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Hardwired Results® 27

Post-Acute Care

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Message from our President

Never has partnership been more important in healthcare. The stakes are high with respect to organizational reputation, patient experience and reimbursement. That's why it's so critical to be proactive with all your stakeholders across the continuum of care, no matter where you work.

In her feature story in this issue of Hardwired Results — "Partnership Matters" — on page 2, Studer Group coach leader Tonia Breckenridge offers a roadmap to succeeding at just this. You'll learn about time-tested Studer Group tools and how to apply them with three key constituencies: employees, patients and organizational partners.

Chief Executive Officer Hugh Brown, of St. David's Georgetown Hospital in Georgetown, Texas, is also reaching out to community partners to raise the standard of care by coaching executives outside of his organization on all of the tools that have worked for him. (See page 6 for the whole story.)

But you don't have to be a chief executive to partner effectively. Or a large integrated health system. Mary Barks, resident and family relations coordinator, at Legacy Living and Rehabilitation Center in Gillette, Wyoming, works daily to demonstrate what right looks like with her team. And it shows. Resident satisfaction is up from the 30th to the 98th percentile as a result. (Read "Living the Mission of Excellence Every Day" on page 8.)

I'd love to hear about your creative approaches to partnerships in 2018. Just drop me a note at **DebbieRitchie@StuderGroup.com**.

Debbie Ritchie

Partnership Matters

BEST PRACTICES FOR COMMUNICATING WITH STAKEHOLDERS IN POST-ACUTE CARE

It's a challenging time in healthcare, and not just in acute care. Daily news stories chronical the failures of post-acute facilities due to staffing shortages, inability to manage risk and quality gaps.

with Managing Director and Studer Group Coach Leader Tonia Breckenridge, MBA, SHRM-CP

Isn't it time to take back control of the narrative, to put what's "right" back into healthcare?

Whether you are an acute, subacute or post-acute provider, partnership matters to your ability to deliver a quality patient experience. When a patient has joint replacement surgery, they're not just focused on the hospital experience. They're also counting on an accurate diagnosis, the right treatment plan, the most qualified provider to deliver that treatment, pre-testing and pre-op to help them get ready for surgery.

They want to know that their rehabilitation and home health providers will keep them safe post-op and on track for a quality clinical outcome after surgery. Seamless communication between all these caregivers across the care continuum is essential.

With the Centers for Medicare and Medicaid Services (CMS) now reimbursing for episodes of care, providers who work together in the best interest of the patient to reduce cost and improve quality will be rewarded while those who don't will face stiff financial penalties.

For successful partnerships, post-acute care facilities must be able to demonstrate value to potential acute care provider partners. Are they easy to access? Excellent communicators? Partners expect a seamless patient and family experience and consistent delivery of quality outcomes.

Likewise, hospitals want to refer to post-acute providers who excel at preventing readmissions and ensuring patient safety and quality. Success is all about communication with caregivers, patients, families and particularly with employees.

PARTNER TO HIRE RIGHT

In any healthcare setting, quality frontline staff are the backbone of an ability to deliver on its promise of quality care and experience to patients. You won't find those individuals just anywhere. Use these tactics to recruit high performers.

- **Fill the pipeline.** Start with an outreach to local middle schools and high schools for presentations on a career in healthcare. Also, are you partnering effectively with community colleges in your area?

  To attract certified nurse's assistants (CNAs) and licensed practical nurses (LPNs), promote the opportunity to earn clinical hours of experience in your organization with quality preceptors. Make sure your organization is the first choice of employment for new graduates based on your great first impression during training.

