American HealthTech®

Reducing Re-Admissions: An Action Plan

Whitepaper

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"Re-hospitalization data is just the tip of the iceberg. Hospitals are going to want specific information on how we manage individual diagnoses, particularly those that CMS is focusing on. AHT products allow us to drill down to that degree of data on the fly."
Ted Smith, CEO, Hillcrest Convalescent Center

Executive Summary

The Challenge

In the aftermath of the 2010 Affordable Care Act, hospitals and ACOs are being held accountable for unnecessary readmissions, complete with financial penalties for those whose rates are too high. The AHCA/NCAL Quality Initiative includes a measurable target of reducing 30-day hospital readmission rates during a SNF stay by 15% by March 2015.

This means that SNFs are under more pressure than ever to help acute-care facilities protect their revenues. Hospital and ACOs are shopping more carefully than ever for post-acute partners. Are you ready to help them fight unnecessary readmissions? The answer revolves around predictable steps that you can take to improve these measures. And today, this has now become one of the more critical issues for your success.

The Takeaway

This white paper outlines a step-by-step action plan for attacking hospital readmissions, encompassing your processes, patient care, and your data.

If your rates are already good, congratulations – this strengthens your hand for negotiating contracts and improving your census. If not, the techniques here will help you show acute care partners what you're doing to improve them – in areas such as improved patient care, specialization programs, or training – that you have or plan to launch. From there you can periodically report your success as you align your business goals with those of your acute-care partners.

The Bottom Line

You'll need a rock-solid, data-driven story to win in the collaborative world of healthcare. Great census is increasingly about great quality outcomes – and starts with your hospital readmission rate.

"Thanks to AHT, we're a seamless partner with our pharmacy. The biggest communication barriers are gone."

Pamela Duncan, Chief Compliance Officer, Agape Senior

Step 1: Tighten Up Your Processes

Many of your preventable readmissions to acute care revolve around predictable issues that can be understood and managed, ranging from your intake process all the way to discharge. Engage your team to identify and troubleshoot areas where hospital readmissions commonly occur. Areas to consider include:

Preadmission Process. Are readmissions happening because you do not have the ability to care for the patient in the first place? Take a hard look in the mirror – what niches of expertise do you have today? Do they match what the hospital needs? Help prevent readmissions by admitting what you can do…and either say no to certain admissions or consider specialized training.

Look at your local hospitals' discharges. Train your staff to take higher volumes of specialized diagnoses. Track outcomes and present back to the hospital – proving you are doing a better job with these specialties over competitors.

Advance Directives. This is a simple step with powerful implications. Having them reduces questions from staff, mitigates concerns of family members, and helps prevent readmissions by keeping residents in your building. Work with your staff to adjust workflows to collect advance directive information at admission time so that the appropriate treatment decisions can be made for residents.

Make gathering advance directives a requirement for every admission. Define one location where you want to store this information and gather it consistently. While detailed advance directives may be more challenging to get, at the very least, get code status for new residents.

Assess Vendor Contracts. Ever send a patient back to the hospital because you couldn't get lab draws or meds fast enough? Can your local partners meet the needs of the complex patients with quick turnaround as patients' conditions change?.

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Revisit every contract you have and scrutinize their steps. Challenge vendors to tighten turnaround times for services and make service levels conditions of contracts. And help prevent readmissions by speeding needed services that help stabilize residents.

Nursing Skill Evaluation. As hospitals and ACOs shop markets, SNFs with specialty programs are becoming attractive – especially those with a proven ability to produce great outcomes. Evaluate what your market opportunities include, expand services, and train nurses to meet new/higher acuity needs. Help prevent readmissions with smart training leading to sharp decision making.

For example, say you partner with your hospital to coordinate care for cardiac patients, and you decide to add respiratory services. You'll need oxygen equipment, respiratory nurse training, cardiac nurse training, and more. When you're out of your league, bring in consultants or partner with nurse practitioners to assess and check off skill sets. Training yields many dividends and lower turnover is often a reward.

How AHT Can Help

Admissions analysis tools can help you with referral tracking.

Outcomes Reporting helps show hospitals you are aligned with them in quality objectives and readmission prevention.

You can indicate DNR status as well as create user-defined fields to facilitate workflow in gathering advance directives.

Pharmacy interoperability eliminates faxing and streamlines order processing. As soon as an order is entered, it is available to the pharmacist and in the AHT medical record. Updates to orders pharmacists make are automatically updated in the AHT medical record, and refills happen in a couple of clicks.

As a member of the AHT community, customers have 'lifetime learning' benefits. Programs like Quicklinks, webinars, and the Annual Customer Symposium help build and refresh skill sets.

