1. **Begin your formalized "internal" culture change movement - initiated & supported by your owner/CEO and fully executed at every leadership level. Culture change away from the traditional *nursing home* model of the past; toward today's true complex medical and rehabilitation centers.**

   If you're trying to rally people around an idea, you can't use fuzzy corporate jargon. A movement idea must be clearly and forcefully articulated – it should sound more like a declaration or, better yet, a manifesto.

   A manifesto is a great way to rally people around a big idea. It may be a page or two in length. And, if you hear the word manifesto and you think of overthrow, good. That's exactly what you're trying to do…overthrow the old, humdrum elements of your existing culture.

   Keep in mind, it is often necessary to change company policies and procedures when you're launching a movement within a corporate culture. And actions speak lower than any of the words in that manifesto that was just written. Executives, Managers, Directors…everyone has to be on board with this new manifesto and with change, otherwise this effort will fall flat on its face.

   Because organizational change cannot occur without the commitment and engagement of organization leaders, some organizations are creating leadership incentive programs based on staffing measures. Others have advocated for nursing representation on boards of trustees, while still others are creating "nursing movements" within their organizations.

2. **Provide ongoing, scheduled, clinical & rehab staff training for "highest" acuity care competency - to meet your hospital partner(s) discharge needs.**

   The issues around nursing education extend into the practice setting. Whether a nurse graduates from a two-year, three-year or four-year nursing program, the transition into practice is quick, with little time for mentoring or on-the-job training. Indeed, with many shifts short-staffed today, managers are reluctant to pull experienced nurses away from resident care activities to serve as trainers and mentors.

   In academic settings, nurses are educated in a silo, much like other professional disciplines. This problem is compounded by the lack of awareness of nursing faculty about actual nursing practice today; the virtual absence of clinical experience from the nursing school curriculum; and the lack of involvement of nurse clinicians in the education process.

   The demographics of the nursing profession (aging nurses, aging faculty, and fewer new entries) and the demographics of a society with aging baby boomers intent on living longer with complex medical interventions are on a calamitous course. Fortunately, it is not too late to change this by encouraging young people to get involved in nursing and continue to educate and reward existing nursing staff.

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3. **Commit to admit 24/7/365 – any and all "clinically" complex medical patients needing to discharge from your hospital partner(s) beds – o*n time*.**

   Simply put, DRGs are designated a set number of days/hours allowable in the hospital bed with care reimbursement, by our nation's health plans. For each day/hour beyond the allowable designation that the hospital provides patient care within their bed, a financial loss to the hospital occurs. As post acute care providers, it is our responsibility to ensure we are admitting any and all clinically complex patients referred by the hospital "before" the hospital experiences an "overage in length of stay"; to be valuable care partners to them – our referral pool.

   For success, SNFs must examine what DRGs their hospitals are experiencing "overages in length of stay" with; and jointly build patient recovery programs that allow for timely hospital discharges and successful SNF recoveries - without hospital readmissions within the 1st 30 days.

   Consistent, daily, doctor and/or Nurse Practitioner involvement in your acute patient recovery programs', will support reduced and/or eliminated 30 day readmissions back to your hospital.

4. **Greatly reduce or eliminate your discharges back to your hospital partner within the first 30 days of patient discharge to your center.**

   Healthcare Information and Management Systems Society (HIMSS) is a great resource of information. In April 2012, it published a comprehensive report about the reduction of discharges and how technology plays into that effort. Some of the key elements include the Readmission-Reimbursement Link, including a review of the Patient Protection and Affordable Care Act (PPACA), Case Management, Communication, Analytics and Modeling, and Post-Acute Care, just to name a few. To access the entire report and learn more about what you can do to positively affect your readmissions, click here.

5. **Implement EMR to support your *need* to provide your hospitals and health plans with proven, documented, evidence on your patients' rehabilitation & discharge "home" success. (Without reporting capability, you will not be considered in your local ACO or bundled care referral model.)**

   In November 2011, HIMSS posted an article about the 6 Golden Rules of Implementing Your EHR, containing the thoughts of Rosemarie Nelson, principal of the MGMA Consulting Group, and asked for her opinion on the best practices for implementing an EMR system. Here they are:

   A. **Include nursing staff.** When we first asked Nelson about the sins associated with implementation, the most detrimental, according to her, was forgetting about your nurses. And now, Nelson stands by that mantra and believes the EMR isn't all about the physician. "Physicians are the owners, or the leaders, or the key decision makers, but they are not the exclusive users of the EMR," she said. She mentioned nurses account for almost 75 percent of the use of the chart, and physicians, 25 percent. "A successful EMR implementation focuses on how the nurses can assist the physician in the integration of the EMR into clinical

workflow," she said. "Too often, an EMR committee is created in a medical practice, and there's no nursing representative. Bring in the nurses."

B. **Recognize the opportunity to change and improve your workflow.** "Most practices have not optimized processes," said Nelson. "And many practices have not standardized on forms and procedures." According to her, technology "changes what is feasible," so look to the EMR implementation as a chance to find new efficiencies in your workflow. It's important to remember, though, the EMR shouldn't be used as a magic bullet to fix holes and other issues in workflow. "Most people think an EMR solves problems," said Steve Waldren, MD, director for the American Academy of Family Physicians' Center for Health IT. "But an EMR will only amplify problems that already exist in the practice."

C. **Schedule even more training.** When we first spoke with Nelson, she mentioned outside influences tend to form attitudes around EMR training. "Microsoft made us think everything is plug and play; the same with a MacBook," she said. "They think 'I can do the same thing with an EMR.' The difference is, it's a complicated environment with a lot of regulation, coding, and documentation. You have to dedicate the time for training." Nelson says to schedule time outside of office hours for you and your staff to "get on the EMR and actually walk through the tasks you'll perform when you go live." It will cost you overtime, she says, or even lost productivity if you close office hours. "Budget for additional training costs, so that you and your staff can get the most from your investment in the EMR."

D. **Anticipate the stress and effort required over several months.** The adoption of technology is an iterative process, said Nelson. "The EMRs are full of features and functions that will bring efficiency to your operations, but it is impossible to take advantage of it all in the first two weeks of your go-live." She said typically, groups will be in the learning and adoption phase of their transition for several months. Sounds tedious? Nelson said that's because it can be. "Be prepared for the long haul," she added.

E. **Round on users (providers and clinical support staff).** Just as nurses and clinicians round on patients at the hospital, Nelson suggests rounding on everyone in the practice to gauge their EMR comfort level. "Thirty days after your go-live and again six months after your go live, visit each user for even a few minutes to observe and identify short-cuts," said Nelson. "Or, you can offer tips on how they can use the EMR more efficiently. Learning elbow-to-elbow is quick and non-threatening." An added bonus? Points for teamwork and collaboration, of course.

F. **Personalize and recognize the differences among physicians.** "Don't try to force all physicians to do the same thing," says Nelson. "Incorporating technology into all personal use is not one-size-fits-all." She continued by saying people approach even the simple technologies, like email and word processing, differently. "The EMR applications provide several ways to accomplish the same task, which adds to the training complexity, so be sure to offer providers the variety to choose what will fit their practice style the best."

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