Next Level Transformation—Care Coordination and Care Managers

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How important is care coordination?

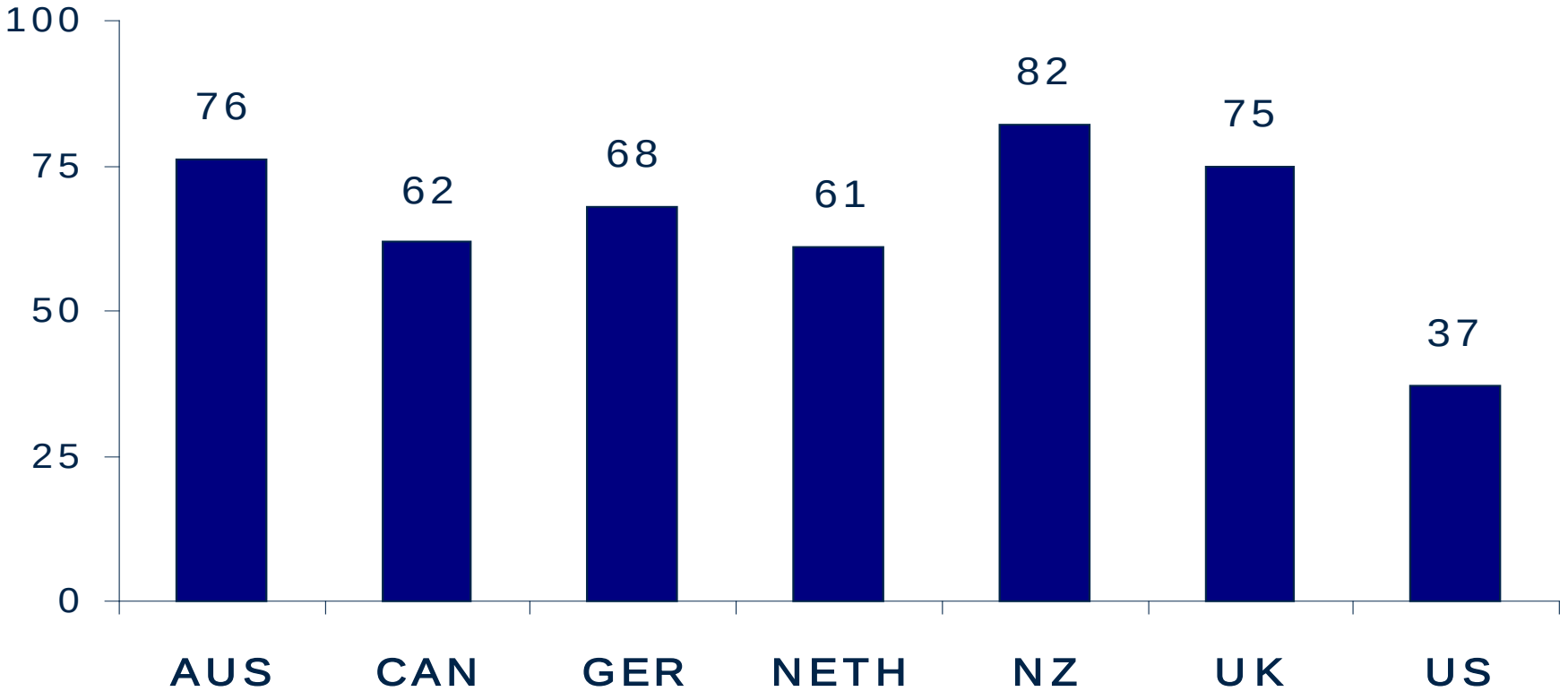
- We need more objective data on the negative impacts of fragmented care on patients!!
- But coordination appears to be critical in reducing readmissions and patient/family distress, and optimizing specialty and community resource use.
- Proactive actions by primary care to assure timely and useful communication with outside providers appear to be relatively uncommon outside of Pediatric practice.
- Other than coordinating the transition from hospital to the community, there has been little rigorous intervention research.

Fragmentation of Care

- Primary care relationships with specialty referral networks and hospitals have become depersonalized and diminished.
- Critical information for referrals and transitions are often lacking or missing, which distresses patients and is unhelpful (or worse) for providers.
- Follow-up care after hospital or ER stay is spotty at best.
- Care coordination is “the deliberate integration of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of health care services.”
- Care coordination refers to activities and interventions that attempt to reduce fragmentation and improve the quality of referrals and transitions.

