

Care Coordination and Chronic Management: A Specialist's View

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Disclosures

- I am a specialist



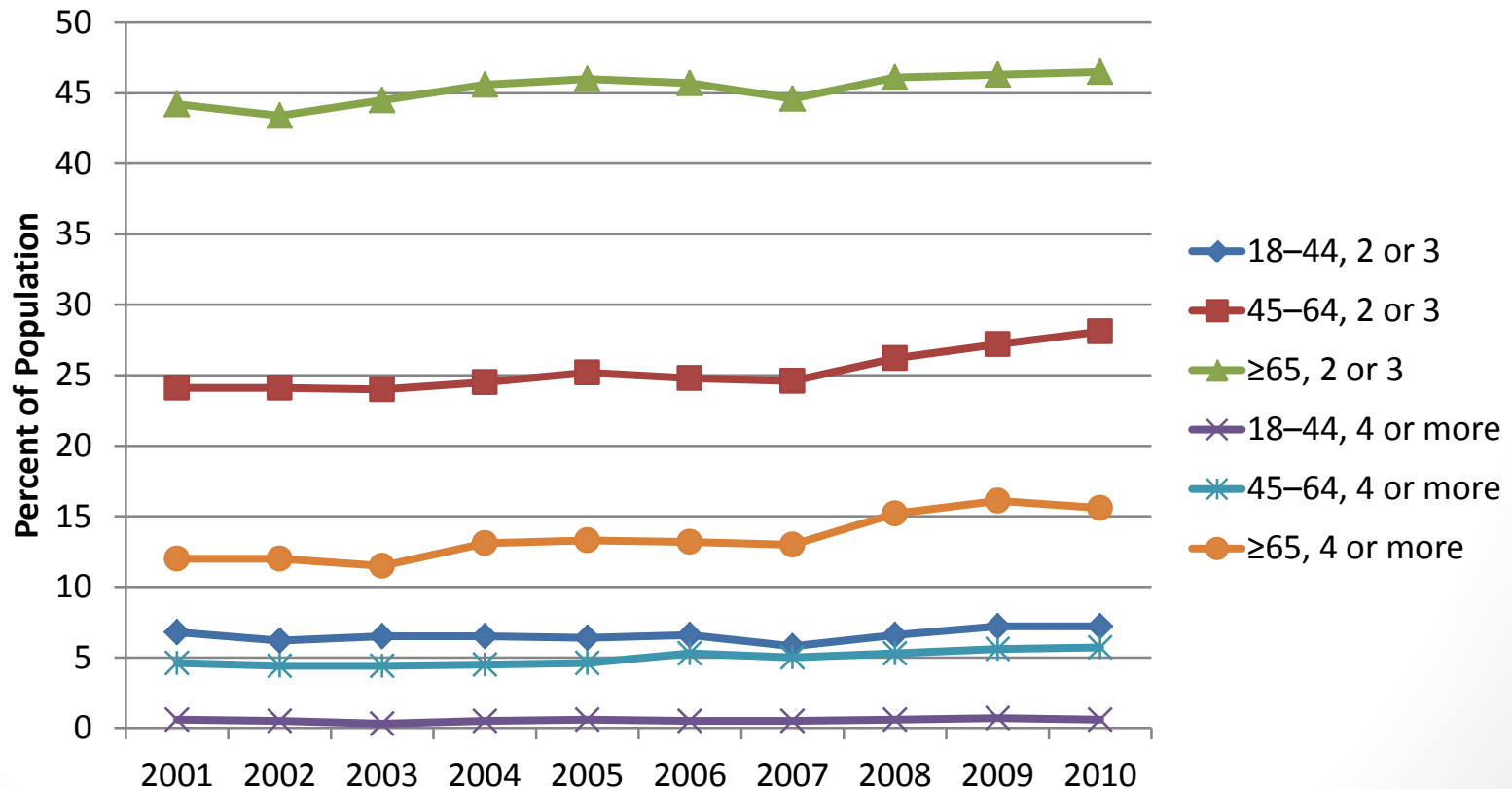
Outline

- Why and When Specialists?
 - Why Not Specialists?
- How Specialists?
- Challenges to meaningful co-management
 - Communication
 - Electronic Health Records
- Conclusions and Recommendations



