Major Health System Works with Freed to Automate Care Coordination Workflow

A major health care system wanted to develop a database to enable its patient care coordinators and social workers to more efficiently refer patients to community resources, following hospital discharges. By doing so, the health system wanted to improve the quality of its patient care

Problem to Solve

Given the inevitability of patient transitions, health care providers need to be adept at ensuring that patients get the care they need, when they need it, across the entire care continuum. Yet the reality is that patient transitions from hospitals to other care settings are often the weakest point in the chain of care, putting patients at risk and potentially driving up the cost of care.

As hospitals and clinics seek to improve care coordination with community providers, they are increasingly turning to integrated technology to assist with their efforts. Recently, a major health care system wanted to develop a database to enable its patient care coordinators and social workers to more efficiently and effectively refer patients to community resources, following hospital discharges. By doing so, the health system wanted to improve the quality of its patient care and enhance patient and staff satisfaction.

Strategy & Goals

Applying a rigorous system selection process, the client and Freed chose a customizable care coordination tool developed by a third-party vendor. The client and Freed then prioritized the client's key goals within a three-

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phased approach, which included:

• **Phase 1:**

• **Creating an extensive database of community service providers** – to create an accurate, searchable "one-stop" digital shop of community resources that is simple to maintain

• **Building reporting capabilities into the system –** to report on the locations, providers and services used most frequently to enable staff to make educated contracting and leadership decisions

• **Phase 2:**

• **Creating a direct referral process** – to support efficient electronic communication between system users and community service providers when scheduling services

• **Creating a feedback loop –** to provide the patient or family member with the ability to view upcoming appointments and notify the health provider if the community resource did not complete the services or completed them poorly

• **Phase 3:**

• **Integrating with the EMR system** – to allow patient data to automatically flow to and from the existing EMR and the community referral directory to minimize system transitions and duplication work for providers

Freed led its client and the vendor through a process to align the client's business requirements and the vendor's system functionality. Freed served as project manager and oversaw many specific work streams. These steps included:

• **Mapping current and future state workflow with all parties involved** – this included a 1-day workshop and group interviews with client staff and all levels of leadership to uncover the organization's diverse needs

• **Prioritizing functionality and translating the desired business results** – into specific functional criteria for software development

• **Establishing success criteria metrics** – including administering a survey to compare baseline metrics with post-implementation results

• **Conducting iterative development and testing** – to allow the client to react to the build, and modify as needed

• **Defining a training plan** – for system administrators and creating training videos and tip sheets for all end-users

• **Selecting and customizing desired reports** – from standard and custom options for use by leadership and system administrators

Results

The client successfully created a highly functional database of community resources available to help clinical staff coordinate patient care. Overall, this new care coordination system delivers four principal benefits to the health system:

1. **Leveraging non-medical resources to improve clinical outcomes** – Vetting of community resources ensures that the community care provider(s) selected for the patient match the health system's quality expectations and the patient's location, timing, pricing, and language requirements.

2. **Increasing patient satisfaction and clinical involvement** – Transparent access to information enables patients (as well as their family members and clinical staff) to see their provider-ordered services, appointment dates and times, and caretaker information.

3. **Reducing the cost of care by decreasing workflow inefficiencies** – Efficient communication with community resources improves the patient experience, as well as staff satisfaction and productivity.

4. **Improving staff efficiency** – By instituting a less time-consuming process for patient referrals, patient care coordinators and social workers are now more able to work at the top of their licenses, handle larger caseloads and deliver faster service.

Conclusion

In today's pay-for-performance era, health care providers can no longer have weak or inconsistent relationships with their nearest community-based service providers. There's too much at stake, in terms of patient care quality, satisfaction and reimbursements. Patients and providers need to rely on high quality in-home care from private organizations.

By proactively and systematically facilitating relationships with local community-based service providers, and developing a new care coordination database, the health care system was able to enhance its patient care across the continuum. This initiative is an excellent example of how an effective technology tool can play a critical role in ensuring that broad-based care relationships succeed.