Commonwealth Survey of Primary Care MDs

Percent reporting that they receive information back for “almost all” referrals (80% or more) to Other Doctors/Specialists



Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

People with chronic conditions see multiple physicians

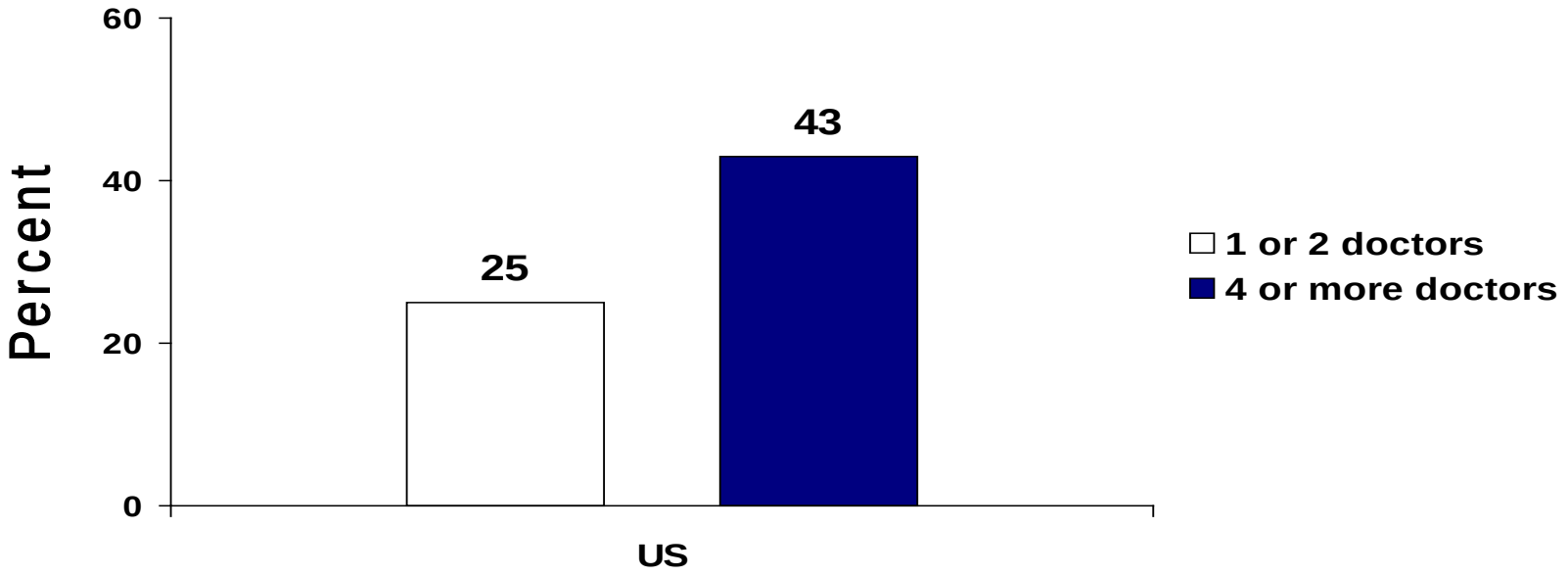
- More than half of people with a serious chronic condition have three or more different physicians
- Medicare recipients with 5+ chronic conditions see an average of 12 physicians annually!

Source: Gallup Serious Chronic Illness Survey 2002.

