DEMYSTIFYING CARE COORDINATION EXECUTIVE SUMMARY

VIEW FULL WHITE PAPER HERE: HTTP://WWW.MEALSONWHEELSAMERICA.ORG/CARE_COORDINATION_WHITE_PAPER

Healthcare has been steadily expanding beyond the confines of traditional medical settings as the industry shifts toward person-centered care to help address social determinants of health among at-risk individuals. While efforts to address social determinants of health are evolving, our fragmented health system is woefully underequipped to remediate these needs.[1] Lack of communication, consultation and coordination can be a common occurrence experienced by patients who have more than one health provider.

Research increasingly shows that such fragmented care combined with poor coordination across multiple care providers compromises the quality of care individuals receive and increases the likelihood for negative outcomes, such as medication errors and preventable hospitalizations and emergency department visits. In fact, it is estimated that inadequate care coordination contributed to between $25 and $45 billion in wasteful spending in 2011 due to avoidable complications and unnecessary hospital readmissions.[2]

Care coordination represents a promising and effectual approach for integrating and optimizing care, especially among high-risk populations such as seniors whose complex and often multiple chronic conditions involve costly treatments and repeated hospitalizations. Through both clinical input and a comprehensive literature review, this white paper seeks to develop a comprehensive understanding of the current state of care coordination across all levels of healthcare and community support by exploring the various approaches to care coordination that hold the greatest promise for improving health outcomes, reducing healthcare costs and being scaled through existing networks.

KEY LEARNINGS

Within this white paper, the nuanced differences between care coordination, case management and care management are examined, and multiple care coordination models that were developed and implemented to address the healthcare needs of high-risk, older adults are explored. In addition, challenges that need to be addressed to facilitate successful scaling and wider adoption are identified, while promising practices and approaches to care coordination are highlighted, including the following essential elements of care coordination:

- **AN INTERDISCIPLINARY TEAM-BASED APPROACH TO CARE WITH A DESIGNATED CARE COORDINATOR.** Responsive, multidisciplinary teams can deliver a wide scope of services to patients with complex needs, helping to ensure successful patient "handoffs" between clinicians and across different care settings. Beyond that, a care coordinator or care manager can serve as the main point of contact between the care team and the patient, creating a bridge between medical providers and community support services and orchestrating care.

- **A PATIENT-CENTERED APPROACH THAT ENGAGES THE PATIENT AND THEIR CAREGIVERS AS PARTNERS IN CARE.** Placing the patient front and center of their own care plan ensures that the care planning process reflects the goals and preferences of the individual over a continuum of care in multiple settings.

- **RISK STRATIFICATION TO IDENTIFY WHO IS MOST LIKELY TO BENEFIT FROM COMMUNITY-BASED CARE COORDINATION.** Older adults with chronic conditions and multiple functional limitations have difficulty adhering to treatment recommendations and coordinating care among specialists. Stratifying services based on patients' needs and investing in post-hospital enhanced services or community-based supports that facilitate and ensure stability in the community setting can be far less costly than recurrent emergency department visits and hospitalizations.

Designing and implementing a care coordination strategy that facilitates and ensures stability across care providers and settings has the potential to improve health outcomes for patients, increase patient satisfaction and decrease the number of costly emergency room visits and overall healthcare utilization. Insights and lessons gleaned from these care delivery programs can help inform the future work of organizations and healthcare systems that seek to improve the health and well-being of high-risk, older adults.

1 J. Michael McGinnis and William H. Foege, "Actual Causes of Death in the United States," The Journal of the American Medical Association 270, no. 18 (Nov. 10, 1993):2207-2212, doi:10.1001/jama.1993.03510180077038 and Ali H. Mokdad et al., "Actual Causes of Death in the United States," The Journal of the American Medical Association 291, no. 10 (March 10, 2004):1238-1245, doi:10.1001/jama.291.10.1238.

2 R. Burton, Health Policy Brief: Improving Care Transitions (Princeton, NJ: The Robert Wood Johnson Foundation, Health Affairs, September 2012).

Work conducted in partnership between Meals on Wheels America and Aetna, a CVS Health business