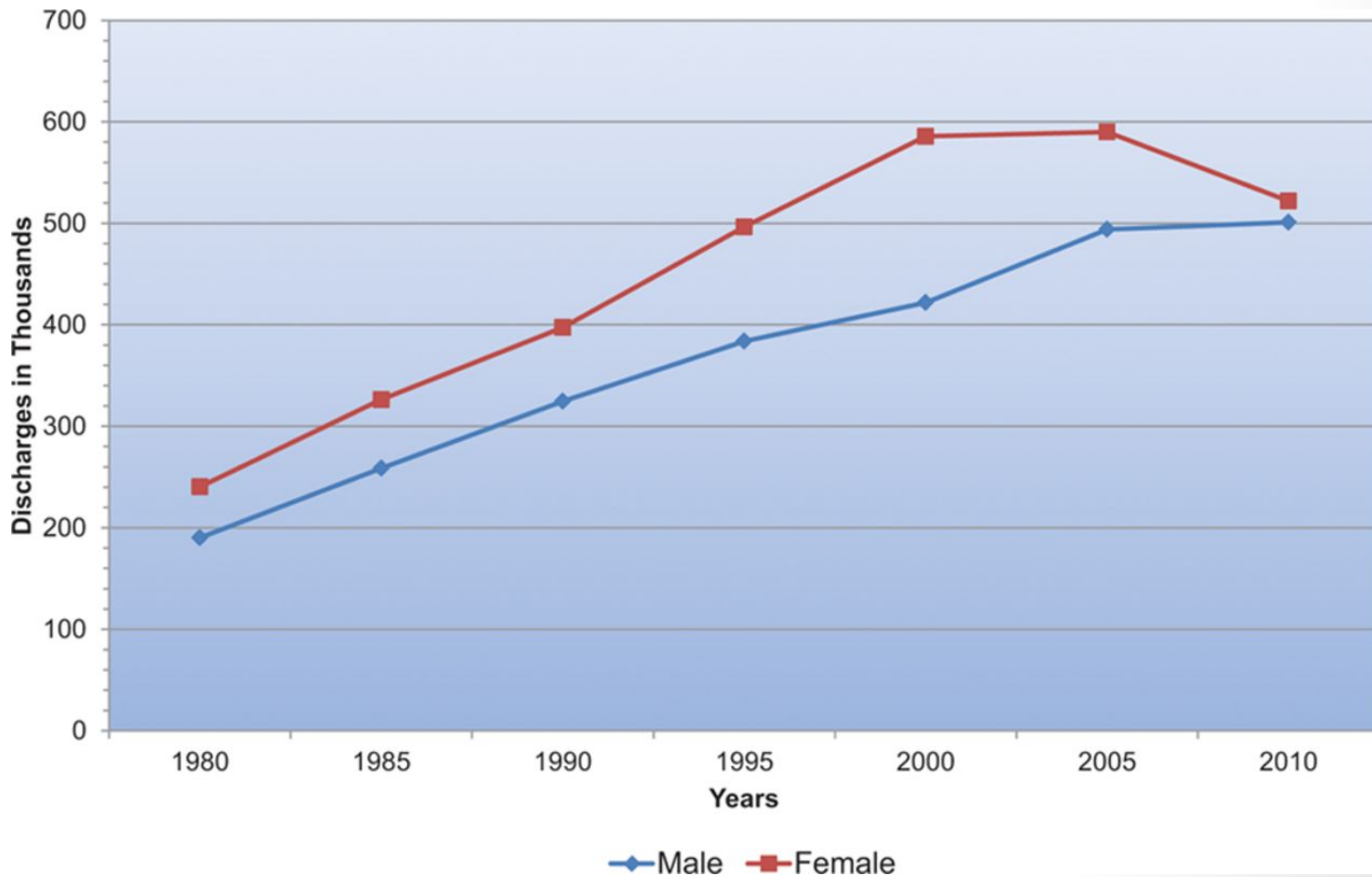
Why Specialists?

- High prevalence of multimorbidity



Why Specialists?

- Increasing prevalence of complex disease



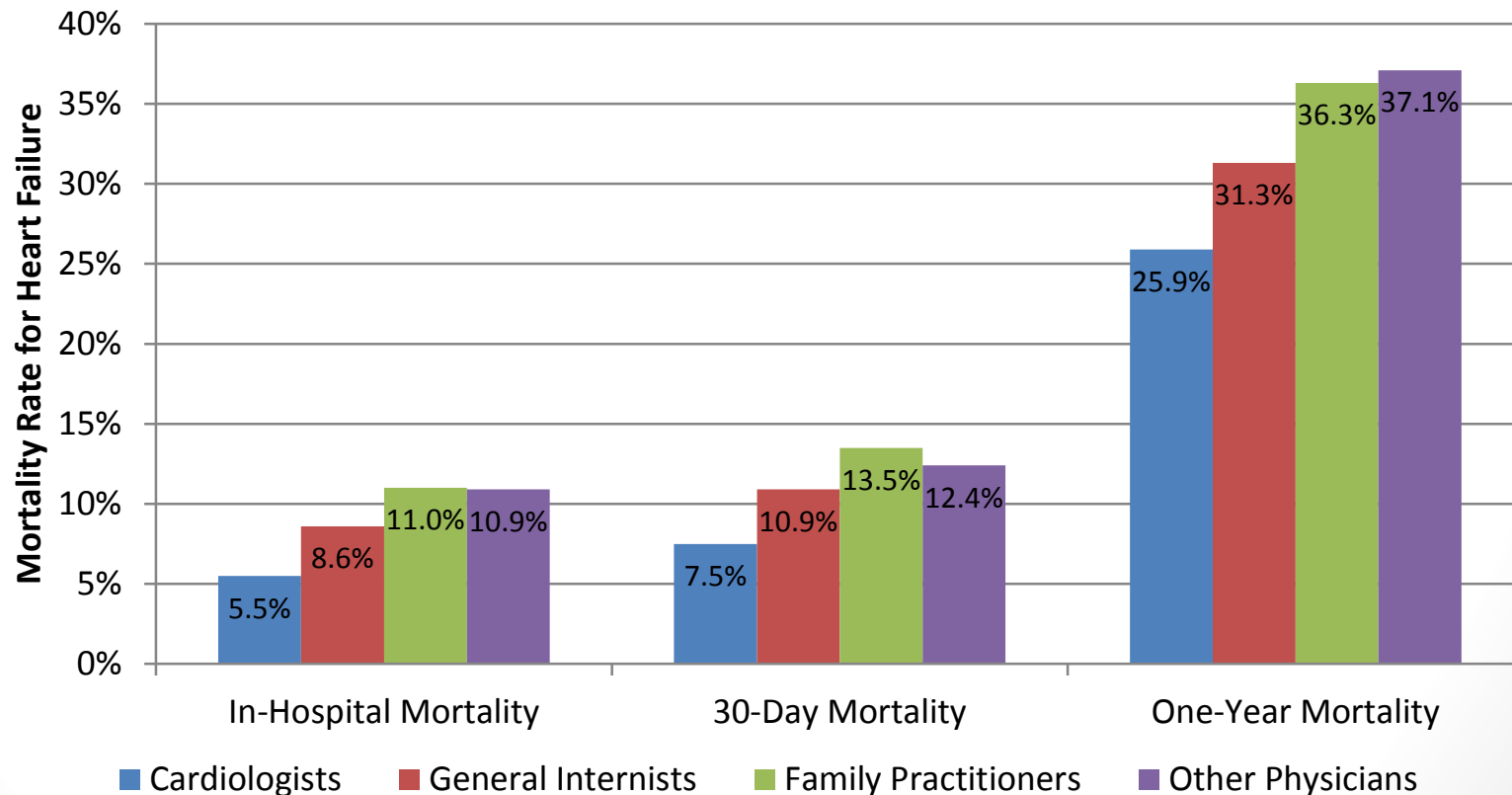
Why Specialists?