Percent of Patients Reporting Medical Errors by Number of Doctors Seen

Base: Adults with any chronic condition

Percent of US adults reporting any errors in past 2 years*



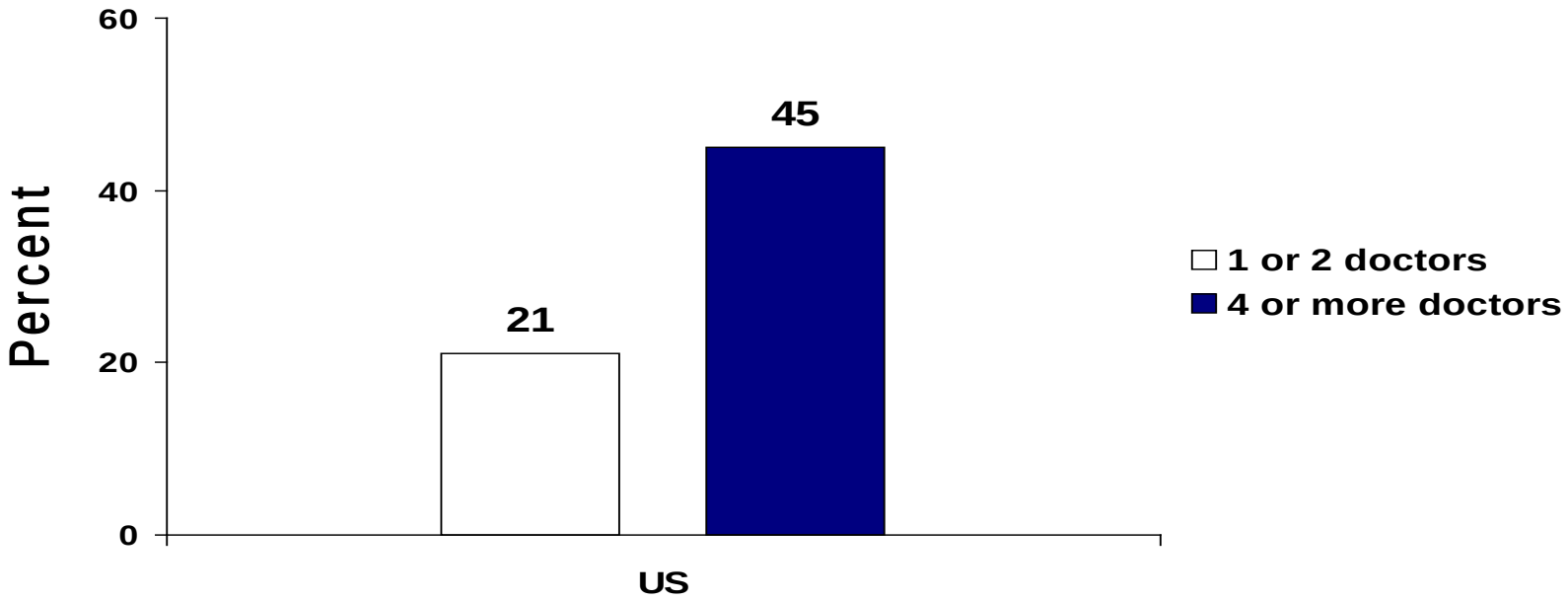
* Experienced medical mistake; medication error; and/or lab test error or delay.

Data collection: Harris Interactive, Inc.

Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.

Percent of Patients Reporting Unavailable Desults or Duplicate Tests by Number of Doctors Seen

Base: Adults with any chronic condition



* Test results/medical records not available at time of appointment and/or doctors ordered medical test that had already been done.

