
Coordinated Care: Key to Successful Outcomes

Best practices in care coordination improve health,
lower costs and increase patient satisfaction



404 Lippincott Drive | Marlton, NJ 08053
856.762.2469 | www.consensushealth.com

Overview

The United States healthcare system is in the midst of rapid change. The passage of the Affordable Care Act has accelerated the transition from fee-for-service reimbursement models to payment models that reward providers for better outcomes and efficient delivery of care.

Meanwhile, the number of Americans with at least one chronic health condition is rising. A Commonwealth Fund International Survey found that 23% of patients with a chronic illness saw four or more doctors over the last year and 46% reported taking four or more prescriptions on a regular basis.¹ These patients have higher than average healthcare utilization rates, making the management of their care particularly vital, yet complicated.

The successful management of patients with chronic conditions requires care that is well-coordinated between providers, patients, and the care team. The Institute of Medicine has remarked that care coordination “has the potential to improve effectiveness, safety and efficiency of the American health care system”² and can result in higher survival rates, fewer emergency department visits, and lower medication costs.³ Furthermore, a Health Affairs policy brief found that the lack of coordinated care is costly and created \$25 to \$45 billion in wasteful spending in 2011 through avoidable complications and unnecessary hospital admissions.⁴

“Lack of care coordination resulted in an estimated \$25-\$45 billion in wasteful spending in 2011 due to avoidable complications and hospital readmissions.”⁴



This whitepaper defines care coordination, examines the need for well-coordinated care, and explores the benefits of centralized care coordination. Common elements of care coordination programs are also identified, as well as best practices for improving patient outcomes and reducing the cost of care.

¹C. Schoen, R. Osborn, D. Squires, M. M. Doty, R. Pierson, and S. Applebaum, New 2011 Survey of Patients with Complex Care Needs in 11 Countries Finds That Care is Often Poorly Coordinated, *Health Affairs* Web First, Nov. 9, 2011.

²“Care Coordination,” Agency for Healthcare Research and Quality, downloaded February 1, 2015, <http://www.ahrq.gov/professionals/preventionchronic-care/improve/coordination/>

³The benefits cited by the American Nurses Association (ANA) apply to care coordination provided by nurses. “The Value of Nursing Care Coordination,” ANA, June 2012, p. 2.

⁴“Improving Care Transitions,” Health Affairs, Sept. 13, 2012, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=76



What is Care Coordination?

The Agency for Healthcare Research and Quality defines care coordination as “deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient’s care to achieve safer and more effective care.” This includes determining the patient’s needs and preferences and communicating them “at the right time to the right people.”⁵

Although the terms are often used interchangeably, care coordination is different than care navigation. Navigation is narrower in scope and is usually confined to a brief checklist for such tasks such as verifying that an ER patient has scheduled a follow-up visit with his physician or confirming that the patient has obtained prescribed medications.

Care coordination is more comprehensive and may also include:⁶

- Creating an individual care plan in conjunction with the patient and/or caretaker
- Ensuring the patient and/or caretaker understand the plan and are equipped to follow it
- Identifying and addressing all barriers that might impede the patient’s or caretaker’s ability to care for himself/the patient
- Helping to assemble an appropriate team of health professionals to meet the patient’s needs
- Assisting the patient/caretaker in navigating the health system and addressing any insurance coverage issues
- Ensuring the patient’s electronic health record is accurate and accessible to all caregivers and the patient/caretaker
- Facilitating complete and timely communication between care team members
- Following up regularly with the patient/caretaker to ensure the patient’s needs are being met and to identify any changes to the patient’s circumstances

While the needs of each practice and its patients vary, a registered nurse is typically the most appropriate person to manage care coordination services.⁷

⁵“Care Coordination;” Agency for Healthcare Research and Quality

⁶“The Promise of Care Coordination: Transforming Health Care Delivery;” Families USA, April 2013, p.4, downloaded February 1, 2015, http://familiesusa.org/sites/default/files/product_documents/Care-Coordination.pdf



“Care coordination has demonstrated improved outcomes and cost savings for patients transitioning from acute care hospital to the home.”⁹

Benefits of Care Coordination

Proper care coordination assists providers in meeting the “Triple Aim”—better patient experience, improved health for the community, and lower overall costs.⁸ For example, care coordination enables providers to:

