Future-proofing your skilled nursing facility
Supporting the new health care paradigm
Future-proofing your skilled nursing facility - supporting the new health care paradigm

A new era in health care in the United States has dawned. The paradigm shift from volume-based care to value-based care, with its focus on improving outcomes and providing the highest possible quality-of-care, is transforming the way health care providers operate. As the old “fee-for-service” model fades away, every venue of care - from acute and ambulatory to skilled nursing facilities (SNFs) and home care organizations - must recognize the immediate need to align around each patient’s entire spectrum of care needs.

This shift seeks to improve overall quality-of-care by moving health care providers towards receiving payments based on quality, rather than the quantity of the care they provide. The overarching goal with these programs is centered on facilitating coordinated care, improving outcomes and developing overall quality comparisons regardless of where a patient receives treatment. Ultimately, this will provide organizations with the ability to truly contribute together and create one longitudinal record and care plan for each patient across multiple venues, so a person has the best chance of improving and returning to a better state of health.

But the opportunities that value-based care provides also brings unique challenges, especially for SNFs that are struggling with evolving market and regulatory forces. As the industry continues to evolve, facilities must seek out innovative ways to improve quality while limiting costs if they are to remain competitive.
Steep challenges in the midst of the paradigm shift

Maintaining census: optimizing partnerships and the importance of referrals

The Centers for Medicare and Medicaid services (CMS) have already instituted programs relating to value-based care, including bundled payments with capitated fees for common episodes of care, and penalties for excessive or avoidable transitions, specifically hospital readmissions.

Because of the critical importance of streamlining care and eliminating duplicative and expensive work, hospitals, as well as insurance providers, are increasingly paying attention to where patients go when they are discharged.

Many hospitals are narrowing their networks into lists of preferred partners, which can cause SNFs to struggle to maintain their census as their referrals decrease. Additionally, home care is significantly less expensive than SNF care, increasing the incentive to reduce the length of stay in the SNF.

Recent data confirms this trend. According to the National Investment Centers for Seniors Housing and Care, SNF occupancy has fallen to 81.7%¹. That’s the lowest level since 2011.

As nursing homes grapple with these occupancy challenges, some facilities are shifting

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Feeling the impact of hospital readmission rates

For the first time, in October of 2018, skilled nursing facilities started receiving incentive payments based on their performance regarding hospital readmissions. As just one of many real-world applications of CMS’s value-based care initiatives, the Skilled Nursing Facility Value-Based Purchasing Program rewards high-performing organizations with fewer readmissions with the highest payment incentives, and vice versa.

Hospital readmissions “are often unnecessary and cost taxpayers more than $4 billion a year.”

In addition, according to a study published in 2017, a “substantial percentage of hospital readmissions from Skilled Nursing Facilities are rated as potentially avoidable.”

The fact is, hospital readmissions from Skilled Nursing Facilities are common, and the causes are many. Poor communication between hospitals and SNFs, improper medication management, and ill-informed decision making all contribute to potentially avoidable hospital readmissions.

Case study

Bethesda Southgate, a community of Bethesda Health Group, needed to find an innovative way to tackle a common problem faced by many SNFs: preventing falls and improving resident safety.

“During rounds at night, someone might find a resident on the floor, so they have to assess that environment,” said Lila Simpson, clinical process and applications coordinator at Bethesda. “What happened? What was the scenario? Was there proper lighting? Were their tissues within reach?”

To meet the challenge, Bethesda Southgate implemented PowerChart LTC™, resulting in a 58% improvement in their quality measure rating for falls with major injury. Their team developed strategies based on data delivered via reporting tools featured within the solution, helping to identify areas where interventions had the potential to minimize future falls.

The team at the 192-bed skilled nursing community also used the solution to improve communication and ensure they accurately report fall information to CMS.

Towards a specialization in treating patients with higher acuity needs by accommodating residents needing ventilators, intravenous therapy, and more. Some organizations are also broadening the slate of services they provide, including home and hospice care, to encompass a wider market of care needs.

In the face of these challenges and changes, forming a solid care team is essential. Doing so goes beyond the SNF and requires the creation of partnerships and the ability to share all kinds of health information. Every caregiver that engages with a patient needs access to the same information, or there will be duplication of work, ultimately raising the cost of care.

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3 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5311021/
Now and in the future, the bottom-line of a SNF will rely on the ability to examine each patient's entire spectrum of care, instead of focusing solely on what happens within the four walls of their organization.

Rocky Mountain Care Centers is comprised of eight skilled nursing facilities and offers home care, hospice and private duty in five western states. The organization uses cutting-edge technology to provide better care for its residents. By utilizing Cerner solutions including CareTracker® and joining the CommonWell Health Alliance, the facility found a way to improve the lives of both patients and workers.
Questions to ask your supplier

Are you a participating member of a national health exchange like the CommonWell Health Alliance? Or have you simply “pledged” to be interoperable? Do you have clients I can talk to?

Is your functionality embedded directly into the solution? Or do you require agreements with third-parties?

Can you generate and accept Continuity of Care Documents? What data elements are included?

Can you reconcile health information directly into each resident’s chart? Or is information just received as a secure email in a read-only format?

