Opportunities for Increased Net Patient Revenue through Improved Care Coordination

nThrive Speakers Bureau // Sample Presentation

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Agenda

- What is “Care Coordination”?
- “Transitions of Care” is the new Discharge Planning
- Critical Metrics for Optimizing Care Coordination/Transitions of Care
- Financial implications of Transitions of Care

What is Care Coordination?

Case Management

- Ensure patients:
  - Are admitted and transitioned to the appropriate level of care
  - Have an effective plan of care
  - Are receiving prescribed treatments
  - Have an advocate
- Plans services needed during and after hospitalization

American Case Management Association

Care Management / Utilization Management

- A “deliberate, longitudinal and pro-active process of sharing information among all providers”
- Intended to avoid:
  - Waste
  - Over, under, or misuse of prescribed medications
  - Conflicting plans of care
- Ultimate Goal:
  - achieve safer and more effective care outcomes

The Agency for Healthcare Research and Quality (AHRQ) and National Quality Forum (NQF)

What is Transitions of Care?

CMS Definition

The movement of a patient from one setting of care to another.

Settings of care may include:

- Outpatient
- Hospitals
- Ambulatory primary care practices
- Ambulatory specialty care practices
- Long-term care facilities
- Home health, and
- Rehabilitation facilities.

Key Statistics

5%
of the Population

USES

50%
of Healthcare Resources

AND

29%
of Individuals with chronic Medical conditions have mental health comorbidities

(Goodell, Druss, Walker, 2011; Perez 2017)

Key Statistics

Average National Cost per Inpatient Stay

$11,259

(Healthcare Cost and Utilization Project 2017)

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