- **Work at the top of their credentials.** Physicians have more quality time to care for patients, since patient care coordinators (PCCs) can directly handle or facilitate with the physician’s care a wide range of patient care tasks.
- **Improve utilization management.** Care Coordination allows physicians and other care team members to focus on proactive care, rather than react to expensive acute care episodes.
- **Engage patients in their own care.** As extensions of the physician and his/her care team, PCCs can stay closely connected to patients. Regular communications help engage patients and focus their attention on preventative actions.
- **Enter into value-based contracts with greater confidence.** Most value-based models require providers to demonstrate ongoing quality improvement, patient satisfaction and lower overall cost of care—rigorous but achievable goals with a strong care coordination structure.

⁸The Institute for Healthcare Improvement (IHI) describes the “Triple Aim” as an approach to optimizing health-system performance through the pursuit of three goals: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care. “IHI Triple Aim Initiative;” Institute for Healthcare Improvement, downloaded February 1, 2015, <http://www.ihl.org/Engage/Initiatives/TripleAim/pages/default.aspx>

⁹“The Value of Nursing Care Coordination;” American Nurses Association, June 2012, p. 8.

The Consensus Care Coordination Model

Consensus Health has refined its model and incorporated numerous best practices for achieving better patient outcomes and improved operational efficiencies.

When the concept of care coordination first emerged, practices typically delegated the care coordination function to their internal staff. However, this approach proved too costly for many practices, particularly those that still relied on traditional fee-for-service payment models that didn't offer reimbursement for care management services. In addition, many practices had difficulty finding individuals with the required education and credentials to handle the multiple tasks of care coordination.

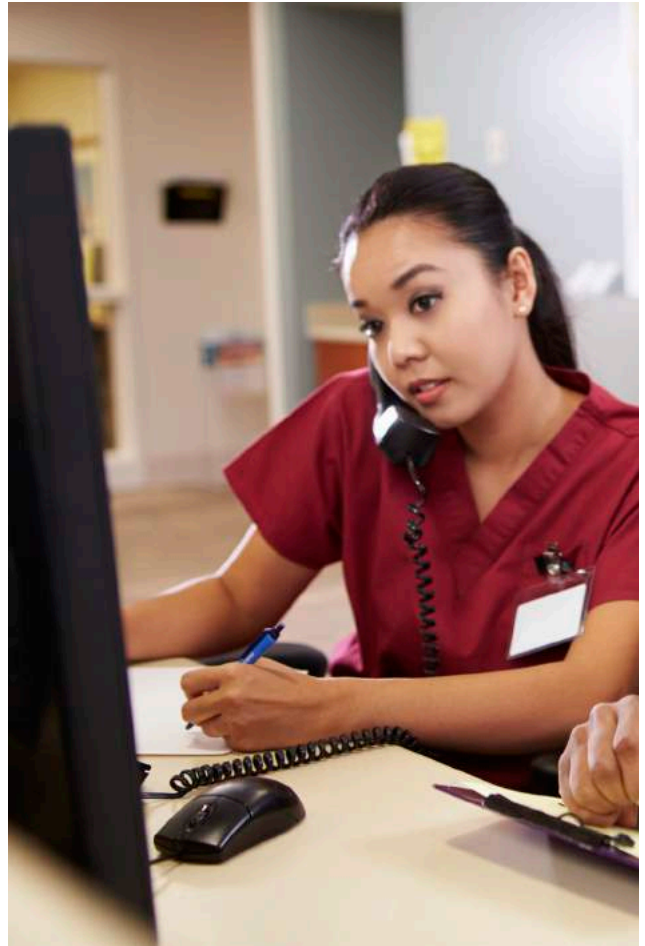
Consensus Health discovered that practices could achieve better results and save money if the care coordination function was centralized and services/costs were shared among multiple practices. Consensus Health's centralized care coordination team includes registered nurses acting as patient care coordinators (PCCs), a social worker, and experienced support staff. Each PCC is assigned 150 to 200 active patients, which is a small enough population to ensure that each patient receives a high level of care and attention.