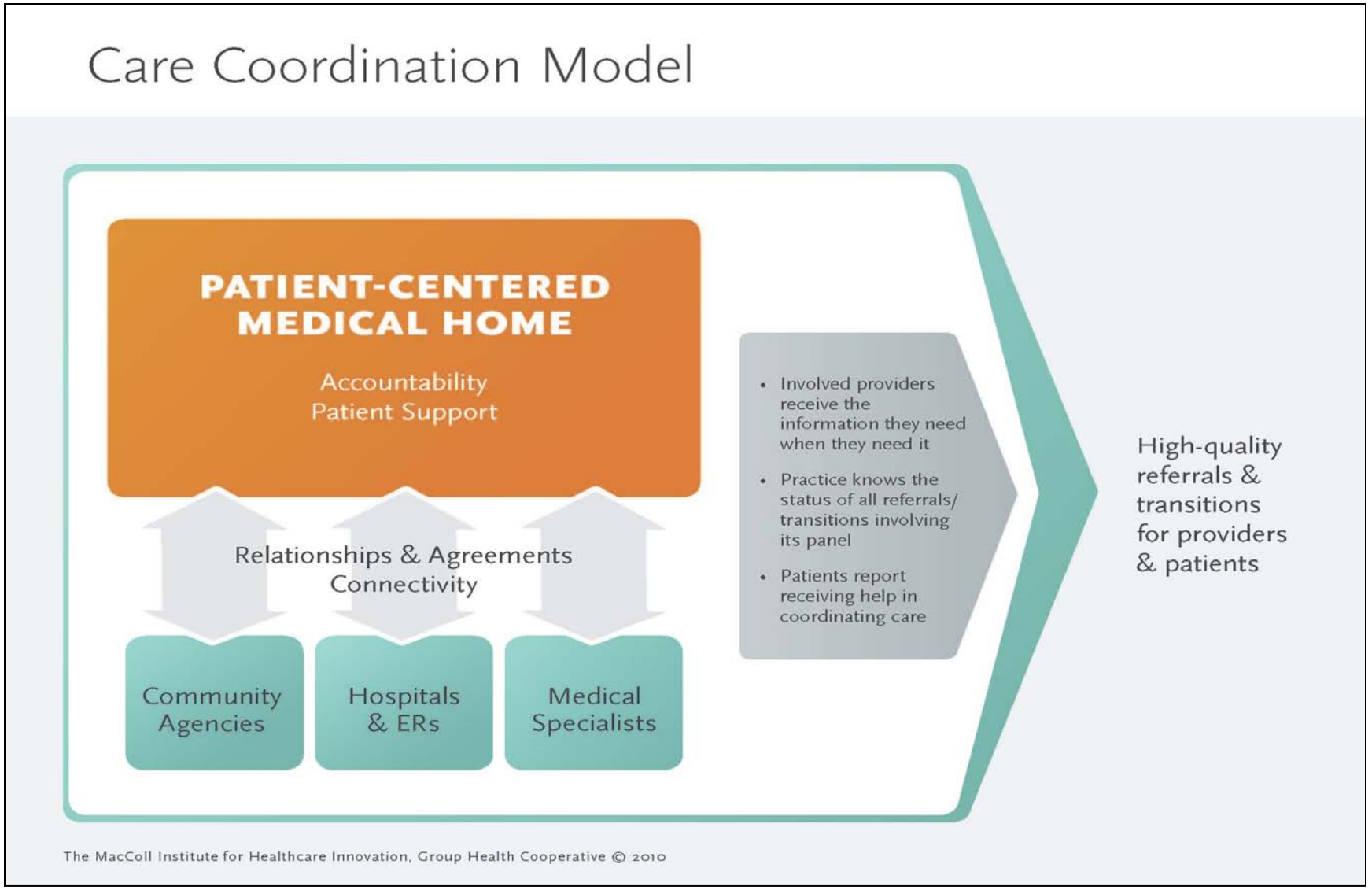
Data collection: Harris Interactive, Inc.

Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.

Care Coordination Key Changes

- Link patients with community resources to facilitate referrals and respond to social service needs.
- Have referral protocols and agreements in place with an array of specialists to meet patients' needs.
- Proactively track and support patients as they go to and from specialty care, the hospital, and the emergency department.
- Follow-up with patients within a few days of an emergency room visit or hospital discharge.
- Test results and care plans are communicated to patients/families.
- Provide care management services for high risk patients.