"Care teams are catching more, and feeling great that issues get handled. If a CNA spots a potential wound issue, she documents it, and the system escalates it."

Krissi Elliott, Business Office Manager, C&G Healthcare Management Inc.

Step 2: Enhance Patient Care

Many readmission issues can be prevented through low-cost interventions designed to enhance the patient experience: for example, proactively addressing medication issues or tracking ADLs. This is one area where you can leverage your SNF's technology to create alerts, review data, and drive other best practices. Key areas include:

Monitor ADL Score Declines. Functional decline, even small changes, can give you a heads up about declining health status leading to a readmission. Accurate ADL coding is also essential for quality measures that impact your star rating. Use a system to review ADL scores regularly and automatically let you know when declines are detected. When scores decline, prevent readmissions by collaborating with the clinical team, intervening early, and updating care plans accordingly.

Create Alerts. Alerts can be used to monitor both changes in condition and follow-up treatment. The more fragile the patient or high-risk the diagnosis, the quicker you'll want to know when issues come up so you can stay on top of care. Likewise, closing the loop on follow-up actions is critical to help stabilize residents and monitor care plans. Help prevent readmissions by closely watching changes in condition and initiating interventions early, and making sure residents are getting all needed treatments.

Use a system to automatically sense changes in conditions that could signal a re-admit (such as no BM for # of days, behaviors, incidents, etc.) or to remind staff of follow-up actions after a specific diagnosis (e.g., a respiratory infection), doctor visits, lab work, etc. The big challenge with alerts is overload: if nurses get too many, you'll see 'notification fatigue' as evidenced by ignored alerts. Prioritize, test, and ramp-up volume over time.

"Thanks to committed leadership, progressive quality programs, and deep use of technology, we have achieved impressively low return to hospital rates of 9.5%."

Donna Conner, Director of Clinical Information Systems, Aloha Nursing Rehab Centre

Manage Medications. A variety of studies cite medication adherence as the culprit in 10-20% of hospital readmits. Help prevent readmissions by looking for trends in refusals, and monitoring reasons behind the trends: evaluate med passes for efficiency, look for late and held medications, and make medication reconciliation a part of the admission process.

Pay particular attention to orders for psycho-active medications that can lead to behavioral changes. When psycho-active med orders are received, collaborate with staff to watch carefully for new problems, review care plans, and organize early interventions. If needed, the prescriber should attempt dose reduction at scheduled intervals to see if the resident can maintain therapeutic results.

Bring in pharmacy consultants at least once per month to do a comprehensive review and make recommendations to physicians. Yes, this step is a regulatory requirement... but is it working well? It needs to be a top priority with pharmacy experts you trust.

Wound Management. Wound care is complex. Help prevent readmissions by catching and treating wounds in early stages – helping to curtail complications and costly treatments later. Assess often and take preventative measures for high-risk residents. When a wound is discovered, implementing the right treatment is imperative to getting wound healing on track.

If you don't have a wound expert in house, contract with outside resources for staff training. Enforce consistency in assessment (same nurse), physician involvement in the plan of care, preventative interventions (nutritional, specialty mattresses, etc.) and proper follow up for non-healing wounds.

Discharge Planning. Discharge is a vulnerable time for patients. In a 2012 study of emergency room visits, 80% didn't fully grasp home care instructions[1]. Help prevent readmissions with clear, concise instructions that promote adherence and healing. Create easy-to-use discharge

[1] Engel KG et al. Patient understanding of emergency department discharge instructions: Where are knowledge deficits greatest? Acad Emerg Med 2012 (http://dx.doi.org/10.1111/j.1553-2712.2012.01425.x)

instructions including medications, side effects, and assistive devices. Enter physician orders in layman terms so that they flow to the discharge summary in layman terms. It will save you time; all you need to do is print, review, and send home with the patient – and as a bonus, it will help align with your brand of providing great service.

How AHT Can Help

In AHT, ADL scores are easily monitored by resident and in reports the system generates. Clinicians can also set up automated alerts.

Clinicians can be automatically notified when out-of-range changes in condition are detected, triggering an email or system message.

Alerts for follow up can be scheduled, with automated reminders of when actions come due.

Nurses can easily keep tabs on medication compliance for any resident.

Alerts can be set up to notify clinicians of a new psychoactive medication so that action can be taken. Special requirements for side effects and behaviors can be set up for medication administration.

Comprehensive wound management in AHT helps assess, document, track, and monitor risk using The Braden Scale. Wound information also flows seamlessly to Outcomes Reporting, to facilitate quality improvement initiatives like QAPI.