The Consensus Health team serves as an adjunct of the practice and each patient is matched with a specific PCC to oversee their care. The number of PCCs per practice varies depending on the practice size, the number of patients requiring care coordination services, and the requirements of any shared savings programs. Commercial payers, for example, typically require one PCC per 5,000 patients, while Medicare requires one per 2,500 patients.

The Consensus Health team works closely with the practice to ensure patients' needs are addressed efficiently and effectively. For example, PCCs can connect directly to the practice's appointment system and schedule a patient's next office visit. Each practice also has a designated Local Care Director who is selected by the physician to act as an extension of the care coordination team. In addition to acting as the PCC's primary practice liaison, the Local Care Director helps identify and engage any patients who may require care coordination services.

Coordination with the physician

The PCC works directly with the primary care provider (PCP) to ensure that patient needs are addressed. The PCC serves as a conduit between the patient and the PCP, helping to obtain and funnel clinically relevant patient information, such as current medications, hospital and specialist records, and mental health status. The additional background information facilitates the care process and provides the PCP with a more comprehensive view of the patient's situation.





Coordination with the patient

Care coordination is more effective when the patient remains motivated to maintain his or her own health.¹⁰ PCCs work closely with patients to provide the education and encouragement they need to achieve their healthcare goals. When patients embrace their care plan, providers are better suited to achieve the Triple Aim of improved care, lower costs, and increased patient satisfaction.

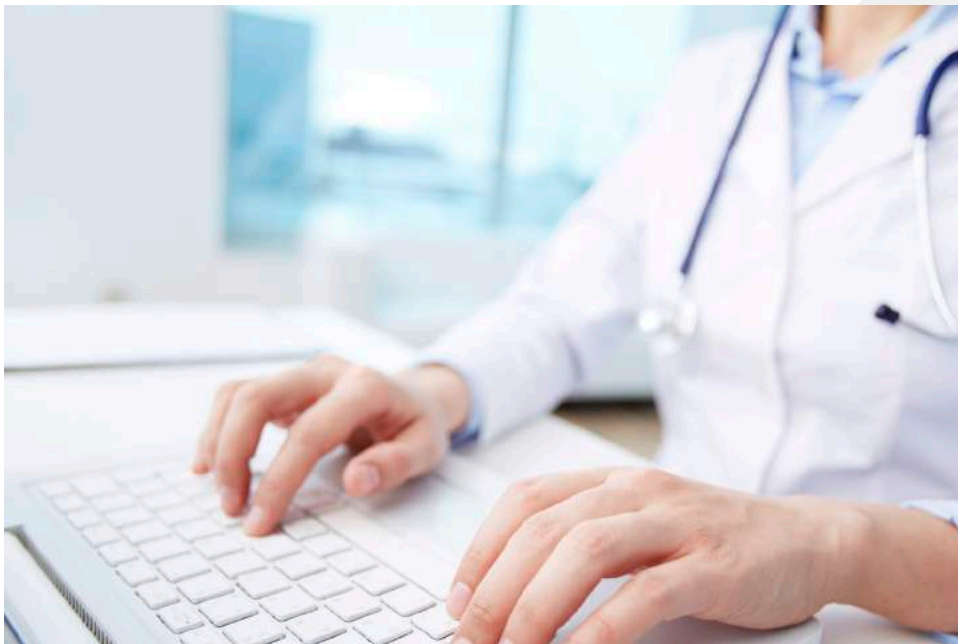
Some of the ways the Consensus Health team works with patients include:

- Scheduling the patient for a visit with his PCP within 24 to 48 hours of discharge.
- Enabling patients to be successful in self-care. PCCs adopt a fully engaged approach that includes frequent outreaches to make sure the patient not only understands his care plan, but is able and committed to following it.
- Identifying any resources that the patient requires to maintain his health, such as transportation to doctors' appointments or access to medical equipment.
- Connecting with the patient's family to request additional support if needed. If a patient's family is unaware that their loved one is struggling and in need of assistance, Consensus Health's care coordination team will reach out and encourage patient-designated family members to get involved in the care process.

