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A Better Continuum Means Better Care

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As healthcare providers, our paramount goal is always the health of our patients. With our population ages increasing in the United States and around the world, that means developing an ever-expanding range of services and new ways to deliver them to meet needs not even envisioned just a few years ago.

Today, we're seeing more age-related diseases, including many forms of dementia. Increasing life expectancies have produced new needs and have made us change the way we think about senior care. The results? More partnerships with acute care hospitals, which increase the value of the continuum of care, especially benefitting patients, physicians and hospitals themselves.

Keeping care at one facility, or within one trusted network of care facilities, means better informed care. It helps assure that caregivers know their patients as individuals, as well as their medical histories, perhaps even from when they were in perfect health in a residential setting.

As medical issues progress, or as new conditions develop, following patients along the continuum aids in efforts to manage cognitive conditions and improve medication adherence.

This streamlined system is especially helpful when acute care hospitals partner with post-acute partners to transition patients within a known and trusted network. Tracking patients throughout their care ensures the comprehensive exchange of information so nothing gets lost in a move from care center to hospital or vice versa. The seamless transitions keep patients' health at the forefront, minimizing administrative background noise that might distract from their care.

Trusted partnerships and known pathways of communication allow caregivers on both sides of the relationship to focus on the patient's health rather than the logistics of a complicated move, which minimizes incidents of readmission for the same conditions. Reducing these rates of readmission benefits patients and hospitals, in turn reducing penalties resulting from the Hospital Readmissions Reduction Program.

Providing ongoing follow-up care can be difficult for individual providers. That's why partnerships between acute care hospitals, post-acute care facilities and home care services are so effective. These partnerships ultimately lead to better outcomes -- these outcomes are physical, but they are also mental and emotional. Continuing care within a trusted network makes patients feel more at ease during health challenges. Easing this stress for patients and their families creates a better experience and, in turn, a better environment for recovery and care.

The environment and the actual continuum of care is expanding. Today, with more than one million adults in the U.S. diagnosed annually with a chronic brain disease or disorder, the need for Memory Care is growing at a steady rate.

That's why over the past two years NHC has built three new facilities around Middle Tennessee specifically for those who struggle with cognitive impairment. We see these facilities as investments in patients' futures -- a way to prepare for whatever issues might arise. Together as a healthcare community, we can take steps like these together to improve overall health in and around our city, strengthening the relationships within the continuum of care to improve patient outcomes.

We've seen the results in our affiliated centers across the state -- the expanded continuum of care is reducing hospital readmissions, keeping costs down and even helping to keep some people safely in their own homes with assistance from our range of home care services. As senior care continues to evolve, what was once exceptional in our industry has become standard practice, and facilities across the nation will need to adjust in order to meet the needs of our growing senior population.

Mike Ussery serves as president and chief operating officer for National HealthCare Corporation. He has been with NHC since 1980 and has served as COO since 2009. In January

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