DSS INCORPORATED

Comprehensive Care Coordination (C3)

Reduce avoidable readmissions

Insufficient pre-discharge planning and post-discharge management put Veterans at unnecessary risk.

Incomplete information or instructions, medication errors, and gaps in follow-up care lead them right back to the hospital.

C3 connects existing resources and provides comprehensive, data-driven insight for Veterans at a higher risk of readmission. Users also gain access to pre- and post-discharge management tools, all in one user-friendly interface.

With enhanced communication and coordination through C3, care teams stay proactive, and reduce readmissions by providing the right care to the right patients at the right time.

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Experience the C3 difference

- EHR agnostic and web-based infrastructure
- Bi-directional VistA interface / real-time information display
- Provides separate views for Inpatient, Outpatient and Connected Care
- Integrates VA sources and non-VA Data sources
- Displays updated risk scores using multiple methodologies (CAN)
- Medical Reconciliation Views
- Medication Reconciliation recognition for Inpatient and Outpatient
- Identification and or assignment of Care/Case Manager pre- and post-discharge
- Identification of Social Determinant Factors (i.e. transportation, care giver)
- PIV Authentication availability
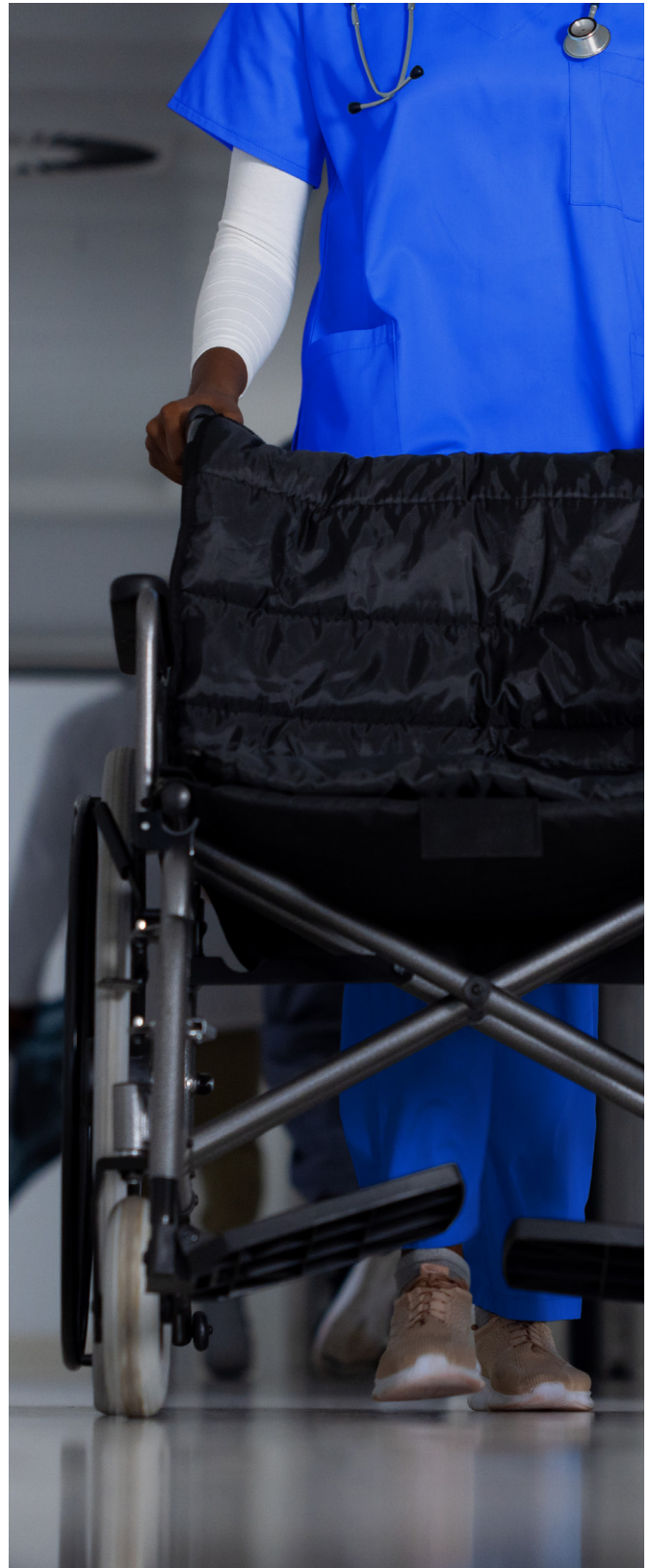
Medical Reconciliation

C3 provides users with a variety of comparative analysis and reviews of Inpatient and Outpatient medication orders.

The C3 Medication Reconciliation provides Inpatient teams an opportunity to review Pre-Admission orders reported in VistA against Post Admission orders and evaluate the orders comprehensively. The Outpatient Reconciliation allows users to review medication orders with views for Pre-Admission, Admission and Post Discharge grid views.

The users may also monitor medication order changes Pre-Appointment to Post-Appointment. Special attention is paid to expired medication orders providing a quick view to determine post expiration needs.

MedRec Features:

+ Identifying high-risk patients in real-time for timely and accurate treatment decisions

+ Improved workflow for PACT/CARE team by removing documentation obstacles (e.g., white boards, paper charts and SharePoint)

+ Assign Anticipated Discharge Dates

+ Discharge Management Dashboard

+ Care in the Community Dashboard

+ Primary Care Dashboard

+ ED Discharge Dashboard

+ Clearly identified social factors to help prevent readmissions

DIGITAL VERSION

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