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Beyond Heroics: Five Levers for Making Care Coordination Excellence the Standard

Key findings from the Olio Care Coordination Engagement Summit

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Care Coordination Engagement Summit

At a recent executive roundtable convened by Olio, 14 senior healthcare leaders from across the care continuum came together to answer a deceptively simple question: Why does excellent care coordination remain the exception rather than the rule?

What emerged from the discussion was a striking degree of alignment. Summit participants—representing payers, skilled nursing facilities, home health, behavioral health, and health systems—quickly converged on a shared definition of excellent coordinated care. They've seen it work. Many have personally delivered it. But they were equally clear about why it doesn't scale: the barriers aren't conceptual. They're structural.

The roundtable also produced something more valuable than diagnosis—it produced a practical blueprint: five structural levers that, when adjusted, can transform coordinated care from a series of individual heroics into reliable system of practice.

The case for action

The pressure to solve care coordination is intensifying. Post-acute demand is surging, behavioral health needs are rising sharply, and staffing constraints are squeezing every care setting. Excellence can no longer afford to be rare.

Summit participants were not discouraged by the scale of the challenge—they were energized by it. They shared a conviction that the path forward is achievable, and that the five levers they identified represent practical, actionable steps the industry can take now.

Improvement imperative

- **40% of hospital discharges go to post-acute care. (MedPAC)**
- **31% projected increase in post-acute volume by 2035. (EY)**
- **48% of adults with mental illness received no treatment in 2024. (SAMHSA)**

What Excellence Looks Like—and Why It Stays Out of Reach

Despite different vantage points across the continuum, summit participants reached near-immediate agreement on what excellent coordinated care looks like: seamless transitions, clear accountability at every handoff, patient-centered alignment, and communication strong enough to function as a structural backbone.

Excellence, when participants had witnessed it, was characterized by trust-based cross-organizational relationships, real-time communication, and measurable results—reduced utilization, fewer readmissions, patients who stayed stable. It was relational, intentional, and accountable.

But it almost always required extraordinary individual effort to achieve—after-hours intervention, personal escalation, staffing ratios that couldn't be replicated at scale. As one participant observed:

> *Success is tied to heroics—and that isn't scalable.*

The roundtable's central insight: excellence isn't rare because people don't care. It's rare because the systems around them don't support it.

Definition of excellence

- **Seamless transitions across the continuum**
- **Clear accountability and loop closure**
- **Patient-centered alignment**
- **Reduction of friction and fragmentation**
- **Communication and relationships as the backbone**

Key insight

Excellence currently depends on individual commitment, not systemic design.

Without structural change, excellence remains episodic rather than scalable.

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Five Levers for Scaling Excellence

- Accountability
- Incentives
- Measurement
- Technology
- Relationships

The gap between knowing and doing can be closed. Summit participants identified five structural levers that, when adjusted together, can move coordinated care from relational and episodic to systemic and consistent. The levers don't require starting over—they require realignment.

Lever 1: Accountability

Define cross-continuum, executive-level ownership

Without a named owner for the full patient journey, accountability dissolves at every handoff. Summit participants described coordination that effectively stops at organizational boundaries—primary care physicians not notified of hospital stays, payers learning of complications after the fact, post-acute teams inheriting patients without adequate transition information.

The solution participants endorsed: assign executive-level, cross-organizational accountability with governance structures that define care coordination responsibilities and decision-making authority across the entire patient journey—not just within individual organizations.

Governance realignment should also include standardization within and across organizations: medication and prescription protocols, documentation requirements, and communication norms for interacting with patients and families. Standardization reduces the friction of every transfer and minimizes the need to start from scratch with each new provider.

The core problem

> *No one is taking responsibility for the patient journey.*

The path forward

Assign executive-level, cross-organizational ownership with governance that defines accountability for the entire patient journey.

Key insight

Excellence requires systemic governance, not just good intentions.

