IT'S TIME!

CARE COORDINATION: A CRITICAL NEED

With access to some of the most highly educated and trained medical professionals in the world, providing Americans with the best patient care possible should be simple. Unfortunately, that's often not the case. Poor communication between specialists, duplicate tests, and unnecessary procedures are often the norm rather than the exception, leading to costly, dangerous, and even deadly consequences. With so many specialists and resources readily on hand, how is this happening?

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The problem is a lack of care coordination. Simply put, care coordination is the idea that all specialists treating a patient should be communicating and sharing information to ensure that everyone is acting as a team to meet patient needs. This includes reporting all results back to a primary care physician or to someone coordinating patient care, and ensuring that labs, specialists, hospitals, and long-term care facilities are working together to communicate information quickly and appropriately. It's about primary care physicians, nurses, technicians, specialists, and caregivers collaborating on patient care rather than working as separate entities.

Why CARE COORDINATION Matters

One in five Medicare patients who are hospitalized are readmitted within 30 days of discharge.

Of the Medicare beneficiaries who are readmitted within 30 days 64% receive no post-hospital care.*

Source: Moore C et al. Tying up loose ends: discharging patients with unresolved medical issues. Arch Intern Med 2007; 167:1305-1311

75% of these readmissions could have been prevented by improved care coordination.

Cost of readmission for Medicare patients is $26 billion annually - $17 billion could be prevented with better care coordination.

SOURCE: The Revolving Door by RWJF

Fragmented Care

A team of specialists is often needed to diagnose and treat chronic illnesses such as diabetes, asthma, hypertension, or heart failure. However, treatment may become fragmented into disconnected facts based on the symptoms each provider is treating. This can lead to:

- Delays and other dangerous mishaps in care. When abnormal test results are not communicated quickly and correctly or prescriptions from multiple doctors conflict with each other, lack of coordination can be unsafe and even fatal. Alarmingly, a study found that 33 percent of physicians do not consistently notify patients about abnormal test results.
- Duplicate and unnecessary services, which result in increased costs and overuse of more intensive procedures.
- Angry patients and family members who can't understand why their doctor didn't know what their specialist found or what their test results were.

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Even when a single provider is handling all the treatment, mistakes can happen, but the opportunities for serious mishaps escalate when multiple providers are involved. This is especially true for elderly people with multiple healthcare needs. The average Medicare beneficiary interacts with seven physicians in four different practices during a single year. For those with chronic conditions, the numbers can be even higher.

A Costly Problem

An increase in chronic conditions has also contributed to a dramatic rise in healthcare costs during the past 20 years. In addition, a lack of care coordination has only added to this expense. In fact, people living in areas with more doctors and hospital beds also receive more duplicate and unnecessary services.

The number of unnecessary hospital admissions is expensive as well. Nearly one-fifth of Medicare patients who are hospitalized are readmitted within 30 days of discharge, and 75 percent of these readmissions could have been prevented by improved care coordination. Too often, patients discharged from hospitals don't get the support and encouragement they need to take their medicine, follow their diets, and adhere to the regimens that doctors have prescribed during their stay.

Improving Care Coordination

Many of these problems can be solved by improving care coordination. When everyone is working together as a team to make sure they are all collaborating on patients' needs, quality of care goes up while costs go down.

For example, having designated staff that will act specifically as care coordinators can help reduce hospital readmissions. Before patients leave the hospital, care coordinators should meet with them to make sure they understand the treatment plans they need to follow at home as well as any changes to their medication regimens. The hospital care coordinators would also follow up on any pending labs and imaging studies and contact primary care physicians to communicate updated medications, treatment plans, and test results for their patients. Hospital readmissions drop significantly when patients leave with a clear understanding of their

treatment plans and when their primary care physicians know what is necessary during follow-up care.

This same communication protocol should also apply to patients who are leaving the hospital to return to long-term care facilities. In this instance, the hospital care coordinator should communicate with the long-term care staff about discharge instructions. As soon as residents return to the long-term care facility, staff there should meet with residents to review their discharge instructions with them, answer any questions they may have, and communicate with the hospital if any further clarification is needed. Long-term care staff should also follow-up regularly with these residents to ensure they are continuing to comply with instructions the doctor has recommended and intervene if any problems arise.

MORE Doctors =
More Chances for MISTAKES

1 Medicare Beneficiary =
7 Physicians, **4** Practices, **1** Year.

SOURCE: Pham, H.H., Schrag, D., O'Malley, A., Wu, B. & Bach, P. (2007, March 15). Care patterns in Medicare and their implications for pay for performance. New England Journal of Medicine, 356(11), 1130-1139.

Preventive care is also essential in keeping patients from returning to the hospital. Ideally, an on-site registered nurse would also regularly screen and monitor long-term care residents for conditions needing intervention and then contact physicians to set up appointments. Staff should communicate regularly with doctors' offices to keep them informed of any significant changes in their patients.

When it comes to improving care coordination, communication is also key to fixing the disconnect between doctors and specialists. When a primary care physician is referring a patient to a specialist, for example, office staff should follow-up to make sure the

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appointment was made and completed. In addition, office staff needs to ensure that the specialist shares his findings with the primary care physician so he can be well-versed on what is going on with the patient and be aware of any additional steps that need to be taken.

Similarly, when patients visit the emergency room or are admitted to the hospital, communication should be a priority. In this instance, hospital staff should notify the primary care physician's office so the primary care doctor can follow the patient's progress through discharge and institute a care plan to prevent future admissions. In addition, the primary care physician's staff can reach out to patients when they leave the hospital to make sure they understand discharge instructions and schedule follow up appointments. When the patient comes in for his follow up care, the primary care physician should have a complete history of what specialists his patient saw during the hospital admission, their recommendations, and what tests were performed along with the results.

The Benefits Are Clear

Improving care coordination leads to better quality of care, improved patient outcomes, lower costs, and higher patient satisfaction. Healthcare can be delivered more efficiently, particularly for those with chronic illnesses and complex needs. Well-managed care coordination includes:

- Recognizing individual and family goals and needs and putting them at the center of care planning
- Maintaining strong clinical and organizational support for effectively coordinating care
- Ensuring care continuity across medical and non-medical services and from acute to long-term settings

What Lies Ahead

Healthcare reform will not be sustainable if it is simply about increasing access to a system that is broken. It also must include efforts to improve care quality while decreasing costs. Many health care providers don't realize how much more efficient they can be until they have a well-managed care coordination program in place.

And once they do, they often wonder how they ever did without.

It's time to improve care coordination. If you're ready to create a more efficient care coordination program, download Transforming Care Coordination: What to Do Now, a care coordination checklist., located at: http://blog.primaris.org/care-coordination-2.

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