PointClickCare®

How to Drive Consistent Care Delivery

Your guide to predicting and managing outcomes while reducing resident risks

Introduction

Once your resident has been admitted, their initial orders and assessments have been completed, and baselines are measured and documented appropriately, your focus is on getting them well enough to achieve their discharge goals.

In this eBook you will learn how to:

- Drive better outcomes with standardized evidence-based assessments
- Monitor real-time changes in condition to intervene quickly
- Reduce your risk of adverse drug-events with a streamlined medication management system
- Ensure you're getting paid for the care you deliver

Money Matters

Getting paid for the care you provide

Before getting into the ins and outs of managing care and services let's talk about managing bills and reimbursement.

In Skilled Nursing Facilities (SNFs), reimbursement is tied to the MDS. With PDPM on the horizon, as well as another set of MDS rules, schedules, and set of questions for PPS, understanding the connection to payer and reimbursement is integral to getting paid. With PDPM, managing which payer will be reimbursing each part of the stay becomes incredibly important.

Medicare Advantage payers may have different assessment requirements than Medicare A and Medicaid, and private insurance will have different requirements on top of that. Completing the wrong assessment will result in payment denials or default rates. Some of these payers have limits on the number of days they can cover, and understanding which payer takes effect and when will change the information that needs to be submitted for payment. Further, the payer at the beginning of the stay may change during the stay so getting it right matters in order to get paid and reduce your DSO.

Determining payer eligibility isn't just an admission process. It needs to be done periodically throughout the stay so that the resident and family, along with nursing and the billing office, are always in sync. This will drive the right timing and MDS assessments to be completed.

The right assessment for the right payer is the only way to ensure reimbursement is timely and done according to the regulations or requirements of the payment source. This is also important to the resident. Co-pays may change with payer and if alternate payment sources are exhausted, the resident and family need to know so they can proactively arrange payment to the home.

Eligibility Verification allows you to instantly retrieve resident insurance data including eligibility, benefits, and co-pays prior to a resident's admission and throughout their stay.

Removing the worry of finances allows your resident to focus on getting better, and allows you to focus on their care.

Focus on Your Resident's Wellness

Ensuring that money matters are taken care of allows you to direct your full attention to the wellness of the patient and ensuring their goals and wishes are achieved.

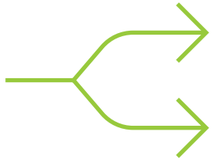
Establishing resident goals is important in understanding what the focus of their stay will be.

Do they want to go home? If so, will home care be available?

Or do they have another discharge goal — an assisted living or a different nursing home for example?

Knowing where they will go next determines the level of wellness and capabilities the individual must be able to achieve in order to be successful in that setting. And it will also allow you to plan for their care and outcomes. Your EHR needs to make documentation easier. Documenting the services, treatment, and care the individual receives and noting changes, no matter how big or small, are the key to success for residents achieving the right outcomes. Your technology needs to be as agile as your nurses are.

Enable your team to accurately and completely capture critical resident data in real-time, at or near the point of resident care with Point of Care. Better data will drive your reimbursements and ensure that you are getting paid on time.



The Value of Standardized Assessments

Driving Evidence-based Approaches to Care that Achieve Resident Goals

The assessment process drives changes to care planning to ensure that the right outcomes are achieved.

The MDS alone is not enough to ensure comprehensive capture of all conditions and diagnoses that need to be addressed during the resident's stay.

The MDS looks at how the resident functioned over a period of time in order to determine what services should be reimbursed, but it is limited. Collection of data up to the completion of that assessment can take several weeks before the care plan is updated with findings. This prevents you from offering your residents a proactive approach to their care.