- More familiarity may mean better care
 - Lower mortality rates
 - Higher use of evidence-based therapies
 - Heart Failure, Heart Attack, Stroke
 - Less evidence in outpatient setting
 - Higher “quality” care but similar outcomes
- Despite a higher burden of disease in specialist-managed patients



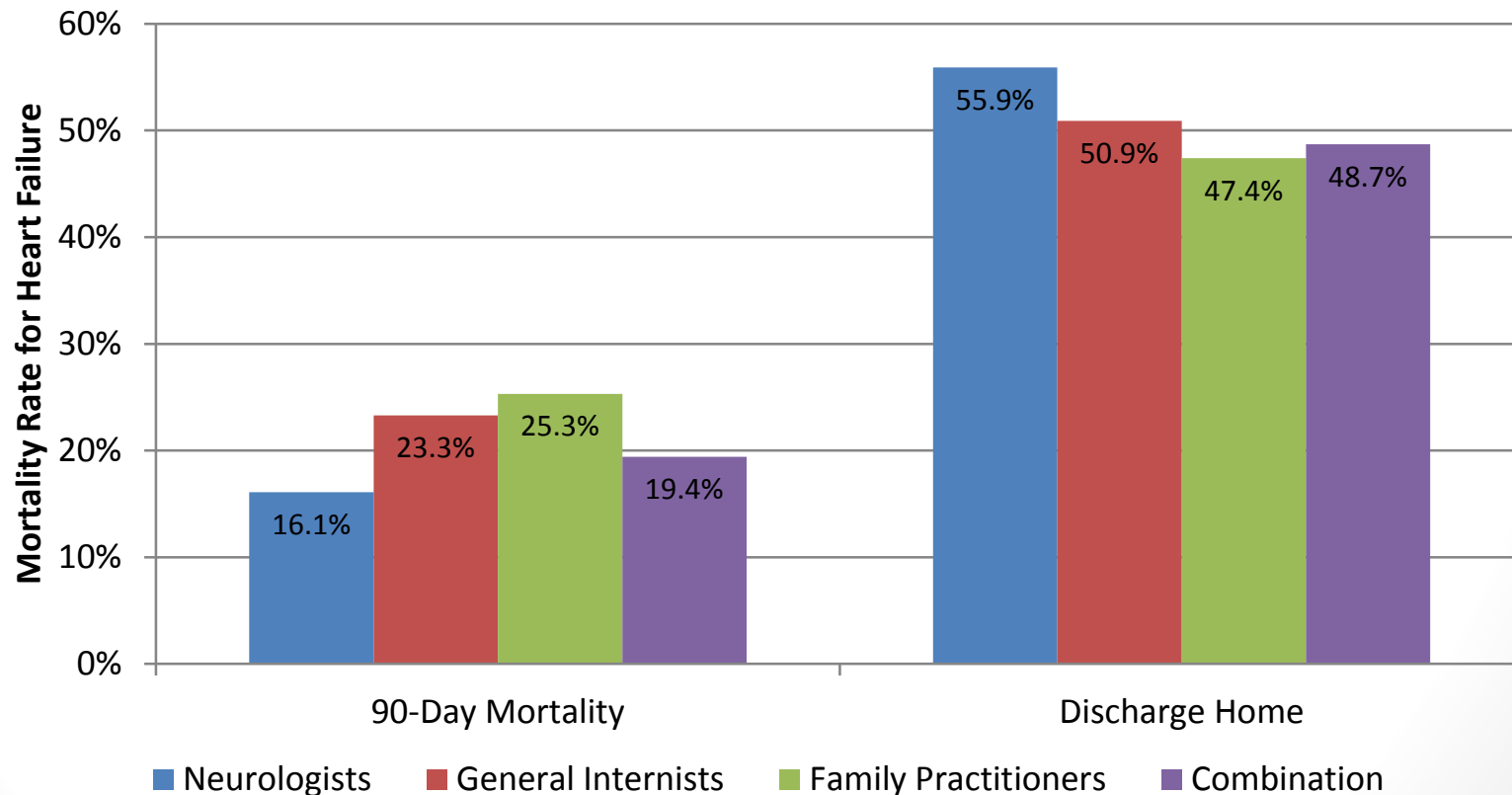
Why Specialists, Continued

- Lower mortality for heart failure patients



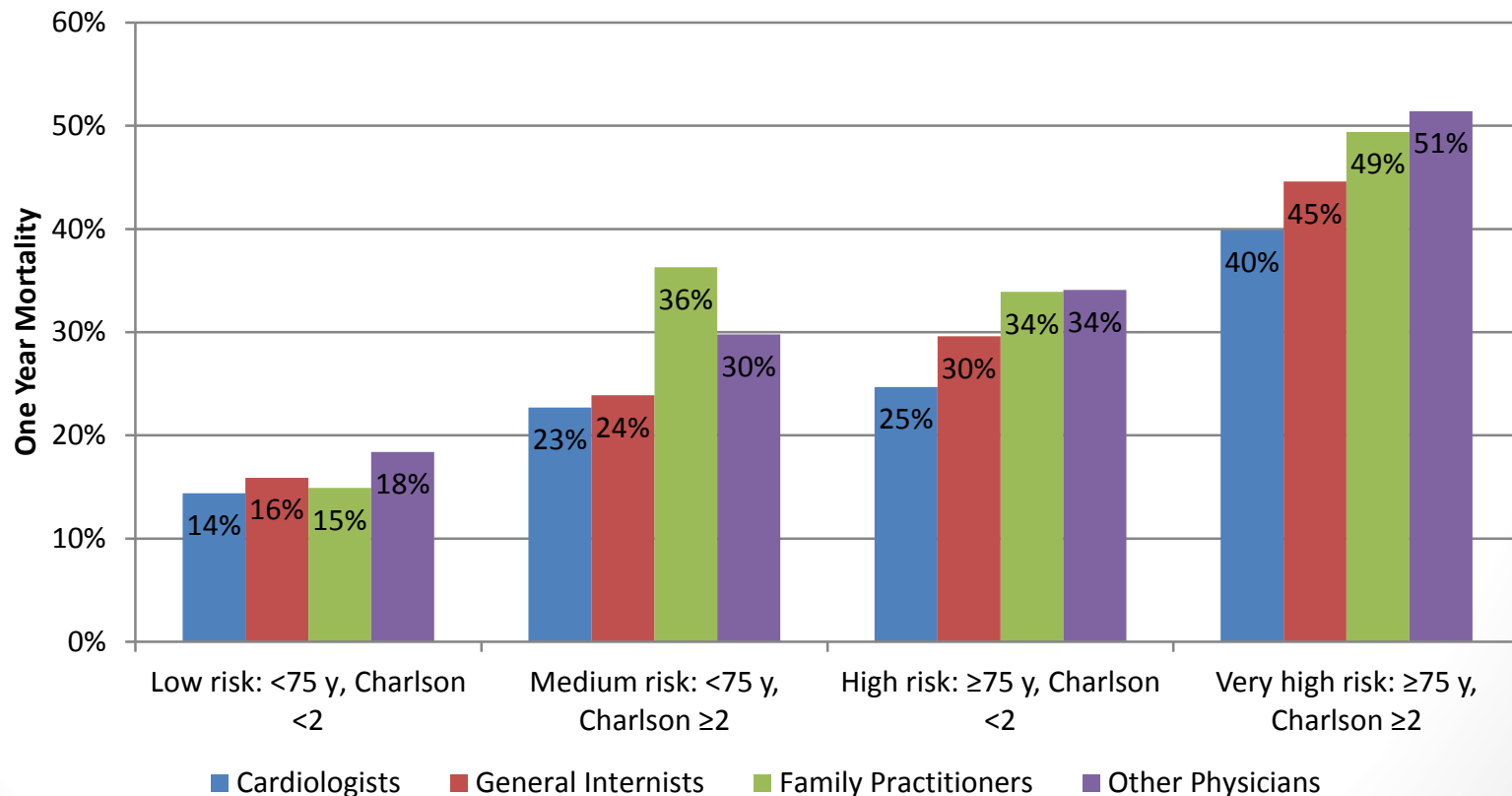
Why Specialists, Continued

