ENSOcare®
— Care Coordination Solutions —

DISCHARGE PLANNING IS THE KEY to REDUCING Costly Readmissions & MEDICARE PENALTIES

Cerner Post Acute Referrals®, powered by Ensocare content, is an add-on feature available within Cerner Acute Case Management®. The solution automates the referral process to help case workers and discharge planners facilitate communication before, during and after discharge

Visit www.ensocare.com/cerner

By employing best practices during discharge and other care transitions, you can reduce the risk of readmission penalties, shorten length of stay, enjoy improved efficiencies and support robust patient care.

DID YOU KNOW ?

20%

of hospitalizations are followed by readmission within 30 days.

Plus

90%

of readmissions are unplanned.

Studies of Rehospitalizations: Reducing Avoidable Hospital Readmissions. Agency for Healthcare Research and Quality, Rockville, MD.

BY THE NUMBERS

75%

or 4.4 million, of Medicare readmissions may be preventable.

These readmissions hurt the bottom line – to the tune of

$17 billion

per year in Medicare spending.

Report to Congress: Promoting Greater Efficiency in Medicare. MedPac (Medical Payment Advisory Commission), Washington D.C.

It's easy to point a finger at one group within the hospital for readmissions.

However, it's often **process and communication failures** throughout the **entire** health-care system

that lead to avoidable readmissions and the costly penalties associated with them.

FILL IN THE BLANK

NEARLY ___%

of medical errors involve miscommunications during patient transfers and handoffs.

- **A** 50%
- **C** 70%
- **B** 60%
- **D** 80%

ANSWER:

D 80%

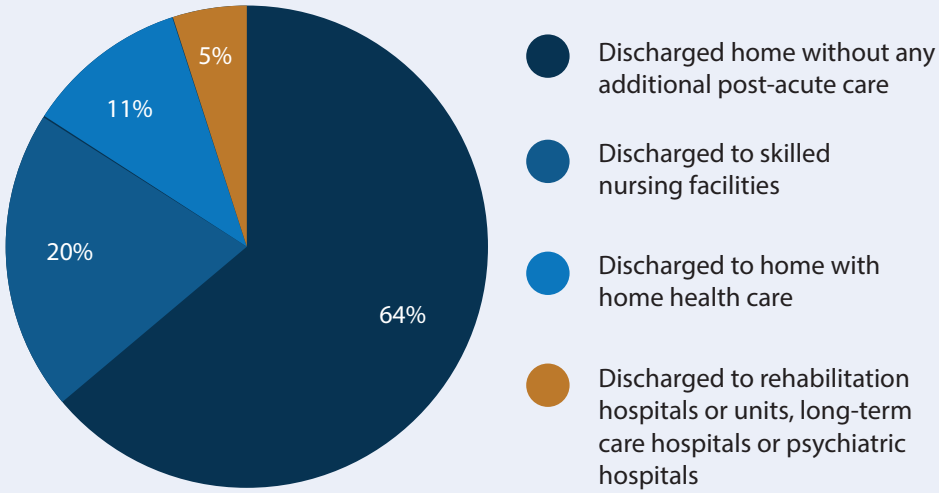
This illustrates the **crucial need for effective, accurate and timely information at discharge** to prevent wasteful spending and improve patient care.

Project Detail: Hand-off Communications. August 2009. Joint Commission Center for Transforming Healthcare, Naperville, IL.

A HOSPITAL'S EVOLVING RESPONSIBILITY

It used to be that hospitals were not held accountable for patients after discharge. However, that has changed as a result of the **Hospital Readmissions Reduction Program** and related regulations that started penalizing hospitals for preventable readmissions.

Rate of Hospital Readmissions for Medicare Beneficiaries and Discharge Destination



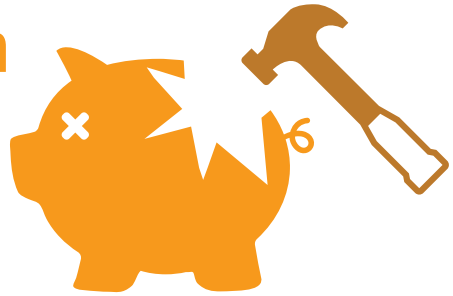
Project Detail: Hand-off Communications. August 2009. Joint Commission Center for Transforming Healthcare, Naperville, IL.

For FY2016, **more than 2,500 hospitals** will be penalized

$420 million

in Medicare fines through HRRP due to excess readmissions.

