Partnering with the right LTPAC provider

Acute care providers are encouraged to partner with LTPAC providers who have proven hospital readmission prevention strategies. To help your organization engage local LTPAC providers, here's a list of important steps that will get your organization on the right path toward a strong and lasting partnership.

1 Open the lines of communication

Connect and set up a meeting with local LTPAC providers to share and learn the processes each of you employ to improve quality of care and reduce hospital readmissions.

In addition, learn about the capabilities and services the LTPAC provider is offering that match patients with organizations who provide proper post-discharge care. Doing so can provide the opportunity to educate discharge planners that the end goal is no longer about finding an empty bed, but rather about placing a patient in a setting that delivers the quality of care needed for a healthier recovery and reduced possibility of rehospitalization.

2

Establish a process for measuring readmission rates

Establish a methodology to measure readmission rates per LTPAC organization, whether planned or unplanned and related or unrelated to the original reason for admission. The underlying goal is to identify LTPAC facility readmission rates, along with understanding the associated timing and nature of these readmissions.

Communicating this information back to the LTPAC organizations can provide valuable insight that can open a dialogue to help bridge communication gaps and improve outcomes for both organizations.

3

Choose a nationally accepted quality improvement program

Work with LTPAC providers who have a nationally accepted program in place to monitor, manage and prevent rehospitalizations. The most popular and successful is eINTERACT®and INTERACT®.

Developed by Florida Atlantic University, INTERACT is a quality improvement program designed to improve the early identification, assessment, documentation and communication about changes in the status of patient's condition. The goal is to improve care and reduce the frequency of transfers to the acute hospital by preventing conditions from becoming severe enough to require hospitalization.

As a quality improvement program endorsed by CMS' Nursing Home Quality Assurance and Performance Improvement program, LTPAC providers are incorporating eINTERACT's and INTERACT's clinical tools into their facilities to improve resident quality of care while reducing potentially avoidable transfers to acute hospitals.

4

Post-Discharge Plan of Care/Post-Partnering

Communication with the LTPAC provider shouldn't end with the patient discharge. Plan follow-up meetings (live or by phone) to enhance collaboration and communication about your acute care transfers.

As partners, you should be managing readmission data and programs to identify and solve your ongoing care challenges. On top of this, try establishing a monthly check-in meeting with key operation stakeholders from both organizations (discharge planner, hospital administrator, DON, etc) to share what is working well for the partnership and where improvements are needed.