



PointClickCare®

White Paper

Improving Care Coordination in Skilled Nursing Facilities

Executive Summary

Providing high-quality care while balancing operational efficiency has never been more important for skilled nursing facilities (SNFs). As post-acute transitional care providers, SNFs play a vital role in supporting the medical needs of the aging population, delivering services that enable them to recover after essential care and getting them well enough to return to home, whether that is with family or independently, a senior living community, or a long-term care facility.

Close collaboration between SNFs, hospitals, senior living communities, and others in the care continuum is essential to resident care outcomes and treating the needs of older adults. The ability to share accurate, timely patient and resident health information guides the delivery of the safest, most appropriate care for the best patient outcomes. Further, by helping patients receive the highest quality of care post-hospital discharge and reducing length of stay and rehospitalizations, SNFs also help control waste and additional costs. Yet, with mounting challenges across the industry, many SNFs are at risk of closure or operating on thin margins as operational costs rise, workforce shortages endure, occupancy rates stagnate, and changing regulations complicate reimbursements.

In addition to these challenges, disparate healthcare systems, technologies and processes make it difficult to coordinate care effectively. Care coordination solutions can help SNFs balance high-quality care with operational efficiency, delivering myriad operational, clinical, and financial benefits. In this white paper, we examine the importance of care coordination and the barriers to implementing it, as well as the ways in which technology can help SNFs, acute care providers, pharmacies, senior living communities, and others within the healthcare ecosystem support high quality, efficient, and cost-effective care delivery.

Table of Contents

Care Coordination in Skilled Nursing Facilities	2
Indicators of Successful Care Coordination	3
The Role of Care Coordination in Value-Based Care Models	4
Achieving Best-in-Class Interoperability	5
Coordinated Care is Connected Care	6
Coordinated Care is Data-Driven	7
Coordinated Care Relies on Complete, Accurate Documentation	8
Coordinated Care is Patient-Centered	9
Integrated Solutions Accelerate Care Coordination	10
Improve Care Coordination with PointClickCare.....	12

Care Coordination in Skilled Nursing Facilities

Through care coordination, SNFs seek to organize resident care across multiple healthcare providers, services, and facilities while advocating for patient needs and communicating preferences to the right people at the right time for safe, effective care from the most appropriate provider.

Disjointed healthcare systems, mismatched technologies, and misaligned processes limit the ability to make well-informed care decisions, which can negatively impact patient health outcomes and increase organizations' exposure to risk. Fragmented information can also leave patients unclear about diagnoses, decisions, recommendations, and follow-up care. Delivering the right information and workflows to the right people at the right time, while maintaining a high level of care and compliance, is the essence of care coordination, with myriad benefits for patients and providers alike.

Better Care Coordination

Improves:

- Patient outcomes
- Operational efficiency
- Staff satisfaction
- Quality metrics
- Reimbursements and financial performance

Reduces:

- Length of stay
- Hospital readmissions
- Infection rates
- Per-patient costs



The Components of Successful Care Coordination

Delivering high-quality, high-value healthcare requires seamless communication between care providers as patients transition between hospitals, clinics, SNFs, and their places of residence. However, successful care coordination doesn't happen by chance. It requires:

- **Connected care** that enables efficient coordination between healthcare providers as patients transition between settings
- **Data-driven tools** that give organizations visibility into clinical, financial, and operational metrics to enhance patient care, improve quality, and drive reimbursement
- **Complete, accurate documentation** that reduces the staff's administrative burden, supports clinical best practices and enables consistent, thorough patient evaluations for better patient outcomes
- **Patient-centered tools** such as telehealth capabilities for accurate diagnoses and faster medical decision-making whenever and wherever a patient seeks care
- **Fully integrated systems** that connect data and information quickly, optimize existing technology investments and extend the value of an organization's EHR

The Role of Care Coordination in Value-Based Care (VBC) Models

By focusing on quality of care, provider performance, and the patient experience — as opposed to the quantity of care in a fee-for-service model — VBC aims to improve patient outcomes by encouraging healthcare providers to work together to manage care holistically and comprehensively. It emphasizes integrated care to support a patient’s unique needs and goals, delivered by providers committed to offering the highest standards for physical and behavioral health.

