

NATIONAL PRIORITY: CARE COORDINATION

Ensure patients receive well-coordinated care within and across all healthcare organizations, settings, and levels of care

OUR VISION: We envision a healthcare system that guides patients and families through their healthcare experience, while respecting patient choice, offering physical and psychological supports, and encouraging strong relationships between patients and the healthcare professionals accountable for their care.

Why is Care Coordination a National Priority?

In 2000, 125 million people in the United States were living with at least one chronic illness, a number that is expected to grow to 157 million by 2020; the number of individuals with multiple chronic conditions is expected to reach 81 million by 2020.⁹⁰ Patients with multiple chronic conditions often receive care from numerous healthcare organizations in multiple care settings, and may see up to 16 physicians annually.⁹¹ As these patients attempt to navigate our complex healthcare system and transition from one care setting to another, they are often unprepared or unable to manage their care. Incomplete or inaccurate transfer of information, poor communication, and a lack of appropriate follow-up care lead to confusion and poor outcomes, including medication errors and preventable hospital readmissions and emergency department visits.

Care coordination is an important aspect of healthcare that helps ensure that patients'

needs and preferences for services are understood and that they are shared as patients move from one healthcare setting to another or to home, as care is transferred from one healthcare organization to another or as care is shared between a primary care professional and specialists. Care must be well coordinated to avoid waste, conflicting plans of care, and over-, under-, or misuse of prescribed medications, tests, and therapies.⁹²

The coordination of care involves making fundamental changes to the current healthcare delivery and payment systems. To address the challenges involved, tools and practices are available to help healthcare professionals improve care coordination for their patients. Medication reconciliation practices, for example, can have a positive impact on outcomes by reducing medication errors and adverse drug events; some have demonstrated reductions in medication errors by 70 percent and reductions in adverse drug events by more than 15 percent.⁹³ Still, compared with other industrialized countries, the United States ranks last in simply reviewing medications with patients prior to discharge (see Chart 5).⁹⁴

Having consistent access to the same healthcare professional over time is an essential element for

care coordination and may be the most important factor in obtaining optimal preventive care.⁹⁵ Having a regular source of care is also associated with better health outcomes and lower total costs.⁹⁶ Both the cost of care and the

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potential for medical errors are greater when patients receive care from many healthcare professionals and do not have an identified and accountable primary source of care.⁹⁷ Primary care practices that offer easy access to care, a long-term, personal relationship with the primary care professional, integrated and comprehensive team care, and the coordination of specialty care and referrals may have the greatest potential to provide the level of care coordination that all Americans

deserve, but that patients with multiple complex health issues so desperately need.⁹⁸

Transition programs geared toward patients with chronic illness that include ongoing plans directed by advance practice registered nurses to address discharge planning and home follow-up can decrease hospital readmissions, increase the length of time between discharge and readmission,

increase patient and family satisfaction, decrease caregiver burden, and decrease healthcare costs.⁹⁹

Hospitals can use tools such as the Care Transition Measure (CTM-3), a survey that includes three simple questions to assess the hospital's performance in honoring patient preferences, helping patients to understand how to manage their health, and helping patients to understand the purpose of taking their medications.¹⁰⁰

Making Care Coordination a National Priority Will:

REDUCE HARM. Nearly one in five patients discharged from the hospital to home experience an adverse event within three weeks, and two-thirds of them are due to adverse drug events.¹⁰¹ Annually, more than 700,000 patients were treated for adverse drug events in U.S. emergency departments in 2004

and 2005, and 1 of every 6 required admission, transfer to another facility, or an emergency department observation admission.¹⁰²

REDUCE DISPARITIES.

There are significant variations in the rates of hospitalizations by ethnicity and patient

income, with nonwhite patients and patients in lower-income areas admitted much more frequently.¹⁰³ Improvement in primary healthcare services is considered one of the most promising ways to reduce avoidable hospitalizations and

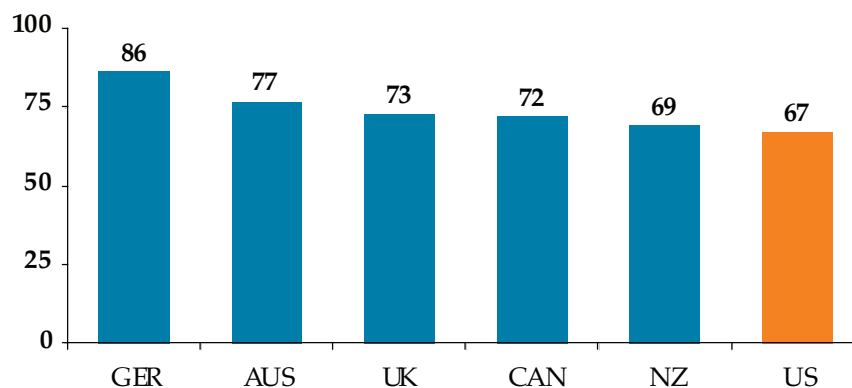
Nearly 18 percent of Medicare patients are readmitted to the hospital within 30 days, and 75 percent of those 30-day readmissions were identified as potentially preventable.

