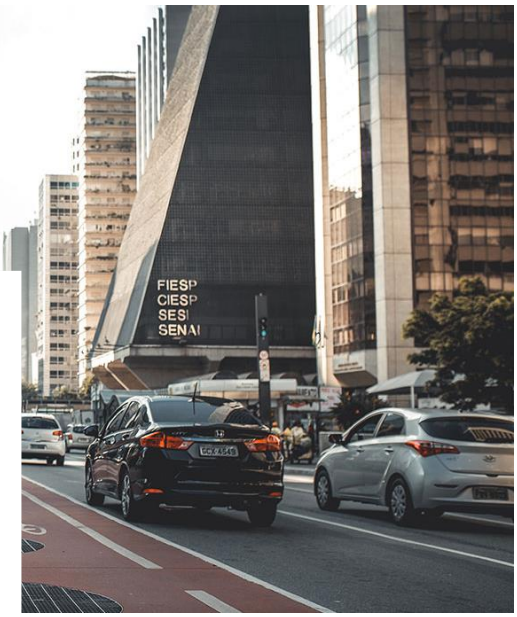
Travel with Margie & Matt through the continuum of care



Objectives

1. Define short-term resident and associated characteristics.
2. Examine service expectations associated with the short-term resident.
3. Define long-term resident and associated characteristics.
4. Examine service expectations associated with the long-term resident.

DEMOGRAPHIC SHIFT IN LTC

ELDERS – 65-100+ YEARS

Traditional LTC Needs

- Loneliness, Helplessness or Boredom
- Fall Risk
- Polypharmacy
- Skin Issues
- Dementia

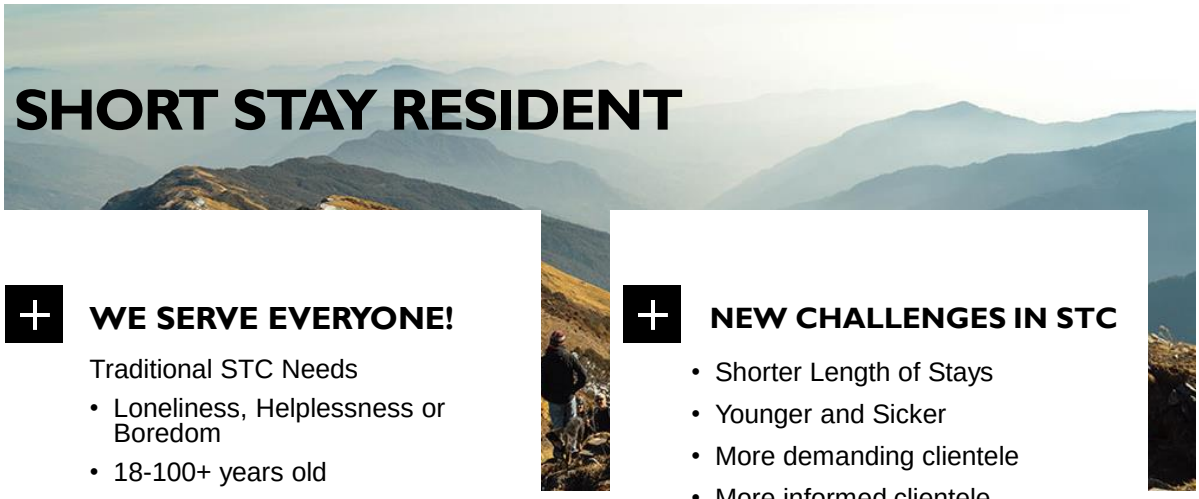
NON ELDERS – 18-65 YEARS

Non-traditional LTC Needs

- Loneliness, Helplessness or Boredom
- Substance Abuse / Addiction
- Mental Illness
- Children & spouses who still need them
- Complicated financial stressors
- Desire to be part of community, peer groups

SHORT STAY RESIDENTS

WHO ARE WE AND WHAT DO WE NEED?