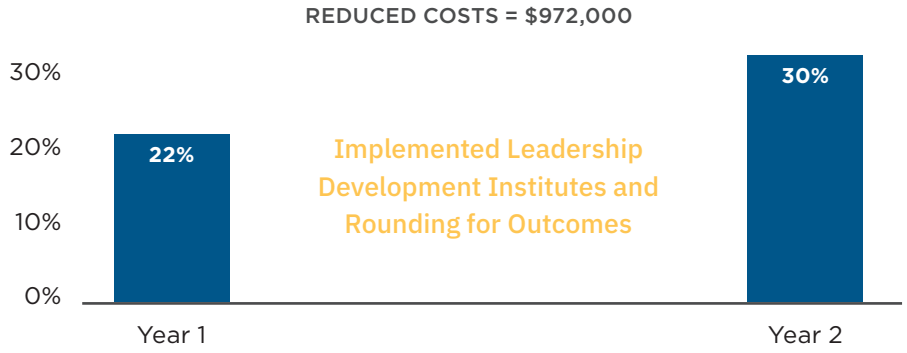
- **Screen for the "engagement gene."** Looking for employees that care deeply about their work? Ask open-ended questions that identify applicants with great communication skills (e.g., "describe a situation where you were able to effectively communicate a difficult or unpleasant idea to a superior") and a team focus (e.g., "describe a team experience you found rewarding").

- **Identify the best fit for the team.** Do you partner with your best employees to identify great new hires? New hires are only successful if their peers help them to excel. After a candidate has been vetted by human resources and his prospective leader, ask high-performing team members to complete a peer interview and evaluate the candidate for cultural fit.

  Be sure to provide training for this important role and always accept the decision of the peer interviewer. It's this process of peers selecting new members of their team that creates an investment in their ultimate success, reducing early turnover.

IMPACT ON THE BOTTOM LINE:

How One SNF Increased Retention of CNAs



These tactics work in every type of provider environment. For example, a South Carolina hospice cut turnover from 75 percent to 18 percent over 12 months resulting in $2.4 million in savings. A Texas-based skilled nursing facility improved CNA retention by 8 percent saving $972,000.

Source: Texas-based Skilled Nursing Facility System

- **Assign a preceptor.** The best preceptor may not be your best clinician or individual with the longest tenure. Find someone who is invested in the success of the mentee, has patience for new learners and is seen as a high performer by the rest of the team.

- **Focus on retention.** It's expensive to recruit and train employees, so once you've hired right, demonstrate your partnership with them. Round on employees consistently to identify what is working well, who to recognize and tool/ equipment needs. Then ask for ideas to improve processes. Recognize employees for great contributions and meet with them after 30 and 90 days to re-recruit them.

Specific questions at 30 and 90 days focus on harvesting new ideas from those with a fresh eyes perspective, recognizing team members that were helpful in onboarding and identifying risk factors that may cause someone to leave the organization. Use Leadership Development Institutes to equip leaders with the leadership skills they need to excel.

In one post-acute care facility Studer Group coached that was struggling with high turnover, caregivers with long tenure said they stayed because of their passion for post-acute care, their respect for coworkers and scheduling flexibility. Some also wanted opportunities for advancement. Find out what your employees value to ensure you deliver on what they want.

PARTNER TO MITIGATE RISK

Falls among older Americans are the number one cause of injury and death from injury. One out of every four people 65 years or older falls annually, resulting in 2.8 million emergency department visits.

These falls also result in $31 billion in direct medical costs, not to mention lawsuits. These long-term care claims are on the rise, too. They arise from a perfect storm of a patient's mental state, lack of provider communication with patients and their families, and a failure of explanations about risk factors, prevention and patient choices that contribute to those risks.

To reduce costs and keep patients safe, partner with your staff to communicate your organization's commitment to avoiding and mitigating risks. Best practices include:

- **Using key words with patients and families.** For example, "We're concerned about the risk of a fall for your mom while she's here, so we are placing her in a low bed. We will proactively toilet her as we round to reduce the risk of falling. You can help by asking for assistance when helping her to the bathroom, encouraging her use of slip resistant socks and keeping the bedrails in the up position."

  Understanding how patient choices contribute to increased risks can help families persuade loved ones to follow staff recommendations like using a walker versus a cane for better support and removing rugs and cords in the home.

