Identifying Key Strategies to Improve Care Coordination

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RELIAS

Speakers

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Founding partner of Case Management Concepts, LLC. She has a 25-year deep working knowledge of case management with specific expertise in denials management, patient flow and the role of the Case Manager and Social Worker in the Case Management process. She has served as a Commissioner on the Commission for Case Management Certification and is a fellow with the Advisory Board. Bev is also the former Vice President of Resource Management at Medical City Dallas Hospital.

Objectives

- Identify key stakeholders in effective care coordination.
- Apply effective care coordination strategies to the role of the RN case manager and social work case manager.
- Develop optimal strategies to impact cost and length of stay.

WHAT IS CARE COORDINATION?

- Involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.
- This means that the patient's needs are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.

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CASE MANAGEMENT IS ALL ABOUT EFFECTIVE CARE COORDINATION

And effective care coordination is the core business of hospitals, and a core responsibility of the case management department!

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VALUE IN HEALTHCARE

- The health outcomes achieved per dollar spent.
- Always defined around the patient.
- Measured by outcomes not by volume.

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MEASURING VALUE IN HEALTHCARE

- Encompasses efficiency and care coordination.
- Cost reduction with regard to the outcomes achieved.
- Relates to the patient's total costs for a full cycle of care.
- Easier to measure under a bundled-payment structure.

$$\text{VALUE} = \frac{\text{Outcomes}}{\text{Cost}}$$

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WHAT ARE OUTCOMES?

- Goals
- Objectives
- Results
- Standards

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DIFFERENCES IN OUTCOMES

Can be linked to variation in structure and process, including clinical care processes as well as system processes

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INTERMEDIATE OUTCOMES

- Those expected goals of care that occur during the course of the hospital stay
- Triggers for change or progression in the treatment process
- Indicate that the patient is progressing toward meeting the discharge outcomes

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DISCHARGE OUTCOMES

- Those expected outcomes that the patient must achieve to be safely discharged from the hospital
- Drive the discharge plan and discharge destination

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RESOURCE MANAGEMENT

- Resources should be consumed based on supportive evidence
- Should be non-duplicative
- Truly necessary
- Free from harm

Choosing Wisely, 2018

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MEASURING THE COST OF CARE

- A cost accounting system is a system for recording, analyzing and allocating cost to the individual services provided to patients (medications, procedures, tests, room and board).
- Organizations without a cost accounting system rely on less accurate measures such as RCC – ratio of cost to charges

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COST ACCOUNTING NEEDED FOR EFFECTIVE CARE COORDINATION

- To manage in an accountable care environment
- To negotiate appropriate rates from third party payers
- To identify opportunities to reduce cost
- To understand total cost of care from in-patient and out-patient
- To bring together financial and clinical outcomes data

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ELEMENTS OF BEST PRACTICE CARE COORDINATION

- Establishing accountability and agreeing on responsibility
- Communicating/sharing knowledge
- Helping with transitions in care
- Assessing patient needs and goals
- Creating a proactive care plan
- Monitoring and follow-up, including responding to changes in patient needs
- Supporting patients' self management goals
- Linking to community resources
- Working to align resources with patient and population needs

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CONTEMPORARY CASE MANAGEMENT ROLES

- Care Coordination
- Utilization and resource management
- Denial management
- Variance tracking
- Transitional and discharge planning
- Quality management
- Readmissions
- Adverse events
- Psychosocial assessments and interventions

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CASE MANAGEMENT'S ROLE IN COORDINATION OF CARE

- The management of all patient care processes that support a patient as they transition through the continuum of care
- In the acute care setting this would include the coordination and facilitation of tests, treatments, procedures, consults and other care interventions

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PURPOSE OF COORDINATION OF CARE

- To optimize each day that the patient is in the acute care setting, including evenings and weekends
- Arrange care interventions that the patients requires to occur in proper sequence
- Facilitate the interventions to ensure that they occur in a timely manner and without delay

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CARE COORDINATION CAN IMPROVE OUTCOMES ACROSS THREE DIMENSIONS

- Improved Patient Safety
- Improved Quality of Care
- Improved Operational Efficiency

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KEY FUNCTIONS OF COORDINATION OF CARE

