Eight Questions to Ask When Using Care Coordination Technology with Community Service Providers

As seen in Becker's Health IT and CIO Review.

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In today's era of value-based care, providers must focus more on care transitions than they have in the past. 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 are often the weakest point in the chain of care, putting patients at risk and potentially driving up the cost of care. This is a huge challenge for health care providers, particularly as new regulatory programs require increased accountability for quality, costs and outcomes across a comprehensive array of health care services. These programs include 2012's Hospital Readmissions Reduction Program (HRRP), which reduces Medicare payments for hospitals with excessive readmissions, and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which rewards physicians for providing higher-quality care.

Based on these new regulatory programs, "coordinated care" now also distinctly includes community-based service providers who assist members in their homes with skilled and unskilled services such as nursing, medication administration, transportation and meal preparation. Hospitals and clinics that establish and maintain quality relationships with community resources like these will more likely provide quality care across the

continuum – and reduce initial hospitalizations and readmissions. The key, however, is care coordination.

As hospitals and clinics seek to improve their care coordination with community providers, they are increasingly turning to integrated technology to enhance their efforts. While the resources, processes, cultures and daily workflows of health care providers vary widely; technology solutions can help organizations significantly enhance their care and decrease their coordination costs.

Transitioning to Technology

The problem is, besides having an inherent, historical unfamiliarity with external care coordination, health care providers are also reluctant to use technology-based coordination tools, according to a recent study published in *The Journal of Managed Care*. The study attributed providers' reticence to a lack of knowledge about patient management, challenges in integrating tools with clinical workflows and a perceived limited value for investment.

For providers seeking to develop a robust and accurate resources database, a care coordination tool developed by a third-party vendor is an option. When selecting a technology solution, the most important factors to consider include up-front costs, system capabilities, and IT support. Some platforms, such as those using Salesforce as their base, may already be approved by an organization's IT security vetting process, and also have dedicated support resources. Other technology solutions will be new and may require an in-depth security assessment and learning curve, both of which will require time and money. Weighing different system options against their cost, security, and functionality is important for selecting the correct platform for each organization.

Regardless of the technology solution, an organization's care coordination system should be able to deliver three principal benefits:

1. Help ensure that patients receive the quality care that they need when transitioning out of the hospital.

2. Ensure that the care providers selected for patients meet their location, timing, pricing, and language requirements.

3. Enable patients (and their family members) to see their provider-ordered services, appointment dates and times, and caretaker information.

Eight Key Questions

When building and adopting a technology-driven community care strategy, here are eight key questions for providers to consider:

1. **Does the system accommodate standardized workflows for discharging patients to their homes?** Clinical workflow components must be in place for successful care coordination, as technology cannot stand on its own.

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2. **Is the database easily accessible and searchable by clinical care coordinators?** Database information must include searchable fields pertaining to the service types provided, the cost and quality of services, and payment types accepted (Medicare, private pay, etc.).

3. **Is there a well-documented training program for clinical staff?** Be sure to have the correct number and type of trained clinical staff available to manage patient referrals to community resources. Remember that patient assessments to determine required external services must be done by an internal staff member or physician.

4. **Does the system have the ability to generate direct referral opportunities?** Enable clinical staff to make referrals directly to community providers. This includes giving physicians the ability to specify the number of treatments or duration of services needed. It also means giving community providers the opportunity to accept and reject referrals.

5. **Can patients directly access the system?** Patients and their families should also be able to browse scheduled appointments and communicate directly with service providers, as referred by clinicians, and have this information communicated back to their primary care provider or care coordinator. In some cases, patients should be able to select their own community providers to fulfill their in-home needs. Providing access to care coordination information through the health system's existing patient portal prevents confusion and allows for a "one-stop shop."

6. **Can the system directly integrate with your EMR?** Integrating the system with your existing EMR allows patient data to automatically flow from one system to the other without time-consuming and error-prone manual data entry. Data entered into one system should be pulled into and accessible in the other system (e.g., referrals completed in the care coordination system should also appear in the patient's Epic medical record).

7. **Can the system provide a feedback loop?** Give patients the ability to easily notify the health provider if the community service provider did not complete specified services, if the services did not meet expectations, or if they chose a different provider, and why. Enable clinical staff to easily follow up with patients and/or community providers to ensure that services are provided satisfactorily.

8. **Does the system include reporting capability?** Build reporting capabilities into the system to facilitate educated contracting and leadership decisions. The number of providers who can provide a specific service to a specific population, or the number of referrals made for a specific service during a given time period, for example, can influence health plan strategy and effectiveness.

Conclusion

Given today's pay-for-performance era, health care providers can no longer take for granted or have weak or inconsistent relationships with their nearest community-based service providers. There's too much at stake – for

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patients and provider reimbursements, satisfaction and quality. Patients need to receive the same degree of quality in-home care from private organizations that they would receive from care teams at their hospital or physician group. Wasting time with inefficient care management processes and systems delays patient care and decreases staff's case capacity, compromising revenue opportunities.

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