- Lower mortality for stroke patients



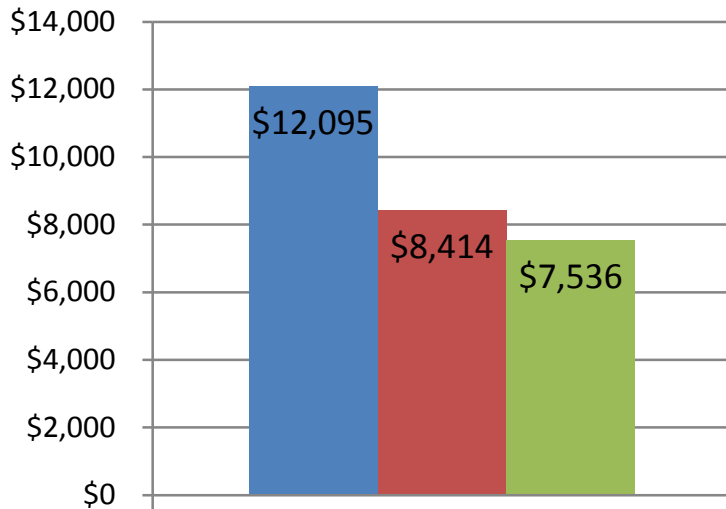
When Specialists?

- Greatest benefit is in highest-risk patients



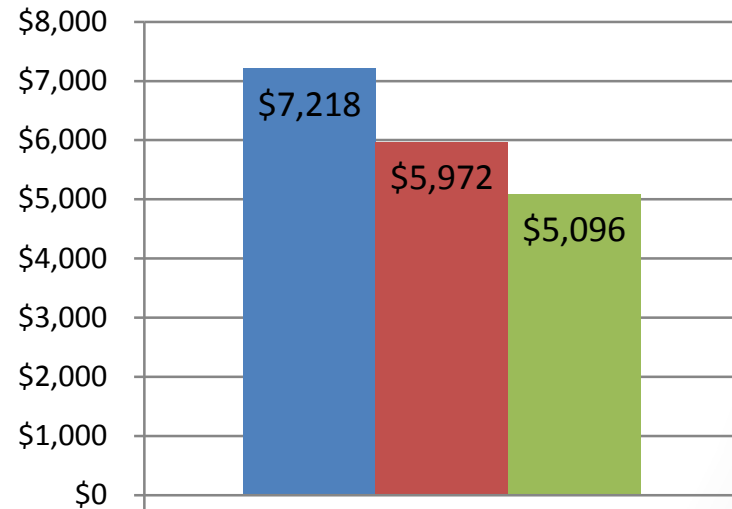
Why Not Specialists?

- Higher costs with more specialists/capita
- Higher costs for HF and stroke



Cost of HF Hospitalization

■ Cardiologists ■ General Internists ■ Family Practitioners



Cost of Stroke Hospitalization

■ Neurologists ■ General Internists ■ Family Practitioners



How Specialists?

