Caring Transitions

A Skilled Nursing Facility’s Turnaround Success Story

By James Lett II, MD, CMD

ill is an 87-year-old man and one of those residents who comes along much too rarely. He loves the “We Care” skilled nursing facility (SNF) where he has stayed several times after hospitalizations, and the staff at We Care—and other residents—love his wit and warm presence.

He was admitted to the hospital for congestive heart failure twice last year, and to We Care both times for reconditioning. Recently, he was again admitted to the We Care Emergency Committee. This time, he did not return to We Care.

Fearing the worst for Bill, the director of nursing called the hospital. She found out that Bill was alive and well but at a different SNF that is the major competitor of We Care. The director of nursing was conflicted. She was happy Bill was doing well but confused as to why he would want to be anywhere else for his care. The director of nursing discussed this disappointing turn of events with the staff.

Some of the therapists and nursing staff who moonlight at other facilities reported that other residents who had once received postacute treatment at We Care had recently gone to other SNFs after hospitalizations. The director of nursing told the We Care administrator of this troubling fact.

The facility medical director happens to be a friend of the vice president of medical affairs at the local hospital where the redirected referrals have occurred. In a frank conversation, the SNF medical director learned that the hospital has been tracking 30-day readmissions closely. We Care had 30-day readmission rates double those of other SNFs in the community. The hospital official stated: “In this tight economy, and with the penalties for excessive 30-day readmissions by the Medicare program, it makes poor economic sense to send hospital referrals to We Care.”

The SNF administrator, in her position only 3 months, was stunned. She called an emergency meeting of the director of nursing (of 6 months) and the medical director (5 years). The administrator’s initial outrage that the hospital was diverting admissions from We Care turned to expectation. With the threats of the potential for serious ramifications, the facility administrators about how to avoid overwhelming the staff and to allow time for in-service training for everyone involved.

The nursing staff learned, through the algorithms of INTERACT II, how to gather appropriate information and perform necessary assessments. They admitted that it took some adjustment to use the card, but it helped nurses significantly when performing comprehensive assessments. The staff began to realize that their actions have a direct relationship to the hospital’s future viability. Soon after, the nursing staff began to realize that their actions have a direct relationship to the facility’s viability, the facility’s jobs, and the jobs of everyone around them.

Once the in-services began, “Stop and Watch” cards were distributed to nursing aides and dietary and maintenance personnel, and each was trained on how to use the card. More importantly, these personnel were empowered by leadership to approach nursing staff and physicians with status changes they observed in residents.

The nursing staff also learned about the value of the INTERACT II program to reduce readmissions from SNFs. Another offered services to reduce hospital readmissions, borrowing from both INTERACT II and AMDA’s clinical practice guideline “Transitions of Care in the Long-Term Care Continuum.” After discussion, the group agreed that ideas gleaned from the recent meeting could work at We Care. The medical director and the director of nursing were tasked to determine which interventions from INTERACT II and AMDA’s guidelines should be adopted. Upon reviewing the elements of INTERACT II as explained on the program’s website (http://interact2.net/), they chose to initiate:

1. “Stop and Watch,” a method to help certified nursing assistants discern resident problems early to allow intervention.
3. SBAR: Situation, Background, Assessment, Recommendation (a communication system to facilitate better interactions between facility staff and attending clinicians).
4. From AMDA’s “Transitions of Care in the Long-Term Care Continuum” and “Stop and Watch” cards were distributed (www.amda.com/toolkit/collateral/tocpp.pdf), they selected some elements that applied particularly well to We Care as follows: Table 5, Essential Information That Should Accompany Every Transitioning Patient; Table 6, AMDA’s Universal Transfer Form; and Table 16, Sample Inter-Performance Measurement Indicators.

Starting immediately, the administrator, director of nursing, and medical director jointly decided the facility would maintain a monthly calculation of the rate at which postacute residents return to the hospital within 30 days of SNF admission. A look back into the facility’s records revealed that the 30-day readmission rate had been 43%, far above the rates of its competitors. The leadership team decided that every unscheduled rehospitalization would be reviewed to determine its cause and see if it could have been avoided. Other parts of the plan were to be implemented in stages to avoid overwhelming the staff and to allow time for in-service training for everyone involved.

First, and foremost, a general meeting was held to emphasize that the facility leadership was united on the plan and that the future viability of We Care was at stake. Soon after, the nursing staff began to realize that their actions have a direct relationship to the hospital, the viability of the facility, their jobs, and the jobs of everyone around them.

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The nursing staff, leadership, and violence reduction teams collaborated to develop and implement the prescribed processes. Corrective action may be necessary to maintain staff focus.

Communicate with your referring hospitals. It is especially important to share what differentiates your facility from others. Meet with hospital leadership and show hard evidence of your commitment to avoiding rehospitalizations and your progress in reducing them.

Your SNF can be as successful as a story as We Care is, or your facility can be a casualty of a tightening market as hospita
tals align themselves with a few partners who can deliver low readmission rates. A knowledgeable, committed medical director can make the difference.

Dr. Lett is the medical director at the Charles E. Smith Life Communities in Rockville, Md. A past AMDA president, he chaired the AMDA workgroup that created the clinical practice guideline “Care Transitions in the Long-Term Care Continuum” and is currently the chairman of the AMDA Transitions of Care Committee. You can comment on this and other columns at www.caringfortheages.com under “Views.”