Lever 2: Incentives

Align around shared outcomes

Excellence will not scale until incentives reward collaboration across organizations, not performance within silos. Summit participants identified a core misalignment in how each sector is financially motivated: hospitals optimize for throughput; payers optimize for total cost; post-acute settings absorb operational complexity; and CFO priorities do not consistently align with quality objectives.

The result is a system in which doing the right thing for patients can feel economically irrational for individual organizations. Summit participants were direct about the implication: unless financial incentives change, structural change cannot follow.

The realignment path includes expanding value-based payment models, building accountable care organizations with shared savings, and creating financial structures that make collaboration the economically sensible choice.

> *A lot of coordination is expensive. Everyone on the continuum has to be on the same page that it gets less expensive over time.*

The misalignment

- **Hospitals optimize for throughput**
- **Payers optimize for total cost**
- **Post-acute absorbs complexity**
- **CFO priorities diverge from quality goals**

Key insight

Financial incentives for collaboration and shared outcomes across organizations are prerequisites for improvement—not enhancements.

Lever 3: Measurement

Track engagement, not just outcomes

The industry measures what it can see most easily: 30-day readmissions, PMPM, ED utilization, cost. These are important—but a critical blind spot was identified. By measuring only outcomes, the system is always reacting to failure rather than preventing it.

The behaviors that produce excellent outcomes—timely handoffs, proactive outreach, loop closure, cross-team communication—are largely invisible in current measurement frameworks. Leading indicators go unmeasured, which means problems can't be identified and corrected until they've already escalated.

The solution: realign measurement to track engagement behaviors along the care journey—by care coordination professionals, by care teams, and across organizational boundaries. When engagement is measured, gaps can be flagged in real time, allowing for intervention before outcomes deteriorate.

> *Engagement is a leading indicator versus the rear-view mirror of outcomes.*

What gets measured now

- **30-day readmissions**
- **PMPM and inpatient per thousand**
- **ED utilization**
- **Cost**

What should be measured

Engagement behaviors: loop closure, proactive outreach, handoff quality, cross-team communication.

Key insight

Without leading indicators, systems are always reacting to failure rather than preventing it.

Lever 4: Technology

Prioritize platforms that care teams actually use

Summit participants had a clear-eyed view of technology's role: it is essential infrastructure for scale, but only if it actually gets used. The roundtable surfaced a consistent frustration with current tools—hard to use, poorly integrated with EHRs, requiring users to jump between systems, and producing data that sits in silos rather than supporting real-time decision-making.

The critical insight from participants: the right technology enables real-time coordination, increases cross-organizational visibility, and scales the human relationships that drive excellence—without replacing them. As one participant put it:

> *"Without that technological interface, you're talking days. Now we're talking minutes."*

Technology also has to respect the human factor. Summit participants valued platforms that build digital relationships—enabling care professionals to develop trust and communication patterns with counterparts they may never meet in person. But they were equally clear that automation cannot substitute for human connection in care delivery.

The bar for adoption is high: if a tool adds clicks, it won't get used. Technology must integrate seamlessly into existing workflows and deliver immediate value to the professionals depending on it.

What summit participants need

- **Real-time communication across the continuum**
- **Seamless EHR and workflow integration**
- **Usable, consolidated data for decisions**
- **Platforms that build—not replace—human relationships**

Key insight

Technology enables coordination, but human relationships determine effectiveness. Tools must integrate seamlessly, allow for personalization, and preserve connection.

Lever 5: Relationships

Institutionalize the human infrastructure of care

Every example of care coordination excellence shared at the summit had one thing in common: a relationship. A community health worker who kept following up. A case manager who picked up the phone after hours. A payer and a SNF team that had developed trust over years of working together. Care coordination, participants agreed, comes down to relationships.

The challenge is that relationships, as currently built, are personal and fragile. They depend on specific individuals and don't transfer when staff turn over or when organizations haven't worked together before. They can't be mandated and they can't be automated.

