The Rehabilitation Nursing Contribution to Value-Based Purchasing for Post-Acute Care
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EXECUTIVE SUMMARY

This white paper is intended for Rehabilitation Nursing Professionals and those struggling with the possibility that in the future where and how they work will likely change. Factors contributing to why and how things are changing face resistance by old habits and historical practices.

The message “healthcare value must be demonstrated everywhere dollars are spent” is inconsistently acknowledged across the continuum of healthcare providers. Providing healthcare requires an objective, a plan, and execution to realize and improve value-information technology and system controls are required.

Every healthcare delivery organization, even if it is not ready to establish an ACO, must build capability to meet value-based purchasing expectations. Nursing support for the delivery of accountable care is critical to ongoing clinical and financial success. The Rehabilitation Nurse will be positioned to assume greater influence in post-acute care management and delivery for patient transitions across integrated provider networks.

For the Rehabilitation Nursing Professional this means advancing their practice with new skills and accountabilities. The functions of the rehab team will be expanded to include other care providers and settings requiring increased communication and coordination around the patient and his care. The potential for the Rehabilitation Nurse’s value contribution exists in key areas of accountable care requirements:

+ Clinical information and point-of-care automation
+ Master data management and integration
+ Health information exchange
+ Patient engagement
+ Care management and coordination
+ Performance management

Management of the continuum of care, resource utilization and gain sharing will demonstrate rehabilitation value... the ultimate goal is to become an Accountable Care provider that shares the risk—and reward—of care delivery. Maximizing the nursing contribution must be a primary objective.
INTRODUCTION

The unsustainable costs of healthcare have created a need for providers to deliver high quality care and doing so at a low cost. Within this environment, the concept of value-based purchasing (VBP) has surfaced as the alternative to fee for service payments. Value-based purchasing is the strategy used by CMS, and increasingly the insurance industry, as a means to stimulate quality and value of healthcare services. Value-based purchasing describes the intent of payers of health care to pay a premium for high quality care that delivers predicted outcomes in the most cost effective efficient manner. The goal of VBP is to create a healthcare system built on value, where every dollar spent is linked to the outcome of care.

This paper reviews an understanding of the economic value of rehab nursing and considerations of changing payment methodologies; expecting refinement of the efforts to identify and measure nursing’s economic value within the broader context of nursing’s value. The inability to understand and explain the economic value of nursing is a liability for nurses in all settings, as well as for patients, for organizations’ viability and for healthcare in general. Healthcare’s transformation is driven primarily by economics and the realization that cost is unsustainable. VBP is standardized, comparative and transparent information on patient outcomes; health care status; patient experience; and costs of services provided. It shifts the Medicare fee-for-service (FFS) payment system, which rewards excessive, costly and complex services, to a payment system that rewards quality and outcomes.

Payment reform has led the initiative and reforming care process and effectiveness has risen to the public consciousness. The question, “is care worth the dollars paid?” is causing payers and providers to look for answers.

At the center of this transformation is the patient. The patient’s ability to access, engage and participate in the decisions affecting care is well established as central to achieving and sustaining better outcomes. All involved with paying for and delivering patient care are challenged to provide that care from the viewpoint and understanding of the patient. This places patient care value on service more than setting. The Rehabilitation Nurse is professionally capable to enforce this standard and influence the evolution of post-acute care delivery for the nation’s population.

Transforming post-acute care to a value-based purchase requires all providers to rethink their patient care delivery and practices, assume accountability for their effectiveness and cost while continually striving to improve patient care outcomes.
What’s needed? More involvement, training, articles, webinars, seminars and conferences that focus on providing practices with the tools, training and experience needed to be more efficient with the efforts they mount.

The need to transform Rehabilitation Nursing professionals to achieve the vision of a reformed health care system requires a balance of skills and perspectives among physicians, nurses and other Rehabilitation professionals.

The current workforce in our Rehabilitation organizations are not prepared to stretch; nurses and other Rehabilitation providers are not changing from paper to digital record keeping and reporting as quickly as needed to gain the insights necessary for rapid improvement. Without the electronic tools to collect and access data, rehabilitation providers are handicapped by the lack of information needed to demonstrate and promote cost-effective care to payers. These data repositories are essential to nursing research and improve clinical outcomes. Rehabilitation Nursing is not advanced with informatics capabilities to support value-based purchasing analytics, leaving this knowledge deficit with a long learning curve to overcome.