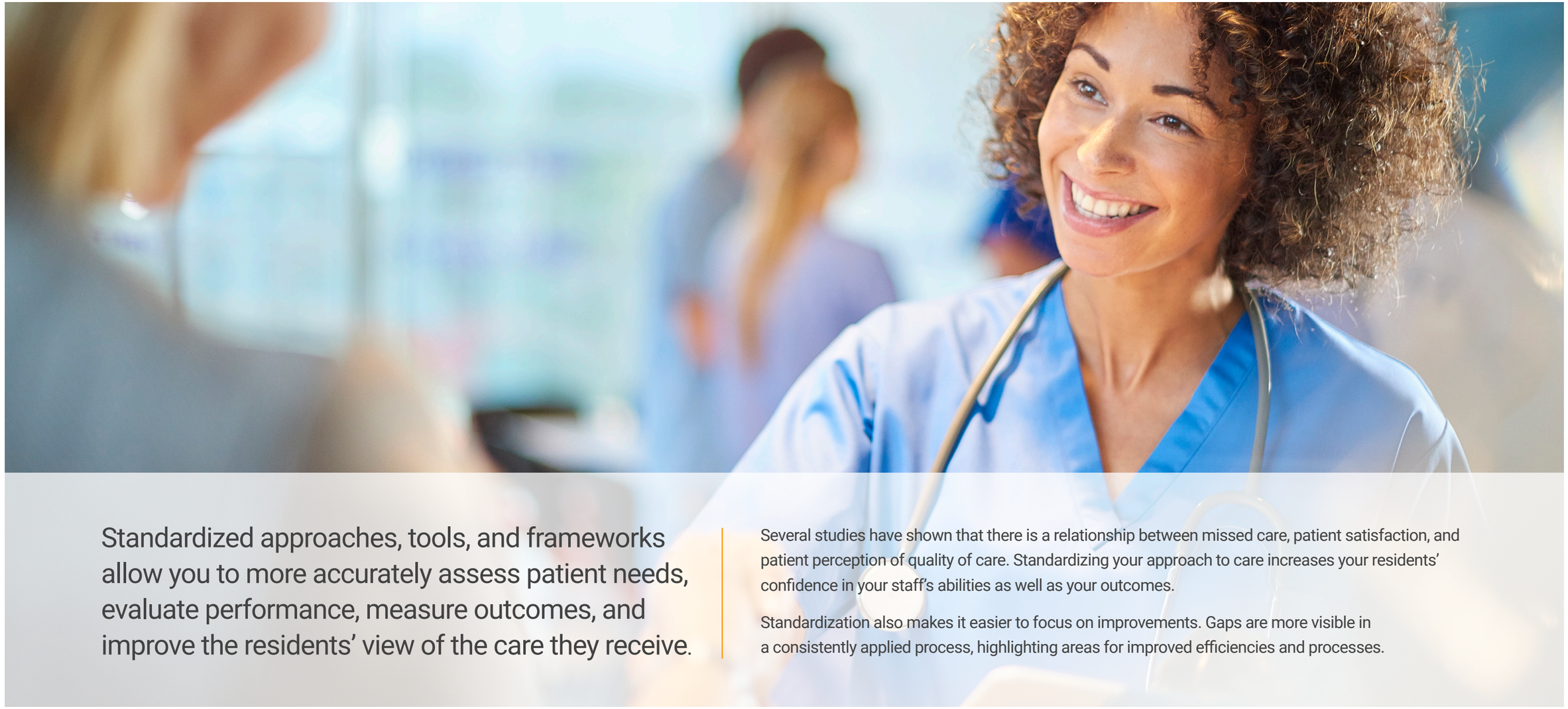
Standardized ongoing assessment of the resident based on their clinical conditions is essential. The cadence and content of assessments should change with diagnoses and the discovery of new or acute signs and symptoms. Assessments need to be smarter, more comprehensive and guide staff through a process that helps your residents to reach their wellness goals.

Standardized Care Content for Better Outcomes

Evidence and standards-based clinical content drives care and services based on research and tested practices. Nursing is both an art and a science, but with the rate that scientific research is affecting care provision, it is becoming more and more difficult to stay current and maintain best practices. This is where technology can support efforts. Let the technology take care of the science, so your nurses can practice their art.

Standardization doesn't mean that you aren't able to personalize the content — it just means that the same approaches are triggered for the same symptoms and conditions.

Care Content by COMS allows you to leverage standardized, evidence-based care assessments that ensure all of your staff are using the same enhanced assessments. This improves your organization's care delivery while reducing the risk of readmissions.



Standardized approaches, tools, and frameworks allow you to more accurately assess patient needs, evaluate performance, measure outcomes, and improve the residents' view of the care they receive.

Several studies have shown that there is a relationship between missed care, patient satisfaction, and patient perception of quality of care. Standardizing your approach to care increases your residents' confidence in your staff's abilities as well as your outcomes.

Standardization also makes it easier to focus on improvements. Gaps are more visible in a consistently applied process, highlighting areas for improved efficiencies and processes.

Tools for Ongoing Observation and Monitoring

When the Nurse Can't be There

Just as important as a standardized cadence of assessments and approaches to care is knowing when to do an off-cycle assessment because something has changed.

The nurse can't be everywhere at once so she/he has to rely on the eyes and ears of the CNAs to say when additional follow-up with the resident is necessary.

Ongoing observation and monitoring is crucial to achieving optimal resident outcomes. CNAs at the bedside know the resident best and can see and report when there are changes in condition. Best practice systems integrate data collection, observation and alerting tools for CNAs at the point of care with the assessment and monitoring tools the nurses use. Changes in activities of daily living tell us whether the residents' ability to care for themself is progressing toward their stated goals and that information sits with the CNA — the person who sees the resident the most during their stay.