- Assess every patient on admission
- Reassess patients daily
- Lead and/or attend daily interdisciplinary care rounds
- Create a plan of care that outlines the key interventions and outcomes to be achieved each day of the inpatient stay

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KEY FUNCTIONS con't

- Coordinate the key interventions among and between the members of the interdisciplinary care team
- Coordinate as needed with family and family caregiver(s)
- Identify delays in patient care processes and intervene to correct them

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GOALS OF COORDINATION OF CARE

- Each hospital day is optimized resulting in appropriate length of stay
- The plan of care is expedited and barriers to efficient through-put are identified and corrected resulting in resource management
- Patient care is provided in a timely manner
- The patient moves smoothly through the continuum of care

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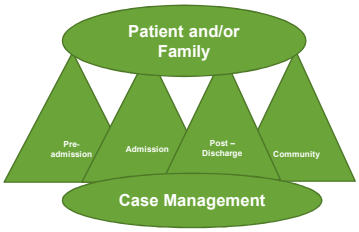

ALIGN BEST PRACTICE
CARE COORDINATION STRATEGIES
ALONG THE CONTINUUM

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INFLUENCES ON EFFECTIVE CARE COORDINATION

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NEGATIVE IMPACTS ON EFFECTIVE CARE COORDINATION

- Poor patient flow
- Case management focusing on themselves rather than focusing on the process
- Consulting specialist timeliness
- Delays in care
- Availability and responsiveness of ancillary services

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NEGATIVE IMPACTS ON EFFECTIVE CARE COORDINATION

- Timeliness of tests and reporting results
- Ability to schedule timely
- Effective communication
- Focused treatment on the reason the patient was admitted (not focusing on “rabbit trail” treatment)
- Avoidable days
- Ineffective discharge planning
- Unfunded/underfunded patients with minimal resources post discharge

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NEGATIVE IMPACTS ON EFFECTIVE CARE COORDINATION

- Availability of post acute care resources, often geographical
- Ineffectiveness of team
- Documentation
- Complications
- Patient acquired
- Hospital acquired
- Ineffective case management and/or hospital leadership

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CASE MANAGEMENT CARE COORDINATION TRANSITIONS

- Case finding
- Patient assessment
- Resource assessment
- Goal setting: What needs to be accomplished and time frame for accomplishment
- Planning: Coordination with all disciplines and all levels of care
- Implementation
- Compliance requirements
- Monitoring/reassessment; and continued interdisciplinary care coordination
- Documentation

Making care seem seamless to the patient, family and/or caregiver

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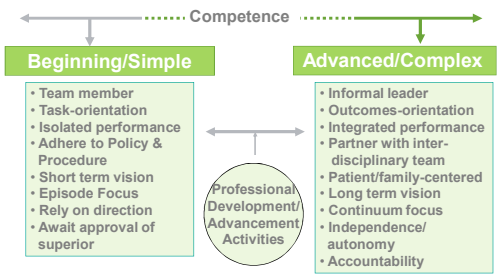
Case Manager's Competence Continuum



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CHARACTERISTICS OF EFFECTIVE COORDINATION BY THE CASE MANAGER

- Clinical competence and experience
- Timely identification of transition plans
- Sets milestones, or next steps for patients
- Acts as liaison with families
- Facilitates care plan with physicians, nursing and ancillary services
- Identifies anticipated LOS and updates, as patient transitions
- Reassesses and updates plans

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CHARACTERISTICS OF EFFECTIVE COORDINATION BY THE CASE MANAGER

- Focus on evidence based best practices
- Monitor outcomes
- Clinical
- Financial
- Compliance
- Understand barriers to transitions for individuals and groups of patients: Identify and intervene through coordination
- Focus on both plan for day and plan for stay

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CHARACTERISTICS OF EFFECTIVE COORDINATION BY THE CASE MANAGER

- Collaborate with key ancillary staff
- Consistently track avoidable days
- Apply interventions for correcting delays and barriers

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STRATEGIES FOR EFFECTIVE CARE COORDINATION

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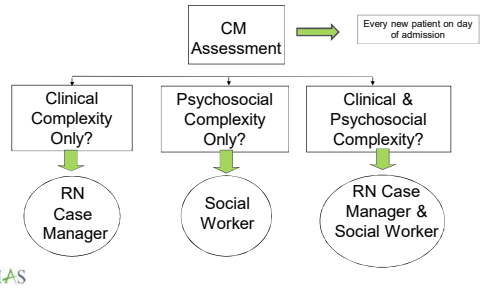
TRIAGE PLAN FOR CARE COORDINATION



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WHAT ABOUT THE PATIENT WHO NEEDS MORE COMPLEX CARE COORDINATION?