It will be hard to find seasoned, experienced nurses to fill this gap. While there is appeal to hiring bright, energetic 23 and 24-year-old nurses, they lack the “element of effectiveness on the job” that comes from having seen and solved problems associated with care requirements and technology deployments. The biggest gap exists in the higher-level set of skilled IT workers with this clinical insight. Clinically experienced nurses will need to step up to this challenge and develop the analytic and informatics skills to meet this need.

Nursing is the largest segment of the nation’s healthcare workforce. Working on the front lines of patient care with more than three million members, nurses are essential in helping realize the objectives set forth in the 2010 Affordable Care Act. Today, many barriers exist. This prevents nurses from effectively responding to rapidly changing healthcare settings and evolving health care system. These barriers must be addressed to ensure that nurses are positioned to lead change and increase healthcare value.

To transform the nation’s post-acute care delivery, all elements of the system must engage. This includes every participant in every sector and discipline. Recognition and acknowledgement that change is necessary is the first step to improving; which means changing professional practice. With change comes opportunity, which will require a refocus in how professionals are prepared and educated. With capability and knowledge, the rehabilitation nurse’s professional skills must be deployed and utilized to maximize each individual’s contribution to the success of improving population health status.
Rehabilitation Nurses manage the patient’s medical and functional limitations within a Rehabilitation facility. These skills are essential to accountable care organizations in managing population health requirements for post-acute episodes. The Rehabilitation Nurse has significant opportunity to contribute to the transformation of post-acute care by applying these care skills in the evolving collaborative team-management delivery settings.

THE FUTURE OF NURSING

The Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM) launched a two-year initiative responding to the need to assess and transform the nursing profession. This report made specific recommendations for transforming nursing practice with the premise that health care transformation requires nursing participation and mutual dependencies. Nursing must transform to maximize their contribution and in doing so creates an expanded role and influence upon the system’s effectiveness. Advanced nursing practice (APRN) will emerge as a cost effective alternative to traditional skill deployments.

The United States has the opportunity to transform its health care system, and nurses can and should play a fundamental role in this transformation. However, the power to improve the current regulatory, business, and organizational conditions does not rest solely with nurses; government, businesses, health care organizations, professional associations, and the insurance industry all must play a role. Only through collaborative effort will these many diverse parties ensure that the health care system provides seamless, affordable, quality care that is accessible to all and leads to improved health outcomes.

The transformation of healthcare is influencing where and how nurses practice. The requirement to demonstrate value will continue to dominate discussion of care cost and effectiveness requiring a focus upon measurement. Value will evolve around two care dimensions deeply embedded in transformation initiatives. The concepts of Accountable Care and Patient-Centered Care will be central to every model of nursing practice. Rehabilitation Nursing will follow this path with development of competencies and training to extend further into settings and systems where rehabilitation is provided.

ACCOUNTABLE CARE

Accountable Care requires practicing beyond the historical boundaries of a disconnected array of providers and the ability to link patient interactions during a discrete episode of acute illness or injury. Even though ACOs are not yet the
dominant model for healthcare delivery and payment, providers in the long-term and post-acute sector will now take steps to obtain a “networked” status integrated with a patient’s episode of care. These programs will rely on rigorous care coordination and well-managed interdisciplinary clinical management to achieve quality outcomes.

Nurses have primary patient care responsibility for attending to a patient’s clinical status requirements. Accountable care requires it delivered in coordination with other providers and clinicians to improve the delivery systems effectiveness. Improving the patient’s medical and functional status is the Rehabilitation Nurse’s primary focus, improving the system’s ability to deliver and achieve better outcome requires refocus upon how care is rendered. Rigorous coordination and interdisciplinary care management improves quality and lowers costs in the long run by reducing readmissions and complications\textsuperscript{6,7}.

**PATIENT-CENTERED CARE**

Patient-centeredness is a dimension of health care quality in its own right, not just because of its connection with other desired aims, like safety and effectiveness. Its proper incorporation into new health care designs will involve some radical, unfamiliar, and disruptive shifts in control and power, out of the hands of those who give care and into the hands of those who receive it.\textsuperscript{8}

Transition from disease-centered to patient-centered care has dramatic effects on nursing. The patient as the source of control and full partner in providing compassionate and coordinated care based on respect for patients’ preferences, values, and needs will alter traditional organization and accountability of nursing structures. This care delivery model eliminates RNs reporting to RNs regarding patient care, flattens the nursing reporting structure, and replaces traditional nurse manager, charge nurse and supervisor positions with additional nurse experts and allied health roles that support direct patient care. Advanced nursing practices opportunities will evolve in post-acute and Rehabilitation settings with the nurses assuming a leader/servant relationship with the patients served. Rehabilitation Nurses need prepare for these positions with education and new skills development to assume greater responsibilities for transforming post-acute care delivery with advanced nursing practices.
BARRIERS