  When a large California-based hospice trained staff to use key words and also began rounding consistently on employees, patient survey ratings on "helpfulness of staff who arranged care" jumped from the 10th to the 59th percentile over six quarters. Likewise, patient ratings for pain control jumped from the 20th to the 95th percentile over 13 months.

- **Rounding hourly on patients.** The goal of rounding on a patient or resident and his family is to both receive and give information. Best practice is to round hourly in hospitals and every two hours in rehab and skilled nursing facilities.

  Also, patient care boards are an effective way to track important information for patients and residents such as caregiver names, dates and times for activities and visits. For those with memory challenges, this can provide essential information that comforts the patient or resident and their family.

PARTNER FOR GROWTH

Once you've laid the foundation for quality care by hiring and retaining an engaged, skilled staff — and trained them to communicate effectively with patients and families — you're ready to grow your organization.

What's the best way to drive growth? Identify organizations along the care continuum in your community that refer patients to you or accept referrals from you. Think out-of-the-box.

Sometimes that means opening a dialogue with local partners where you may have been reluctant to refer in the past to speak frankly about challenges and brainstorm solutions. (Read about the experience of St. David's Georgetown Hospital in "Improving Quality and Patient Experience through Partnership" on page 6.)

Communication and partnership are the themes that drive excellence across the continuum. Both are essential to the delivery of quality care and a world-class patient experience. When you hardwire these best practices in your organization, your organization will reap the benefits of these collaborative partnerships.

Learn more.

For more on Studer Group's coaching for post-acute care organizations, please visit **StuderGroup.com/Post-Acute**

A Shared Commitment to Quality and Patient Experience

ST. DAVID'S GEORGETOWN HOSPITAL RAISES THE STANDARD OF CARE OUTSIDE HOSPITAL WALLS

When CEO Hugh Brown rounded on the orthopedic surgeon responsible for 35 percent of the hospital's volumes to ask what he could do for his patients, the surgeon responded definitively: Improve patients' experiences at post-acute facilities.

At St. David's Georgetown Hospital, a 111-bed community hospital near Austin, Texas, patients are wowed by the organization's commitment to excellence. After all, the hospital is part of St. David's HealthCare, a 2014 winner of the prestigious Malcolm Baldrige Award.

with Hugh Brown, CEO, St. David's Georgetown Hospital, Georgetown, Texas

But at post-op visits, these same patients would express frustration with the post-acute care providers to whom they were referred for rehab. Delays in receiving pain management and physical therapy were among the leading concerns.

OPENING A DIALOGUE

Since St. David's Georgetown Hospital isn't affiliated with any post-acute care (PAC) providers, the hospital's contact with them had been mainly transactional, admitting patients who needed hospitalization, discharging patients who needed their services, and documenting readmission rates and transfers. But, with CMS incentivizing performance networks between acute and post-acute providers through its 2014 IMPACT Act, a more collaborative approach was due.

When Brown approached the executive directors of several PAC providers in the community, he was met with enthusiasm about collaborating. They were interested in growing volumes and reducing length-of-stay as they shifted to episodic reimbursement mandated by CMS. Earning back referrals from St. David's would align with that plan.

THE APPROACH

"I explained that for our physicians to begin referring patients again, we'd need to address two issues: clinical quality and culture…and that it was in the best interest of the health of our community for us to work on these things together," explains Brown. "It was straightforward for their clinical leaders to rework processes to ensure patients received pain medication promptly and physical therapy the day of arrival, as our surgeon required."

"What was more challenging was addressing the cultural component to ensure our hip and knee replacement patients would enjoy the same commitment to 'exceptional care to every patient, every day' that we made at St. David's. They didn't have the resources that we did to access Studer Group coaching and evidence-based leadership tools."

So Brown offered to coach the executive directors and nursing directors as a group during a series of executive leadership collaboration meetings he hosted at the hospital. He shared the "why" of establishing a mission-driven culture and introduced Studer Group's healthcare flywheel®, as well as the AIDET® communication framework and leader rounding on employees.