Chart 5

QUALITY: COORDINATED CARE

Medications Reviewed When Discharged from the Hospital, Among Sicker Adults, 2005

Percent of hospitalized patients with new prescription who reported prior medications were reviewed at discharge



AUS = Australia; CAN = Canada; GER = Germany; NZ = New Zealand; UK = United Kingdom; US = United States.
Data: 2005 Commonwealth Fund International Health Policy Survey.

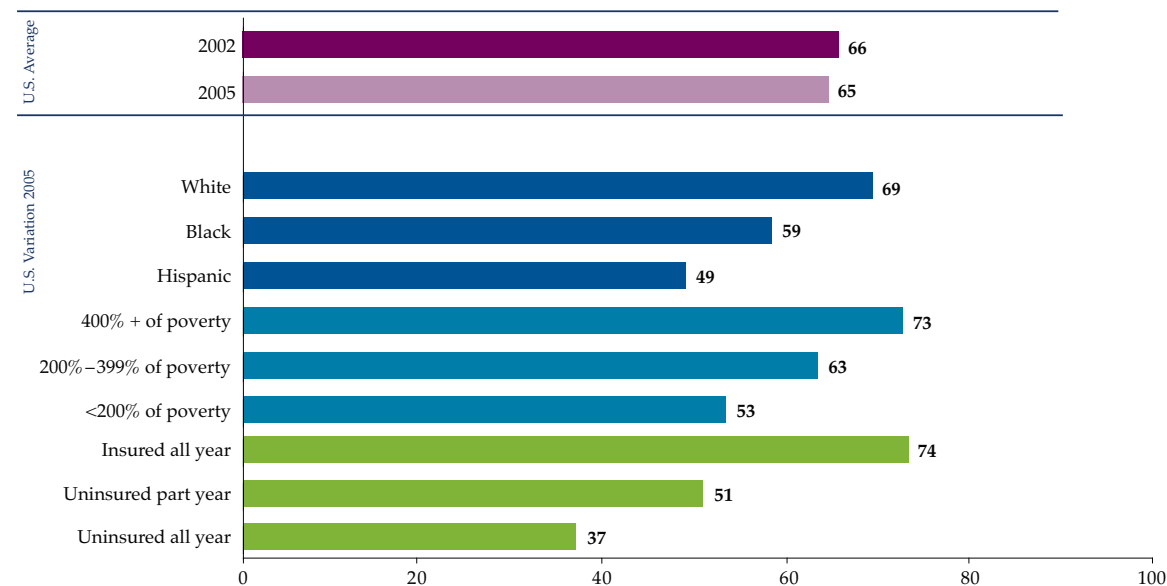
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

Chart 6

QUALITY: COORDINATED CARE

Adults with an Accessible Primary Care Provider

Percent of adults ages 19–64 with an accessible primary care provider*



* An accessible primary care provider is defined as a usual source of care who provides preventive care, care for new and ongoing health problems, referrals, and who is easy to get to.

Data: B. Mahato, Columbia University analysis of Medical Expenditure Panel Survey.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

emergency department visits; however, access to primary care organizations also remains variable depending on race, income, and insurance (see Chart 6).¹⁰⁴

REDUCE DISEASE BURDEN. Nearly 18 percent of Medicare patients are readmitted to the hospital within 30 days, and 75 percent of those 30-day readmissions were identified as potentially preventable.¹⁰⁵ Nearly 20 percent of patients admitted to the hospital with a preventable admission had at least one preventable readmission within six months,¹⁰⁶ and emerging evidence suggests that many patients are not receiving timely follow-up with their primary

source of care after being discharged from the hospital.¹⁰⁷ Despite the high cost of healthcare, the United States consistently ranks behind other industrialized countries in the frequency of emergency department use for conditions that could have been treated with appropriate primary care.¹⁰⁸

REDUCE WASTE. The cost to Medicare of preventable hospital readmissions that occur within 30 days of discharge is estimated to be upwards of \$15 billion.¹⁰⁹ For those 20 percent that have another preventable admission within six months, the costs skyrocket to \$729 million, or \$7,400 per readmission.¹¹⁰

The Transitional Care Model (TCM), led by master's-prepared advanced practice nurses (APNs) in conjunction with the patient's entire healthcare team, targets patients at increased risk for poor postdischarge outcomes and focuses on transitional care. TCM assures that APNs establish a relationship with patients and their families soon after hospital admission; design the discharge plan in collaboration with the patient, the patient's physician, and family members; and implement the plan in the patient's home following discharge, substituting for traditional skilled nursing follow-up. TCM reduces the incidence of poor communication among healthcare professionals and healthcare agencies, inadequate patient and caregiver education, and poor quality of care, and enhances access to quality care. Findings from three clinical trials consistently demonstrate that the APN TCM improves quality of care and substantially decreases healthcare costs. Compared to standard care there are longer intervals before initial rehospitalizations, fewer rehospitalizations overall, shorter hospital stays, and better patient satisfaction. Following a four-year trial with a group of elderly patients hospitalized with heart failure, the APN TCM cut hospitalization costs by more than \$500,000, compared with a group receiving standard care, of an average savings of approximately \$5,000 per Medicare patient.¹¹¹ Ongoing National Institutes of Health (NIH)-funded studies are examining the impact of TCM among older adults with cognitive impairment and setting the stage for its application between the acute and long-term care.

