

NEW PERSPECTIVES: PART I

Funding Care Coordination in Health Care Delivery Redesign

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Care delivery in primary care is changing by necessity. Health care reform, growing patient demand, and the complexity of caring for patients with multiple morbidities have forced us to reexamine how we care for patients. Team-based care is the trend and involves care provided to patients by physicians and other allied health personnel. Recently, the Centers for Medicare and Medicaid Services (CMS) have recognized the team approach and agreed to reimburse for oversight of home health care and transitional care services from hospital to home. In 2015, CMS will release CPT codes for care coordination, which has been defined as “the deliberate organization of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of health care services.”¹ Several studies have shown the benefits of care coordination. In 2010, Kruse et al. described the impact of an ambulatory case management program over five years that reduced emergency room and urgent care visits.² Since 2003, the health system at Gundersen has had a care coordination system bridging the inpatient and outpatient world that has resulted in reduced hospital stays, lower inpatient costs, and increased patient satisfaction.³ Based on these types of results, CMS believes that incentivizing care coordination services for an appropriate target population will improve quality of care, increase patient satisfaction with care, and reduce overall expenditures.

Let us examine a case involving care coordination in a typical general internal medicine practice:

A 68-year-old male with history of type 2 diabetes and hypertension

was admitted for hypertensive urgency. During his hospitalization, the admitting physician found that the patient had not been taking his losartan and hydrochlorothiazide and restarted these blood pressure medications. Upon initiation of the prescribed doses, the patient had episodes of hypotension and was advised at discharge to take half of his prescribed losartan dose and to continue the full hydrochlorothiazide dose. At his hospital follow-up appointment five days later, the patient’s blood pressure was 168/88. He stated that he had been taking “everything you told me to” but that he did not have medication bottles with him and could not recall if there were any changes to his medications at the time of discharge. He knew that he was not cutting any pills in half. Based on the assumption that he had not changed his losartan dose, the primary care provider added low-dose nifedipine. Two days later, the patient called and said he felt lightheaded since starting the nifedipine. Presuming hypotension, the provider told him to hold the nifedipine, monitor his blood pressure, and call if his blood pressure rose above 180/100. Worried about his fluctuating blood pressures, the provider also scheduled the patient for follow-up in four days and instructed him to bring his pill bottles to that appointment. The patient did not arrive at that follow-up visit; in fact, that afternoon the provider received notice from the emergency department that the patient presented there with an acute MCA infarct, in the setting of elevated blood pressure.

With this unfavorable outcome, it is prudent to examine the ways in which the system or individuals

might have failed this patient. One might question whether the internist in this case was engaged fully in the care of this patient. In the changing era of team-based care, it is worth considering what a care coordinator could have done to improve the trajectory of this patient’s course. The general internist with a busy practice has many competing patient needs, making it nearly impossible to attend to every issue as desired. With the advent of the patient-centered medical home (PCMH) and care coordination, there is a way to provide more efficient and patient-centered care. There were several care coordination opportunities in this patient’s case:

1. *Identification of barriers to care.* A care coordinator, such as a licensed nurse, can spend time identifying barriers to care on initial assessment. This patient’s blood pressure had been uncontrolled for a prolonged period of time prior to the hospitalization, as he was only intermittently taking medication when he could afford it.
2. *Communication of discharge instructions.* It is critical to verify that the patient understands his discharge instructions. Once home, we must confirm that the patient is actually following them. Care coordinator RNs and pharmacists can call patients shortly after discharge to do this.
3. *Evaluation of patient understanding and health literacy.* RNs can thoroughly assess patients’ health literacy and communicate limitations to primary care providers. If gaps in understanding are identified, they can help coordinate appointments with other members of the health

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care team (dietitians and pharmacists) to improve the patient's understanding of his/her own chronic illnesses and facilitate better self-management.

4. *Coordination of timely follow-up.* A blood pressure medication was added, and the patient called with unclear symptoms after this change. Facilitating close follow-up with the internist likely would have identified definitively if the patient was experiencing medication side effects or worsening disease.

Care coordination is another opportunity to provide better care for our patients. CMS is now taking steps to provide reimbursement for quality care that can reduce or prevent the type of patient outcome described above. Commitment to the process and dedicated personnel are required for this type of program. Within the Division of General Internal Medicine at The Ohio State University Medical Center, we have prioritized the care coordination model in our PCMH. While the reimbursement is not expected to begin until January 2015, we have moved forward in hiring dedicated care coordination nursing staff. We are currently working with physicians, managers, nurses, pharmacists, and social workers to develop workflows that align with the rules described in the federal registry regarding transitional care codes. Listed below are targeted aspects of the information released by CMS that we have used to focus our efforts.^{4,5}

1. Patients must have two or more chronic health conditions (multimorbidity).
2. Patients should have 24/7 access to address acute and chronic care needs. Providers should have

24/7 access to the electronic health record and offer electronic communication to patients.

3. Patients with successive routine appointments should have a designated provider who primarily manages their chronic health conditions and performs annual wellness visits.
4. The primary care practice should manage care transitions with trained staff who contact patients and coordinate care in order to prevent readmissions or emergency room visits.

Within the proposed care coordination model, CMS has linked financial incentives with better care for our patients. While a promising program for primary care providers, there are unanswered questions that will need to be addressed as this program unfolds. When CMS agrees to reimburse this service, there will be cost sharing for which patients will be liable. It remains to be seen if the most vulnerable patients (who might benefit most from this program) will agree to participate, knowing there are costs involved. Additionally, in this financial model, further study will be needed to evaluate the extent to which this program can provide long-term improvement in quality of care of chronic illnesses and overall cost reduction.

The proposed CMS reimbursement for care coordination services is not only a financial acknowledgement of the need for improved care of our chronically ill patients but also a validation of the work that we are already doing as primary care providers. This affirmation is an opportunity for general internists to move forward with improved patient care. Our incentive to develop more robust care coordination programs, while

perhaps rekindled by the possibility of reimbursement, resides in what we set out to do as primary care providers—to provide the best, most coordinated care possible for the patient.

References

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