SHORT STAY RESIDENT

WE SERVE EVERYONE!

Traditional STC Needs

- Loneliness, Helplessness or Boredom
- 18-100+ years old
- Rehab & Recovery
- Pain Management
- Fall Risk
- Polypharmacy
- Skin Issues

NEW CHALLENGES IN STC

- Shorter Length of Stays
- Younger and Sicker
- More demanding clientele
- More informed clientele
- Generational differences / challenges
- Customer service expectations have changed!

What Do You See?

Typical Short-Stay Resident

Short-term Stay Residents

- Recover from surgery, injury or illness expected to improve in a short period of time .
- Require post-acute care from a registered or licensed nurse while they rehabilitate.
- Stay a few days to a few weeks.
- Tailored to each patient’s individual rehabilitation needs - involve a range of services including speech, physical or occupational therapy.
- The goal - return home to their active and independent lifestyle

SHORT STAY RESIDENTS

HOW DO YOU MEET THE NEEDS WITH LESS TIME?

Are you seeing shorter and shorter length of stays?

Is your team prepared to meet their needs?

Let's talk about the needs of the STC resident in our homes:

- More co-morbidities / complex needs / higher acuity
- They are sicker when they come with less time for recovery
- They need the strongest case management from the IDT
- Their support systems are overwhelmed and need our attention
- Our traditional approach will not work for them

MEET MATT

HE IS NOT YOUR AVERAGE SHORT STAY RESIDENT

MATT IS AN 89 YEAR OLD RETIRED FARMER WHO FELL AND FRACTURED HIS PELVIS.

HE HAS HTN, DM, DEPRESSION AND PRIOR TO HIS FALL HAD BECOME INCREASINGLY WEAK AND FRAIL.

HE CARES FOR HIS 87 YEAR OLD WIFE WHO HAS DEMENTIA AND THEIR DAUGHTER LOOKS IN ON THEM DAILY.

HE HAS A MANAGED CARE PLAN AND THE IDT ANTICIPATES A VERY SHORT STAY.

MATT'S ITINERARY

DID HE EVER THINK HE WOULD BE IN A HOME FIRST?

REHAB & RECOVERY	ELIMINATING SETBACKS
PT/OT	BEHAVIORAL HEALTH SERVICES
WORLD CLASS NURSING CARE	MEDICATION RECONCILIATION
ACITIVITES: EXERCISE PROGRAMS	COMPLEMENTARY MEDICINE
COMMUNITY RESOURCES	COMMUNITY RESOURCES (FOR HIS WIFE TOO)
CARE PARTNER EDUCATION	CARE PARTNER EDUCATION
INVOLVEMENT IN HIS OWN CARE PLAN	INVOLVEMENT IN HIS OWN PLAN OF CARE
DAUGHTER INVOLVEMENT IN THE DC PLAN	DAUGHTER INVOLVEMENT IN PROGRESS
	RESIDENT & REP GOAL SETTING

TRAVEL GUIDE

BUILDING A MODEL OF SUCCESS STEP BY STEP

REHAB & RECOVERY	GOAL SETTING	DC PLANNING / SUPPORT
DOES NURSING SUPPORT REHAB'S GOALS AT THE FLOOR LEVEL	WHAT ARE THE RESIDENT'S GOALS	COMMUNITY RESOURCES ARE MORE LIMITED THAN EVER
IS PAIN MANAGED SO THERPAY CAN BE A SUCCESS	ARE THESE REALISTIC FOR THE RESDIENT AND THE CAREGIVERS AT DC	HOME HEALTH SERVICE STRUGGLES
ACTIVIITIES: EXERCISE PROGRAMS	WHAT BARRIERS NEEDS TO BE ADDRESSED TODAY	PCP STRUGGLES
CARE PARTNER PARTICIAPTION & FEEDBACK	HOW WILL TRANSPORTATION WORK	IS DC THE BEST PLAN OR IS LTC
CARE PARTNER EDUCATION	DOES THE HOME NEED TO BE MODIFIED	SUPPORT WITH FINACIAL IMPLICATIONS
HAVE A POINT PERSON	HAVE A POINT PERSON	HAVE A POINT PERSON
*DAILY FEEDBACK IS NECESSARY	*DAILY FEEDBACK IS NECESSARY	*DAILY FEEDBACK IS NECESSARY

