Five Key Steps for Better Health Care Coordination

Incrementally working to enhance your care coordination can positively contribute to the long-term success of your organization.

If there was ever a time for health care organizations to be at their best in care coordination, it's now, during a global pandemic. Amid considerable uncertainty in health care, quality care coordination is largely within your own control and can make an immensely positive impact on those you serve.

While "care coordination" can mean varying things to people, ultimately it's about having a patient-centric approach that consistently anticipates and meets the needs of patients and their caregivers. Think of great care coordination as "seeing around corners" on behalf of patients – helping them know what's next in their care and paving the way for care to happen more smoothly.

Often, great care coordination comes down to a provider's ability to share information, as patients progress from one provider to another, or one care setting to another. For example, this could mean the care and handling an elderly patient receives as she progresses from an inpatient stay to home. In some networks the inpatient case manager differs from the case manager who manages outpatient services. The ability to share information seamlessly is critical to avoid care gaps.

Clinically and financially, superior care coordination can make a real difference toward achieving more consistently positive patient health and reimbursement outcomes, especially in today's pay-for-performance era.

How can you achieve better care coordination results? Consider these five key steps.

Step 1: Champion Your Patient-Centric Mission and Vision

Great care coordination means executing on a mission of meeting patients' needs, first and foremost. It's about *everyone* in a patient's care team collaborating, no matter their specialty, role or location.

Make your patient-centric mission and vision for care coordination specific to your organization. It should be whatever is most relevant to the needs and interests of *your* patients and providers.

At a top leadership level, regularly articulate and champion your vision for care coordination. Then, create advocates and partners for your vision by telling and re-telling why you believe care coordination is so important. Illustrate your "big picture" vision with details. For example, these details might revolve around improving your length-of-stay performance and supporting provider panel management.

Know up-front you may encounter internal roadblocks to your vision. These could range from competing initiatives drawing away leadership attention and resources to outright staff resistance. That's why it's important to use data to show how care coordination can deliver tangible benefits. For instance, you might show how care coordination can help clinical staff work at the top of their licenses and handle growing patient volume.

Step 2: Find and Celebrate Short-Term Accomplishments

Achieving a long-term goal such as improved care coordination requires finding and celebrating short-term and intermediate "wins." These wins are important for helping clinical and non-clinical staff see the direct benefits of their care coordination activities – and engage them in longer-term efforts.

Leverage your organization's existing assets to address future needs. For example, by using existing data related to care coordination, you can create new dashboards and reporting processes to measure productivity, quality and outcomes.

Consider how a leading health care system began with three readily achievable short-term goals for its longer-term care coordination transformation:

1. Integrating in-patient and ambulatory programs into a unified case management team using consistent tools, assessments, care paths and services.
2. Redesigning staffing models to include standardized job descriptions, workflows and documentation.
3. Creating a centralized care transition services "hub" providing seven-days-a-week coverage to streamline patient transitions to appropriate care settings.

Step 3: Get Everyone Talking

Your greatest allies in care coordination transformation efforts are often the clinical staff closest to the daily moving parts of health care, such as hospitalists and nurses. Be sure to engage these clinicians in your care coordination improvement conversations, yet know also the importance of involving those you might not ordinarily think of as care coordination stakeholders.

For example, this could mean getting care coordination buy-in and resources from key non-clinical departments, such as IT and Finance, and even housekeeping and transportation. For example, if your care coordination efforts involve addressing disparate systems and processes used by your inpatient and ambulatory care coordinators, know what additional resources you'll need to change things. If this work involves considerable effort, consider implementing a change management team to address this need.

Step 4: Pay Attention to Workflows

Care coordination barriers often occur due to workflow inefficiencies. That is why documenting current state workflows from those closest to care coordination – providers, case managers, care coordinators and social workers – is so important. Based on this documentation, you'll know better how to improve your workflows.

This work can also serve as a great opportunity to standardize clinical documentation, which is often overlooked. Document workflow benefits through key performance indicators. For example, what's the quantifiable result of delivering complex, coordinated care to patients?

Step 5: Know Your Technology Capabilities

Assess your current technologies to know their capabilities (and limitations) related to care coordination. With high-value work streams, such as those related to tracking length-of-stay, it's better to immediately understand your technology strengths and weakness now than find glaring gaps down the road.

Addressing your technology capabilities can often mean thinking broadly about all of your inputs and outputs. For example, as a health care system was seeking to document items related to expected discharge date, a host of unanswered questions arose, such as: Who is ultimately responsible for determining this? How is it communicated? How does it appear within the system? If you have not thought through answers to questions like these, your best efforts can quickly become derailed.

Conclusion

Improved care coordination benefits all involved, patients and health care providers alike. Incrementally working to enhance your care coordination can positively contribute to the long-term success of your organization.

