Enhanced Leadership Development Academy
2013 Quality Improvement Project

The Bluffs
Admission–Discharge Journey
Resident and Referral Centered Approach

THE BLUFFS

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Objectives

- **The Bluffs**

- **The "Journey"**
  - **Root Cause Analysis**

- **Quantifying Results**

- **Discussion**

The Bluffs
3105 Bluff Creek Drive
Columbia, Missouri

- 132 bed skilled nursing facility
  - Not for profit, stand alone building
  - All beds Medicare/Medicaid certified

- Five "Neighborhoods"
  - Oak: Sub–acute rehab unit (24)
  - Cherry: Long term care (34)
  - Walnut: Long term care (34)
  - Elm: Long term care (24)
  - Maple: Memory care unit (16)

The Admission–Discharge Journey

Who has seen this question on board exams....
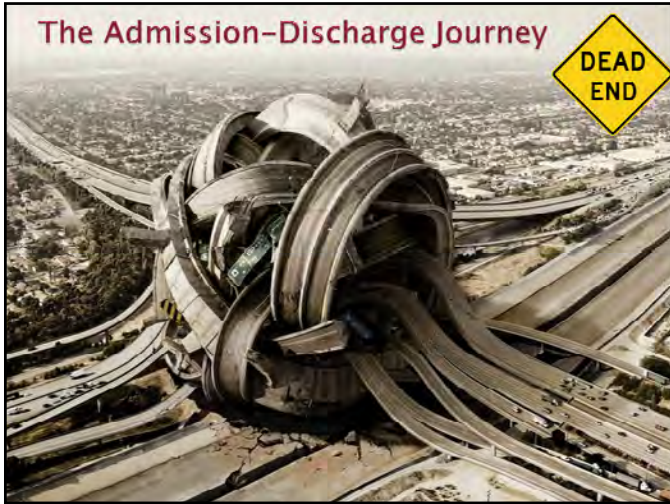
"When does discharge begin?"

ADMIT ONE
0560418

...On Admission

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The Admission-Discharge Journey

DEAD END

The Admission-Discharge Journey

- Efficient customer journeys are a basic requirement for our success.

- We Mapped out the admission-discharge journey and used it as a tool to investigate, analyze and improve our customer experiences.

- We understand that there are few things more powerful for building loyalty than creating distinct, positive customer experiences that reflect a facility's promise.

The Admission-Discharge Journey

The Bluffs did not have a clear plan...

How do we:

- Understand the journey's customers make?
  - Root Cause Analysis

- Systematically improve process and performance?
  - Root Cause Solutions

- Quantify the realistic benefit from improving journeys?
  - Key performance indicator dashboard
  - Customer feedback

The Bluff's Road To Success

D. R. I. V. E.

The Admission–Discharge Journey

Differentiate

Relate

Innovate

Valuate

Evaluate

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Root Cause Analysis

Issue: Social Services/Admissions Team

Description	Source	Criticality	
		Level (High/Med/Low)	Rationale
The Bluffs Social Services/Admission team not performing at a high level	Low census for 1st and 2nd quarter 2012. Family and resident satisfaction low	High	Budget numbers not being met. Down staffing employees due to low census.

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Root Cause Analysis

Likely Root Cause: Staff–Centered

Description	Likelihood	Information
	(High/Med/Low)	Tests To Clarify
Social Services/Admission team became staff centered and not engaged in proactive census development	High	Low census numbers for 1st and 2nd quarter 2012 Referral source stereotyped our admissions and overall not recommending our facility to potential residents

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Root Cause Analysis

Possible Solutions: Differentiate

Description	Risks			Measure of Success	
	Description	Likelihood	Mitigation	Test	Results
Redesign Social Services/Admissions team and focus on census development. New name: Family and Social Support Team	Team does not embrace change and redesigned processes	Med	Corrective action plan and re–evaluate after 30 days	Increase daily census	Key indicator dashboard
Differentiate between long term care and sub acute rehab short stay residents and assign to social workers	Confusion from residents, family and staff on new roles	Med	Continuous communication from Family and Social Support team on roles	Resident and family satisfac–tion	Data from post discharge surveys

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Possible Solutions: Differentiate

Director of Family & Social Support

Drill Down…

- Single Point of Contact for all admissions.

- Provide support and advisement for social workers.

- Clinical Liaison: Supporting residents and families in the hospital with answering questions regarding The Bluffs and potential admission.

Possible Solutions: Differentiate

Elder & Family Care Coordinator

Drill Down…

- Social worker for long-term residents.