The current state of healthcare presents varied and disconnected barriers to realizing the objectives of Accountable Care to deploy and utilize nurses to full extent of their education, competence and training. Variation in state and professional practice standards prevent a nationwide platform for universal change. These barriers; legal/regulatory, institutional, and cultural restrict access to quality care by limiting APRNs from practicing to the full extent of their education and training.

LEGAL/REGULATORY BARRIERS

+ State practice acts restrict nurses from performing advanced care or ordering supplies, often requiring a physician’s oversight of collaboration to authorize.
+ CMS policy and regulations are slow in adapting changes to recognize advanced nursing practices within Medicare programs. The impact of lower payment on utilization of advanced practice nurses within health care systems, and the current financial incentives that keep many of their services invisible, are significant barriers to identifying and realizing the economic value of their services.
+ Medicaid will not reimburse APRNs codes or pharmacy supplies.
+ Health insurance companies exclude APRNs from provider status.

INSTITUTIONAL BARRIERS

+ Value based purchasing demands accountability for every dollar spent. All healthcare professionals including nurses must enter this reality into their practice mentality
+ Medical staff bylaws prohibit APRNs from admitting patients or performing advanced nursing procedures (invasive monitor placements, catheter or trach removal).

CULTURAL BARRIERS

+ While the benefits of team-based interprofessional care are well documented, implementation remains a challenge, because some patients prefer care by doctors only and because traditional authoritarian leadership models persist in some organizations.
+ Economic interests often restrict professional practice opportunities when perceived as threatening to earning potentials; even when evidence to the contrary exists.9

Value based purchasing demands accountability for every dollar spent. All healthcare professionals including nurses must enter this reality into their practice mentality.
The recognition and intent to maximize nursing skill to the full extent of preparation and professional competency as put forth in the Patient Protection and Affordable Care Act faces many challenges before realizing the goals of reform. Transforming Healthcare will change provider behaviors, nurses can lead by example when they break the habits formed by the practice constraints of the past and use the opportunities provided by the intent accountable care.

**FUNDAMENTAL CHANGES**

One may argue the barriers to healthcare reform far outnumber the potentials for success. Given the complexity of healthcare and the seemingly endless maze of variables to providing care for a person’s condition and problems, the attempt to determine individual value of any therapeutic intervention appears impossible. Still, determining what works best and when applied for the greatest effect is exactly what CMS and commercial healthcare insurers will require for payment of those services. All providers and clinicians must be prepared to respond to the questions of cost and effectiveness of their services.

Nursing care has been not been questioned for its value and importance to patient care. As we enter into the reality of bundling and paying for all episode services with a prescribed amount, providers now must attempt to quantify cost and effect to allocate appropriate resources to accomplish both value and outcome expectations. Value based purchasing demands accountability for every dollar spent. All healthcare professionals including nurses must enter this reality into their practice mentality. This is a fundamental departure from the past; and it will cause significant anxiety for those unable to demonstrate value.

Rehabilitation Nursing is not beyond this scrutiny. Sometimes, poorly understood Rehabilitation Nursing has the additional expectation their efforts contribute to the functional restoration of patients within their care, and a significant reduction in care burden results for those patients and their caregivers. Where is the documentation evidence of this? Evaluating whether the “right” employee is doing the “right” work with the “right” outcomes and at the “right” cost to determine the value of an investment in nursing is a component of practice/delivery system analyses and redesign that requires expertise to complete thoroughly and thoughtfully.10

Nursing leadership must do this. Nurses are caring and compassionate individuals, highly educated and skilled clinicians, with the responsibility to use professional judgment in the course of treatment. Nurses are responsible for making sure patients know how to safely manage their medications and care at home. The tools and capabilities required for practicing value-based accountable care are more complex and far reaching than typical acute hospital EMRs.

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time of discharge may not be the best time to teach patients/families regarding medications or other processes. Failure to teach or to be able to demonstrate that the patient/family received educational materials can lead to medication errors or other safety issues. Documentation is evidence of practice; “if it wasn’t charted, it wasn’t done.” Nursing value is quantified by what they document and record; electronic tools will demonstrate this value if properly used.