Integrated Ability to Flag and Notify any Changes in Condition

CNAs are the primary vehicle for resident information and changes in condition being relayed to the nurse. CNAs are instrumental in picking up small changes from usual function. If the nurse can be alerted when changes occur, then assessment and changes to approaches can be quickly adapted to mitigate poor outcomes. Even the smallest change in condition can be an indicator of a larger problem. The ability to alert the nurse to problems in real time means that she/he can act in real time.

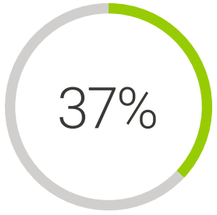
Tools that simplify the communication process and push alerts directly to the nurse mean that actions and responses are accelerated, and interventions are altered to get the resident back on track.

Similar tools should be alerting staff to when care should be provided, assessments are due, care plans need to be reviewed, and if there are any medication order risks such as allergies, drug-to-drug interactions, and dose allowances.

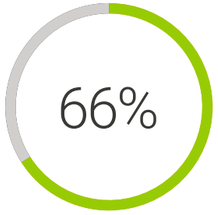
eINTERACT empowers your care team to identify and document potential changes in their resident's condition, enabling them to be proactive and prevent unnecessary readmission to hospital. If a transfer is necessary, eINTERACT allows your care team to relay all critical resident information to the hospital in order to ensure a smooth transition of care.

Medication Management Should Never be a Bitter Pill to Swallow

Almost every resident in a SNF receives medication as part of their care. SNFs are required to provide more complex care, as they are seeing more patients with post-cancer treatment, organ transplants, and complex medical conditions being treated with more complicated medications such as biologicals and customized treatments. On top of that, residents may be frail, have difficulty swallowing, or display behaviors which make medication administration even more complicated. Moreover keeping on top of multiple administration times, refused doses and special needs is no small feat.



adverse events related to medication management



preventable adverse events related to medication errors

The office of the Inspector General identified that 37% of adverse events in SNFs were related to medication management and 66% of the preventable adverse events were related to medication errors. Minimize the risk of adverse drug events by having instant access to med pass statuses, automated medication reconciliation with the pharmacy, and a reduced risk of transcription errors. By electronically integrating with the pharmacy, manual, error-prone communication is significantly reduced.

With IMM, you can demonstrate to your partner network how regulatory quality standards are achieved by having access to accurate, complete, and timely medication information for all residents.

By virtue of entering medications in the EHR, nurses are no longer struggling to read what their co-worker or the doctor wrote. eMARs also present medications in the order they should be administered, display alerts and black box warnings, and prompt for the appropriate assessments to be conducted — again promoting resident safety and preventing adverse events. Medication Management takes a lot of the worry out of passing meds.

By organizing passes, providing the equipment and documentation required, and allowing the rescheduling of meds that have been refused, nurses are more efficient with their passes and are prevented from forgetting something along the way. No more missed medications means reduced auditing time and less worry for home management. Residents and families are also reassured knowing that the full treatment plan is being followed. Medications are integral to preventing readmissions to hospital as part of a treatment plan but when handled poorly medication errors often lead to rehospitalizations and patient injury.

Conclusion

We all have the same goal for care — to provide the best experience possible for each resident from admission to discharge. Not only does this help the resident, but it will benefit your facility as well. Hospitals partner with facilities that have fewer readmissions and can manage transfers smoothly. Ensuring the best quality of care means incorporating standardized care protocols to create a level of consistency in care delivery that enables you to easily predict outcomes and mitigate the risk of unplanned rehospitalization. With the right technology in place, care oversight and care process management tools identify those residents at risk so that intervention can occur as soon as possible to reduce the risk of transfer.

LEARN MORE

[i] https://onlinelibrary.wiley.com/doi/full/10.1111/jocn.14058

[ii] https://onlinelibrary.wiley.com/doi/full/10.1111/jocn.14058

[iii] https://www.beckershospitalreview.com/pharmacy/drug-costs-put-squeeze-on-skilled-nursing-facilities.html

[iv] https://www.beckershospitalreview.com/quality/8-statistics-on-adverse-events-at-skilled-nursing-homes.html

---

References

1. 4 ways your admission process is failing your residents and staff. Darren Mathis. McKnights, October 25, 2017.
2. Cognitive Status of Older Adults on Admission to a Skilled Nursing Facility According to Discharge Diagnosis of Dementia: J Am Med Dir Assoc. 2017 Aug 1;18(8):726-728. doi: 10.1016/j.jamda.2017.04.021. Epub 2017 Jun 13.
3. Mortality risk doubles for SNF residents readmitted to hospital; McKnights, January 18, 2016
4. Close, specific hospital-SNF partnerships drive down readmission rates, researchers find; McKnights, October 30, 2013
5. Skilled Nursing Data Report: Key Occupancy and Trend Reports, National Investment Center for Seniors Housing & Care (NIC). March 2018

PointClickCare®