Clinical Integration And Care Coordination: A Means To Reducing Fragmentation

Building Leaders – Transforming Hospitals – Improving Care
Who We Are

Our Company
Formerly known as Brim Healthcare we have a 45 year track record of delivering superior clinical & operating results for our clients.

Our Team
Our Executive Team has experience in managing hospitals from multi-billion $ healthcare systems to community hospitals

Our Mission
We believe that the combination of People, Process & Technology transforms healthcare & provides the required results

Management
• Turnaround Strategy
• Financial
• Operations
• Corporate Compliance
• Board Development

Consulting
• Regulatory Compliance and Accreditation Preparation
• Lean Process Improvement
• Community Health Needs Assessments

Placement
• Executive Recruiting
• Interim Executive Placements
• Mid-level and Specialty Placements

Technology
• Gaffey Revenue Cycle Management
• CrossTX Population Health Platform
• Optimum Productivity

© HTS3 2016  |  Page 2

Building Leaders – Transforming Hospitals – Improving Care
Diane began her health care career as a staff nurse in the Emergency Department of a major Medical Center. She has worked in diverse areas of nursing in acute care, long term care, and behavioral health. While in the U.S. Army, she advanced to Chief Nurse of a 400-bed field hospital, and again was appointed as the Chief Nurse in a multihospital system after the Army. Diane has been in her current position as Regional Chief Clinical Officer with HealthTechS3 for almost seven years.

In her role as Regional Chief Clinical Officer, Diane provides guidance and assistance to hospitals to integrate her expertise into operations, clinical areas, quality and patient safety, and board functions. Her special interests include mentoring and coaching clinicians, leadership development, quality and patient safety, patient engagement, conducting mock surveys, and especially addressing the unique needs of each organization and the demographic they serve.
Instructions for Today’s Webinar

• You may type a question in the text box if you have a question during the presentation.

• We will try to cover all of your questions – but if we don’t get to them during the webinar we will follow-up with you by e-mail.

• You may also send questions after the webinar to Diane Bradley (contact information is included at the end of the presentation).

• The webinar will be recorded and the recording will be available on the HealthTechS3 web site www.healthtechs3.com

HealthTechS3 hopes that the information contained herein will be informative and helpful on industry topics. However, please note that this information is not intended to be definitive. HealthTechS3 and its affiliates expressly disclaim any and all liability, whatsoever, for any such information and for any use made thereof. HealthTechS3 does not and shall not have any authority to develop substantive billing or coding policies for any hospital, clinic or their respective personnel, and any such final responsibility remains exclusively with the hospital, clinic or their respective personnel. HealthTechS3 recommends that hospitals, clinics, their respective personnel, and all other third party recipients of this information consult original source materials and qualified healthcare regulatory counsel for specific guidance in healthcare reimbursement and regulatory matters.
Clinical integration is a term that describes the integration of clinical information and healthcare delivery services from distinct entities. Clinical integration refers to the coordination of care across a continuum of services, including preventive, outpatient, inpatient acute hospital care, post-acute including skilled nursing, rehabilitation, home health services, and palliative care to improve the value of the care provided.

Source: The Camden Group
Paradigm Shift

FEE for SERVICE

QUALITY
Triple Aim

- Experience of Care
- Health of a Population
- Per Capita Cost

Our Vision: “A health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren”

Triple Aim:
- Population Health
- Experience of Care
- Per Capita Cost
Focus

The focus is on:

- Quality – outcomes, wellness
- Patient experience – caring, empathic, patient centered
- Value – low cost, efficient, right place
Aspects of Clinical Integration

Flow of Funds

Contracting Options

Information Technology

Legal Options

Physician Leadership

Participation Criteria

Performance Improvement

Source: Butts, D. Strilesky, M. Fadel, M. Dixon Hughes Goodman
Strategic aspects of Clinical Integration:

- “What do we do?”
- “For whom do we do it?”
- “How do we excel?”
- Determine benchmarks for success
- SWOT analysis
Operational aspects of Clinical Integration:

- Management
- Finance & Budget
- Human Resources
- Measuring Performance (CQI)
- Communications (Internal & External)
- Resource allocation
- Managing risks
- P³ - Policies, processes, procedures
Tactical aspects of Clinical Integration:
Benefits of Clinical Integration

1. Increased Collaboration
2. Improved Efficiency
3. Integrated Systems
4. Payer Partnerships
5. Improved Care Management
6. Integrated Continuum of Care
7. An integrated technology platform
8. Patient-centered Communication
9. Improved Pharmaceutical Management
10. Improved Health of the Community

Care Coordination

Definition: 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 and preferences 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.

