Product Sheet

Care Coordination Manager

Automating care coordination for episode management

With the advent of fee-for-value reimbursement, Accountable Care Organizations (ACOs), and quality measures, hospitals and health systems have millions of dollars in reimbursement tied to outcomes of Medicare and commercial patients. That financial risk now extends for 30 to 90 days after a patient is discharged from an acute admission. Reimbursement is now linked to the quality and the cost of post-acute care, even though this care will likely occur in facilities and with providers not controlled by the health system that originally admitted the patients.

Visibility into the compliance of a patient's post-discharge care plan through the duration of the entire episode is critical, even when the patient is being seen for follow up by independent physicians, treated by home health agencies (HHAs), or admitted to skilled nursing facilities (SNFs) or long-term acute care facilities (LTACs).

Care Coordination Manager is a rules-driven, closed- loop messaging platform that enables hospitals, or other at-risk entities, to share and assign care plan requests across a diverse provider community and get back structured replies. It's the industry's first solution designed to help hospitals, health systems and provider-led health plans succeed with 30 to 90 day episode management, whether for ensuring bundled payment profitability, maximizing ACO savings, managing post-acute costs, or reducing readmissions.

Spanning the care continuum, Care Coordination Manager serves:

- Hospitals
- Home Health
- Health Plans
- MD Groups
- SNFs/LTACs
- ACOs
- Care management companies
- Bundled payment conveners

How we do it

- Based on the healthcare organization's rules, Care Coordination Manager uses feedback received from MDs, SNFs, LTACs, HHAs and other network providers to:
  - » Adjust the care plan accordingly;
  - » Update the patient's episode record;
  - » Trigger care manager intervention when needed.
- Using interoperability standards inherent in every certified electronic health record (EHR), the solution integrates with the EHR of the hospital/health system and those of community providers to streamline coordination and share clinical information required for effective care transitions

What you get

- Full visibility into the compliance of a patient's post-discharge care plan throughout the duration of the entire episode of care
- Certainty of care plan compliance, even 30-90 days after leaving the hospital
- Bundled payment profitability
- Fewer avoidable readmissions
- Reduced post-acute care costs
- Improved patient engagement
- Incremental revenue from Transitional Care Management (TCM) visits
- More efficient use of care managers