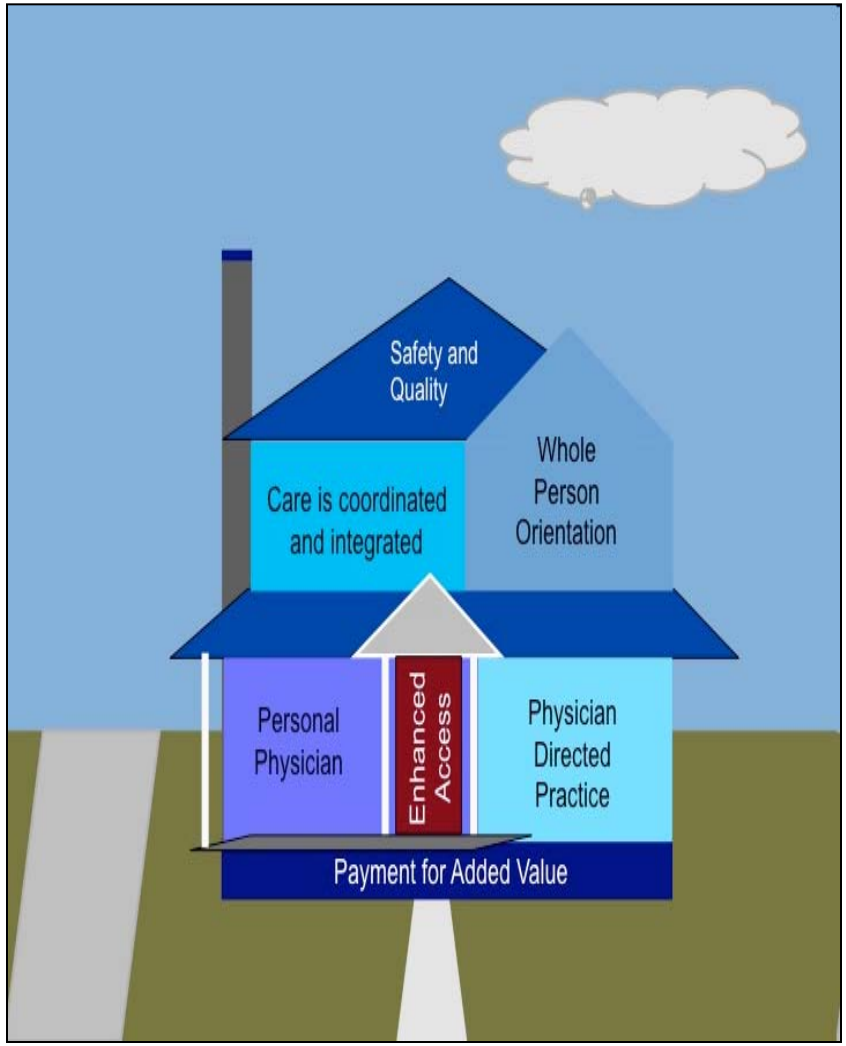
Coordinating Care in PCMH



Key Changes

1. Assume **accountability**
2. Provide **patient support**
3. Build **relationships and agreements**
4. Develop **connectivity**