Expectation of Short-term Stay Residents

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Improving Care Transitions

1. Actively involving patients and caregivers in decisions and preparing them for care in the next setting,
2. Insuring good bidirectional communication between sending and receiving clinicians,
3. Developing policies that promote high quality transitional care,

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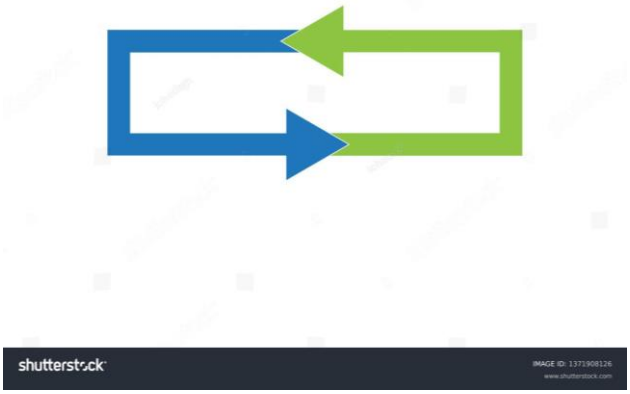
Actively Involving Patients And Caregivers In Decisions

- Discharge meeting early in stay – do not wait for first care conference

Bidirectional communication between sending and receiving clinicians

- Uniformity and accessibility of information, electronic or other systems of communication, and opportunities to involve a 'coordinating' health professional
- Discharge Summary
  - Requirement for Transmission of Health Information
  - Requirement for Medication Reconciliation



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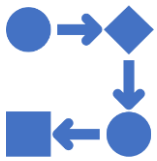
Developing Policies That Promote High Quality Transitional Care

Hold physicians accountable



Process

Education To All Involved In Transferring Patients Across Settings

- Staff
- Resident
- Family
- Friends
- Caregivers in the home

LONG STAY RESIDENTS

WHO ARE WE AND WHAT DO WE NEED?

Long-stay Residents

- Complex medical needs, such as wound care, tube feedings or IV therapy.
- Chronic, debilitating, or progressive medical conditions, such as Parkinson's disease, Alzheimer's, heart disease, or stroke
- Care needs are no longer able to be met at a lower level of care.
- Require ongoing long-term care to improve their quality of life.
- 24-hour care designed to support individual medical needs and may include a combination of a customized diet, restorative exercise, and assistance with daily activities.

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Expectation of Long-term Stay Residents

Differences in Expectations

MEET MARGIE

SHE IS NOT YOUR AVERAGE LONG STAY RESIDENT

SHE IS A 37 YEAR OLD ADMITTED BECAUSE HER PARENTS CAN NO LONGER CARE FOR HER.

SHE HAS MS, BIPOLAR DISORDER, DEPRESSION, ANXIETY AND DEBILITATING MIGRAINES

SHE HAS TWO KIDS – BENNY AGE 8 AND SARAH AGE 6 AND IS A DIVIORCEE.

MARGIE HAS THREE BEST FRIENDS WHO CAME TO SEE HER AT FIRST, BUT THEY HAVEN'T BEEN AROUND IN A WHILE.

MARGIE WANTS A RELATIONSHIP WITH A MAN, WANTS TO DATE, SHE WANTS TO LIVE!

MARGIE'S BOARDING PASS

Margie does not adjust to life in a nursing home, **we adjust the nursing home to give Margie the best life possible** while she travels the continuum of care.