Leaders learned how to collect actionable feedback using five evidence-based questions during rounds (rather than "howdy" rounds, as Brown calls them). Then he showed them how to use a stoplight report to track implementation of action items transparently. They also studied the principles of patient and employee engagement from Craig Deao's book "The E-Factor: How Engaged Patients, Clinicians, Leaders, and Employees Will Transform Healthcare."

THE RESULTS

Within a few days of beginning the coaching sessions, Brown heard from one of the executives who was excited about the staff's reception of the new tools and the actionable feedback he was getting with evidence-based rounding. Physical therapists and charge nurses from the PAC providers are also now meeting with St. David's service line leaders to share challenges in their operating environment and to brainstorm solutions (e.g., rounding on patients every two hours instead of hourly due to larger patient-to-nurse ratios).

Today, PAC facilities can confidently meet St. David's Georgetown Hospital's clinical expectations, so physicians are referring patients to them again. Patient experience is also improved, and the organizations are still working to hardwire excellence. The focus of coaching has shifted to accountability.

Over the next six months, St. David's will begin tracking readmissions, infection rates and patient experiences based on surveys, as well as patient days for its post-surgery hip and knee replacement patients in skilled nursing facilities in order to meet targets established by each surgeon.

"Like most great sea changes in healthcare, this type of initiative needs to be executive-led," advises Brown. "Reach out fairly and uniformly to all post-acute leaders with a message that what happens after discharge matters. Don't your patients deserve to have the same great experience in every organization?"

Living the Mission of Excellence Every Day

A POST-ACUTE CARE PROVIDER DELIVERS ON ITS PROMISE

"In acute care, patient experience is all about making a good first impression in the hospital. In post-acute care, patient experience depends on sustaining a lasting impression," explains Mary Barks, resident and family relations coordinator at Legacy Living and Rehabilitation Center, a long-term care and short-term rehabilitation facility with 160 beds in Gillette, Wyoming. Legacy is part of the Campbell County Health system that serves diverse patients in rural Wyoming.

with Mary Barks, resident and family relations coordinator, Legacy Living and Rehabilitation Center, Gillette, Wyoming

Today, overall resident satisfaction at Legacy is at the 98th percentile up from the 30th percentile in July 2015. Here's how they did it:

1. TRAINING ON WHAT RIGHT LOOKS LIKE

"We explain at new employee orientation that we are committed to creating an environment and culture where people can have the best time of their life at this time in their life," notes Barks. "We tell new employees that if they're just here for a job, Legacy won't be a fit for them. We want staff who are here every day to provide the best care possible."

When it comes to training staff on the use of AIDET® — Studer Group's communication framework to reduce patient fear and anxiety — the Legacy team is laser focused on demonstrating the care, compassion and safety intent behind it, much more than the actual words. Communicating safety through both words and body language is critical.

In fact, Barks enlisted one of the residents, Rosetta, to share her personal experience with new staff on what it feels like to be truly cared for. Rosetta said, "I can tell what kind of day it will be when I roll over in the morning and see whose

name is on my whiteboard...whether it's someone who really cares about me or someone just going through the motions." Employees are validated for AIDET during new employee orientation and during annual competencies. AIDET and the use of key words is ever-present in ongoing training and coaching at Legacy.

2. A CULTURE OF ALIGNMENT AND ACCOUNTABILITY

Accountability starts at the top with Legacy's Vice President of Continuing Health Services Jonni Belden, who communicates the "why" with a clear vision for the strategic plan as well as specific expectations and resources for the leadership team to meet those goals. Legacy uses Studer Group's Leader Evaluation Manager® to align and track leadership goals to measure success.

For example, one of Campbell County Health's strategic goals is to increase resident satisfaction for seven key drivers above the 50th percentile. The vice president of continuing health services (which includes long-term care) and Legacy's administrative director of nursing also carry that goal. Both leadership and staff evaluations align to that overall goal by measuring things specific to their roles.