#1 Assume **Accountability**

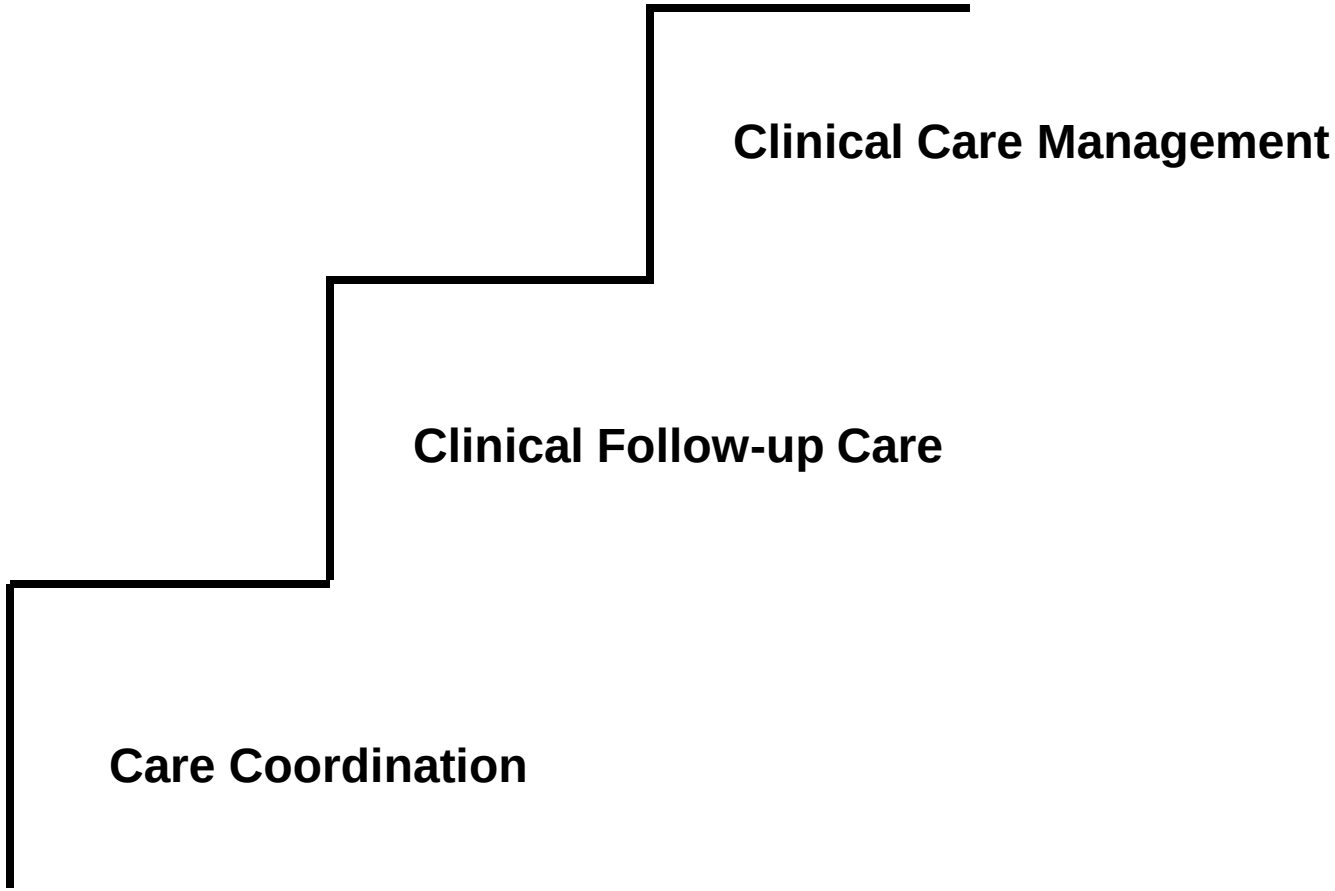


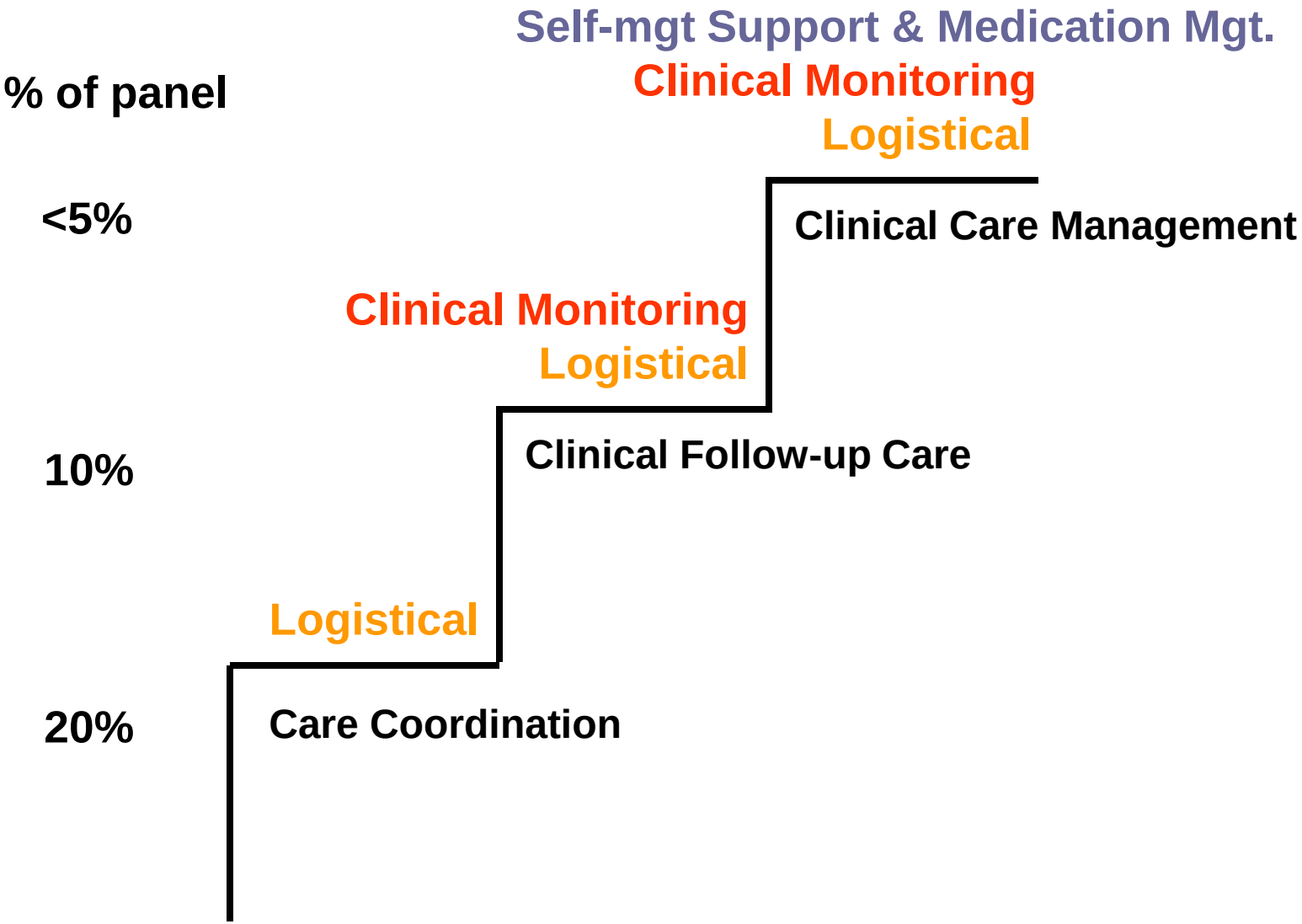
- Why must the medical home assume primary responsibility for coordinating care when accountability is obviously shared?
  - Because specialists, ERs, and hospitals aren't.