¹⁰"Patient Engagement;" Health Affairs, February 14, 2013, http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_86.pdf

Best Practices for Care Coordination

Consensus Health embraces numerous best practices for effective care coordination, including:



Targets are high-need, clinically high-risk or rising-risk patients. Focusing on clinically high-risk patients or those with rising risk provides the greatest opportunity to improve health outcomes and lower costs.¹¹ Services are typically triggered by a payer-generated notice of admission, identification by the practice, or utilization-based claims data. Clinically high-risk, high-need patients require at least 90 days of follow-up—well beyond the standard four to six weeks—to ensure they are fully educated and engaged in their care and any barriers to care are resolved.

Access to hospital/ER admission information is timely. Patients are especially vulnerable after discharge, and follow-up from their primary care provider within 24 to 48 hours is ideal. Providers need to know details about the admission as it provides an important foundation for the transitional care plan.¹²

Transitional care programs are strong. A strong transitional care program helps patients to successfully transition from the hospital to their home/community and reduces readmissions.¹³ The plan should be in place for at least four to six weeks¹⁴ and include periodic follow-up to ensure the patient understands discharge instructions, can recognize symptoms that might require immediate attention, and attends follow-up appointments with his primary care provider.¹⁵

Includes patient education and engagement. Patients with chronic conditions need to play an active role in maintaining their health, so the transition plan should seek ways to educate, motivate, and empower the patient and/or caretaker to do so. The team should identify any barriers that might prevent a patient's full engagement, including depression and other mental health disorders, and coordinate services as needed.

¹¹Randall Brown, *The Promise of Care Coordination: Models That Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses* (Princeton, NJ: National Coalition on Care Coordination, 2009), available online at <http://www.nyam.org/social-work-leadership-institute/docs/N3C-Promise-of-Care-Coordination.pdf>.

¹²"The Promise of Care Coordination: Transforming Health Care Delivery," *Families USA*, p. 12.

¹³Randomized controlled trials indicate that strong transition programs help reduce readmissions. Brown, *Promise of Care Coordination: Models That Decrease Hospitalizations*.

¹⁴"The Promise of Care Coordination: Transforming Health Care Delivery," *Families USA*, p. 12-13.

¹⁵Consensus finds that a minimum of 90 days of follow-up is necessary to ensure success. See p. 5-6, "The Consensus Model," under Length of Service.

Utilizes multi-disciplinary teams. Many patients face psychosocial and economic barriers to maintaining their health. Care teams should include a social worker and/or other professionals who have the skills to address non-clinical barriers to success.

Employs data to drive quality improvement. A population health management platform embedded in the patient's electronic health record (EHR) is essential for care coordination. Care team members can refer to dashboards to identify gaps in a patient's care or to prevent duplication of services. A population health platform can also be used to identify clinically high-risk or rising risk patient populations within a practice so that providers can initiate strategies to deliver the right care at the right time and place. In addition, providers can analyze their overall progress in meeting performance goals, such as improving quality and reducing the overall cost of care. Such data points are particularly important for practices participating in value-based payment models.

Scope of Service. Patients' health maintenance needs are multi-faceted, often extending beyond one episode of transition. Consensus Health takes a broad approach that includes identifying the root cause of any problem and helping patients incorporate necessary changes into their lives.

Medication Reconciliations. Many readmissions are due to mismanagement of medications. Consensus Health's centralized care coordination team takes a preventive approach by reviewing all medications **within 24 hours of every transition and every specialist visit.** This detailed process includes comparing the providers' orders with the patient's description of each medication and dosage instructions. If a discrepancy is found, the care team notifies the primary care provider, as well as the source of the error (e.g., the hospital or pharmacy). The care team medication review and physician-directed reconciliation process may also trigger a "super visit" as described below.

Follow-Up Attendance. Though the majority of contact occurs via telephone, in-person contact is particularly effective and encouraged.¹⁷ During follow-up appointments, patients and caretakers often have difficulty absorbing all the information provided and sometimes fail to ask the right questions. Outcomes can often be improved if the PCC attends certain office visits. The PCC can facilitate the conversation as necessary and encourage the patient/caretaker to take an active role in the care process.

Super Visits. The PCC may meet with the patient/caretaker 30 minutes prior to the scheduled appointment time. During these "super visits," the PCC will typically review medications with the patient/caretaker and ask questions about the patient's status and care routine. Though the patient may receive an hour of care, he is only billed for the physician's 30-minute visit.