- Conduct mental health assessments.

- Conduct abuse/neglect investigations.

- Resolve roommate disputes.

- Work with families to answer questions and coordinate care.

- Long-term care plan meetings.

- Quality assurance interviews.

## Possible Solutions: Differentiate

Sub-Acute Care Coordinator

Drill Down…

- Social worker for short-stay residents.

- Conduct mental health assessments.

- Conduct abuse/neglect investigations.

- Resolve roommate disputes.

- Work with families to answer questions and coordinate care.

- Coordinate Med A discharge.

- Med A care plan meetings.

- Med A care coordination after discharge.

Family and Social Support Machine

Elder & Family Care Coordinator

Sub-Acute Care Coordinator

Director of Family & Social Support
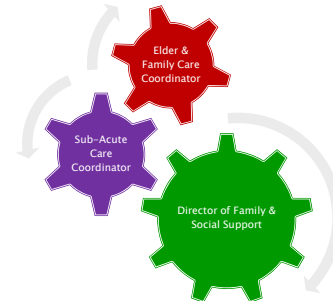
- Proactive approach with staff and customers to address issues with satisfaction or care before they become serious issues.

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Root Cause Analysis

Issue: Referral Communication			
Description	**Source**	**Criticality**	
		Level (High/Med/Low)	**Rationale**
Relationship with referral customers poor	Referral source admissions manager	High	Potentially missing quality referrals

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Root Cause Analysis

Likely Root Cause: Neglected Relationships		
Description	**Likelihood**	**Information**
	(High/Med/Low)	**Tests To Clarify**
Poor communication with referral customers. Not updating referral source on services offered or availability of beds	High	Meeting with referral customer management team and confirmed issues and concerns

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Root Cause Analysis

Possible Solutions: Relationship Repair					
Description	**Risks**			**Measure of Success**	
	Description	**Likelihood**	**Mitigation**	**Test**	**Results**
Setup a face-to-face meeting with referral customer management team and share what is new at The Bluffs. Communicate new processes and ask "how can we make your job easier?"	Management not interesting in meeting with The Bluffs	Low	Show the value to referral source management that we are working toward the same goal for overall customer satisfaction	Feedback from case managers and social workers	Dashboard key indicators and customer satisfaction data

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Possible Solutions: Relationship Repair

Drill Down…

- Face-to-face meeting with upper management and share what The Bluffs can provide for their patients during a transition in care and what new services we bring to the table.

- Medication management, innovative technology and flexible transportation services.

- Introduce the role and responsibilities of Clinical Liaison.

- Build a relationship of "trust" and "adaptability" with our customers and maintain a strong, long term, almost irreplaceable competitive edge.

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Possible Solutions: Relationship Repair

Innovative Technology

- **Omnicell®**
  On-site pharmacy

- **matrixcare**

- **vocera®**
  Voice-driven, hands-free communication.
  Text messages and alerts

- Smart Care Neighborhoods

smart care system

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Possible Solutions: Relationship Repair

Setting the Sub-Acute Market

- **Control4**
  Room automation

- **iPad 2**

- **tv**

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Possible Solutions: Relationship Repair

Transportation Services

- After hour admissions

- Saturday and Sunday admissions

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Root Cause Analysis

Issue: Referrals getting "lost"			
Description	**Source**	**Criticality**	
		Level (High/Med/Low)	**Rationale**
Referrals not accepted effectively and efficiently	Social Services and Admissions Team	High	Referrals going to other facilities and we will not be a preferred choice for referral customer and resident/family

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Root Cause Analysis

Likely Root Cause: Process Breakdown

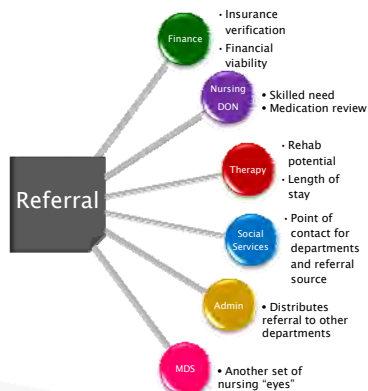| Description	Likelihood	Information
	(High/Med/Low)	Tests To Clarify
Facility-centered approach to approval of referrals. Process failing and leadership not willing to develop a better system	High	Referrals taking too long for approval. Referral source feedback that we take too long to get back to them. Low census data confirms that we are missing referral opportunities because of poor process