- Gatekeeping
 - Prevent specialty visits at all costs
- Consultation
 - Obtain limited specialist input
- Shared management
 - Co-manage multiple conditions, share ideas
- Specialist management
 - Assume all aspects of care for patient



How Specialists?

- Gatekeeping
 - Healthy outpatient with occasional needs
- Consultation
 - Patient with complex organ-system disease
- Shared management
 - Patient with multiple chronic conditions
- Specialist management
 - Patient with rare needs (ESRD, VADs, TxP)



Barriers: Communication

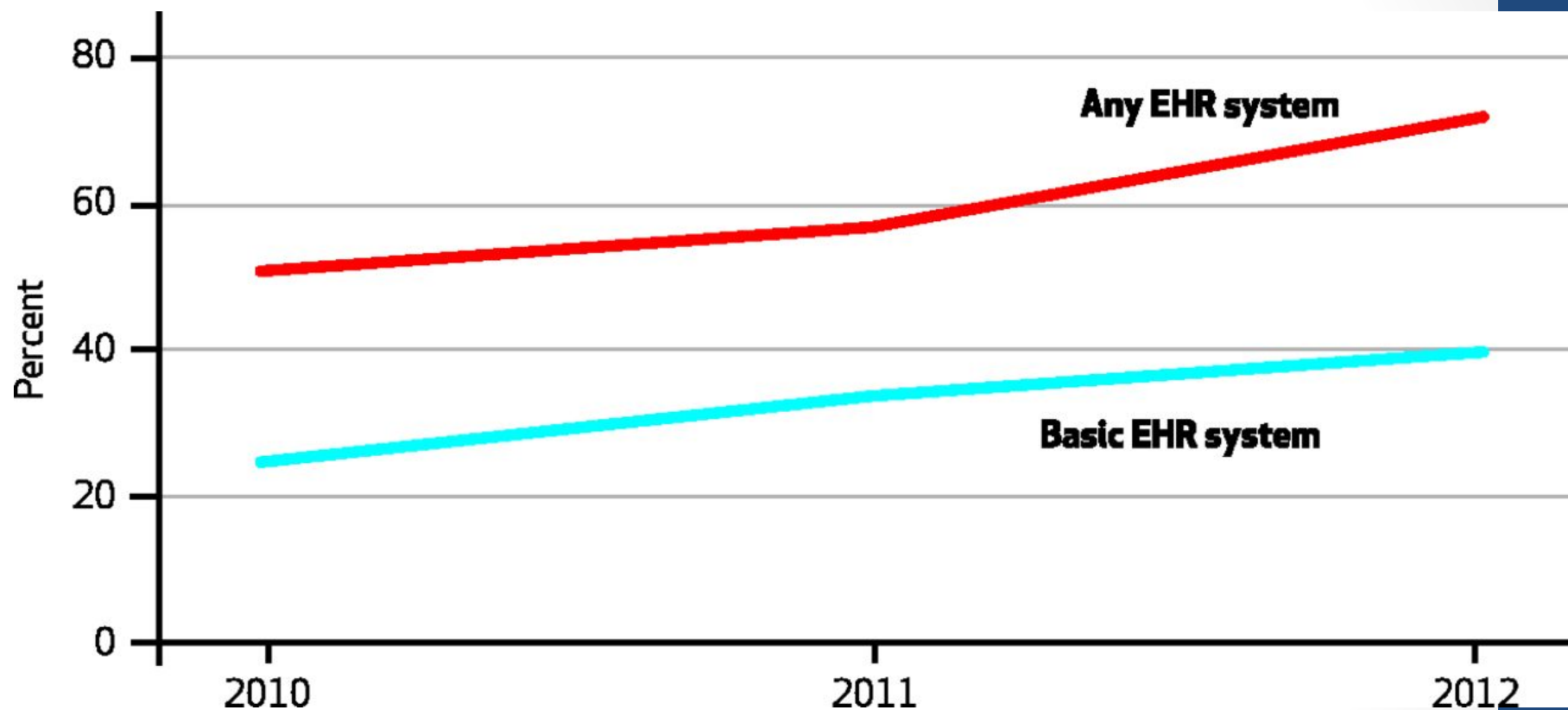
- The typical primary care physician has 229 (interquartile range, 125 to 340) other physicians working in 117 (interquartile range, 66 to 175) practices with which care must be coordinated, equivalent to an additional 99 physicians and 53 practices for every 100 Medicare beneficiaries managed by the primary care physician.