Nursing staff have a goal, for example, of achieving the 50th percentile or better for resident ratings for courtesy and respect and coordination of care on satisfaction surveys. Likewise, nutrition supervisors need to rate higher than the 50th percentile for quality of food and dining service.

3. PROCESS IMPROVEMENT

When Toyota chose Legacy's nutrition services as a LEAN improvement project in November 2017, resident ratings were low: quality of food was at just the 15th percentile. Eight months later, patients rate quality of food in the 61st percentile (compared to long-term care facilities nationwide), and a new item surveyed reflected the dining experience is at the 68th percentile.

A core team of 12 staff and leaders at Legacy began by measuring the time it took to serve food daily for a month; they set a goal of reducing that time by 47 percent through better coordination and efficiencies.

Now, cold food is cold and hot food is hot, and the bar has been raised on the quality of meals that are served to residents. An unexpected outcome: better team work. Clinical staff now huddles with nutrition services workers before meals so they can communicate about pertinent nutrition issues.

Barks' top tip for success? Communicate the "why" behind new initiatives consistently for high staff engagement. "When we initially asked leaders to round on staff, they viewed it as a time sink," says Barks.

"But when we explained that we round because we care about the people who work here...that we want to recognize them for great work and find out what they need to do their jobs better, that made sense to them. We connected the dots by asking, 'If our mission is to deliver great care to everyone we serve, don't we need our staff to feel the same thing from us?'"

Leading Practices for Post-Acute Placement

PERSPECTIVES FROM HOSPITAL CASE MANAGERS

with Pam Lastrilla, RN, MBA
Huron director

In the evolving healthcare landscape, hospital case managers play an integral role in care coordination and seamless transition planning. Their days are spent ensuring patients are in the right status (e.g., inpatient vs. observation), helping the inpatient care team provide efficient care in the right setting, managing patients at high risk for readmission, and identifying patients with discharge needs and developing a transition plan. But one of the most important responsibilities of case managers is helping patients find the right post-acute provider.

NEEDS-BASED TRANSITION PLANNING

The transition planning process is initiated with a discharge assessment to determine if a patient needs post-acute support. And yet, it can take a long time to find the right post-acute provider and obtain the authorization from the payer.

That's why it's so important to start transition planning as soon as possible. In fact, best practice is for case managers to assess a patient's needs for post-acute care on the first day of their hospital stay.

If the need for post-acute care exists, the case manager should begin the transition planning process, starting with a determination of the appropriate post-acute level of care, such as an inpatient rehabilitation facility (IRF), skilled nursing facility (SNF), home health, long-term acute care hospital or hospice.

This determination is based on objective criteria. A few examples: the capacity to make measurable improvement in an IRF setting, medical necessity criteria such as the need for skilled nursing services around the clock, and payer requirements, such as a three-day inpatient hospital stay within the last 30 days required for Medicare reimbursement.

PROVIDING INFORMATION ON POST-ACUTE PROVIDERS TO PATIENTS AND FAMILIES

In discussing post-acute care options, case managers should make a conscious effort to preserve patient choice. However, it is appropriate to provide information to patients and their families to assist in their decision-making.

The case manager should send a referral to facilities that can meet the patient's post-acute needs and are in-network for their plan. The case manager then provides the list of "accepting" providers to the patient.

It is appropriate to share quality information such as the Star Rating from the Centers for Medicare and Medicaid Services Nursing Home Compare website or the U.S. News & World Report Best Nursing Homes ranking. In addition, case managers should provide information on payer coverage for different post-acute care options.

LEADING PRACTICES OF PREFERRED POST-ACUTE PROVIDERS

Hospital leaders are focused on decreasing length-of-stay (LOS) and reducing costs while expanding their capacity to serve more patients. For most hospitals, discharges to post-acute facilities such as skilled nursing facilities offer the opportunity to do just that.

Post-acute providers who have a timely and efficient intake process help hospitals manage LOS by avoiding delays in the discharge process. Leading practices of post-acute providers who are good partners to hospitals include:

- **Automated referrals:** This is the ability to accept automated referrals and respond in a timely fashion with an accurate response. If a post-acute facility indicates they will accept a patient, then later reverses that decision, it is detrimental to a positive working relationship.