Changes in emergency department utilization patterns prompted researchers from the NYU Center for Health and Public Service Research and the United Hospital Fund of New York to develop an algorithm to analyze administrative data. Using the algorithm, patients are assigned into one of four categories:

- ✦ nonemergent;
- ✦ emergent/primary care treatable;
- ✦ emergent/emergency department care required but preventable/avoidable; and
- ✦ emergent/emergency department care required, not preventable/avoidable.

The implementation of this classification system showed extremely high rates of emergency department use for nonemergent care and for care that could otherwise be provided in a primary care setting. Such information can be helpful in predicting patients at greatest risk of hospitalization and tailoring interventions to meet the needs of particularly vulnerable populations.¹¹²

Two community hospitals in Southern California, Sharp Chula Vista Medical Center and Sharp Mary Birch Hospital for Women, implemented a culturally sensitive medication reconciliation program for residents of their community. Under the supervision of a staff pharmacist, pharmacy technicians bilingual in English and Spanish were trained to obtain comprehensive medication histories within 24 hours of a patient's admission into the hospital using a specially designed medication history form for this population. As a result of this intervention, medication errors on admission, mostly involving drugs that were omitted, were reduced.¹¹³

Care Coordination: Examples of Actions

The Santa Cruz County Health Services Agency's *Project Connect* was developed to specifically target frequent users of the county's two emergency departments. Enrolled patients receive community-based health and related services via case management along with chronic disease management, preventive care, and access to social services. In early 2006, *Project Connect* tracked changes in emergency department utilization of 78 adults who were referred by one or both of the hospitals and who in the year prior to enrollment were responsible for a total of 785 emergency department visits. In the 12 months following enrollment in the project, they recorded a 51 percent reduction in emergency department visits for the group, along with a decrease in the number of hospital inpatient days and ambulance transports by 50 percent and 47 percent, respectively. They also estimated a cost avoidance of \$803,946 as a result of the reductions in emergency department visits, hospital inpatient days, and ambulance transports.¹¹⁴

An evaluation of one care coordination model utilizing a disease management program (DMP) for patients receiving mechanical ventilation was conducted at University Hospitals of Cleveland. The objective of the DMP was to reduce hospital readmissions of chronically critically ill patients requiring mechanical ventilation. Prior to patient discharge, an advanced practice nurse met with the patient and family to engage them in the development of the discharge plan. The discharge summary included the plan of care, the patient's goals, the existence of advance directives, and the assessment of family support and coping skills. At discharge, the summary was provided to all relevant out-of-hospital healthcare organizations and professionals (e.g., extended care facility or home care staff, family physician, or consulting specialist). Patients who received the services had significantly fewer days of rehospitalization (11.4 days compared to 16.7 days for the control group). Total costs savings were approximately \$480,000.¹¹⁵

CARE COORDINATION:

HOW WILL WE GET THERE?

The Partners will work together to ensure that:

Goal: Healthcare organizations and their staff will continually strive to improve care by soliciting and carefully considering feedback from all patients (and their families, when appropriate) regarding coordination of their care during transitions.

To get there, all healthcare organizations and their staff will gather input regarding coordination of care using a valid and reliable tool (e.g., the CTM-3) for all discharged patients.

Goal: Medication information will be clearly communicated to patients, family members, and the next healthcare professional and/or organization of care, and medications will be reconfirmed each time a patient experiences a transition in care.

To get there, an active process that fully engages the patient will be implemented by all healthcare organizations and their staff. This will include documentation by the healthcare professional(s) of analysis of the medication list; resolution of any discrepancies; and a monitoring component of high-risk drugs and relevant laboratory tests.

Goal: All healthcare organizations and their staff will work collaboratively with patients to reduce 30-day readmission rates.

To get there, all healthcare organizations and their staff will implement evidence-based models, such as the TCM,¹¹⁶ beginning with patients diagnosed with heart failure, acute myocardial infarction, and pneumonia. This will include a process for discharge planning, a focus on self-care, and plans for a postdischarge visit with the healthcare professional.

Goal: All healthcare organizations and their staff will work collaboratively with patients to reduce preventable emergency department visits.

To get there, the patient's plan of care will be jointly created and managed by the patient/family and the healthcare professional(s) and coordinated by the patient's primary source of care. Both the patient's current and longstanding needs will be assessed; goals will reflect those needs in a culturally appropriate manner, consistent with the abilities and desires of the patient; medications will be actively reconciled; and patients will be educated as to appropriate rationales for emergency department visits.