- High risk chronic condition
- Frequent admitter: ED, observation or inpatient
- LOS greater than __X___ number of days
- Patients of specific physicians (those most likely to have long stays and/or avoidable days)
- Increased avoidable days
- Unfunded and underfunded
- Multiple diagnoses and high charges
- Psycho/social issues
- Complex patients with minimal family/caregiver support

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THE SILOS OF CARE COORDINATION

IT'S NO LONGER JUST ABOUT US!

CARE COORDINATION INCLUDES THE PATIENT AND FAMILY/CAREGIVER

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ROLE OF THE TEAM IN CARE COORDINATION

- Identify the team
- Assure each team member understands their critical role

- "Utilizing cohesive teams limits adverse events (AE) (e.g. including morbidity/mortality), improves patient outcomes, decreases patient length of stay (LOS), and increases patient satisfaction"

Surgical Neurology International, 2014
National Institutes of Health

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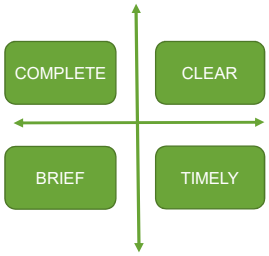
EFFECTIVE COMMUNICATION



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IN-PATIENT AND OUT-PATIENT COORDINATION

- Safe and timely communication hand-offs
  - Verbal and written
- Action items for follow-up in the community
  - Tests completed but not reported in the hospital
  - MD appointment within 7 days
  - Prevention of readmissions in the ED
- Information technology

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INTERDISCIPLINARY IMPACT ON CARE COORDINATION

- Bedside rounds
- Effective multidisciplinary discharge planning rounds
- Long stay care conferences
- Unfunded/underfunded care conferences
- Patient/family care conference
- Connect patients to OP services to decrease readmissions
- Discharge lounge
- Care coordination has a direct impact on LOS, which has a direct impact on Medicare Spending Per Beneficiary

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CARE COORDINATION STRATEGIES

1. Develop LOS goals for predictable populations first: population where there is a likelihood for standardization
2. Identify critical team members
3. Develop process time frame for goals for predictable populations
   - Pre-hospital phase
   - Hospital phase, including operative phase, if appropriate
   - Pre-discharge phase
   - Discharge
   - Post-discharge, especially patients with readmission risk

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CARE COORDINATION STRATEGIES

- For each process time frame identify expectations for the core functions of case management: utilization management, care coordination, discharge planning and resource management
  - Pre-hospital phase
  - Hospital phase, including operative phase, if appropriate
  - Pre-discharge phase
  - Discharge
  - Possible readmission
4. Track and report
   - LOS
   - Avoidable days
   - Discharge destinations
   - Readmissions
   - Denials

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MANAGING RESOURCES IS PART OF CARE COORDINATION

QUALITY	COST
• Poor hand-off communication	• Length of stay
• Delays in service delivery	• Increased or unnecessary use of resources
• Over or under-use of resources	• Returns to the emergency department
	• Preventable admissions/readmissions

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CARE COORDINATION STRATEGIES FOR LONG STAY PATIENTS

- Identify most vulnerable groups of long stay patients
  - Diagnosis
  - Dually eligible
  - Other
- Define long stay: Patients staying longer than a specific number of days
- Develop approach
  - Identify patients
  - Have long stay rounds
  - Include physician advisor
  - Partner with ancillary and nursing colleagues
- Use long stay patients as case studies or grand rounds to improve future lengths of stay

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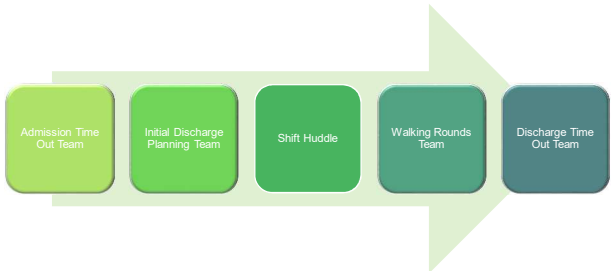
TEAMS IMPACTING EFFECTIVE CARE COORDINATION