But they can be institutionalized. Summit participants pointed to care coordination platforms as the mechanism for building and sustaining cross-disciplinary, cross-organizational relationships at scale—creating structured communication pathways that outlast individual staff changes and enable care professionals to develop real working relationships even when they've never met in person.

> *"They've developed relationships and they've never physically seen each other.*

The goal is not to replace the human element—it is to create the structural conditions in which human connection can happen reliably, and not just when the right people happen to be in the right place at the right time.

The scalability challenge

Care coordination comes down to relationships. But relationships built on individual heroics don't scale.

The solution

Leverage care coordination platforms to institutionalize cross-disciplinary, cross-organizational relationships—making human connection structural, not accidental.

Key insight

Technology drives scale and efficiency. Human relationships determine care coordination effectiveness.

What This Means for the Industry

The Care Coordination Engagement Summit produced findings that extend beyond any single organization. Taken together, they represent a set of industry-level imperatives that summit participants—across every sector of the continuum—expressed.

1. Care coordination is not a knowledge problem.

The industry understands what excellence looks like. The barrier is structural, not conceptual. The work is realignment, not reinvention.

2. Excellence is relational, but must become systemic.

Trust and accountability produce results. But they currently depend on individuals rather than being embedded in systems. The field must move from relying on exceptional people to building exceptional structures.

3. Incentives and ownership determine sustainability.

Without aligned financial incentives and defined cross-continuum accountability, coordinated care will remain fragile regardless of how much individual organizations invest in coordination tools and programs.

4. Measurement must shift upstream.

Lagging outcomes dominate today's dashboards. Engagement, accountability, and loop closure must become measurable if excellence is to be repeatable and not just retrospectively visible.

5. Technology is essential infrastructure for scale—but not a silver bullet.

Digital connectivity enables real-time coordination, cross-organizational visibility, and relationship building at scale. Its impact is maximized when paired with clear ownership and aligned incentives—not deployed in the absence of them.

Five industry imperatives

- **Shift from individual heroics to systemic design**
- **Embed relationships in platforms, not just people**
- **Align incentives for cross-org collaboration**
- **Measure what drives outcomes, not just outcomes**
- **Treat technology as infrastructure, not a shortcut**

Optimism on the horizon

Summit participants were aligned on the challenges—and equally united in their conviction that the path to excellence is achievable. The levers are identified. The will exists. The work is structural.

The Call to Action

Summit participants left the roundtable with a shared urgency. With post-acute and behavioral health needs accelerating, staffing constraints deepening, and patient complexity increasing, the industry cannot continue to rely on isolated instances of excellence driven by individual commitment.

The five levers identified are not aspirational—they are actionable. Organizations that align governance for cross-continuum accountability, restructure incentives around shared outcomes, build measurement frameworks that capture engagement, invest in technology that integrates into workflow and builds relationships, and systematically institutionalize the human infrastructure of care coordination will be positioned to deliver on the promise that this summit articulated.

The summit closed not with resignation, but with resolve. Excellence in care coordination is achievable—not as an occasional breakthrough, but as standard practice. The structural conditions for it are within reach. The question is whether the industry—payers, providers, health systems, and technology partners—will build them together.

The Summit Vision

A system where care coordination excellence is the standard, not the exception—built on aligned governance, shared incentives, leading-edge measurement, practical technology, and durable relationships.

We need to establish accountability outside the walls of our own organizations.

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For more information on the summit or this report, contact growth@olio.health.

About Us

Olio transforms post-acute and behavioral health care coordination by solving what other platforms can't: sustained network provider engagement.

Olio automatically connects care teams and keeps them engaged—from SNFs and behavioral health facilities to home health and hospice—delivering the actionable insights organizations need to improve outcomes and reduce costs. This isn't just participation—it's the active engagement that makes coordination work.

For more information about Olio's game-changing care-coordination platform or to request a demo, contact growth@olio.health

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