VBC also incentivizes preventative care and early intervention, shifting the focus to wellness instead of sickness. As VBC model adoption accelerates at the behest of legislative initiatives such as the Value in Health Care Act, care coordination will help make SNFs more proactive and collaborative, bolstered by integrated technologies that make data sharing fast, seamless, and secure.

SNF Value-Based Purchasing (VBP) Program

Administered by the Centers for Medicare & Medicaid Services (CMS), the SNF Value-Based Purchasing Program awards incentive payments to encourage SNFs to improve the quality of care they provide to patients, as measured by the number of unplanned hospital readmissions within a 30-day period after discharge.

90 million patients

will be covered under VBC models by 2027¹

VBC models were designed to improve patient outcomes through care coordination that reduces rehospitalizations and promotes overall health through high-quality care. Technology supporting VBC programs can deliver data-driven insights that allow SNFs to track and measure the quality of care delivered by providers for a patient-centered approach grounded in personalized, relevant care. Such an approach lowers the overall cost of care without compromising patient health.

¹ [Patel, N., Singhal, S. “What to expect in US healthcare in 2024 and beyond.” McKinsey & Company, Jan. 5, 2024. Accessed Aug. 16, 2024.](#)

Achieving Best-in-Class Interoperability

Healthcare technology must meet robust technical, security, and interoperability requirements to support effective care coordination. Such products play a crucial role in supporting federal, state, and private programs, including the Promoting Interoperability (PI) Programs administered by CMS. To ensure interoperability, healthcare organizations should consider:

- **IT products built on a Consolidated Clinical Document Architecture (CCDA)** – This allows patient data to follow them wherever they go, providing a meaningful snapshot of their health information. The real-time exchange of CCDAs enhances efficiency for operators, clinicians, and healthcare professionals, ultimately improving data capture and centralizing information for streamlined decision support.
- **Healthcare technology platforms with Certified EHR Technology (CEHRT) designation** – A bequest of the Office of the National Coordinator (ONC), CEHRT platforms reinforce a company’s commitment to ensuring patient safety, improving health outcomes, and reducing the cost of care—the core tenets of VBC—particularly in senior care where CMS requires² that all reporting of healthcare data related to incentivized quality measures be submitted through an ONC CEHRT designated EHR.
- **EHR platforms incorporating a Fast Healthcare Interoperability Resources (FHIR) repository built on the latest federal standards (G10)** – This empowers healthcare providers to share patient information seamlessly with third-party applications, ensuring real-time data exchange.
- **Full mobile access** – Integrated into the facility’s EHR, tools that provide access to real-time, clinically rich data—including resident charts and encounter documentation—improve collaboration and coordination across the full continuum of care. HIPAA-compliant mobile apps can also be deployed to improve medication management.

“Interoperability is a key driver for us in long-term and post-acute care (LTPAC). The ONC CEHRT designation enables compliance with major federal mandates, such as the 21st Century Cures Act, and healthcare regulations, including HIPAA and HITECH.”

Robin Roberts,
Healthcare Technology Affairs Director
PointClickCare

² <https://www.cms.gov/medicare/regulations-guidance/promoting-interoperability-programs/certified-ehr-technology>

Coordinated Care Is Connected Care

The number of seniors requiring long-term care and associated costs will grow significantly over the coming decades. For senior care practitioners, this means higher caseloads. For those without modern healthcare IT systems, it also means dealing with outdated workflows and a lack of timely access to patient information. A convenient way for practitioners to access charts, document progress notes, view and bulk sign orders, and facilitate e-prescribing workflows for residents in their care empowers them to improve care decisions and care delivery. Connected care tools that integrate directly into their facility's EHR:

- Enhance efficiency and productivity by streamlining documentation
- Improve care outcomes by enabling confident decision-making
- Reduce the risk of delayed treatment and medication errors

1 in 5

People will be 65 or older by 2040³

24%

of people 65 or older assess their health as fair or poor²

Learn how Quality Life Services used Practitioner Engagement with Secure Conversations to improve performance, care outcomes, and efficiency.

[Watch Video](#)



Practitioner Engagement

Practitioner Engagement is a dedicated workspace and app designed to streamline documentation and manage orders on the go, fostering better coordination and collaboration with care teams.