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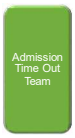
TEAMS IMPACTING EFFECTIVE CARE COORDINATION



- Review medical necessity
- Identify any present on admission diagnosis
- Initiate any core measures
- Readmission risk
- Specific needs—clinical, financial, family, psycho/social
- Implement appropriate compliance requirements
  - 2 midnight rule
  - Discharge planning assessment and reassessment
  - MOON delivery, if observation service

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TEAMS IMPACTING EFFECTIVE CARE COORDINATION

- Extended discharge planning needs from admission time out
- Based on initial assessment
- Must be conducted face to face

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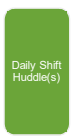
TEAMS IMPACTING EFFECTIVE CARE COORDINATION



- Shift discussion with key representatives from multidisciplinary team
- Continued stay medical necessity
- Barriers to discharge
- Other critical patient needs

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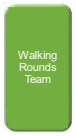
TEAMS IMPACTING EFFECTIVE CARE COORDINATION



- Multidisciplinary rounding at bedside
- Includes patient and family, as appropriate

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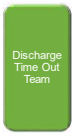
TEAMS IMPACTING EFFECTIVE CARE COORDINATION



- Allows staff to have the opportunity to ensure that all appropriate actions have been taken before patient leaves hospital
- Review discharge plan
- Identify likelihood for readmission
- Complete core measures requirements
- Close the loop on any needs identified in any earlier team meetings

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CARE COORDINATION DOCUMENTATION

MEDICAL RECORD

- Outcomes of assessment
- Communication (except with payer), referrals, interventions
- Plan of care (from the assessment)
- Record of interdisciplinary team meetings
- Record of family meetings
- Anticipated discharge date (depending on agreement with physician)
- Expected discharge disposition

CASE MANAGEMENT SOFTWARE (NOT IN MEDICAL RECORD)

- Communication with payer
- Variances/avoidable days (in case management software)
- Agreement or disagreement with denials identified by payer
- Anticipated discharge date

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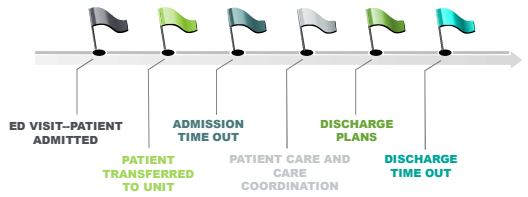
EFFECTIVE TIME-OUTS



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HISTORY OF THE TIME OUT

- 1999 Institute of Medicine (IOM): "To Err Is Human" identified surgical injuries, near misses and deaths
- 2003: Time-out for procedures first identified as National Patient Safety Goal to prevent wrong sided surgery
- Nonprocedural time out
  - July 2011: Society for Hospital Medicine published an article, Critical Conversations: A Call for a Nonprocedural "Time Out"
  - Critical conversations tool:
    - Innovative communication tool to potentially limit communication failures at critical junctures
    - Purpose: Ensure high quality and safe care

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DISCHARGE TIME OUT

Purpose

- Identify risk areas for patient discharge and transition to next level of care: Readmission, quality, finance, care coordination, appropriate transition to next level of care, safe discharge, compliance, patient choice, patient experience, CDI
- Improve relative lack of attention to detail from hospital team at time of discharge (compared to admission process)

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DISCHARGE TIME-OUT: INSTITUTE FOR HEALTHCARE IMPROVEMENT RECOMMENDATIONS

- Schedule the date and time of discharge with the patient and family and place the dates on white board
- Orchestrate the discharge by completion of the following (one day ahead of time)
  - Education
  - Medication reconciliation
  - Notify all ancillary services (by whiteboard, extranet notification and/or phone call)
- Synchronize admissions and transfers to discharge schedule

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DISCHARGE TIME-OUT CAN BE COORDINATED BY VARIOUS CASE MANAGEMENT TEAM MEMBERS