Orders flow to discharge summaries in AHT. Medication side effects can also be printed, as well as drug education reports to help residents and families – in layman's terms.

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Step 3. Manage Your Data

Your efforts to improve hospital readmissions can only be as good as the data you collect. This means that the third step, and perhaps the most important one, in creating better outcomes involves devoting attention to how you capture, use, and leverage care data within your operation.

Improve Data Capture Workflow. More data translates to a better picture of resident health. The closer data can be captured at the point of care, the faster alerts can be triggered. This helps prevent readmissions with earlier interventions.

Scrutinize every workflow to tighten up the time between interaction and documentation. There is no such thing as too much training on this subject. Schedule and execute as many in-services as your budget allows, and continuously brush up on self-performance and support levels. At the same time, be realistic and expect pushback as CNAs and nurses are incredibly busy. Monitor hourly documentation performance by individual, and offer rewards for the behavior you want to see.

Resident Condition Summaries. This is a question of the forest versus the trees. You have a lot of data, but are you aggregating it to make impactful strategic decisions? Help prevent readmissions by piecing together causative factors, and create consolidated snapshots of resident health.

For example, a clinician notices that a resident has had 3 falls in the last two days. She also sees that two days ago the resident started a new B/P medication. Summaries like these allows for quick action to help clinicians prevent further adverse events, AND DONs, nurse managers, and others may find them useful for picking up on abnormalities that need early intervention.

Deploy QAPI. CMS recognizes that many times outcomes are not monitored or analyzed correctly – that's why they are proposing new rules to enforce quality tracking and management with the Quality Assessment and Performance Improvement (QAPI) initiative. Help prevent readmissions by identifying and attacking risk areas with QAPI and your

"We see patterns sooner, and use what we learn to improve our services. Now we're driving quality in real time, which translates to amazing service for residents."

Tim Stuteville, Administrator, The Wesleyan at Scenic

interdisciplinary team. Mobilize teams, initiate training, and implement QAPI early – then track all goals in a system and make every decision you make data driven. For more tools and resources on designing a program, visit http://www.ahcancal.org/facility_operations/survey_certification/Documents/QAPI_resources.pdf

Use Paperless Intervention and Quality Tools. Help prevent readmissions using simple tools that are easy-to-learn and implement. Studies have shown facilities using INTERACT™ II tools reduced acute care transfers 17-24%.[2,3]

Visit http://interact2.net/ to review and deploy paper-based tools; and if possible, execute paperless. A White Paper about Paperless INTERACT tools can be found at: http://www.healthtech.net/post-acute-care-whitepapers/. While the industry buzz surrounding INTERACT is about reducing readmits, INTERACT data is also great for smarter, faster decision making.

How AHT Can Help

In AHT, supervisors can monitor progress all shift long as care is completed and in a central command center.

Resident Condition Summaries can be viewed at any time on any resident by authorized team members for a real-time picture of health.

You can use Outcomes Reporting in AHT to measure and monitor goals for QAPI, and include a goal for lowering readmission rates.

SBAR and Stop and Watch tools are integrated as paperless clinical workflows. More INTERACT tools will be available in coming releases.

[2] The INTERACT™ trademark and copyrighted materials are used with the permission of Florida Atlantic University. For more information, please visit www.interact2.net.

[3] 2011 Commonwealth Fund Project Results

About the Authors

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With over 20 years of healthcare experience, Brenda Kessler is among the industry's leading experts in improving efficiencies to drive higher clinical and financial performance. Having served as a DON, ADON, and wound care nurse in long-term care, she has first-hand knowledge of the challenges providers face today. Brenda joined American HealthTech in 2010. As a Clinical Project Manager, Brenda helped dozens of providers transform operations with technology and quantify the clinical as well as financial benefits. In her current role as a Clinical Specialist, Brenda works with providers nationwide to map their vision for technology to action.

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Maria Arellano, MS, RN has over 28 years' experience in nursing, specializing in post-acute care including direct care, nursing administration, consulting and teaching. She was a quality improvement specialist for Colorado's quality improvement organization and assisted nursing homes and home care agencies with regulatory compliance and quality improvement activities. Maria has served as an expert witness, providing consultation to attorneys on nursing standards of care and nursing home operations. As Clinical Product Manager at American HealthTech, Maria plans and executes clinical software design throughout the product lifecycle.

About American HealthTech

American HealthTech is one of the nation's leading EHR providers for LTC facilities. We believe you need MORE than software. We're here providing software, service and ongoing support to help you succeed today and meet the industry challenges of tomorrow. Get the power you need out of your EHR. Visit us at www.healthtech.net to learn more.