Source: ahrq.gov
Care Coordination & Integration

WE CARE ABOUT YOU
Benefits of Comprehensive Care Coordination

- Easier navigation of the healthcare maze
- Individual engagement
- Seamless transitions
- Focus on wellness and not illness
- Individual centered
- Services and information are matched to individual’s needs
- Improved teamwork and communication
- Proactive vs reactive
- Aligning all services to benefit an individual, e.g. community agencies, hospitals, home care
- Effective management of chronic illnesses
- Standardizing practice to improve outcomes
Transitional Care

- Involve all principals
- Conduct an RCA to determine where gaps have occurred that prevented a smooth transition
- Determine priorities for improvement
- Educate care/case management staff
- Educate staff regarding new roles
- Design communication models across the continuum
- Focus and evaluate processes
- Provide leadership – who will be the “cheerleader”
Alignment Steps

- Improve Communication
- Assign Accountability
- IT-Maximize EHR Systems
- Build a Support System for Individuals/Patients
- Build an Effective Referral System
- Build Relationships/Identify/Clarify Roles
Improve Communication

• Standardize communication – forms, e-forms to assure everyone receives information
• Identify patient preferences
• What you need to know, others should know
• Documentation should tell a story – Ø gaps
Assign Accountability

- Dedicated teams for managing individuals/patients
- Who is following up on what
- Define specific responsibilities – transferring patient to other providers
- Referrals to specialists are tracked and completed

"It is not only what WE do, but also what WE do not do for which WE are accountable."
- John Baptiste Molière
IT – Maximize EHR

• Systems have to talk to each other across the continuum of care
• EHR entries should include individual/patient preferences
• Use extensive communication tools/methods
Build Relationships/Identify/Clarify Roles

- Establish clear expectations
- Develop guidelines regarding how information is shared
- Facilitate information sharing between PCPs and specialists
- Determine information that will be shared with other providers, e.g. LTC, Home Health
- Document all agreements in writing to assure compliance
Build an Effective Referral System

• Develop a referral system to manage referrals – track and follow-up
• Generate physician reports regarding referrals – type of specialist, diagnosis, appropriateness of referral
• Establish referral guidelines for physicians
• Assure transparency between PCP and specialist(s) post-referral
Develop Support Systems

- Set up a team to support patients and families
- Keep patients informed and educated
- Assure follow-up post referral visit
- Focus on patient-centeredness
Summary

• Move outside the four walls of the hospital
• Individual/Patient-centered
• Involve physicians in process change
• IT is an essential component of the change we need
• Educate everyone on the changes
• Change will happen whether we do it or someone else makes us change
Upcoming Events

Community Health Needs Assessment: Developing an Action Plan

Date: Friday – December 2, 2016
12:00 – 1:00 p.m. CDT
Host: Carolyn St.Charles, RN, BSN, MBA, Regional Chief Clinical Officer

Leading Change: Shifting To Population Health Management

Date: Monday – December 12, 2016
12:00 – 1:00 p.m. CDT
Host: Diane Bradley, PhD, RN, NEA-BC, CPHQ, FACHE, FACHCA, Regional Clinical Officer
Contact Information

If you would like to schedule a consultation or have questions, please contact:

Diane Bradley
Regional Chief Clinical Officer

Email: diane.bradley@healthtechS3.com
Phone: 585-671-2212
THANK YOU

Diane Bradley, PhD, RN, NEA-BC, CPHQ, FACHE, FACHCA
HealthTechS³
Diane.Bradley@healthtechs3.com