- RN case manager
- Social worker
- Complex discharge planning social worker
- Perioperative case manager: patients discharged same day
- ED case manager and/or social worker—for patients held in ED, but never transferred to floor

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OTHER STRATEGIES FOR EFFECTIVE CARE COORDINATION

- Huddles
- Care Conferences
- Walking Rounds
- Physician Rounds

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HUDDLES

- Shortened version of patient care rounds
- Typically done in the afternoon as a follow-up to the full rounds done in the morning
- Can be scheduled or impromptu
- Usually attended by staff RN, case manager, social worker (if appropriate)—may be with or without hospitalist
- Best if scheduled at same time each day
- Allows each huddle member to be prepared with outcomes, questions, concerns
- May not need to include every patient
- Should include patients with outstanding issues identified during morning rounds

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PATIENT CARE CONFERENCES

- Adjunct to walking rounds
- Used when additional information needs to be discussed or shared
- Provides opportunity for team to have more in-depth discussion of issues such as:
  - End-of-life
  - Family barriers
  - Other discharge delay issues
- May include family members or family care givers

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WALKING ROUNDS

- Key care coordination strategy
- Real-time in-person exchange of information
- Makes goals and plan of care for each patient clear to all members of team
- Formal and organized approach to patient care
- Ensures patient/family receive consistent and accurate information
- Increases efficiency and safety of patient care
- Decreases gaps
- May be proactive process to eliminate avoidable days or delays

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WHY WALKING ROUNDS?

- Enables all members of the team caring for the patient to offer individual expertise and contribute to patient care
- Disciplines come together to coordinate care
- Improves communication among and between team members
- Considered best practice by the Institute for Healthcare Improvement (IHI), The Joint Commission and The Institute of Medicine
  - Mechanism for interdisciplinary collaboration
  - Decision support at patient care level
  - Evidence-based management processes

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WALKING ROUNDS AS AN ADJUNCT TO CARE COORDINATION

- Critical to care coordination
- Is not report
- Should focus on
  - In-patient plan of care
  - Expected outcomes of care
  - Barriers to care
  - Transitions in hospital (one level of care to the next)
  - Transitions out of hospital
- Script your rounds
- Share patient tips and checklist for patients and caregivers

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ROUNDS FOCUS – COORDINATION OF CARE AND COMMUNICATION

COORDINATION OF CARE

- Coordinate care among disciplines
- Review the patient's current status
- Clarify patient goals and desired outcomes
- Create a comprehensive plan of care
- Identification of safety risks
- Identification of daily goals
- Patient education
- A consistent approach by all team members

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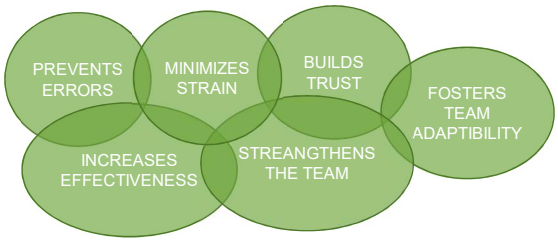
COMMUNICATION AND TEAMWORK ON ROUNDS



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SETTING DAILY GOALS

- Determine the key goal or goals for the day;
- Document the goals so that they are readily accessible to the care team and the patient and family;
- Provide daily feedback on the goals to refine and reset them for the current day.

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EXAMPLES OF DAILY GOALS

- Discontinue oxygen by 4 pm
- Wean off vasopressors by midnight
- Mobilize the patient to walk 20 feet
- Initiate hospice referral

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SEGMENTING ROUNDS

- You may segment populations on units to retain consistency among team members
- Use staff nurse as frame of reference
- If rounding with specialty physicians, focus on those patients with that physician – for example heart failure

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STUDY OF IMPACT OF BEDSIDE INTERDISCIPLINARY ROUNDS ON LOS AND COMPLICATIONS

- Occurred daily at 10:00 or 10:30 (2 research groups—control and study group)
- Transformed daily rounds in a conference room model to structure bedside model with scripted roles
- Attendees: Hospitalist, staff nurses, unit medical director, nurse manager, social worker, case manager
- Focus: Plan of care and disposition with structured script
- Did not last longer than 30 minutes
- No difference in LOS in the 2 study groups, but LOS was decreased for patients transferred to the study unit
- Team results
  - Benefits ranked highest: Communication, coordination and teamwork
  - Greatest barriers: Efficiency and outcomes
- Needs to be further studies