The average Medicare payment reduction is 0.61 percent per patient stay—**a major hit to the bottom line.**



Kaiser Health News analysis of data from Centers for Medicare and Medicaid Services, Aug. 2015.

Regulations outlined by CMS' Meaningful Use incentives have u**nderscored the need for hospitals to improve post-discharge communication**.

These incentives require hospitals to engage the patient and deliver a Transition of Care summary when the hospital hands the patient off to another provider or care setting—demanding more resources of an already strained system.

As CMS continues to intensify its initiatives, **hospitals must actively seek ways to improve communication between and across settings** to avoid steep financial penalties associated with preventable readmissions.

Eligible Hospital and Critical Access Hospital Meaningful Use Menu Set Measures. April 2013. Centers for Medicare and Medicaid Services, Baltimore, MD.

By employing the following 3 key strategies during care transitions, hospitals can **comply with new care model requirements and avoid increasing readmission penalties**—ultimately protecting your organization's financial health.

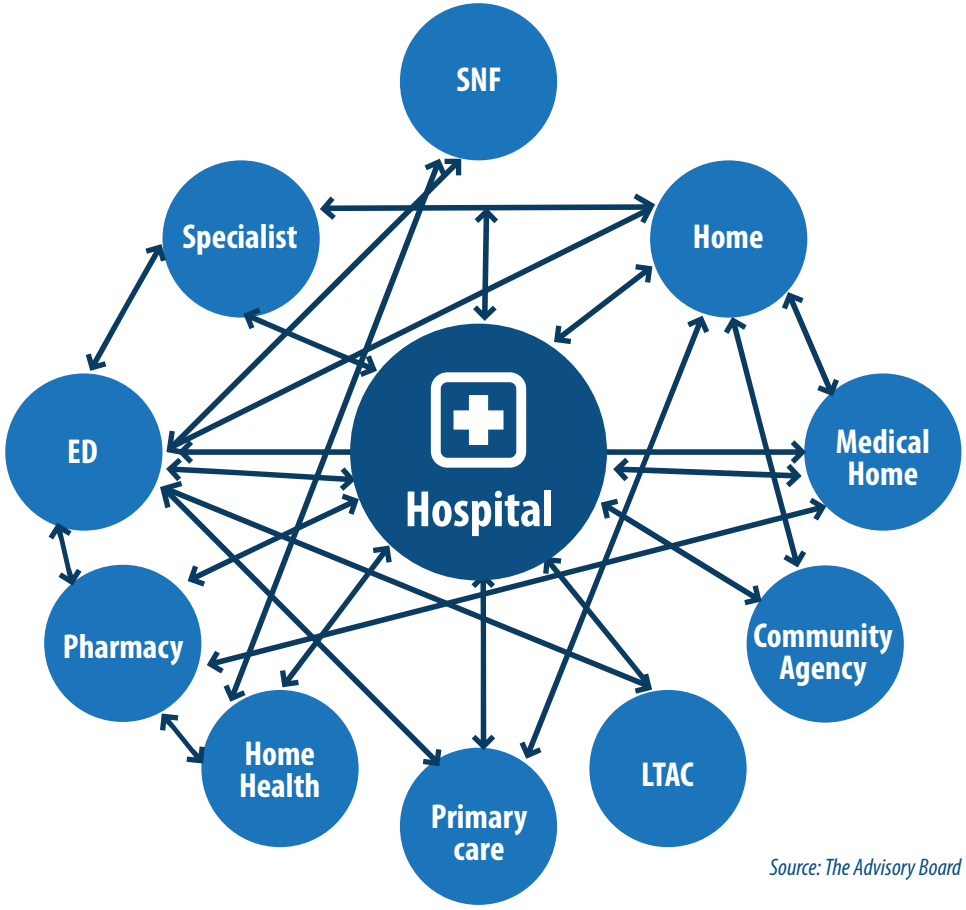
NUMBER 1

COMMUNICATE MORE

than just clinical information

A key element in limiting readmissions is how well a hospital transitions a patient from acute to post-acute care, whether to the patient's home, a rehabilitation or skilled nursing facility or another setting.

Strong, interactive communication is therefore essential.



Source: The Advisory Board

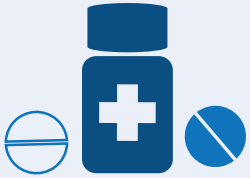
Electronic health records (EHRs) and health information exchanges (HIEs) **have improved communication efficiency across different settings**; however, these tools focus on sharing clinical information—diagnosis, treatment plans, medication lists and so on.

