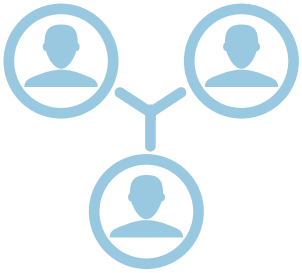
CARE COORDINATION

A CHECKLIST FOR NURSING HOMES

Let's face it, no matter how much nursing homes like the idea of care coordination, when you are faced with pressing matters like managing staffing issues, or you lack access to timely data, figuring out how to make care coordination a priority can seem next to impossible. But the reasons for working toward more coordinated care are clear.

For long-term care facilities, care coordination can create better patient experiences and help reduce the stress of transitions. It makes avoiding safety issues (like falls) and providing quality care to patients much easier. Not to mention the fact that coordinated care heavily impacts reimbursements - especially since financial and regulatory incentives are changing. For these reasons and many others, long-term care facilities must find ways to improve care processes that are currently somewhat fragmented.

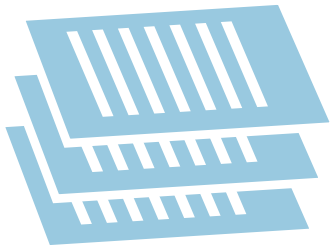
This checklist is designed to help your organization make improvements to your coordination of care efforts.



1 COLLABORATE WITH A BROAD COMMUNITY

Nursing homes historically have had care planning processes that include residents and families, but those processes need to be solidified and expanded to include the entire care community. Nursing homes frequently interact with hospitals and home healthcare providers, so promoting good communication between these groups is an obvious step. For care coordination to really be effective, even more of the healthcare community needs to be involved. You want your organization to be collaborating with everyone that your patients come into contact with.

- Regularly communicate with your patients, their families, primary care physicians, pharmacists, hospitals, home healthcare teams, social workers, nurses, and other members of the healthcare community that may have or need information about residents of your facility.
- Conduct in-person care team meetings with a broader team. Bring to the table as many members of the care community as possible. Rely on direct-care workers to play a central role in the meetings since they have frequent contact with patients and can share insights.
- When available, take advantage of electronic health record system features that allow you to share information with other providers.
- Push for the development and use of EHRs and other forms of communication that can be used by residents and their families.



2 ESTABLISH SYSTEMATIC PROCESSES

There are a lot of pieces to the care coordination puzzle. Focus on making sure care processes are not disjointed. Put in place systematic processes to ensure that you are consistently doing the things you need to be doing. You don't have to reinvent the wheel to implement good processes. There are several different care coordination tools available to help you with this.

- Consider using one of the following in order to establish systematic processes for your facility: INTERACT, The Bridge Model, Boost, Project Red, Care Transition Program, or the Transitional Care Model.
- Choose a program that both aids you in designing processes and provides tools and templates that you can use.
- If you have a care coordination tool, like INTERACT, commit to using it fully. Do not pick and choose only a few portions to implement. Most of these tools have many different elements that are designed to be used together to really be effective.
- Follow a clear set of procedures for using transfer forms. Make sure you and the outside hospitals and care providers you work with are using a common language.

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3

PUSH TO EXPAND EHR USE

The lack of access to timely patient data is a problem for many long-term care facilities. Inconsistent staffing and disjointed communication with other healthcare providers are two things that make it difficult to see when there has been a change in a patient's condition. Electronic health records are helping to change this.

■ If your organization has not yet put EHR technology into place, make every effort to do so.

■ If you are without an EHR system, use "on-paper" tools, from INTERACT for example, that will help you systematically document and share essential patient information. Don't let lack of technology be a reason to avoid quality improvement.

■ Organizations with an EHR system need to make sure their staff is trained and using the technology correctly and consistently — so everyone can access valuable health history data and info on patients' conditions.

■ Supplement EHR use with live communication to make sure that, in a sea of patient info, the most important things are clearly communicated.

4

EDUCATE PATIENTS AND HELP THEM IMPROVE SELF-CARE SKILLS

Health outcomes improve when patients are involved in their own care. When appropriate, work to help patients practice good self-care. Also, educate family members that may be involved with caring for older adults.

■ For patients that are able, teach them (and any family caregivers) what they can do to manage their own health.

■ Provide patients with literature on effective self-management of specific chronic diseases or conditions. Give them clear instructions they can reference on how to use medication correctly.

■ Involve patients when developing treatment plans to keep them informed and empowered.

■ Pay attention to the mental and emotional needs of patients when designing treatment plans. Make this an important component of care as patients cross through different facilities and see different providers.

5

MEASURE YOUR PROGRESS

You need to be able to measure your care coordination efforts and find out where you are and where you need to go. The best way to start measuring is to track care transition data. Tracking this helps you identify a baseline, set goals and measure progress.

■ Track resident and family satisfaction information regarding transitions of care.

■ Track the number of discharges to both lower and higher levels of care.

■ Track your rate of exacerbation of chronic illness.

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