The Rehabilitation Nurse must accomplish these expectations in coordination with the team of professionals attempting to accomplish the same care objectives. This care culture and its coordination of activities require management and measurement for effectiveness both in the rehabilitation hospital and across providers upon discharge. Delivering on care plans cost effectively, using clinical technologies and innovations, requires coordinating and integrating the activities and information from multiple care settings and many different providers. This model requires a cultural shift, nurses have to “work harder and think harder” as they do much more than task completion, follow-up and background work. Physicians must recognize and rely on RNs as teammates. The Rehabilitation Nurse will come to rely upon digital information reflecting the patient’s care process and its results to evaluate effectiveness and resources utilized. The tools and capabilities required for practicing value-based accountable care are more complex and far reaching than typical acute hospital EMRs. New skills must be developed practiced and mastered. Communication in the language of informatics and performance improvement will be required. Rehabilitation nurses who advance skill levels to include clinical data analytics and management intelligence disciplines will find greater opportunities in the new post-acute care environment.

The Rehabilitation Nurse will exert significant influence upon value in post-acute care delivery. We associate this influence with the value determinations for future care requirements and its payment. This influence is demonstrated through administrative and clinical functions required for operating in a value-based purchased care delivery environment. Value levers will help identify the opportunities where the Rehabilitation Nurse alters patient care management and coordination of post-acute care.

A lever is one of the 6 classic “simple machines” that change the magnitude of force. This very definition describes a value lever. With data tools nurses will increase the effectiveness of their efforts in achieving desired results. The following six areas of nursing practice are value levers where the Rehabilitation Nurse will influence and improve care systems with advanced tools and skill sets.
Successful value-based accountable care requires:

+ Clinical information and point-of-care automation
+ Master data management and integration
+ Health information exchange
+ Patient engagement
+ Care management and coordination
+ Performance management

**CLINICAL INFORMATION AND POINT-OF-CARE DOCUMENTATIONS**

Practicing accountable care requires the provider to deliver patient care that is responsive to immediate circumstance and consistent with a longitudinal care plan across the episode’s continuum of care.

Access to information about the patient, whenever and wherever is required for care providers to make decisions, is at the center of accountable care capabilities. Nursing value relies upon the use of this information and is reflective of its accuracy and timeliness.

Healthcare providers communicate primarily through the notes they write in a patient’s chart; nurses should seek to continually improve the speed, timeliness and accuracy of patient charting.

Throughout the care delivery process, providers will ensure that incremental healthcare decisions and interventions are consistent with the overall plan for that patient. Concurrent nursing assessment and interpretation of plan of care effectiveness is first line intelligence for delivery process control. The Rehabilitation Nurse will become proficient in recognizing, reporting and correcting care plan variance.

**DATA MANAGEMENT AND INTEGRATION**

Rehabilitation Nursing documentation is not just for nursing personnel, it must be integrated with the requirements to provide meaningful information and use by all providers and the patient across the episode continuum. Advanced nursing practice for Rehabilitation will step up to insure this requirement is met with standardized data and reporting within and across post-acute systems of care delivery. Nursing will advance clinical data use to support practice transformation from a reactive model of patient care to a proactive disease management model, analyzing population data to effectively measure, monitor and manage care of patients and present results and outcomes to executive leadership and professional groups. This will require more than a minimal data set to accomplish.
In addition to documenting care performed, accountable care requires the measurement and reporting of care effect and outcome. Caregivers will complain about and resist this added documentation requirement, but without these data a provider will be lacking evidence to support an equity share of bundled payment or performance incentives.

Currently, insufficient data exists on the numbers and types of health professionals currently employed, where they are employed, and in what roles. The Rehabilitation Nurse in advanced practice will understand the impact of bundled payments, accountable care organizations, health information technology, comparative effectiveness, patient engagement, and safety, and the growing diversity of the American population to analyze the need for Rehabilitation nursing personnel in various settings of care. For cost-effectiveness comparisons, for example, different team configurations, continuing education and on-the-job training programs, incentives, and workflow arrangements—all of which affect the efficient use of the health care workforce—must be evaluated. These data are vital in the development of accurate models for projecting workforce capacity. Those projections will inform and guide the transformation of nursing practice and education.12

ACOs are data-driven. Moreover, the data is dynamic. They are not looking at last month's data printed in a monthly report. They are looking at yesterday's data to make decisions about what should happen now. For you to improve your influence within these systems, you need to be data-driven and talking about today's data. Your ability to partner within ACOs requires an understanding the reimbursement issues associated with the professional skills required and the operational constraints associated with paying for them. ACOs need care management intelligence and individuals with advanced nursing skills to direct patients through these systems. They are moving away from nurses who have just long-term care background because they do not have the right kind of training needed for this transitional care.