- **Easy intake process:** The best post-acute provider partners have clear and efficient processes for communicating the discharge plan and clinical information needed to transition the patient safely to the post-acute care team.

  Additionally, it's helpful to be open to transfers at least 12 hours per day. And yet, there are still many providers that do not accept patients after a certain time, such as after 2 p.m., or do not have admissions staff after 4 p.m.

- **Willingness to partner on clinical initiatives:** Strong post-acute partners are willing to collaborate with hospitals on improvement initiatives such as understanding and addressing root causes for readmissions. Training may also help to improve their ability to accept patients with clinical needs they may be unfamiliar with, such as special wound care.

Strong partnerships between hospitals and post-acute providers that address barriers and challenges lead to a better transition process and benefit all parties, especially the patient.

Case Study

HOW ONE REHABILITATION HOSPITAL NEARLY DOUBLED EMPLOYEE ENGAGEMENT

THE CHALLENGE

While this 395-bed acute facility in the Midwest was well known for its exceptional patient experience, employee engagement hovered near the 50th percentile. After solidifying the organization's reputation as a top provider for rehab services, leaders wanted the organization to also be recognized as providing an exceptional working environment for employees and clinicians.

THE TOOLS

- **Hardwired use of three specific tactics to drive engagement:** rounding on employees, stoplight reports and thank you notes for reward and recognition.
- **Implemented Senior Leader Rounding** and created employee forums as a way to harvest feedback and improve engagement.
- **Leveraged High Solid Low Conversations** to manage low performer behavior.
- **Recently began Nurse Leader Rounding and Hourly Rounding®** to ensure patient experience continually improves and scores remain in the top decile.

THE RESULTS

- Between 2015 and 2018, employee engagement reached the 90th percentile.
- In three years, inpatient beds more than doubled due to growth.
- Patient experience continues to score consistently above the 90th percentile.

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High Reliability Strategy Workshop | The Healthcare Transformation Summit

October 17: Nurse Executive Summit

Self-test: How effectively do you partner with stakeholders?

Take this quiz, and see how you rate.

STATEMENTS:

Y N We are active in partnering with local high schools and community colleges to fill our pipeline with great candidates for CNAs and LPNs on our team.

Y N We use best practices like peer interviewing and behavioral-based questions to identify prospective candidates for our team to ensure best fit and high retention.

Y N We engage employees by rounding to harvest recognition and process improvement ideas, resolve tool and equipment needs and connect with each individual on a regular basis.

Y N We actively manage fall risks by consistently rounding on patients and using key words with patients and families.

Y N Our organization is involved in an active and proactive collaboration with top referrers in our community to improve care transitions.

Y N Quality and patient experience are a clear focus in our ongoing partnership with other organizational stakeholders in our community.

Y N Within our hospitals, our case managers use needs-based transition planning and always work to preserve patient choice when making post-acute referrals.

Y N As post-acute providers, we accept automated referrals from hospitals and have clear and efficient processes for communicating both the discharge plan and clinical information for a safe transition.

Y N We hold our leaders accountable for measurable outcomes and share results with our team to improve engagement, quality, experience and growth and to reduce costs.

ANSWERS:

IF YOU ANSWERED "YES" 7 OR MORE TIMES:

Congratulations. Your organization is a team player! Want to grow faster? Learn more about Studer Group coaching for post-acute care organizations by visiting **StuderGroup.com/Post-Acute**

IF YOU ANSWERED "YES" 5 TO 6 TIMES:

Your team is on the right track for collaborations that deliver results. Learn how a Michigan rehab hospital hardwired a culture of 'always' by visiting **StuderGroup.com/No-Excuses-Culture**

IF YOU ANSWERED "YES" 4 OR FEWER TIMES:

Are you ready to level up? Schedule a call with a post-acute coaching expert to discuss immediate steps by emailing **Partnerships@StuderGroup.com**

