COORDINATING CARE

A Guide For Nursing Homes

A WHITE PAPER FROM THE HEALTHCARE EXPERTS AT Primaris Healthcare Business Solutions

The meaning of care coordination

Nursing home residents interact with many different physicians, nurses, medical assistants, and other trained professionals across multiple settings. In fact, the average Medicare beneficiary sees seven physicians in four different practices during a single year. Because of this, for long-term care facilities, care coordination comes into play at nearly every point during patient care.

Think about it, when a patient transitions to long-term care from a hospital, the receiving facility needs the hospital to provide detailed information in order to properly care for that person. That's care coordination.

They also need to work with residents and their families to design and update care plans. Again, that's care coordination. And, if a patient shows signs of needing acute care, the long-term care facility needs to notify the primary care physician and provide transfer information to the hospital. Of course, that's also care coordination.

Why care coordination matters

Since care coordination runs throughout every part of long-term care, and it impacts the quality of care patients receive, it needs to work. Unfortunately, a lot of times it doesn't – or at least not as well as it should. Why? For the most part breakdowns are due to communication gaps, lack of timely data, and coordination efforts that are somewhat fragmented.

The time to fix these problems is now. Long-term care facilities that take steps to improve care coordination will see benefits for both their residents and their organization.

Why Care Coordination Matters

The case for improved care coordination in long-term care facilities is strong. Just look at some of what is at stake:

RESIDENT QUALITY OF LIFE. Nursing home residents don't like to be sent to the hospital. It can be scary and stressful, especially for those without a family member or advocate to help them through the ordeal. Unfortunately, about one-fifth of Medicare patients who are hospitalized are readmitted within 30 days of discharge. This cycle of back and forth between long-term and acute care negatively impacts the quality of life of nursing home residents.

SAFETY. When all involved healthcare providers, residents and their families do not communicate with each other, the opportunities for serious mishaps escalate. This is especially true when individuals are moved between several different care settings, like hospitals, nursing homes and home healthcare. It is also an issue because older adults typically have more complex health needs. They have higher rates of chronic disease, they are more susceptible to falls, and they often require more medication. Lack of coordination and communication about care instructions, risk factors and other health information can be unsafe or even fatal.

REIMBURSEMENT. New payment models are driving care coordination to the point

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All of these things only scratch the surface of what is at stake. There are many more reasons why care coordination matters to nursing home residents, patients that pass through long-term care facilities, and also the provider organizations themselves. But even just these few examples clearly show that long-term organizations need to focus on care coordination.

where it is no longer optional. Instead, it is essential for reimbursement. Consider this: nursing homes and hospitals – two groups that historically have had somewhat of a chasm between them – are being brought together forcefully by looming payment changes that are on the horizon. One example of this is The Comprehensive Care for Joint Replacement payment model, a new protocol for knee and hip replacement that CMS is currently working to institute. The push behind this program indicates that eventually payment to hospitals and long-term care will be based on how well these groups work together. So the incentive to coordinate care is definitely there. Reimbursement and protocols for evidence-based care are going to push nursing homes into more cooperative relationships. If they don't work closely with acute care and other providers, nursing homes will have a harder time financially.

All of these things only scratch the surface of what is at stake. There are many more reasons why care coordination matters to nursing home residents, patients that pass through long-term care facilities, and also the provider organizations themselves. But even just these few examples clearly show that long-term organizations need to focus on care coordination.

Care coordination in nursing homes takes on several forms because of the fact that there are multiple groups of people with different needs served by these facilities. One group includes

What does care coordination look like

residents that live in nursing homes permanently. Another group consists of those individuals that live elsewhere in the community and end up needing care from a skilled nursing facility while they recover from a health issue.

Long-term care residents need coordinated care to help them maintain the highest possible level of health, avoid unnecessary hospitalization, and be involved in designing their own care plans when appropriate. Patients that are not long-term residents need coordinated care to keep treatment on track, provide information and education on how to follow care plans, and ease transitions to lower-level care environments. Of course, for both groups, the basic idea behind care coordination is the same: Anyone involved in treating an individual should be communicating and sharing information to ensure that everyone is acting as a team to meet the person's needs.