**HEALTH INFORMATION EXCHANGE**

Industry sources agree, “Health information exchange is the transmission of healthcare-related data among providers, facilities, health information organizations and government agencies, according to national standards for interoperability, security and confidentiality. The HIE implementation challenge will be to create a standardized interoperable model that is patient-centric, trusted, longitudinal, scalable, reliable and financially sustainable”.13 And like healthcare transformation, the barriers to achieving these objectives have slowed progress requiring the rethinking and assessment of each step taken.
Whether national priority or departmental requirement the need to share and communicate electronic healthcare information is the lifeblood of our care delivery effectiveness. The requirement must be continually addressed and solutions developed to place patient centric information in front of those who need it.

The accountable healthcare delivery organization must transcend the limits of disparate systems in use across the continuum of patient care. Along with robust enterprise data management practices, HIE enables the transmission and exchange of information beyond the boundaries of the enterprise. The coordination of care and transfer of patients within and between integrated care providers demands the exchange of health information without compromise. At the minimum, a patient longitudinal plan of care should accompany the patient throughout the post-acute care episode. Nursing personnel should make this exchange a priority.

Rehabilitation Nurses will ensure that patient-level clinical information, updates and clinical decision support are not only available but also populated with the most current version of the information that is required. The care plan is the most current clinical and demographic information about the patient and about available care providers. The Rehabilitation Nurse will insure the care plan is delivered, monitored, adjusted and updated.

**PATIENT ENGAGEMENT**

Mobilizing patients to participate as partners in the delivery of accountable care will be new territory for most health delivery organizations. Careful choices and priority setting will be required to ensure that investments in patient engagement are consistent and leveraged to promote accountable care capabilities. The actions that patients take to better control their health and benefit from care is crucial to achieving better health outcomes and a more efficient health system. Payer-supported consumer engagement will be required to provide incentives for individuals to stimulate patient behaviors. The Rehabilitation Nurse will be looked to for information and education to assist patients as they navigate through complex and convoluted decisions required in their care and health management choices.

The National eHealth Collaborative has outlined a Patient Engagement Framework and resource tools to assist developing strategies to improve patient participation within provider care models. Nurses will appreciate this work to assist their roles as leader/servants for patient engagement.
CARE MANAGEMENT AND COORDINATION

Delivering accountable care requires mechanisms to manage and coordinate the efforts of all the participants. Collectively, care management and coordination tools provide that order and accountability for the providers of care. They support collaboration and cooperation and they provide the framework for continuous improvement in accountable care delivery at the individual patient level.

Accountable care management and coordination activities have their roots in traditional care management tools and techniques, such as: care planning and management, disease management, case management and discharge planning. The move from managing care for an individual patient in a hospital to management and coordination of the activities of many providers in a variety of settings and addressing patient needs before they present clinically while obviating the potentials of poor care consequences requires access to and command of relevant information. A single source for information to accomplish these requirements does not currently exist; nurses accepting this responsibility will need be skilled in multiple data systems to integrate the necessary information to plan and optimize effective patient centered care plans.

Successful organizations share several important features: care management strategies directed by nurses who were integral to the organization’s practice model, who coordinated care and communication between the patient and all members of the interdisciplinary team serving the patient and who directly provided health care services via in-person and telephonic/electronic methods.

Increasing evidence is showing that enhanced and integral involvement of nurses in both the coordination and delivery of care, particularly for patients enduring multiple chronic illnesses and complex care regimens, and in care management is critical to achieving cost and quality targets. Rehabilitation Nursing embodies these practice requirements. The dedicated transitional care nurse or navigation nurse works with patients, families and medical staff to ensure smooth transitions into and out of the unit, facility and episode.