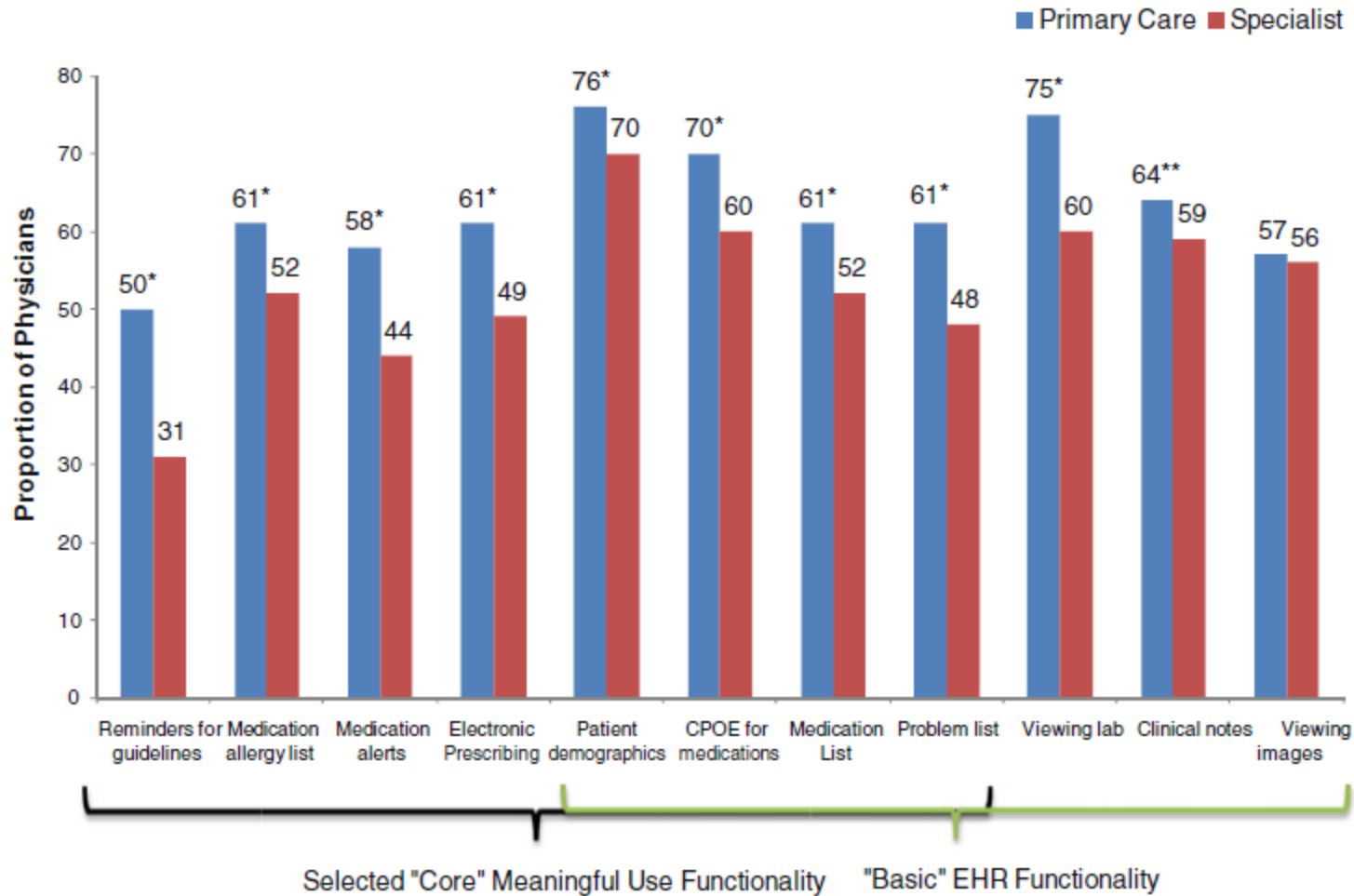
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Electronic Health Records

