Case Study

Improving Transitions
from Hospitals to Skilled Nursing Facilities

In January 2018, BlueCross BlueShield of Tennessee, the Tennessee Hospital Association (THA) and five THA-member hospitals, along with their skilled nursing facility partners, began a pilot to improve the post-acute discharge experience and share best practices. A white paper entitled *Working Together to Improve Patient Transitions* was published in 2019 to share the findings. The following excerpt highlights how **AHC West Tennessee Transitional Care** worked with the hospital to enhance patient access to skilled nursing care after a hospital stay.

AHC American Health Communities

First-Hand Results From Two Pilot Participants

An Interview with Debbie Ashworth from Jackson-Madison County General Hospital and Justin Broadway from AHC West Tennessee Transitional Care

Located in Jackson, TN, Jackson-Madison County General Hospital is the only tertiary care hospital between Memphis and Nashville. The hospital serves a 17-county area of rural West Tennessee and an estimated 400,000 residents. Given the amount of business this hospital manages, it's essential for staff to work as efficiently as possible, especially when it comes to discharging patients to skilled nursing facilities.

That's why Debbie Ashworth, Jackson-Madison's Executive Director of Care Management and Document Improvement, was pleased to join the Post-Acute Discharge Pilot Program. She partnered with Justin Broadway, Facility Administrator for AHC West Tennessee Transitional Care (WTTC). The 67-bed facility is a comprehensive short-stay rehabilitation facility and located adjacent to Jackson-Madison.

The partnership made sense, since the two facilities already had a strong working relationship. They had also been working on aligning processes prior to the pilot, so were able to share their experiences with the larger group. We've included some of their best-practice tips in this article.

Relationships Are Important

Debbie acknowledged it can be difficult to balance patient needs and business requirements. That's why she stressed the importance of getting to know people — everyone who plays a part in a patient's care. As well, she commented on the importance of collaboration and working toward common goals.

Debbie stated, "I meet quarterly with Justin and the Director of Nursing to discuss any readmissions to the hospital from their facility. We are looking for processes to help reduce hospital readmission rates. Meeting on a regular basis has also developed a great working relationship between our facilities."

Justin agreed. "Collaboration among health care providers in regard to patient care and satisfaction is the key to ensure the best possible outcome for each patient," he said. "Quarterly meetings with Debbie Ashworth and her team allowed us to share best practices and, in our situation, reduce hospital re-admissions over a 12-month period."

You Need to Look at Staffing

Both the hospital and skilled nursing facility adjusted staffing to address delays. At one time, Jackson-Madison relied on their staff social workers to manage pre-certifications. However, realizing these employees were often too busy to manage their caseloads and pre-certification requirements, they decided they needed a full-time clerical person to manage pre-certifications.

WTTC also saw the value of focusing on a consistent pre-certification process, so they hired a clerical specialist to work at the hospital and manage pre-certification full time. Debbie mentioned this improved the pre-certification process a great deal.

"This process has decreased the time our social workers are working on pre- certifications," she said. "This allows them to spend more time with the patients and focus on the discharge planning needs."

WTTC also hired a nurse practitioner to help ease the load for the facility's admitting physician. The nurse practitioner can treat 75-80 patients a month, while also coordinating care with the admitting physician. Justin believes this has proven to be a best practice for the facility, enabling more personalized care and ultimately reducing the occurrence of hospital readmission.

"With the addition of a physician assistant on-site, we have been able to increase staff knowledge and clinical skills," he stated. "We are now able to more quickly identify and intervene when a patient has had a change in status in order to implement the correct care path."

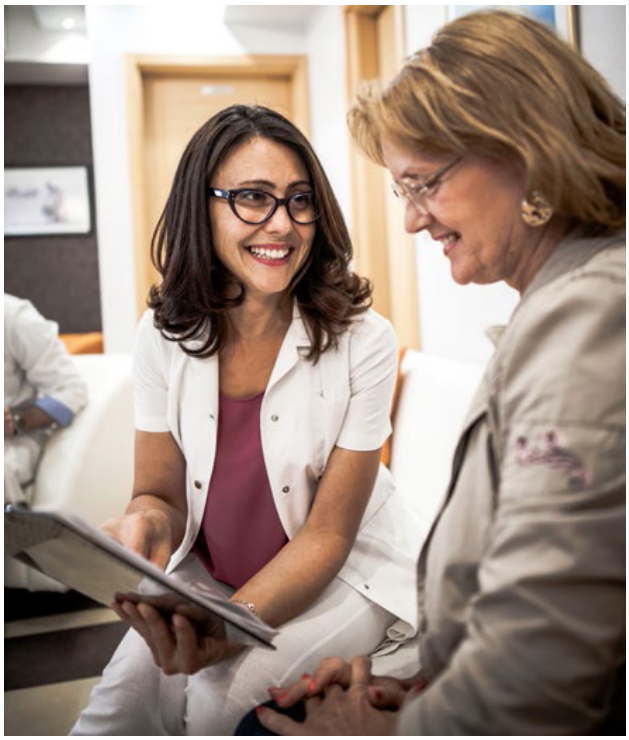
Assess the Patient's Needs When Managing Transportation

Debbie mentioned that prior to the pilot, they had already developed an effective system to manage timely transfers to the skilled nursing facility. In order to meet same-day transfer goals, the hospital manages pre-certifications in the mornings and then notifies the skilled nursing facility that patients will soon be on their way.

In addition, Debbie and team notifies the hospital's EMS liaison so they can prepare for transport. The patient's name is added to a "will call" list indicating they're preparing to transport the patient that day. The liaison then contacts the patient's insurance to determine what transportation is covered, and makes arrangements.

As Debbie stated, they don't need an ambulance for every situation. In many cases, the family will transport the patient. In other cases, they may decide a wheelchair van, taxi or TennCare transportation is the best approach.

If patients are still waiting to be discharged in the afternoon, Debbie and her team work with the family to reassesses their patients' needs and determine next steps. In some cases, the patient may need to stay another day in the hospital or move to a sister facility. However, patients are able to stay comfortably in their rooms until the final decision is made.



How This Pilot Improved the Patient Experience

When Debbie and Justin were asked about their overall experience with the pilot, they had positive feedback.

"By participating in the pilot program, we were able to adjust some of our processes and streamline to better transition the patients to the next level of care," said Debbie.

Justin added, "As a result of this program, patients have been able to transition to the post- acute setting in a significantly quicker time frame. This has allowed patients the opportunity to begin their rehabilitation process without delay."

For a copy of the full report email Newsroom@AmHealthpartners.com