Accountable care management and coordination activities are likely to include the activities of many providers in many care settings and address patient needs before the onset of an acute episode. This extends well into the follow-up wellness activities and lifestyle management strategies that may be required to manage recovery and prevent recurrence. Nursing must look to extend their influence and control into the practices beyond their specific setting.
The skilled Rehabilitation Nurse has the opportunity to engage and address the broader scope of responsibilities that accountable care requires, moving from the management of an individual patient in a particular care setting, to managing and coordinating care across settings and professionals within the broader continuum for the patient episode. This opportunity is the expectation of advanced nursing practice. The care management and coordination strategies adopted by ACOs and other types of integrated delivery systems require an RN workforce that is linked to the patient, can readily transition with the patient across time and care settings and is ultimately accountable for outcomes that transcend time and place. RNs working in this context are by the ACO, one of its practices or contracting care coordination organizations and would be responsible for care management for the most complexly ill patients in the group and for their care transitions. These transitions would include from hospital to home or other post-acute setting, from home to hospital or from ongoing primary care to intensive outpatient secondary care.

Care quality and outcome is enhanced with these practices and will be a value purchasing criteria for future payments. The American Nurses Association position endorses this role of the nurse.

1) Patient-centered care coordination is a core professional standard and competency for all registered nursing practice. Based on a partnership guided by the healthcare consumer’s and family’s needs and preferences, the registered nurse is integral to patient care quality, satisfaction, and the effective and efficient use of health care resources. Registered nurses are qualified and educated for the role of care coordination, especially with high risk and vulnerable populations.

2) In partnership with other healthcare professionals, registered nurses have demonstrated leadership and innovation in the design, implementation, and evaluation of successful team-based care coordination processes and models. The contributions of registered nurses performing care coordination services must be defined, measured and reported to ensure appropriate financial and systemic incentives for the professional care coordination role. The transitional care coordinator is a nurse who helps patients “connect the dots” between providers in the episode continuum. A key function is to serve as a liaison between the patient’s many providers, knowing who is available to deliver follow-up care, knowing which health plans they work with, and who should be contacted to get things moving and assure the care plan is performed without interruption or mishap. The concept of coordinated transitional care has been around for decades. However, due to the upfront costs involved, few hospitals have implemented it. The solution is to hire a
Rehabilitation Nurse for this role. Not only are they cost-effective, they are trained and experienced in interdisciplinary team care and often practice across a wide range of disciplines. This skill set enables them to connect with a wide range of providers and effectively guide patients through the medical maze.

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ACOs have deployed a Rehabilitation Nurse and in this role, their contribution to care value is demonstrated through:

1. Screening Patient Problems and Quick Solution Response
2. Engaging Elderly/Caregivers as the go-to-First Resource for Knowledge and Education
3. Managing Acute and Chronic Symptoms
4. Educating/Promoting Self-Management and Functional Independence
5. Collaborating with all Providers
6. Assuring Continuity and Longitudinal Care Plan Update
7. Coordinating Care
8. Maintaining Relationships
PERFORMANCE MANAGEMENT

Patient care effectiveness is resultant of and determined by the delivery system that it provides. Nurses will influence system level performance through their individual attention to patient care requirements and the coordination with other elements of the system.

Nurses support the development of insights, interpretation and recommendations for improvements in clinical, quality, administrative and financial performance.

Initially these capabilities will be retrospective, but the objective must be to integrate them into the analytical tools that support point-of-care decisions, care management and coordination across the continuum of care.

BUILDING ACCOUNTABLE CARE CAPABILITY

Most health delivery organizations struggling under the demands of achieving Meaningful Use of EHRs for HITECH Act incentives, meeting ICD-10 deadlines, reducing cost and maximizing reimbursement, have little desire or capacity for new organizational changes. However, nursing leadership and patient centric accountability are essential to establishing and coordinating all initiatives to improve system effectiveness. As we move further into the implementations of the Affordable Care Act, doing more, not less is expected; doing things to attain better outcomes will be the foundations of value.

Rehabilitation Nursing will continue as a primary provider resource for ACOs and their contribution will be weighed and measured by evolving value-based standards. Nursing reliance upon the digital tools to capture, record, analyze and communicate care process and effectiveness will solidify their contribution to value-based purchasing of patient care.
ABOUT MEDIWARE

Mediware’s all-encompassing selection of rehabilitation software solutions are designed to meet the specific needs of inpatient rehabilitation, outpatient rehabilitation and private practice therapy by addressing the unique challenges rehabilitation providers face. With more than 25 years of experience and industry expertise, Mediware’s solutions address the highly regulated workflows, compliance and documentation needs that are unique to physical rehabilitation and produce results that significantly improve compliance, outcomes, revenue and efficiency. To learn more about Mediware’s rehab-specific solutions, visit www.mediware.com.
SOURCES


11. http://wiki.siframework.org/Longitudinal+Care+Plan+SWG+Charter