What's involved in assuming accountability?

- Initiating conversations with key consultants, ERs, hospitals, and community service agencies.
- Setting up an infrastructure to track and support patients going outside the PCMH for care.

#2 Provide **Patient Support:**
Three levels of support




Self-mgt Support & Medication Mgt.
Clinical Monitoring
Logistical
% of panel
<5%
Clinical Care Management
Clinical Monitoring
Logistical
10%
Clinical Follow-up Care
Logistical
20%
Care Coordination

What's involved in providing logistical support?

- Helping patients identify sources of service—especially community resources
- Helping make appointments
- Tracking referrals and helping to resolve problems
- Assuring transfer of information (both ways)
- Monitoring hospital and ER utilization reports
- Managing e-referral system

#3 Build **Relationships and Agreements**

- Primary care leaders initiate conversations with key specialists and hospitals around mutual expectations.
- Specialists have legitimate concerns about inappropriate or unclear reasons for referral, inadequate prior testing etc.
- Agreements are sometimes put in writing or incorporated into e-referral systems.

Topics for Discussion

With specialists

- Guidelines for referral, prior tests and information.
- Expectations about future care and specialist-to-specialist referral.
- Expectations for information back to PCMH.

With ERs/Hospitals

- Notification of visit/admission and discharge.
- Involvement of PCMH in post-discharge care.

#4 Develop **Connectivity**

- Most of the complaints from both PCPs and specialists focus on communication problems—too little or no information, etc.
- Evidence indicates that standardized formats increase provider satisfaction.
- Three options for more effective flow of standardized information—shared EMR, e-referral, structured referral forms.

Electronic Referral

- Web-based, and may or may not be connected to EMR.
- Effectiveness depends on consultants or hospitals participating.
- Can embed referral guidelines and other elements of agreements.
- Can monitor completion of referrals and return of information to the PCMH.
- Users of e-referral systems often gravitate to experimenting with e-consultations.

Transitions

- Medicare has found that nearly one-half of Medicare recipients re-admitted after a hospital discharge within 30 days never saw an MD.
- Many hospitals have instituted some form of transition management with care managers following high risk patients post-discharge.
- Transition care needs to be integrated with the PCMH.
- Checking with patients shortly after discharge from ER or hospital may be critical.

The Complex Patient

- A particular care coordination challenge.
- The complex patient will be seeing multiple providers and agencies.
- The complex patient often requires primary care clinicians to integrate inconsistent or conflicting advice.
- The complex patient will generally benefit from more intensive follow-up than is possible through office visits alone.

Effective care for multi-problem patients increases the need for:

- A well-organized primary care medical home with “whole-person” knowledge of the patient and clear accountability for the totality of care.
- Primary care clinicians able to integrate input from patients/families and multiple specialties/agencies into an effective, patient-centered treatment plan.
- Greater sharing (interactive communication*) of care planning and care management between primary and specialty care.
- Clinical care management services integrated with medical homes
- More aggressive care coordination.