Strategies to thrive in the new value-based paradigm

Solutions that start with true interoperability

It’s still far too common for a patient to show up at a SNF at the end of a Friday afternoon with pieces of paper attached to the gurney. To meet the demands of modern value-based care, that must stop.

With Cerner, SNFs receive true interoperability and can accept and send each patient’s discrete data elements directly into their EHR system from other providers. Health care professionals can save time and provide better care by easily importing care items (like past problems, allergies, medications, immunizations, lab results, and others) directly into the chart when a patient is admitted. Broadly, this level of interoperability takes steps towards eliminating the unfortunate issues of yesterday across the entire health care industry: medication errors, duplicative lab tests, and missing diagnoses, that so often lead to readmissions and add significantly to the cost of care.

This level of interoperability, however, can prove to be elusive. Today, the word “interoperability” often serves as an umbrella term that refers to any piece of functionality that might be used to electronically send health information from one point to another—like the ability to send a large multi-page file that rarely gets looked at, might get attached to a chart, and offers little in the way of actual benefit to the patient or organization.

More knowledgeable organizations are demanding clarity from their EHR providers to determine exactly what they mean when they claim that they are interoperable. True interoperability enables liquidity of health data and allows providers to trust each
other’s information through secured, standards-based, and accessible data that is kept current and constantly updated.

Cerner connects clients to national and local health care networks, such as CommonWell Health Alliance®, a national health information exchange, which allows these clients to share data bidirectionally and streamlines and improves the quality of the transition. Access to these national networks gives SNFs a clear advantage as they work with their hospital partners to improve care and maximize referral opportunities.

**Analytics functionality that levels the playing field**

There is, also, an additional important reason to improve health data liquidity throughout the continuum-of-care. SNF organizations can play a key role in predictive-analytics and population-health initiatives, given that they acquire weeks, months, even years of patient health data, compared to a couple of days for most hospitals.

Cerner’s scorecards and dashboards are powerful analytical tools that provide guided workflows to and feature color-coded alerts specific to the different roles and needs of the leaders within organizations. Users can quickly identify areas of interest and concern to address issues before they become problems. The solution allows the creation of goals and thresholds for targets, like admissions, to let you visualize trend lines throughout the month to ensure your organization is staying on target.

However, the reality today is that many SNFs are at a disadvantage when it comes to the ability to collect and analyze their own health data. They are often outmatched by the very organizations that scrutinize them, including regulatory agencies, payers, and their own referral partners.

It is essential that SNFs be able to affirm, through data, that they have the ability to offer the best care at a given location, and for the right kind of patients. They must be able to prove to their referral partners that transitioning patients are in good hands when they check in to their facility. Without the robust tools to provide those deep insights, it’s nearly impossible to substantiate that data.
Solutions with predictive analytics can also do things like identify residents that are most likely to return to the hospital within 30 days. Once identified, organizations can arrange for these residents to receive the resources to fully comply with their care plans and avoid that hospitalization.

Robust analytics functionality for SNFs delivers meaningful data to operators, allowing them to be proactive in their care, whether it’s working to prevent falls or improving transitions of care, leading to increased health care quality overall. The insights provided by access to advanced analytics can also help SNFs communicate their capabilities to potential referral sources, an essential component of long-term success.

Coordinating care to meet new challenges

Many SNFs are increasingly moving beyond their traditional roles, specializing in more clinically complex efforts to support residents needing more acute care. Other SNF organizations are broadening their business offerings, providing home care or hospice services in addition to skilled nursing, for example.

To satisfy these new needs, providers must engage with software suppliers that can meet the demands for both clinical robustness and portable health care records in multiple venues of care.

Cerner’s PowerChart LTC™ is purpose-built to help manage the current and future needs of skilled nursing providers. As providers expand their offerings, they can take advantage of the integrated support for more acute needs like ventilators, dialysis services, IVs, ports, and more.

*PowerChart LTC* features intelligent workflows that can suggest care plan modifications as clinicians document, including a plan of care for falls, or a post-chemo and radiation plan of care for those who need it.

Because of Cerner’s unprecedented breadth across so many venues of care, we’re able to assist SNFs evolving needs by incorporating advanced solutions that connect the full continuum of care. This includes solutions like *PowerChart Touch™*, which assists physicians in making their rounds at nursing homes, and *CareAware®*, a platform that seamlessly automates the collection of data from medical devices, nurse call systems, location-based technologies, and other network-connected systems.
Partnering with Cerner delivers future-proof innovation for SNFs

The health care industry is moving very quickly, and your technology needs to keep pace with the changes that are happening. As an SNF today, you need a trusted supplier with the resources to offer broad health care applications that can span the entire continuum of care. You need solutions that provide data that is useful, easily recorded, and immediately actionable within the value-based care paradigm. You also need to build and optimize relationships with referring partners by demonstrating and substantiating a proven track record of reducing the potential for readmissions. Cerner delivers the true interoperability you need, with powerful digital tools, advanced EHR Analytics, and a strong network backing that leads to better communication and improved transitions-of-care.

As one of the largest providers of health information technology in the world, Cerner connects people and systems at more than 27,500 contracted provider facilities globally. Cerner’s experience in a wide range of services, supporting clinical, financial, and operational needs of any-sized organization, allows them to develop and scale solutions to meet the varying needs of health care providers in many different venues, including SNFs.