An Ensocare White Paper

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5 Fundamental Tactics for Reducing Risk During Care Transitions

» Prevent Readmissions
» Improve the Patient Experience
» Protect Your Bottom Line

With risk migrating from payers to providers, hospitals and health systems are now accountable for patient outcomes following discharge. Because things like readmissions, increased length of stay, poor patient outcomes and dissatisfaction can negatively impact not only the patient experience but also the organization's bottom line, health-care leaders are seeking effective solutions for mitigating these threats.

Known as the "sandwich generation," boomers often face the challenges of caring for the needs of a parent and their own children. Increasing life expectancy means that 71 percent of boomers have at least one living parent, according to a Pew Research Center national survey of more than 3,000 adults. Of those surveyed, 63 percent reported having at least one adult child over the age of 18, with almost two-thirds of those surveyed saying they support the adult child financially.

Although technology and automated solutions can streamline and facilitate patient care across the continuum, there are no "quick fixes" to address these complicated issues, forcing organizations to look deeper into their workflow to make necessary improvements.

By strategically deploying the following five tactics, hospitals and health systems can take actionable steps to reduce care transition risks while improving the patient experience as well as the organization's financial health.

1 Initiate Discharge Planning Earlier

Most hospitals generally empower their discharge planners to begin the discharge process following physicians' orders, which typically occur within hours of a patient's anticipated departure. This often does not allow enough time for discharge planners to effectively plot a patient's next steps for care, potentially leading to poor transitions or suboptimal post-acute placement.

On the other hand, by using the patient's diagnosis (DRG) and associated geometric mean length of stay (GMLOS), clinicians and staff can project a probable discharge schedule, the patient's likely discharge disposition and recovery course, as well as probable outcomes, and begin preparing for the patient's transition soon after admission. Hospitals can then engage discharge planners earlier, allowing ample time to discuss the care transition plan and post-acute options (if needed) with the patient, his or her family, nursing staff and physicians.

Involving discharge planners earlier no doubt will necessitate a fundamental change in workflow sequence; however, doing so will ensure the care team proactively collaborates with the patient and family to realize a smooth and efficient transition. If hospitals also equip discharge planners with innovative care coordination technology, they can further optimize their human resources to yield the best outcomes.

2 Leverage Robust Teaching and Assessment Methods

Prior to discharge, health-care organizations should be educating patients and families about the patient's condition and best

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practices for recovery or health maintenance, including critical information about the patient's follow-up care, medications, self-care and so on.

To be effective, patient education should involve more than just ticking boxes. In fact, hospitals should reach out to patients and families early, educating them through best teaching practices such as the teach-back method, which includes an assessment component for evaluating a patient's understanding and retention of his or her condition and associated risks.

Likewise, hospitals should enlist different teaching approaches tailored to individual learning styles. For instance, to teach patients how to change a wound dressing, the discharging clinician may want to show pictures and verbally discuss each of the steps to help visual and auditory learners understand the information. Staff may also want to demonstrate the steps for tactile learners, making sure there's enough time to answer questions and re-teach if necessary.

Regardless of the methods used, patient education should be an important part of the organization's broader vision of improving patient care and clinical outcomes. By engaging patients and families early and often, staff can be sure patients are prepared for discharge when it's time to make the transition.

3 Ensure Optimal Placement by Matching Patients' Needs

Today, when patients require post-acute care following discharge, they and their families are frequently asked to choose a facility from a provided list of options. Typically, this list is not tailored to a patient's social or clinical needs, so if the patient requires special treatment or therapy, it may be the family's responsibility to inquire about available services with each provider. This method can be burdensome for the family and possibly result in the patient being placed in a less-than-ideal setting.

An effective discharge process should align patients' clinical and social needs with appropriate providers upfront to ensure optimal placement and support continuity of care. Not only can this promote better patient outcomes and reduce readmissions, it can also increase discharge efficiency, which can reduce length of stay.

Although some organizations choose to hire additional staff to manually coordinate discharge, by leveraging technology to predetermine appropriate locations and facilitate communication with only viable options, hospitals can efficiently align patient needs with post-acute facilities while optimizing their human resources.

4 Enable Smooth Transition of Clinical Data

Sharing health information between settings is challenging, particularly for organizations using paper-based records. Nonetheless, it is important for post-acute facilities to know patients' needs prior to their arrival in order to effectively plan, write orders, fill prescriptions, or begin scheduling treatments or therapies. If a post-acute facility does not receive relevant clinical information before a patient arrives on site, gaps in care may arise.

Using enabling discharge and care coordination technology, relevant patient information can be extracted from the hospital's electronic health record (EHR) and shared with a receiving facility as soon as the organization agrees to take the patient. This technology can either directly populate the receiving organization's EHR—the ideal scenario—or be sent via electronic fax prior to the patient's arrival.

5 Continuously Assess and Stratify Risk

A patient's risk for poor health outcomes and hospital readmission depends on a variety of factors—the patient's condition, prognosis, treatment plan and compliance, for example. Not only does risk vary between patients, but it can fluctuate for the same patient throughout a hospital stay and beyond. For instance, when patients meet critical milestones in the post-acute setting, their risk may actually diminish. Conversely, factors such as declining biometric levels, missing key appointments or not filling prescriptions can all elevate risk.

Because risk is not static, hospitals should employ a robust stratification methodology to calculate patient risk throughout the care continuum—from admission through post-acute care. Organizations that do not have such a methodology may miss opportunities to mitigate risks which can lead to readmissions and poor patient outcomes.

A responsive stratification methodology should include triggers for nurses and other clinicians to intervene as various risk factors surface. For instance, at discharge, a seasoned nurse may intuitively know the patient's risk is

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elevated based on historical noncompliance, lack of family support and multiple comorbidities. An effective methodology would enable workflow to change and alert appropriate clinicians to enlist additional interventions, such as home health-care services or tele-monitoring.

Although risk stratification can be performed manually, technology streamlines the process, allowing staff to intervene in situations when clinical judgment and personal contact yield the highest benefit.

The Payoff

Though these tactics provide a clear path forward, implementing them will not be easy, as they require significant commitment; hospitals will need to revisit their processes, workflow and culture to effect fundamental change.

Yet, when organizations embrace these strategies, they can begin yielding benefits such as improved patient outcomes, reduced readmissions and overall improvements in the patient experience. The payoff stands to be significant and makes the effort worthwhile.

About Ensocare

Ensocare provides care coordination solutions to help manage patient care transitions, reduce length of stay and reduce readmissions. Unique technology and a proactive service model enable Ensocare's no-cost, all-inclusive post-acute provider network. Our software integrates with existing EHR platforms to encourage patient compliance, build operational efficiencies and improve patient satisfaction.

Learn more at www.ensocare.com