Root Cause Analysis

Possible Solutions: Innovate New Process

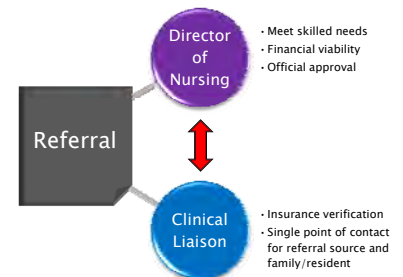| Description	Risks			Measure of Success	
	Description	Likelihood	Mitigation	Test	Results
Develop a new referral approval process.	Leadership team will not want to adapt to changes	Med	Get "buy-in" from leadership team and let them become part of the process improvement	Time elapsed from when referral is received to when approved and customer notified	Number of admission and feedback from customer

Possible Solutions: Innovate New Process

• Too many decision makers in the process.

• Referral taking up to 24 hours to get approved by all departments.

• Referrals getting "lost" in the journey to get approval.

- Finance — • Insurance verification • Financial viability
- Nursing DON — • Skilled need • Medication review
- Therapy — • Rehab potential • Length of stay
- Social Services — • Point of contact for departments and referral source
- Admin — • Distributes referral to other departments
- MDS — • Another set of nursing "eyes"

Possible Solutions: Innovate New Process

• Bundled roles and responsibilities from six to two departments.

• Referrals are now getting approved in 10 minutes.

• Clinical Liaison: Single point of contact for our referral customers.

- Director of Nursing — • Meet skilled needs • Financial viability • Official approval
- Clinical Liaison — • Insurance verification • Single point of contact for referral source and family/resident

Root Cause Analysis

Issue: Sub-Acute Case Management			
Description	**Source**	**Criticality**	
		Level (High/Med/Low)	**Rationale**
Med A care coordination and overall experience not fluid and managed effectively	Resident feedback via customer satisfaction surveys	High	Potential increase re-hospitalizations and overall poor customer satisfaction that will reduce residents requesting our services again

Root Cause Analysis

Likely Root Cause: Poor Care Coordination		
Description	**Likelihood**	**Information**
	(High/Med/Low)	**Tests To Clarify**
Break down between social services and resident/family and no post discharge care coordination plan implemented	High	Interviews with social service staff as well as residents and family members

Root Cause Analysis

Possible Solutions: Value-Based Care					
Description	**Risks**			**Measure of Success**	
	Description	**Likelihood**	**Mitigation**	**Test**	**Results**
Develop a commitment to clinical excellence via care coordination and transition care strategies	Resident and staff not engaged in new strategies. Change is always difficult	Low	Communication to the resident that we value their input to our program is important to the overall customer satisfaction and prevents possible Re-hospitilization	Feedback from discharge planner and "life line" feedback	3-day survey results as well as comments from the 30 and 60 day calls and key indicator dashboard data

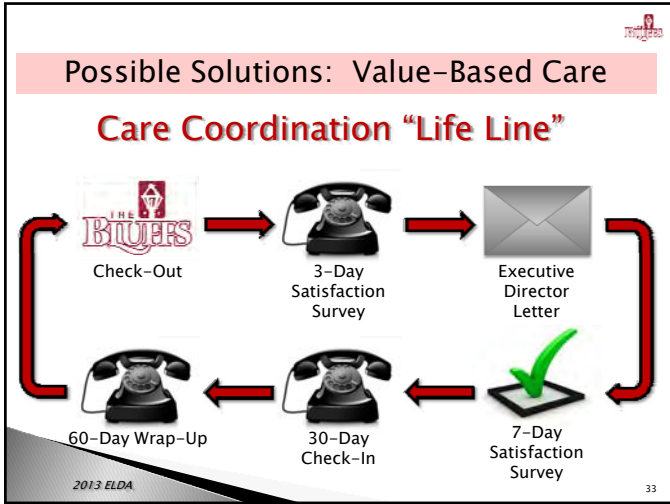## Possible Solutions: Value-Based Care

Creating Value: Resident Care Coordination

- Maintain a **"life line"** of communication after discharge.

  - 3-day telephone call after discharge to answer resident's questions, reinforce specific health information and confirm follow-care appointments. Ask 10-question survey on overall customer satisfaction during stay.

  - Executive Director letter to thank them for choosing The Bluffs and follow up on areas of concern as well as what went well during their stay.

  - Customer satisfaction survey mailed. (7-days after check out)

  - 30-day telephone follow-up call to "check in".

  - 60-day telephone follow-up call.