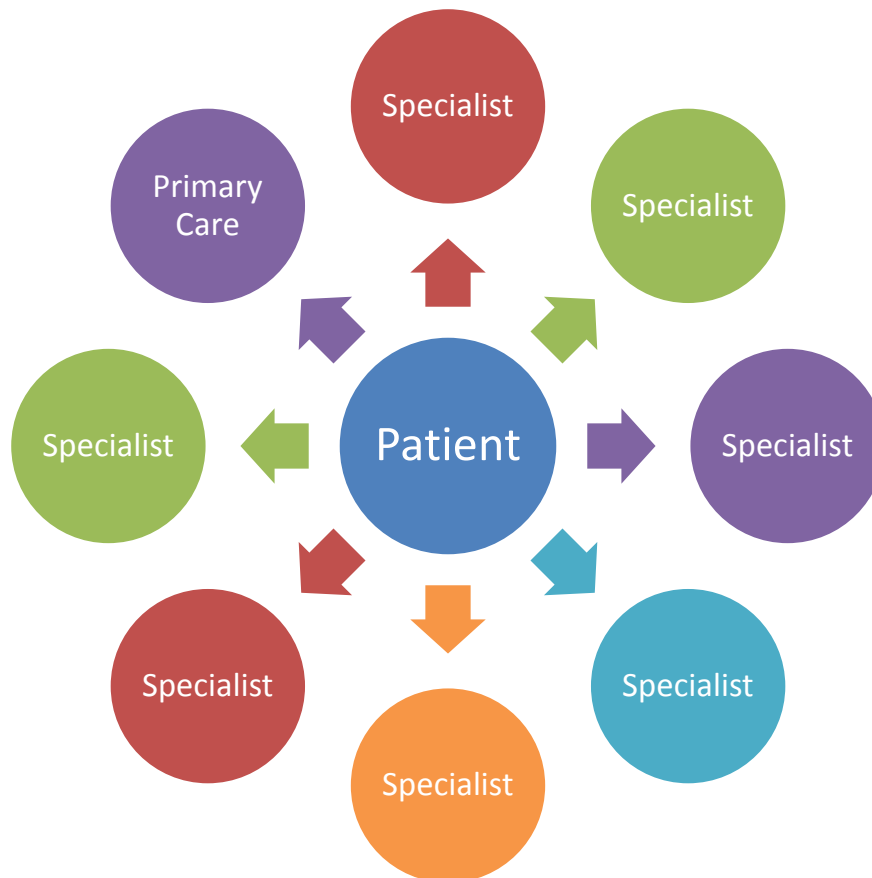


EHRs: Specialty Care



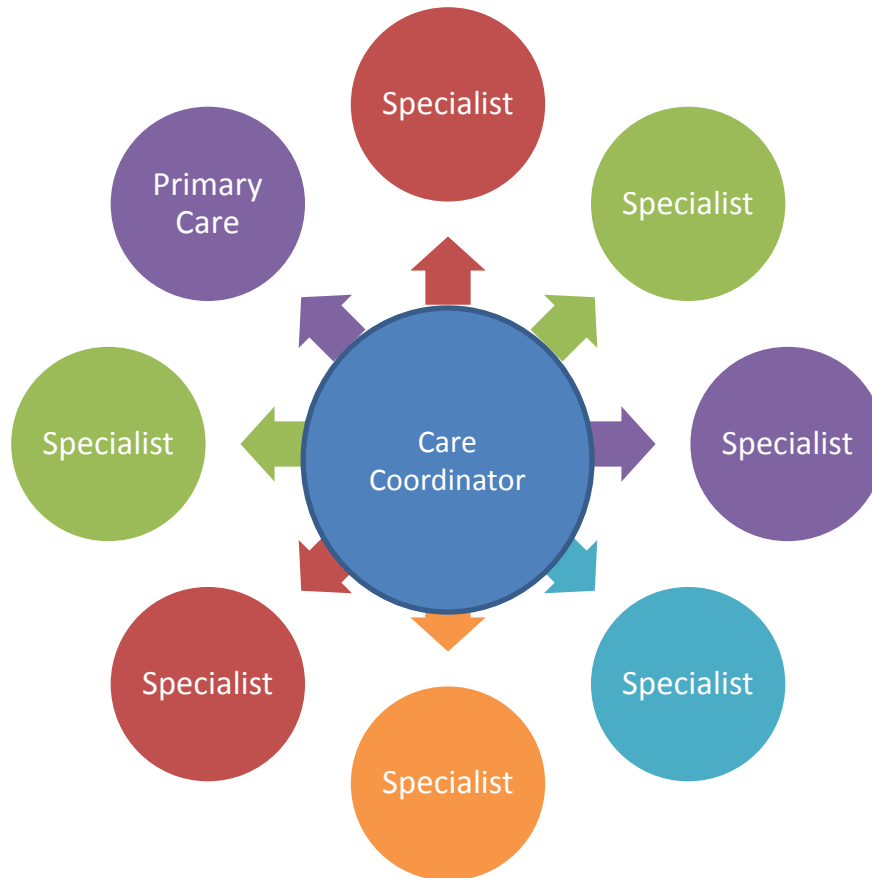
What is the Right Model?

- Care coordinator linked directly to patient



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What is the Right Model?

- Care coordinator centered with PCP



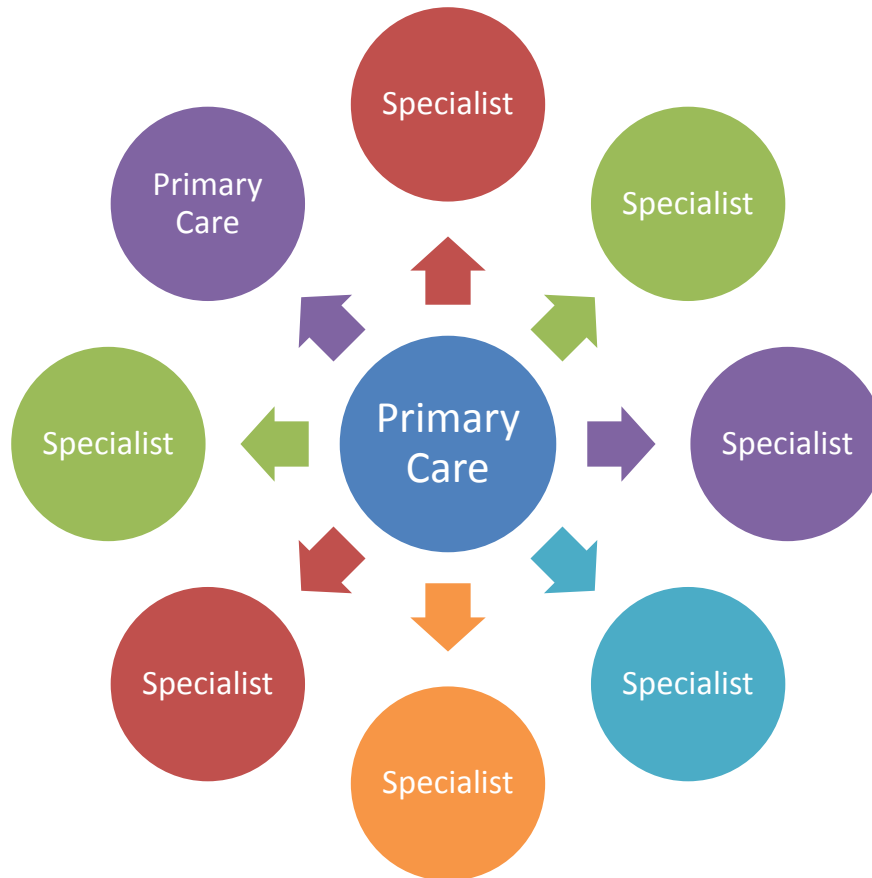
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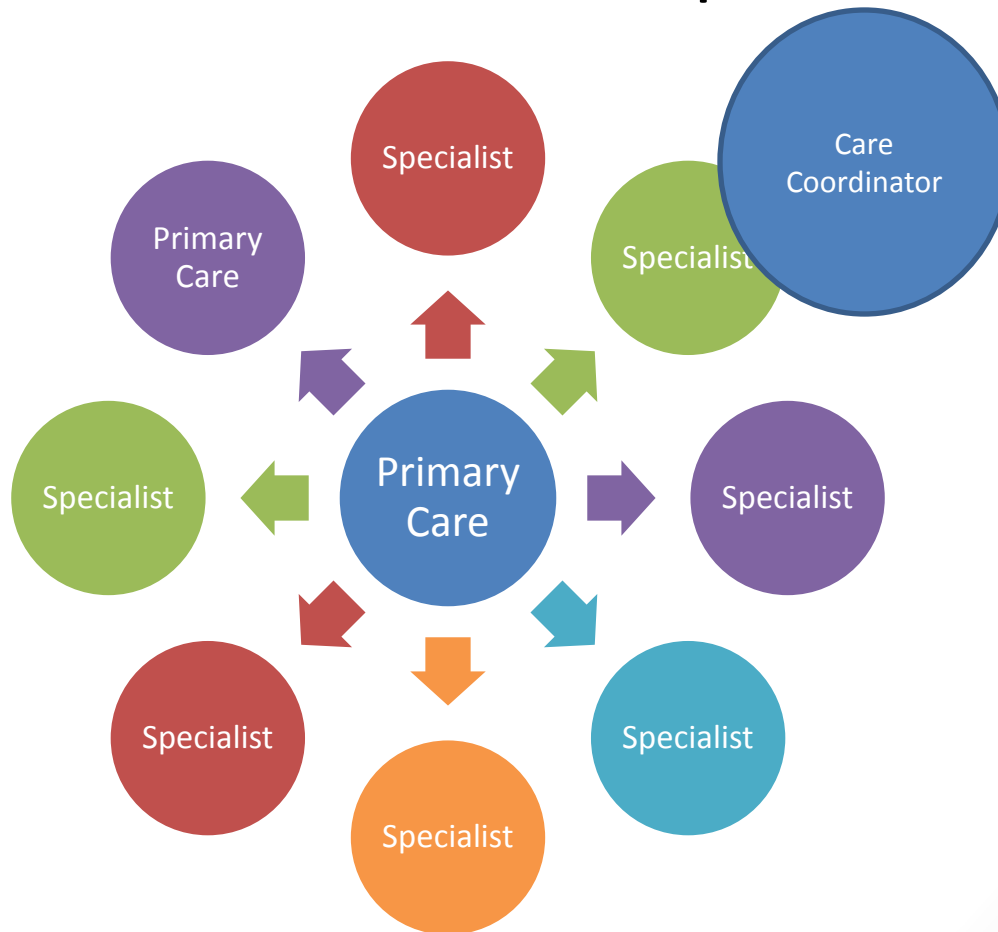
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- Care coordinators linked to specialists