Dual Focus. In many care coordination models, care is reactive and occurs after a patient has been hospitalized. Because more proactive care coordination improves patient health and helps to reduce overall cost of care, Consensus Health offers a dual approach that focuses on care coordination that is both



"Care coordination is foundational to high-quality health care."¹⁶

¹⁶"Quality Connections: Care Coordination;" National Quality Forum, October 2010, Abstract, http://www.qualityforum.org/Publications/2010/10/Quality_Connections_Care_Coordination.aspx

¹⁷Ibid.

patient-centered and population-centered. Consensus Health’s proactive, population-centered approach utilizes Consensus Health’s technology platform to target a particular population—such as patients with high blood pressure—and initiate the care process accordingly in order to prevent hospital admissions.

The Bigger Picture. Care coordination is enhanced when a practice has access to an integrated population health management platform offering best-of-breed technology with data-driven processes and analytics. The platform should also provide the quality measurements and reporting capabilities that providers require when participating in value-based reimbursement programs.

Care Coordination in Action*:

- **Mark, a newly diagnosed diabetic, wasn’t administering his insulin injections.** Mark revealed that he couldn’t see the numbers on the syringe but was reluctant to tell anyone, so after consulting with the primary care provider, the care team arranged for Mark to obtain reading glasses.
- **The hospital had arranged for Sara to receive visiting nurse services after her discharge.** However, the nursing agency was unable to reach Sara because they were unaware that Sara was staying with her daughter. The social worker followed up with the agency and arranged for care at Sara’s daughter’s home.
- **Anthony wasn’t filling his prescriptions.** The PCC discovered that Anthony could not afford his medications. The PCC engaged the team’s social worker, who arranged for Anthony to receive prescription assistance.

**All names have been changed.*

The Results

Consensus Health’s centralized care coordination services have played a major role in dramatically altering outcomes. Providers and care teams supported by care coordination show improvements in patient outcomes, lower overall cost of care and even provider financial performance. For example, Consensus Health’s centralized care coordination team worked with primary care practices over a 24-month period and:

- Decreased the overall cost of care by 17%
- Reduced hospital admissions by 18.8%
- Achieved 90th percentile ranking for care quality
- Earned financial awards in a shared savings program equal to 5-10% of annual revenue



Consensus Provider Enablement Case Study

Cost of Care Strategy Increases Provider Revenue by 5–10%



Delivered **17%** Lower Cost of Care



Reduced Inpatient Admissions by **18.8%**



Achieved **90th** Percentile of Care Quality



Increased Ambulatory Footprint by **8-9%**



Reduced Hospital 30-Day Readmissions to **12%**
(National Industry Average is 18%)



Reduced Emergency Department Visits by **3.2%**



Increased Generic Drug Dispensing to Medicare Patients by **11.3%**



Increased Provider Revenue by **5-10%** Through Value-Based Rewards

Outlier Product Mix Adjusted Global Cost of Care vs. Peers. Results from 24-month period.

This case study is intended to provide an example of how an actual Consensus Health client has benefited from Consensus Health's services. Consensus Health does not claim that the outcome of this particular case study is a typical result, or that it is necessarily representative of all those who will use its services.

A Final Word

Care coordination is a logical and effective strategy for improving care, reducing overall cost of care and increasing patient satisfaction. Well-coordinated care not only results in better health outcomes, it also helps practices participating in value-based payment models meet their quality care and financial goals.

While practices may attempt to delegate care coordination services internally, many will find it too expensive to recruit, train, and manage an experienced care team. A centralized care coordination team allows physicians and patients to leverage the skills of a highly experienced team, while sharing the cost with other providers.

“Centralized care coordination allows doctors to be doctors; to do what they do best, and still make a living,” — Dan Fabius, DO, FACP, Vice President of Clinical Informatics, Consensus Health

ABOUT CONSENSUS HEALTH

Consensus Health is a high-performing, physician-owned medical group for New Jersey's independent primary care and specialty providers. By joining other like-minded peers, you'll experience a better, faster and less expensive solution that can substantially improve revenue, job satisfaction and work/life balance. Providers retain autonomy without membership fees or long-term contracts. Consensus Health members also enjoy a full spectrum of proven and scalable practice management and population health services designed to make health-care more efficient and effective. Learn more at www.consensushealth.com.



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