Get a complete picture of my facilities performances

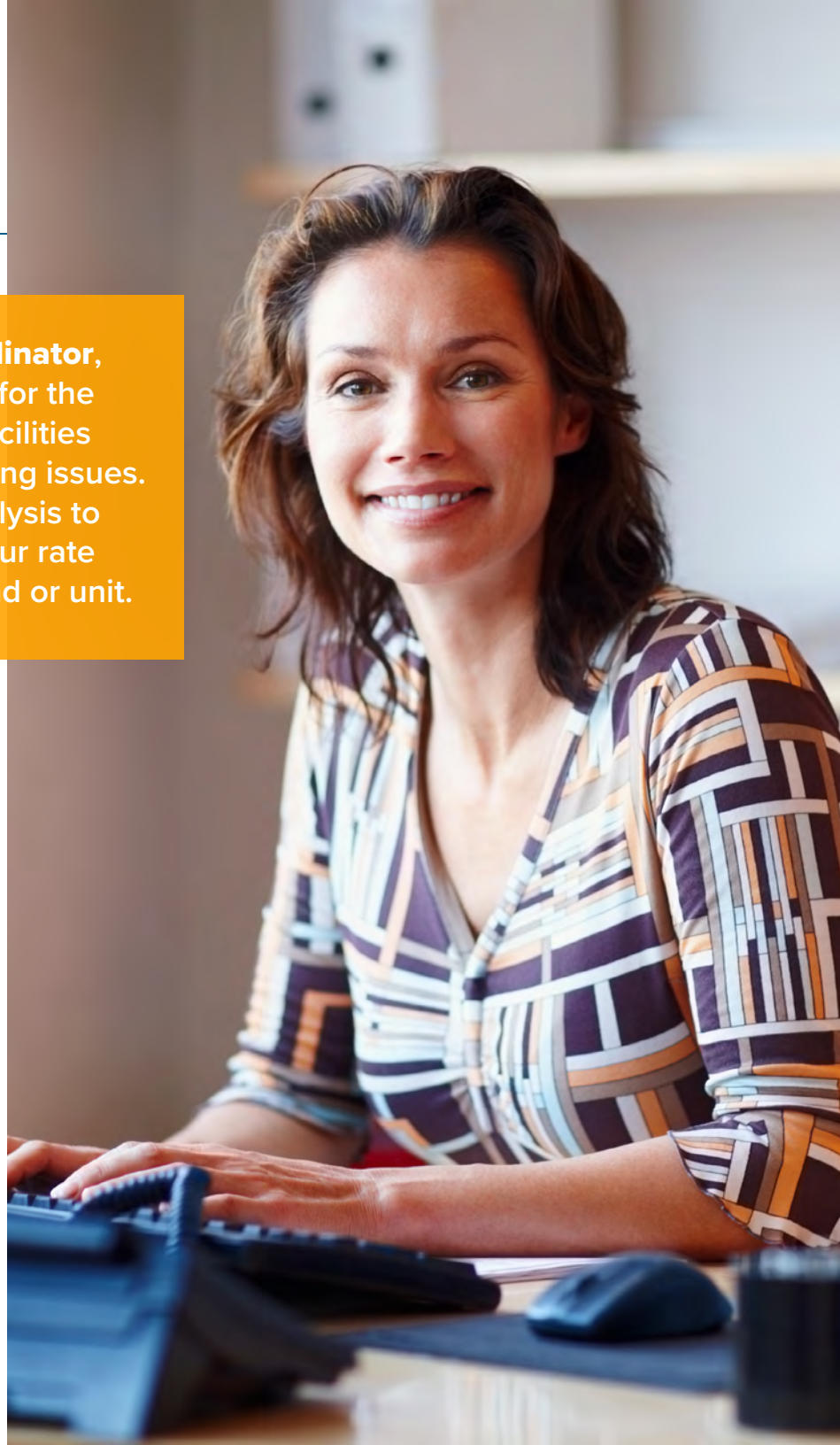
Use Case

#1

As a **Regional Quality Improvement Coordinator**, I need to monitor closely the readmissions for the 5 facilities I oversee. I need to see which facilities are having great results and which are having issues. I want the ability to perform root cause analysis to see what residents or other factors affect our rate the most. I suspect a diagnosis category and or unit.

