9 | | 10 | 10 | 10 |
| | Percentage: | | 67% | 0% | 60% | 80% | 10% |
| **Quality (% Defects):** Number of times the resident is not present at initial RCC | Numerator (# defects): | chart reviews | 2 | | 8 | 8 | 6 |
| | Denominator (sample size): | | 8 | | 10 | 10 | 8 |
| | Percentage: | | 25% | 20% | 80% | 80% | 75% |
| **Quality (% Defects):** Number of times the surrogate decision maker is not present (if appropriate) | Numerator (# defects): | chart reviews | 1 | | 0 | 0 | 1 |
| | Denominator (sample size): | | 1 | | 0 | 0 | 2 |
| | Percentage: | | 100% | 20% | N/A | N/A | 50% |

We developed targets:

- 100% documented estimated discharge date at initial RCC
- 80% resident/SDM participation at initial RCC
- 100% of initial RCC within 7 days of admission

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# Thank You!

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

- Kaizen team co-workers and supervisors
- Resident Care Teams
- Interviewees
- Short stay residents
- PMS, S2, S3, S4, S5, S6, NM, N1, N2, N3, N4, N5, N6
- eHR work group
- Education Department
- Garrett Chatfield
- Janet Gillen
- Medical/Dental Clinics
- Nutrition Services
- Wilmie Hathaway, Jennifer Carton-Wade
- Elizabeth Schindler, Olivia Thanh, Quoc Nguyen
- Mivic Hirose, Michael McShane. Regina Gomez, Madonna Valencia

# Team

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