- DOES SHE WANT TO BE CALLED AN ELDER?
- WHO IS HELPING HER WITH MENTAL ILLNESS AND MS?
- HOW WILL YOU MANAGE THE MS?
- HOW DO YOU ASSIST HER SAFELY WITH DATING?
- HOW DO YOU SUPPORT HER SEXUAL HEALTH NEEDS?
- HOW DO YOU HELP HER WITH HER ROLE AS A MOTHER?
- HOW DO YOU HELP HER WITH RELATIONSHIPS WITH OTHER YOUNG RESIDENTS WITH SIMILAR NEEDS AND PREFERENCES ?
- HOW DO YOU SUPPORT THE COMMUNTIY IN THIS DEMOGRAPHIC IN YOUR HOME?

Discussion

WHO IS MARGIE AND HOW DO WE PROVIDE THE SERVICES SHE NEEDS?

HOW DO WE NAVIGATE THIS JOURNEY?

GATHER DATA REALTED TO THEIR EXPERIENCES IN YOUR HOME

Our traditional approach will not work for our residents. We need to learn from them so we can adjust and plan for future residents. This builds our "travel guide" and will improve their overall experience as they travel the continuum of care.

- Personal interviews with the resident and the family and OFTEN!
- What works? What DOESN'T?
- What can we change today?
- What should we stop doing?
- How can we make it easier for you?
- **Establish a point person – who on your team is the "cruise director"? ****

HOW DO WE NAVIGATE THIS JOURNEY?

GATHER DATA REALTED TO THEIR EXPERIENCES IN YOUR HOME

- Grievances Process
- Resident Council
- Complaints
- Participation on facility committees **
- Get to know your residents and families **
- Positive Feedback Forms **
- Random Satisfaction Surveys **

Questions that Get At Heart of Person-Centered Experience

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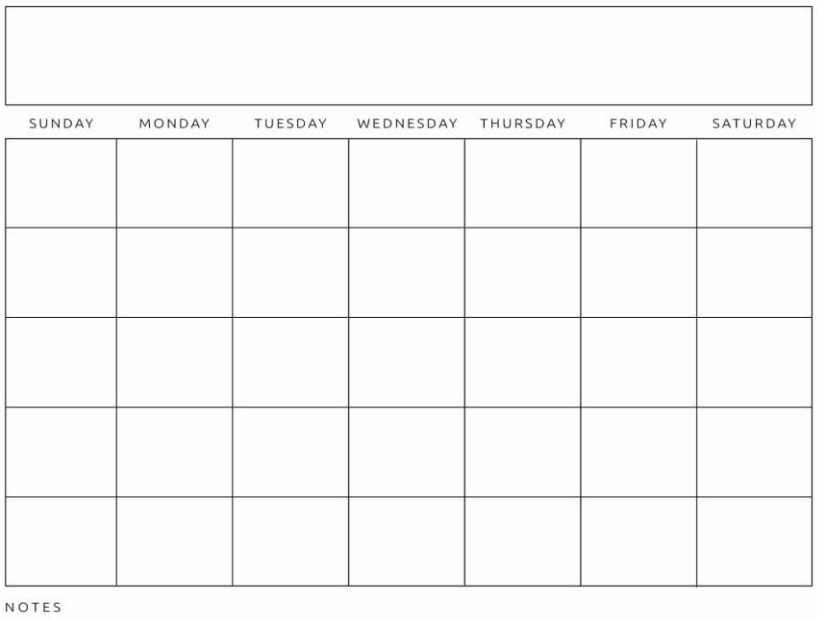

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

NOTES

Timelines for Service Feedback

- Grievances Process
- Resident Council
- Complaints
- Participation on facility committees **
- Get to know your residents and families **
- Positive Feedback Forms **
- Random

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Key to Success – CNA Empowerment

- Involvement in care planning
- Day-to-day decision making
- Cross training
- Involve in social planning

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Q&A

Evidence Based References

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