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ENGAGING PATIENT AND FAMILY IN ROUNDING PROCESS

- Invite families to participate – this can be very powerful
- Orient the family to rounds before inviting them include:
  - Focus
  - Routine
  - Expectations
- Post time of rounds
- When rounds begin, start with brief introduction to patient and family
  - Purpose
  - Time
  - Encourage participation, but develop boundaries for “rabbit trail” discussions

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CASE MANAGER ROUNDING PROCESS

- Review admission status – inpatient versus observation
- Review case management admission assessment
- Review initial discharge plan and payer
- Review expected LOS and discharge date

- Discuss expected LOS and discharge day
- Discuss discharge plan, or updated plan, with patient and family
- Identify any additional patient education needs
- Identify any social work triggers for referral to social work

- Clarify next steps based on patient's goals achievement
- Document any changes to discharge plan
- Refer to social work as needed

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SOCIAL WORKER ROUNDING PROCESS

- Review case management admission assessment
- Screen patient for psychosocial needs
- Review initial discharge plan
- Review expected LOS and discharge date

- Discuss expected LOS and discharge day
- Discuss discharge plan, or updated plan, with patient and family
- If accepting the case review/begin psychosocial assessment

- Clarify next steps based on patient's goals achievement
- Document any changes to discharge plan
- Complete in-depth psychosocial assessment

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TALKING POINTS FOR INTERDISCIPLINARY ROUNDS

GENERAL INFORMATION REGARDING ROUNDS

Rounds must occur daily, Monday through Friday, at a consistent time

Ideally, rounds would also occur on weekends

All critical members of interdisciplinary team are expected to attend

Physician and nurse manager will facilitate rounds

PROCESS FOR ROUNDS

Each person has talking points

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WALKING ROUNDS OUTCOME MEASURES

- Reduction in Length of stay
- Reduction in ICU patient days, including ventilator days
- Reductions in morbidity and mortality
  - Proactive approach to patient care through collaboration and use of evidence-based care bundles helps care goals become realities
- Quick assessment and checks
  - Environmental check
  - Safety check
  - Regulatory check

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WALKING ROUNDS OUTCOME MEASURES

- Decrease in number of pharmacy changes
- Decrease in number of discharge delays
- Improved patient satisfaction
- Improved staff satisfaction and education

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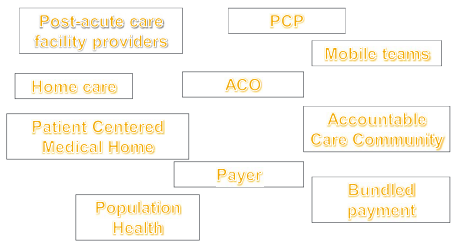
CARE COORDINATION MUST ALIGN WITH NEXT LEVEL OF CARE PROVIDERS



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EXPECTED RESULTS FROM EFFECTIVE POST-ACUTE CARE COORDINATION

- Decreased ED utilization
- Decreased readmissions
- Decreased costs
- Improved quality
- Improved patient satisfaction

Not just in the hospital, but across the continuum

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COORDINATING CARE WITH POST-ACUTE CARE

- We can no longer refer to a post-acute care provider (facility or home care) without providing the patient with complete information regarding the quality of the provider
- Post-acute care facilities/home care must prove their "worth" to receive referrals from us
- We must expect high quality care and outcomes for our hospital-owned or system-owned acute care providers
- We must be aware of any other network in which the patient may be involved
  - ACO
  - Bundled payment
  - PCMH
  - Population health

RELIAS 77

POST-DISCHARGE FOLLOW-UP

Phone calls to patients after discharge

- Did home care arrive?
- Did DME equipment arrive?
- Are you taking your medications?
- When is your next md appointment?
- Do you have a way to get to the md appointment?