³ ["2023 Profile of Older Americans." U.S. Dept. of Health and Human Services, Administration for Community Living, May 2024.](#)

Coordinated Care Is Data-Driven

Holistic business intelligence grounded in accurate, reliable data helps SNFs identify areas to improve, understand business impacts, and investigate root causes—all of which can be used to anticipate patient needs, improve care quality, and boost financial stability. Clear, consistent reporting empowers organizations to monitor key indicators to proactively manage risk and act swiftly and confidently to identify priorities and deliver effective care.

For instance, predictive return to hospital insights allows SNFs to anticipate patient acuity levels. This enables SNFs to provide more appropriate care and resourcing for better patient outcomes and lower rehospitalization rates.

“Data integration definitely improved our workflow, allowing alerts to fire off in a timely fashion within threshold values and giving administrators and physicians clear visibility into interventions that support better care.”

Kay Loricka, Informatics Nurse, Parker Life Group

Advanced Insights



Advanced Insights gives skilled nursing organizations the operational transparency and business intelligence needed to make data-driven decisions that improve operational outcomes and the quality of resident care. Interactive operational reports make complex data accessible and actionable at the corporate, facility, and resident levels.

[Watch the Video](#)

Coordinated Care Relies on Complete, Accurate Documentation

With higher acuity residents, new regulations, nursing shortages, and rising expectations from hospitals and payers, SNFs are under more pressure than ever to deliver consistent, quality care. Technology that enables the creation of complete and accurate assessments is invaluable. When caregivers can rely on high-quality documentation, they are empowered to deliver effective care, leading to improved clinical outcomes for residents.



Nursing Advantage

Nursing Advantage improves outcomes through comprehensive, diagnoses-based assessments for early detection of changes to a resident's condition, coupled with condition-specific clinical guidance and alerts for proactive interventions.

Case Study

Clinical Insights and Comprehensive Assessments Improve Care Quality



Lifespace Communities turned to PointClickCare's Nursing Advantage solution to support their nurses with best-practice, diagnosis-based assessments that thoroughly evaluate each resident's condition and help nurses proactively react to resident changes across 17 communities in seven states.

15% increase
in Five-Star Quality Ratings

26% decrease
in hospitalization rates

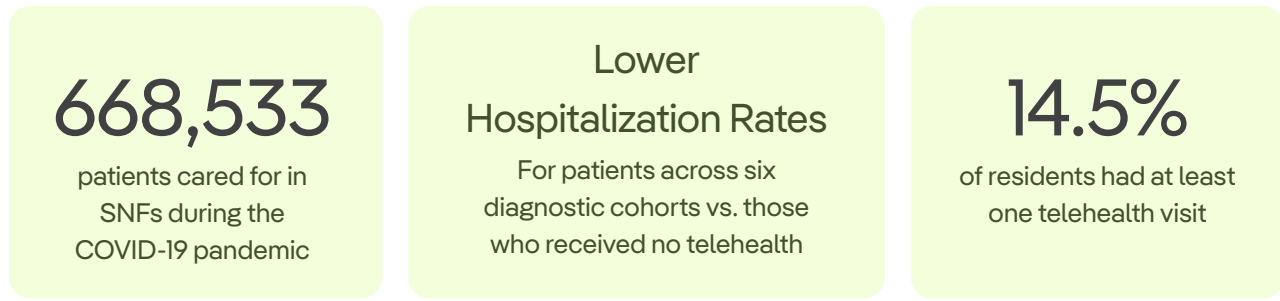
Learn more about how PointClickCare can improve care quality and positively impact resident outcomes.

[Learn More](#)

Coordinated Care Is Patient-Centered

Having a provider familiar with a patient's care available 24/7 ensures senior residents receive the attention and treatments they need when they need them. However, that's not always feasible, especially during nights, weekends, and holidays when practitioner coverage gaps may be more difficult to address. Telemedicine has revolutionized access for SNF residents and caregivers alike, making face-to-face care immediate, keeping patients and their families well-informed, and providing the expertise necessary for staff to make confident care decisions.

COVID-19 Telehealth Impact Study⁴



Virtual Health

Virtual Health tackles staffing shortages and facilitates after-hours care with remote physician access, ensuring high-quality care and reducing preventable, costly hospitalizations. Seamlessly integrating into the EHR, it captures accurate data for improved care collaboration and smoother transitions.