* Foy et al. Ann Int Med 2010; 152:247-258

Will greater sharing of care between primary and specialty care improve care for complex patients?

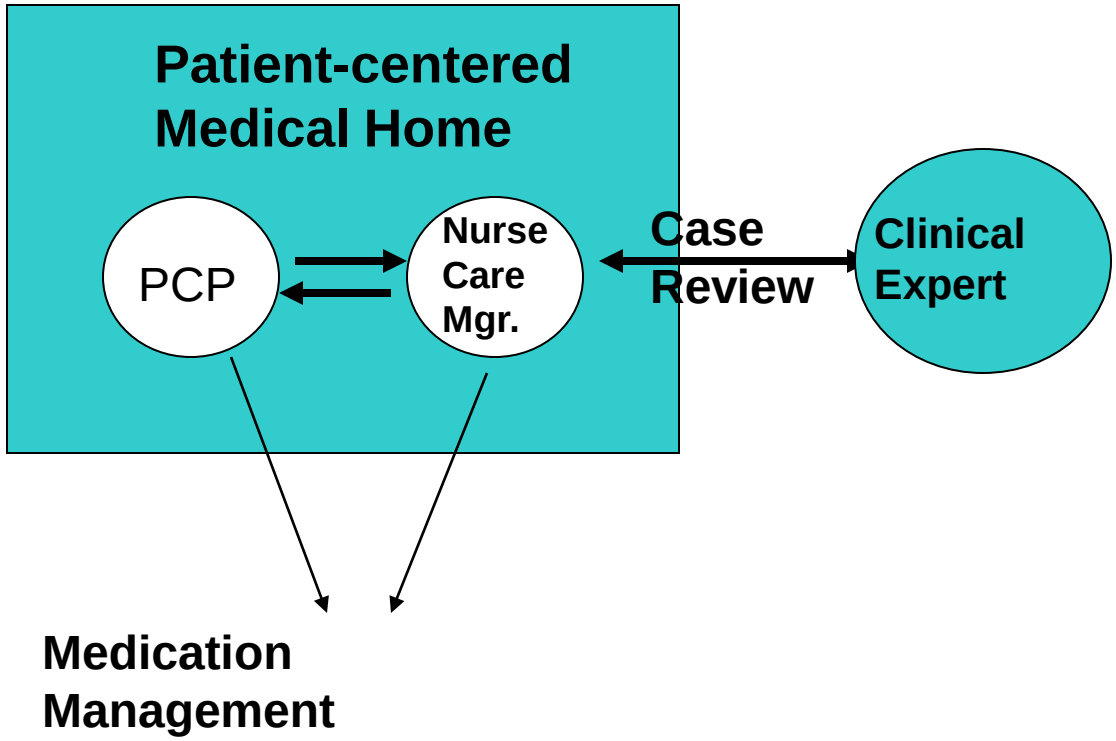
- Recent meta-analysis* of interventions to increase collaboration between primary and specialist physicians found consistently positive effects on patient outcomes in mental illness and diabetes.
- Effective interventions include:
  - Interactive communication—telephone, E-mail, videoconference
  - Quality of information—structured information, pathways to improve information quality
  - Needs assessment—input based on initial and continuing identification and tracking of needs.

* Foy et al. Ann Int Med 2010; 152:247-258

Will care manager interventions be effective for multi-problem patients?

- Nurse and pharmacist care manager interventions improve outcomes in diabetes, depression, bipolar disorder, CHF, etc.
- Care managers in studies usually have experience and expertise in the targeted condition.
- Some care manager interventions now targeting complex patients with evidence of effectiveness—e.g., Guided Care, Team Care.

Keys to success of care manager interventions



The future of primary care may well depend upon its ability to cost-effectively care for the complex, multi-problem patient.

Why make care coordination a priority?

- Patients and families hate it that we can’t make this work.
- Poor hand-offs lead to delays or other problems in care that may be dangerous to health.
- There is enormous waste associated with unnecessary referrals, duplicate testing, unwanted and unnecessary specialist to specialist referral.
- Primary care practice will be more rewarding.

Contact us:

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