Possible Solutions: Value-Based Care

Care Coordination "Life Line"

Check-Out → 3-Day Satisfaction Survey → Executive Director Letter

60-Day Wrap-Up ← 30-Day Check-In ← 7-Day Satisfaction Survey

Possible Solutions: Value-Based Care

Creating Value: Hospitals

- Telemedicine: Virtual Visits

- Telehealth technology: Follow-up visits via iPad. telehealth bridges the distance between patient and physician by allowing patients to remain in their communities while being seen by a health care provider at a distant site

- The VidyoMobile™ app transforms your Android or iOS smartphone or tablet into a virtual meeting place so you can collaborate with others from wherever you are

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Possible Solutions: Value-Based Care

Creating Value: Hospitals

- Health Information Exchange

Global Health Care Record – Redesigning Care Transitions

- Health information exchange (HIE) is an electronic, patient-centered approach to securely share health related information between physicians, hospitals and other health care providers at the time it is needed to make quality clinical decisions.

Possible Solutions: Value-Based Care

Creating Value: Hospitals

- Health Information Exchange

- Immediate access to important health information from other members of the exchange.

- Reduced need for tests and treatment being duplicated.

- Reduced likelihood of dangerous medication interactions.
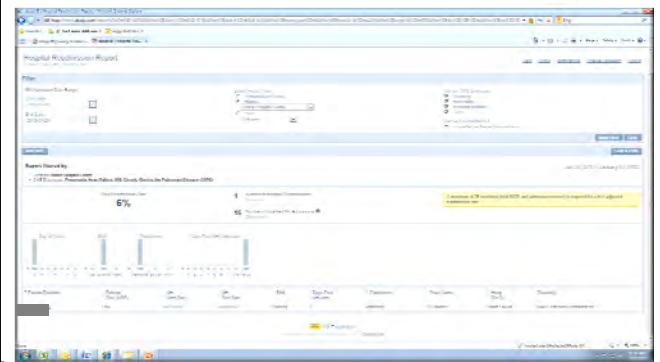
- Reduction in rehospitalizations.

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Possible Solutions: Value-Based Care

Creating Value: Hospitals

abaqis Quality Management System

- abaqis® Quality Management System

  - Survey Readiness – efficiently monitor compliance on a daily basis.

  - Customer Satisfaction – continuous satisfaction measures that can be constantly monitored and identify areas of concern and use root cause analysis to help you correct.

  - Hospital Readmissions – trend analysis, risk stratification and high-value information reporting.
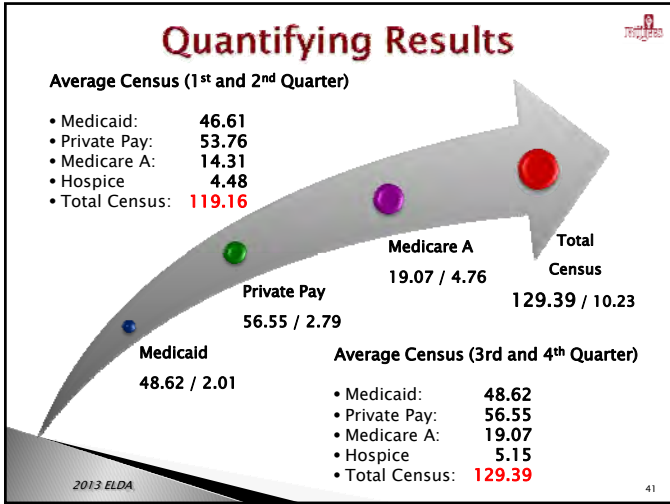
  - Quality Assurance – A solid foundation for QAPI.

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Hospital Readmission Data

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D.R.I.V.E. Admission-Discharge Journey

Director of Family & Social Support

Referral → Admission → Discharge → Care Coordination

Elder & Family Care Coordinator

Referral

Discharge & Outreach Coordinator

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Evaluate

- Continuous measurement of results, experiences, methods and outcomes.

- Assess services based on excellence, uniqueness, and results.

- Harness the power of Information Technology and examine how it can improve your processes.

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Quantifying Results

Average Census (1st and 2nd Quarter)

- Medicaid: 46.61
- Private Pay: 53.76
- Medicare A: 14.31
- Hospice 4.48
- Total Census: 119.16

Medicare A
19.07 / 4.76

Total Census
129.39 / 10.23

Private Pay
56.55 / 2.79

Medicaid
48.62 / 2.01

Average Census (3rd and 4th Quarter)

- Medicaid: 48.62
- Private Pay: 56.55
- Medicare A: 19.07
- Hospice 5.15
- Total Census: 129.39

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Key Indicator Dashboard

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Discussion

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