Care Coordination: Acute Hospital Becoming a Preferred Provider in the Narrow Network

Length: 1.5 hours

Target Audience: Healthcare professionals including hospital executives, physician executives, nursing directors, post acute providers, nursing home administrators, home health providers, palliative care and hospice providers, and consultants.

Description: There are six programs in the Affordable Care Act that incentivize hospitals to coordinate care with post-acute providers. Improved communication between levels of care, as well as data sharing are just a few of the basic expectations in coordinating care. In this program, participants will learn how health systems are coordinating care with post-acute providers and private duty caretakers through innovation and utilizing new technologies. Participants will hear from thought-leaders in care coordination, readmission prevention and population management. Specific focus will be given to the financial impact of effective care coordination on ACO’s, Bundled Payment Programs (BPIP) and Medicare Spending Per Beneficiary (MSPB).

Faculty: This program is designed to have one moderator and 2-3 panelists:

Moderator: The moderator should be a current or former hospital or health system CEO, COO, CNO or vice president who is a thought leader on care coordination, readmission prevention and population management.

Panelists: Panelists should include (1) a hospital or health plan Director of Case Management, nursing director, or director with direct responsibility for care transitions at the hospital or health system level; and (2) a representative from the state’s CMS designated Quality Improvement Organization, Hospital Association or skilled nursing trade organization; or a skilled nursing administrator or executive. Panelists should have expertise in care coordination and be able to articulate what doctors, hospitals and case managers seek in a quality post acute partner.

Topics for Discussion:

- The six programs in the Affordable Care Act that incentivize Coordinated Care
  - ACO’s
  - Bundled Payment Initiatives
  - Value Based Purchasing
  - Readmission Penalty
  - RAC Audits
Medicare Spending Per Beneficiary

- The traits hospitals and case managers seek in post acute providers
- Relevant data collection for post acute providers to supply to hospital case managers
- The importance of risk stratifying patients
- Ambulatory case management being provided by community and private organizations
- Effective use of the POLST (Physician Orders for Life Sustaining Treatment) form and the Interact “Return to Acute” Log and Root Cause Analysis
- Personalized medicine and how genetic testing is preventing readmissions and reducing medication errors and costs

**Questions for Discussion:**

1. Which of the six coordinated care initiative programs in the ACA is most relevant to hospitals?
2. How do emergency room physicians and case managers change the culture in the Emergency Department to first ask if the patient can be cared for at home?
3. How does genetic testing and knowing a patient’s DNA map assist in preventing unnecessary hospitalization?
4. Can you provide examples of organizations that have driven positive results in coordinating care?
5. How does a post acute provider become part of a hospital’s post acute narrow network?
6. Will hospitals and health systems seek to own or buy post acute services including skilled nursing, home health and hospice?

**Materials for Distribution:**

POLST Form
Interact Return to Acute Log
Interact Return to Acute Root Cause Analysis


**Additional Resources:**

No Place Like Home – [http://www.noplacelikehomeca.com](http://www.noplacelikehomeca.com)

Official Medicare Website – [www.medicare.gov](http://www.medicare.gov)


Cantulpe, R. 2012. “Creeping Toward Care Coordination.” *HealthLeaders* June

http://www.hhnmag.com/display/HHN-news article.dhtml?dcrPath=/templatedata/HF_Common/NewsArticle/data/HHN/Magazine/2013/Jan/01 13HHN_Feature_strategy

American Academy of Family Physicians. “Risk-stratified Care Management.”