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ISBN 978-1-62218-105-6
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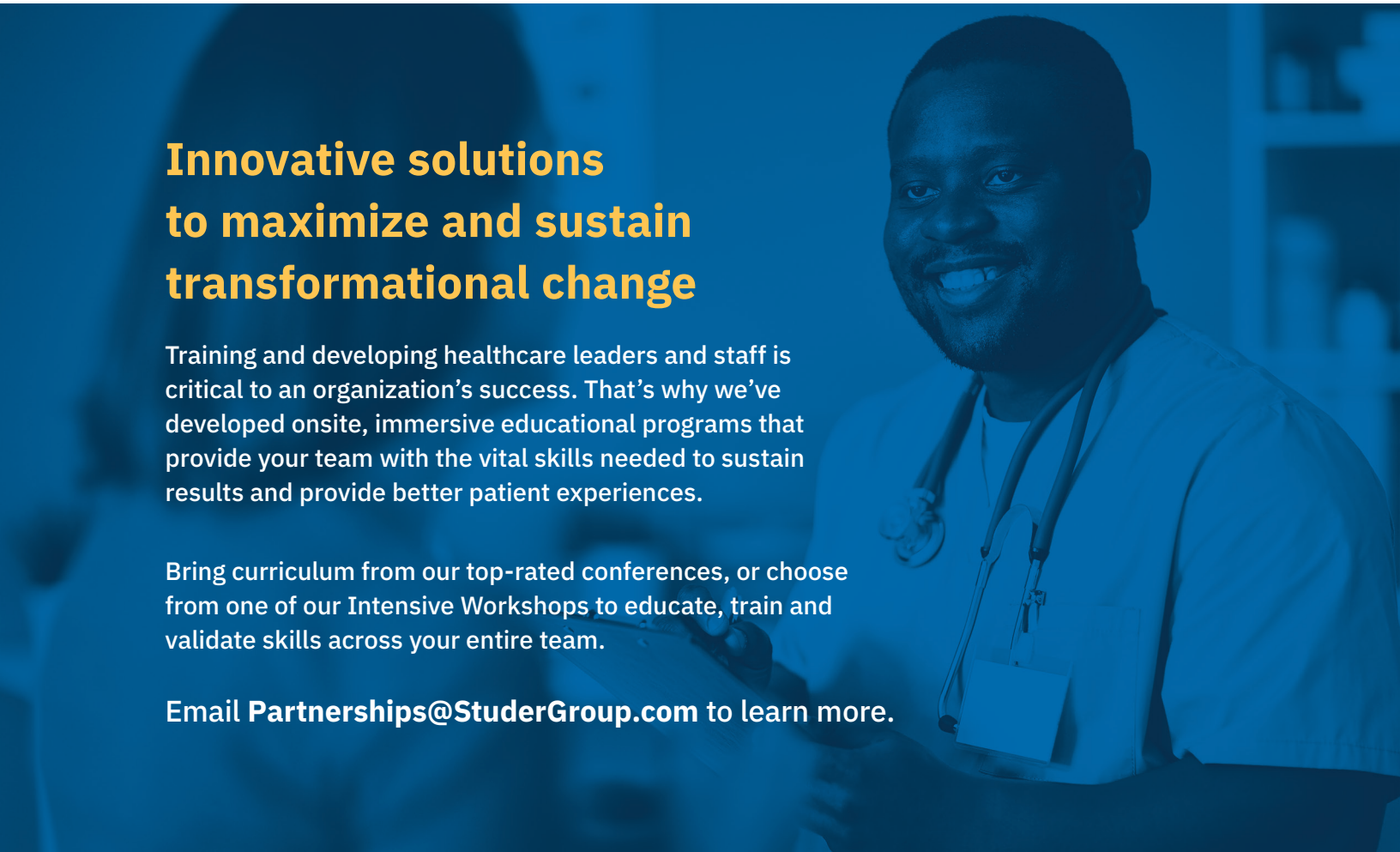

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