Well-managed care coordination in long-term care facilities includes:

1. WORKING WITH A BROAD GROUP TO DEVELOP AND EXECUTE CARE PLANS.

Residents, their families, primary care physicians, specialists, acute care, social workers, nursing staff, and other community providers all need to be part of care planning and treatment. Nursing homes need to bring these different people together – in person – for resident care team meetings whenever possible. That way they can all give input into how to best serve individual residents. Plus, this helps the left hand know what the right hand is doing – so caregivers can better align their services to achieve common goals.

One of the most important groups to have involved in care plan development is a resident's family. Family members often serve as caregivers outside of the long-term care facility, so they must understand prescribed orders. Also, the more that family members understand about the condition of a resident's health, the more able they are to make appropriate care decisions based on what is in the best interest of the resident.

2. DEVELOPING GOOD COMMUNICATION PROCESSES AND WORKFLOWS.

Most long-term care facilities use some sort of tool to communicate with hospitals and other community care providers. But these tools alone are not enough. There needs to be a systematic process in place in

Creating an effective care coordination system

order for communication to be effective.

Sharing information is a key part of care coordination. Long-term care facilities need to develop systematic communication processes in order to share and receive relevant and timely patient health information. This might mean collaborating with area hospitals to design better transfer forms, for example. Or it could involve working with home healthcare providers on discharge planning to make sure patients are well-prepared and have support once they leave a skilled nursing facility.

There are several tools available that can help improve communications processes and workflows. INTERACT, for example, is a solution that gives long-term care facilities exact processes to follow and tools to use for improved communications. Project Red, Boost, and The Bridge Model, along with a few others, also offer assistance with planning communications processes and smoothing care transitions. Long-term care facilities can also partner with a company like Primaris to get help designing effective communication processes and workflows. Primaris not only designs care coordination programs, but it also offers education and support with using tools like INTERACT.

3. USING ELECTRONIC HEALTH RECORD TECHNOLOGY TO SHARE AND RECEIVE DATA.

A lack of access to timely data is a significant problem for nursing homes. Adopting electronic health records can help with this problem. EHRs have the potential to integrate patient health information such as current medications, lab results, etc. and instantly distribute important medical data to those involved in a patient's care.

Nursing homes are a little behind the curve when it comes to EHR implementation, although adoption is increasing. Cost is a barrier. But the benefits of EHRs and the fact that they facilitate communication and can help reduce medical errors make a convincing case for investing in this technology.

Long-term care facilities that do have EHR technology in place should work to optimize use of their systems. This means doing things like enabling live data sharing, sending out alerts to primary care physicians and specialists when a resident has been seen in the hospital so doctors can follow-up, and allowing secure messaging between providers within the EHR system. It is a good idea to have at least one designated EHR expert on staff that can troubleshoot problems and answer questions.

A final note about EHRs: they don't replace live (face-to-face or over the phone) conversations. Picking up the phone and sharing a few key pieces of information that are buried within an electronic medical record is a good way to make sure that important details aren't missed, and that quick action saves someone else the time and effort of pouring through pages of patient info.

The benefits of care coordination are clear

Top-performing long-term care facilities are the ones putting systematic communications processes into place and taking steps to improve care coordination. Care coordination helps nursing homes provide a higher quality of care to patients, improve clinical outcomes, reduce medical costs, avoid unnecessary hospital readmissions, and increase revenue.

If you would like to take steps to improve your organization's care coordination, contact Primaris to learn what you can do to get started.

Primaris
Healthcare Business Solutions

Primaris is a healthcare consulting firm that works with hospitals, physicians and nursing homes to drive better health outcomes, improved patient experiences and reduced costs. We take healthcare data and translate it into actionable quality improvement processes that create the foundation for highly reliable healthcare organizations.

Primaris has more than 30 years of experience advising healthcare organizations on how to improve quality, patient safety and clinical outcomes. Contact us to learn more.

To learn more about Primaris and how we can help you improve patient experiences and reduce costs, visit our website at www.primaris.org, or call toll-free at 1.800.735.6776.

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