RELIAS 78

HOME CARE IS CRITICAL

- Make sure patients have at least one home visit
- Medication reconciliation can be repeated by home care
- Patient education can be reinforced

RELIAS 79

Identification of Patients for Referral to Home Care Services Guidelines for Home Care Assessment (1)

- Patients requiring assessments/education relating to:
  - New diagnosis
  - New medications or change in medications
- Change in patients physical environment and/or new assistive device.
- Patients with unstable disease process; cardio/pulmonary, diabetes, neurological, neuromuscular, metabolic, cerebrovascular, cardiovascular, renal, cancer, pediatric/including asthma, premature infants, psychiatric
- Patients with open wounds, VAC wound care, pressure ulcers
- Patients with ostomies, trachs, feeding tubes
- Patients with drainage tubes and catheters
- Patients requiring I.V. and injectable drug therapies

RELIAS 80

Identification of Patients for Referral to Home Care Services Guidelines for Home Care Assessment (2)

- Patients with recent change in functional status including but not limited to: falls, paralysis, fractures, amputation or other physical impairment, change in custodial needs, ortho, neuro and or deconditioned diagnosis
- Patients with pain control management
- Patients with end stage disease and palliative care needs
- Patients with new oxygen and/or nebulizer treatments
- Patients receiving any type of home care services, i.e., CHHA, LTHHCP, PCA, private care, at time of hospital admission
- Patients re-hospitalized within 60 days and/or known history of repeated hospital readmissions.
- Patients requiring expedited discharges (EHD/Bridge Program)

RELIAS 81

THE HOME CARE GUIDELINES CAN BE USED AT:

- Admission
- Patient care rounds
- Individual case conference with members of the health care team
- Inquiry from patient/family/physicians
- Review of medical records

RELIAS 82

DEFINITION OF HOMEBOUND STATUS

Considerable and taxing effort may include

- Needs help of another person to leave home
- Needs assistive devices to leave home
- Needs special transport
- Leaving home exacerbates symptoms (e.g. shortness of breath, pain, anxiety, confusion, fatigue)
- Patient who leaves home infrequently for short durations or for health care MAY STILL be considered homebound. This may include patients who attend:
- Adult day programs
- Outpatient medical care
- Religious services
- Dialysis
- Hairdresser

RELIAS 83

INTERNAL AND EXTERNAL TEAMS TO MOVE FROM VOLUME TO VALUE

INTERNAL TEAMS

- Physicians
- Physician advisor
- Nursing
- Ancillary services
- Midlevel practitioners
- Service line leaders
- RN case managers
- Social workers
- Case management extenders
- Leadership team members
- Executive team champion(s)

EXTERNAL TEAMS

- Next level of care providers
  - Internal to your facility
  - Outside your facility
- Payers who may delay discharges
- Payer medical directors

RELIAS 84

PATIENT-CENTERED MEDICAL HOME

- Agency for Healthcare Research and Quality recognizes that revitalizing the nation's primary care system is foundational to achieving high-quality, accessible, efficient health care
- Primary care medical home, also referred to as the patient-centered medical home, advanced primary care, and the healthcare home, is a promising model for transforming the organization and delivery of primary care
- 5 functions
  - Comprehensive medical care
  - Patient-centered
  - Coordinated care
  - Accessible services
  - Quality and safety

RELIAS 85

POPULATION HEALTH MANAGEMENT (PHM)

- Aggregation of patient data across multiple health information technology resources;
- Analysis of that data into a single, actionable patient record; actions through which care provider improves clinical and financial outcomes
- Typically, PHM programs use a business intelligence tool to aggregate data and provide a comprehensive clinical picture of each patient-- using that data, providers track, and improve, clinical outcomes while lowering costs
- Best-in-class PHM program brings clinical, financial and operational data together from across continuum and provides actionable analytics for providers to improve efficiency and patient care

RELIAS 86

CARE COORDINATION

- Should not be seen as MORE work.

- Should be seen as THE work!

RELIAS 87

PATIENT-CENTEREDNESS

"Patient-centeredness" is a dimension of health care quality in its own right… Its proper incorporation into new health care designs will involve some radical, unfamiliar, and disruptive shifts in control and power, out of the hands of those who give care and into the hands of those who receive it.
-- Don Berwick, IHI

RELIAS 88

BEST PRACTICE

CARE COORDINATION + COMMUNICATION = VALUE



RELIAS 89

RESOURCES

- Porter, M. (2010). What is Value in Healthcare? The New England Journal of Medicine.
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RELIAS 90

IT'S TIME FOR QUESTIONS

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THANK YOU

RELIAS