Case Study



Reducing Hospital Readmissions With Telemedicine

Ignite Medical Resorts used PointClickCare's Virtual Health solution to provide access to healthcare professionals outside of regular business hours to increase staff satisfaction, improve patients' clinical outcomes, and streamline operations.

10%
reduction in rehospitalizations within 3 months of implementing Virtual Health

[Learn More](#)

"The staff experience has improved, especially during late shifts. Personally, knowing I can count on immediate support within 10 to 15 minutes would make me much more likely to pick up a night shift. It's a real selling point for the facility."

Tammy Brown, Director of Clinical Informatics, Ignite Medical Resorts

⁴Campion, F., Mathur, A., Konczewski, B. "The Impact of Telehealth on Hospitalization of Skilled Nursing Facility Patients During the COVID-19 Pandemic." *Telehealth and Medicine Today*, July 10, 2023. Accessed Aug. 16, 2024.

Integrated Solutions Accelerate Care Coordination

To improve care coordination, SNFs are integrating smarter, more connected technologies through their EHRs. A connected network gives physicians, nurses, and care managers better visibility into clinical data, enhancing interactions and improving patient outcomes through real-time data and insights that enable facilities to:

- Streamline administrative workflows within the EHR
- Support better after-hours care and decision-making through telehealth services
- Capture details for proper and timely reimbursement
- Maintain compliance with state and federal regulations

Enhance the value of the EHR by integrating additional tools and workflows that support after-hours care, advanced insights, or documentation and reporting to transform care delivery and optimize financial health.



EHR for SNF

PointClickCare's EHR platform offers SNFs a fully integrated, secure solution to improve care coordination and transitions throughout the patient journey, empowering care teams and maximizing clinical and financial outcomes.



Marketplace

Integrated partner solutions available via the PointClickCare Marketplace help organizations maximize the power of their EHR, optimizing existing technology investments to make them more efficient, intelligent, and scalable — all of which powers better resident experiences and higher quality care.

Case Study



Using Data To Improve Response Times and Reduce Errors

To improve care coordination, SNFs are integrating smarter, more connected technologies through their EHRs. A connected network gives physicians, nurses, and care managers better visibility into clinical data, enhancing interactions and improving patient outcomes through real-time data and insights that enable facilities to:

- Streamline administrative workflows within the EHR
- Support better after-hours care and decision-making through telehealth services
- Capture details for proper and timely reimbursement
- Maintain compliance with state and federal regulations

Enhance the value of the EHR by integrating additional tools and workflows that support after-hours care, advanced insights, or documentation and reporting to transform care delivery and optimize financial health.

62%

reduction in time
to chart vitals

96%

faster response to vitals
outside patient thresholds

99%

fewer errors in
recording vitals

Discover how PointClickCare partners help SNFs deliver the highest quality care to patients.

[Read Case Study](#)



Improve Care Coordination With PointClickCare

Access greater real-time data and care insights to enhance collaboration among care teams and enable safer, smoother care transitions with a connected care experience at every stage of the patient healthcare journey.

Providing effective care coordination across the care continuum is challenging for myriad reasons, from disjointed healthcare systems and mismatched technologies to misaligned processes.

Care coordination solutions can help SNFs balance high-quality care with operational efficiency.

The benefits are many, including:

- **Operational benefits** – By integrating care pathways and leveraging tools such as EHRs, organizations can better manage patient flow, reduce administrative burdens, and optimize resource allocation.
- **Clinical benefits** – Care coordination fosters a more comprehensive, personalized approach to managing complex cases and chronic conditions. By managing conditions proactively, SNFs can avoid acute episodes and complications that threaten patient well-being.
- **Financial benefits** – Ensuring patients receive appropriate care and follow-up can reduce redundant tests and procedures and prevent avoidable hospital readmissions that, under VBC models, puts financial reimbursement at risk.

PointClickCare offers products that support care coordination between SNFs, hospitals, behavioral health clinics, pharmacies, and others within the healthcare ecosystem to support high-quality, efficient, and cost-effective care delivery.



Ready To Improve Your Care Coordination?

Implement technology solutions that can help your skilled nursing organization achieve better-integrated care for residents with timely and accurate data insights from PointClickCare.

[Get Started](#)

PointClickCare is a leading health tech company with one simple mission:
to help every provider deliver exceptional care.

Discover more



PointClickCare[®]