NATIONAL QUALITY STRATEGY
Better Care. Healthy People/Healthy Communities. Affordable Care.

PRIORITIES IN FOCUS

June 2016

Effective Communication and Care Coordination

BENEFICIARIES WITH MULTIPLE CHRONIC CONDITIONS MAY SEE UP TO 16 PHYSICIANS PER YEAR.

THE ISSUE: EFFECTIVE COMMUNICATION AND CARE COORDINATION

Navigating today's health care system is complicated. Patients receiving care often interact with many physicians, nurses, medical assistants, or other trained professionals across multiple settings; a situation especially true for the sickest populations. The typical Medicare beneficiary sees at least two primary care providers and five specialists, while beneficiaries with multiple chronic conditions may see up to 16 physicians per year.[1]

When health care providers coordinate with each other, outcomes improve for everyone. Improved coordination decreases medication errors, unnecessary or repetitive diagnostic tests, unnecessary emergency room visits, and preventable hospital admissions and readmissions—all of which together lead to higher quality of care, improved health outcomes, and lower costs. Because delivery of coordinated care necessarily brings together disparate sectors of the health care system, improving care coordination offers a potential opportunity for drastically improving care quality that could save $240 billion a year.[2]

THE NATIONAL QUALITY STRATEGY SOLUTION

The National Quality Strategy calls all stakeholders to promote effective communication and coordination of care across the health care system by focusing on three long-term goals:

- Improving the quality of care transitions and communications across care settings
- Improving the quality of life for patients with chronic illness and disability by following a current care plan that anticipates and addresses pain and symptom management, psychosocial needs, and functional status
- Establishing shared accountability and integration of communities and health care systems to improve quality of care and reduce health disparities

The Affordable Care Act created opportunities to design and test new models of care delivery and payment that improve care coordination, leading to improved health and health care quality and reduced spending. Accountable care organizations, models specifically structured to improve care coordination, unite a patient's providers from across the health care delivery system with the common goal of preventing medical errors and ensuring that their patients do not receive unnecessary services. If designed thoughtfully, care coordination programs can achieve the three aims of the National Quality Strategy by improving patients' experiences with the health care system and their health outcomes while reducing

TWENTY PERCENT OF MEDICARE BENEFICIARIES ARE REHOSPITALIZED WITHIN 30 DAYS AFTER DISCHARGE.

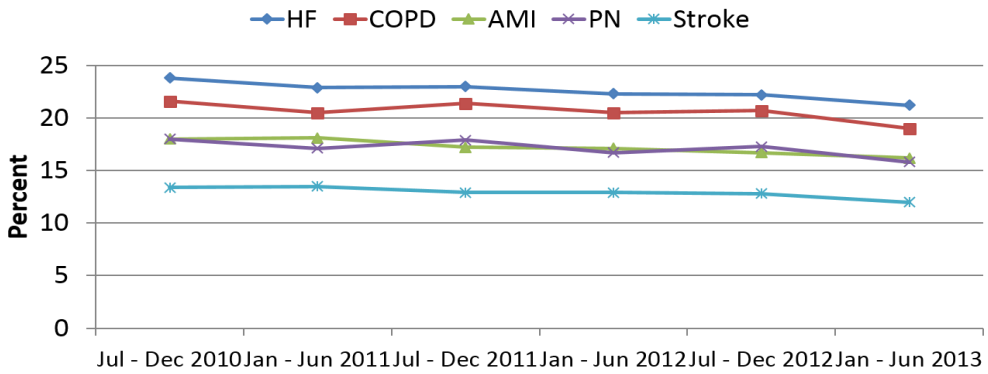
wasteful spending in the long run. For example, the Centers for Medicare & Medicaid Services' (CMS) Community-based Care Transitions Program coordinates discharge from hospitals to other care settings and seeks to reduce hospital readmissions. Care coordination also is facilitated by the meaningful use of health information technologies.

WHERE WE ARE NOW: 2015 CARE COORDINATION CHARTBOOK

An important measure of care coordination is the proportion of patients who receive discharge instructions for serious conditions. Cardiovascular conditions are a leading cause of morbidity and mortality in the United States, and showed improvement in the 2015 National Healthcare Quality and Disparities Report Chartbook on Care Coordination: from 2005 to 2013, the percentage of hospital patients with heart failure who were given complete written discharge instructions increased overall, for both sexes and all racial/ethnic groups.

Another good approximation of the degree of care coordination is preventable readmissions. According to a 2009 study, nearly 20 percent of Medicare beneficiaries are re-hospitalized within 30 days after discharge at an annual cost of $17 billion, yet only 10 percent of those readmissions were planned.[3] While readmissions result from a variety of factors, lack of care coordination and effective care transitions are important contributors. Under the Affordable Care Act, CMS calculates the average risk-adjusted, 30-day hospital-readmission rates using claims data. If a hospital's risk-adjusted readmission rate exceeds that average, CMS penalizes the hospital in the following year.[4] As shown in the chart below, this policy successfully led to a reduction in all-condition Medicare readmission rates.

Median hospital 30-day risk standardized readmission rate (%) for certain conditions, July 2010 – June 2013



Key: HF = heart failure; COPD = chronic obstructive pulmonary disease; AMI = acute myocardial infraction; PN = pneumonia
Source: Centers for Medicare & Medicaid Services, 2014 Medicare Hospital Quality Chartbook.

[1] Bodenheimer T. Coordinating care—a perilous journey through the health care system. N Engl J Med 2008 Mar 6;358(10):1064-71. Available from http://www.nejm.org/doi/full/10.1056/NEJMhpr0706165.

[2] Institute of Medicine Roundtable on Evidence-Based Medicine; Yong PL, Saunders RS, Olsen LA, editors. The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Washington (DC): National Academies Press (US); 2010. Available from: http://www.ncbi.nlm.nih.gov/books/NBK53938/.

[3] Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. N Engl J Med 2009; 360:1418-1428. Available from http://www.nejm.org/doi/full/10.1056/NEJMsa0803563.

[4] CMS is targeting Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN). http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html.