SHP FOR SNFs:

- Review your daily **Dashboard** widgets to see your 30-day readmission rates, and your immediate 3 and 7-day readmissions, for each facility.
- Review **Scorecard Overview** by *Facility* to proactively monitor key metrics for the five facilities
- Review your **Readmission Resident Detail** report for a specific facility to identify if a *Referral, Unit, Shift, Diagnoses*...etc., is having the greatest impact on the facility's readmission rates
- Drill further into a facility-specific **Scorecard** to review previous time periods



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Improve functional outcomes under PDPM

Use Case

#2

As an **administrator**, to make sure we are doing well with PDPM, I need to review how well we have been improving our residents' functional status. I also need to know how efficient and effective my staff is at improving the resident's functional care.

SHP FOR SNFs:

- Start your day with the **Dashboard** *Functional Improvement* widgets. Review by *PDPM Categories* and *Net Functional Improvement* to see how you're performing and identify outliers
- Review the **Scorecard Overview** report to identify a negative *Net Functional Improvement* by *Facility*, or by a specific PDPM category
- Drill down further to the **Functional Resident Detail** for further analysis of root causes
- To identify the most efficient levels of therapy that will result in the best functional outcomes, run the **Scorecard Overview** to see each facility's *Efficiency of Functional Improvement*. Drill down further to discover optimal efficiencies for each *PDPM Clinical Category*

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Collaborate with HHAs to prevent future readmissions

Use Case

#3

As a **discharge planner**, I want to proactively monitor my facilities discharge success, and as residents are discharged to a specific home health agency (HHA), I want to identify and monitor the specific residents that are at a higher risk of a 30-day readmission. As I am responsible for the remaining 30-day readmission window, I want to engage more closely with that particular agency.

SHP FOR SNFs:

- Monitor **Dashboard** widgets for *Facilities, Discharge To* and *Risk Analysis* categories
- Run **Scorecard Overview** report to identify successful *Discharges to Community All* by *Facility*, and then filter by *HHAs*.
- Review the **Readmission Resident Detail** report for a particular agency's residents to identify which had a higher risk for readmission
- Identify which agencies (HHAs) those residents were discharged to and discuss their cases with my HHA counterparts (share risk, discharge functional status...etc.)

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Show my referring partner positive change

Use Case

#4

I have a quarterly meeting with University Hospital, one of my referring partners. I want to show them that the newly implemented discharge transition process is having a positive effect on our readmission rate for their patients.

SHP FOR SNFs:

- Review **Scorecard Overview** to confirm successful metrics for University Hospital
- Filter by *University Hospital* and run a **Referral Scorecard** for their patient population
- Print your *University Hospital* **Referral Scorecard** to bring to your meeting
- Present your 30-day readmission rate for this period vs. the previous period along with other metrics to demonstrate your success
- To identify further improvement opportunities, drill down into the **Resident Detail** report

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Identify high-risk residents and adjust care plan

Use Case

#5

As the **Quality Improvement Coordinator**, I need to monitor recently admitted residents and their risk of hospitalization to verify we have adjusted our care plans accordingly.

SHP FOR SNFs:

- Review your **Dashboard** census widgets for *Admissions, Discharges* and *Risk tiers* in the last week
- Review **Resident Detail** report and filter by *High Risk* residents to see which *Unit* in your facility they were admitted to and ensure that *Unit* is staffed appropriately, or to assign future *High Risk* admissions to other *Units*
- Follow-up with the *Unit* and *Shift* charge nurses to make sure the right plan of care is in place.

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ABOUT SHP

Strategic Healthcare Programs (SHP) is a leader in data analytics and benchmarking that drive daily clinical and operational decisions. Our solutions bring real-time data to post-acute providers, hospitals, physician groups and ACOs to better coordinate quality care and improve patient outcomes. Since 1996, SHP has helped more than 7,000 organizations nationwide raise the bar for healthcare performance.

Strategic Healthcare Programs (SHP)
www.SHPdata.com
805.963.9446
solutions@SHPdata.com