Laguna Honda Hospital

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

JCC Presentation

March 13, 2018
Future State

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 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)
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.
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.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Baseline</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead time</td>
<td>Document estimated discharge date</td>
<td>no deadline</td>
</tr>
<tr>
<td>Lead time</td>
<td>Initial RCC</td>
<td>&lt;=14 days</td>
</tr>
<tr>
<td>Quality (% Defects):</td>
<td>Document estimated discharge date</td>
<td>0%</td>
</tr>
<tr>
<td>Quality (% Defects):</td>
<td>Resident present at initial RCC</td>
<td>50%</td>
</tr>
</tbody>
</table>
Interviews
The Gemba: Where the work is done

Resident Care Conference
Wastes

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

- Education
- Notification
- Communication
- Optimization
Root Cause Analysis: 5 Whys

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!
# Experiments

<table>
<thead>
<tr>
<th>Problem</th>
<th>Experiment</th>
<th>Expected Result</th>
<th>Actual Result</th>
<th>Still to Do</th>
</tr>
</thead>
</table>

## Specific Problem to be Solved

- [Image of specific problem to be solved with post-it notes]

## Experiment

- [Image of experiment section with post-it notes]

## Expected Result

- [Image of expected result section with post-it notes]

## Actual Result

- [Image of actual result section with post-it notes]

## Still to Do

- [Image of still to do section with post-it notes]
Failing Forward

• Not all of our experiments were successful in getting us toward our goals.

• We kept trying...!
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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### Interdisciplinary Team Meeting Note

**Short Stay**

<table>
<thead>
<tr>
<th>Meeting Type (check one)</th>
<th>Initial (~day 7)</th>
<th>Readmission (~day 14)</th>
<th>Quarterly</th>
<th>Special Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident/Representative Attendance:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident:</td>
<td>Representative:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If resident or representative did not attend, indicate reason:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Length of Stay:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident agrees with Plan of Care: Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature</th>
<th>Title</th>
<th>Signature</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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/SLP
- Vocational
- Psych/Neuro Psych
- STARS: Accept/Decline
- Other Specialty:

**NURSING**

**ADL Functions/Restorative:**

<table>
<thead>
<tr>
<th>Dressing/Grooming:</th>
<th>Mobility/Ambulation:</th>
<th>Toileting:</th>
<th>Bladder:</th>
<th>Bowel:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel and Bladder Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Transfer:**

<table>
<thead>
<tr>
<th>Eating:</th>
<th>Mood and Behavior:</th>
</tr>
</thead>
</table>
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

• 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.
Work Product: Educational Program

What is Short Stay?

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

Short stay residents can be identified by their codes:

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

Short stay residents have a blue sticker on chart spine.

**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.
<table>
<thead>
<tr>
<th>Item #</th>
<th>Countermeasure</th>
<th>Responsibility</th>
<th>Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clean handoff of validation of form and summary</td>
<td>Jo</td>
<td>9/29/17</td>
<td>Done.</td>
</tr>
<tr>
<td>2</td>
<td>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</td>
<td>Michelle</td>
<td>10/2/17</td>
<td>Done. Meeting invite sent by Michelle on 10/06/17.</td>
</tr>
<tr>
<td>3</td>
<td>Format and Title for MD standard work</td>
<td>Eric</td>
<td>10/4/17</td>
<td>Done. Dr. Hoo to work on what will be the Title.</td>
</tr>
<tr>
<td>4</td>
<td>Develop standard process instructions for PAAG</td>
<td>Loretta</td>
<td>10/13/17</td>
<td>Done. 9/30/27</td>
</tr>
<tr>
<td>5</td>
<td>Unit and department based training on new RCT meeting form, observe use and be available for support.</td>
<td>Jen coordinates with Adam, Cindia and Loran</td>
<td>10/13/17</td>
<td>Training completed, Friday, 10/27/17 and PM &amp; S2 will be implement/ piloted on Monday, 10/30/17. Nurse Manager/Units will email KZ team for updates</td>
</tr>
<tr>
<td>6</td>
<td>Determine how to use RCT documentation form without requiring duplicate documentation during pilot.</td>
<td>Jen</td>
<td>10/12/17</td>
<td>Done. 10/13- consider fillable pdf vs handwritten</td>
</tr>
<tr>
<td>7</td>
<td>Notify team of form approval</td>
<td>Jen</td>
<td>10/13/17</td>
<td>Done. 10/10/17</td>
</tr>
<tr>
<td>8</td>
<td>Initiate implementation of trial and spread plan</td>
<td>Grace coordinates with</td>
<td>10/16/17</td>
<td>Grace to coordinate with Leanne and Valerie (Nursing Ed), Units</td>
</tr>
</tbody>
</table>
**Final 1-2-3 Target Sheet**

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

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
Thank You!

- 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