While necessary, **clinical information alone may not be sufficient** for a patient, family and post-acute provider to fully appreciate how to keep the patient on track.

Families and providers need to understand more than just the medical aspects of the patient's health to grasp the processes necessary to ensure the patient receives the care he or she needs.

Through an EHR, a post-acute provider might know a patient's:

Medical History



Current Medications

When the hospital has scheduled a follow-up appointment

However, what the provider may not know is that the particular patient:

Has a history of medication noncompliance

Tends to skip follow-up appointment

Doesn't have transportation to get to the pharmacy or doctor's office

Without communicating these important processes and recommending interventions, t**he hospital puts the patient at substantially higher risk** for experiencing a **preventable readmission**.

KEY TAKEAWAY

Finding ways to **share information about care process needs**, as well as **clinical data**,

is key to **supporting care transitions** that set the stage for **optimal patient care and reduced length of stay**.

NUMBER 2

EXPAND YOUR REACH

to non-medical providers

To effectively facilitate care transitions, hospitals may need to **reach beyond traditional medical providers** to make sure patients and post-acute care organizations have **all the resources they need to complete care plans**.

A home-bound patient without family support may need transportation to get to appointments or pick up prescriptions.

Patients with diabetes or congestive heart failure may have specific nutritional needs that they cannot meet on their own, necessitating in-home, non-medical assistance with meal preparation or grocery shopping provided by an organization like Home Instead Senior Care.

KEY TAKEAWAY

Reaching out to non-medical providers to supply transportation, deliveries, cleaning and other services **is an effective way to fill care gaps**.

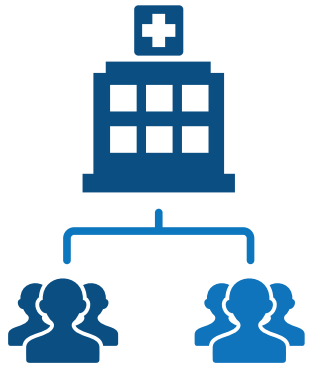
Whether using manual methods of outreach or automated technology solutions, **hospitals can coordinate essential non-medical resources and services** to ensure **patients are able to effectively follow their care plans**.

NUMBER 3

LEVERAGE TECHNOLOGY

to manage large patient populations and maximize staffing resources.

To manage the discharge process for a large patient population, **hospitals typically stratify patients by risk, including their risk for readmission.**



Many EHRs stratify risk based on conditions at the time of admission; however, this approach assumes care provided while in the hospital or following discharge has no effect on a patient's readmission risk.

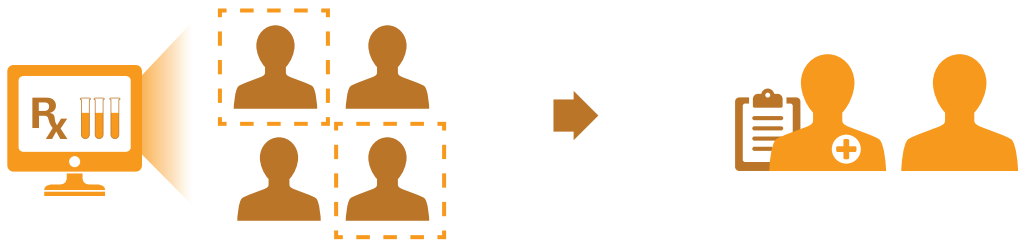
Instead, **hospitals should employ technology that provides a holistic view of the patient** and recalculates readmission risk at the point of discharge and at different stages throughout the patient's recovery.

A patient who misses a follow-up appointment 72 hours after discharge should be **at higher risk for readmission** than a patient with a similar diagnosis who attends the appointment and receives care from the physician.

By identifying patients whose risk for readmission is increasing during post-acute care, **providers are able to intervene appropriately** and manage a **larger population of patients**.

Likewise, if **patients are following their care plans**, their risk may decrease and therefore **require less staff intervention from the provider**.

Targeting High-Risk Patients



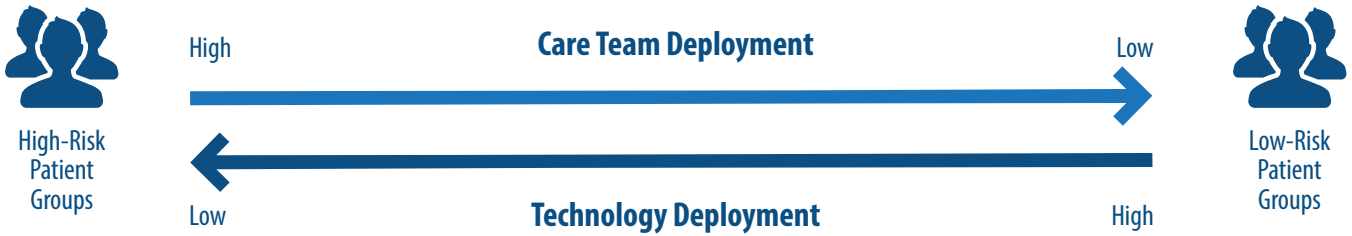
Predictive tool analyzes data, risk stratifies patient

Case manager works with high-risk patient, develops care plan to prevent risk escalation

Source: The Advisory Board

KEY TAKEAWAY

Through risk stratification, hospitals can direct highly technical, low-touch interventions to low-risk patients, while aiming low-tech but high-touch staff resources at higher-risk patients.



Source: The Advisory Board

IN THE REAL WORLD

A 25-year-old woman who is discharged from the hospital, expected to make a full recovery and goes home to a supportive family will be identified by the hospital as a low risk for readmission. By leveraging an automated discharge process or using technology solutions such as texting or direct messaging, the hospital can effectively engage the patient without consuming staff resources.

A 90-year-old high-risk patient with little family involvement who is being transferred to a skilled nursing facility is less likely to engage in high-tech, low-touch solutions. The best way to reach this patient is through a care provider, family member, phone call or personal visit—all of which require staff intervention.

SO THERE YOU HAVE IT

With staffing shortages and an influx of medically complex patients, there often **aren't enough care coordinators or discharge planners** to efficiently manage care transitions, **leaving some patient populations vulnerable to preventable readmissions and other negative outcomes**.

By employing technology solutions that maximize resources and streamline communication during care transitions, **hospitals can ensure vital care needs follow patients throughout their care journey**. This not only enables better continuity of care and patient outcomes, but **reduces the risk of avoidable readmissions and associated penalties**.

GET MORE NUGGETS

Like the information you see here? Get more nuggets of gold from Ensocare's:

Blog

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ENSOcare®

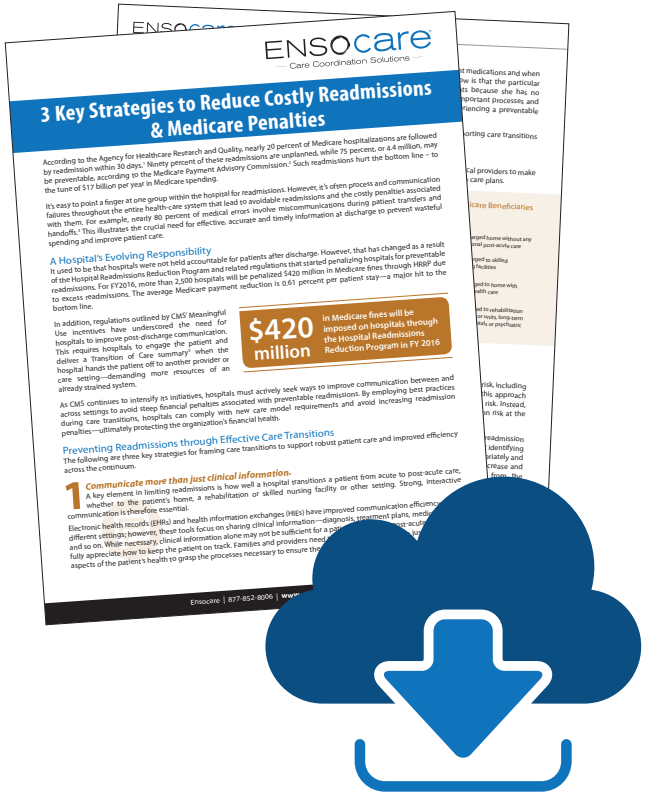
Care Coordination Solutions

Automated discharge by Ensocare, embedded right inside Cerner Post Acute Referrals®, allows your staff to **work more efficiently so you can spend more time with patients**

- Discharge case management
- Workflow **fully-embedded** into Cerner Acute Case Management®
- **100+** successful Cerner/ Ensocare implementations to date
- **24/7 live customer support** drives provider engagement and **median response time of less than 30 minutes**
- No-cost national post-acute network
- **Post-acute** clinical documentation sharing
- Direct and efficient **electronic notifications**

DOWNLOAD THIS E-BOOK

as a condensed, printable PDF.



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