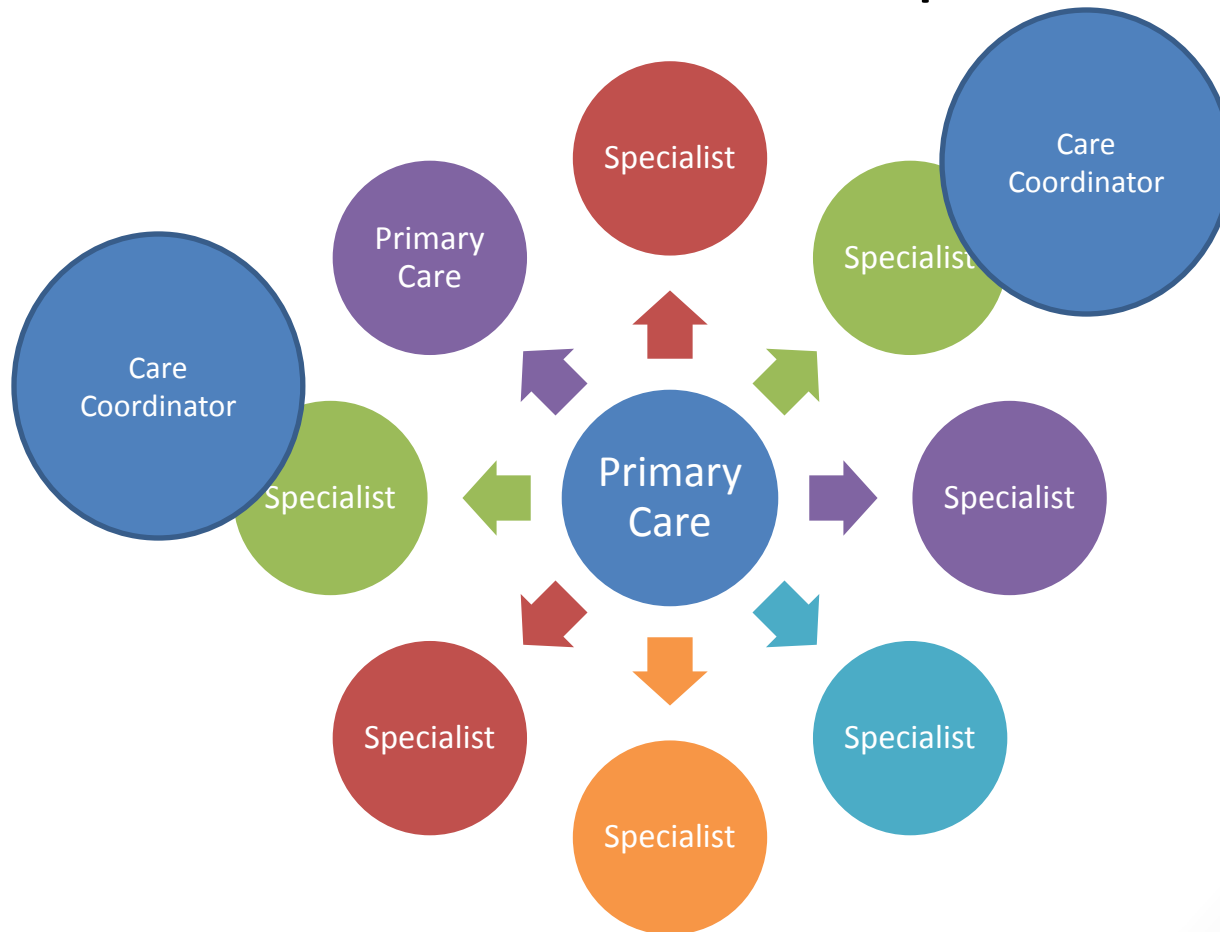
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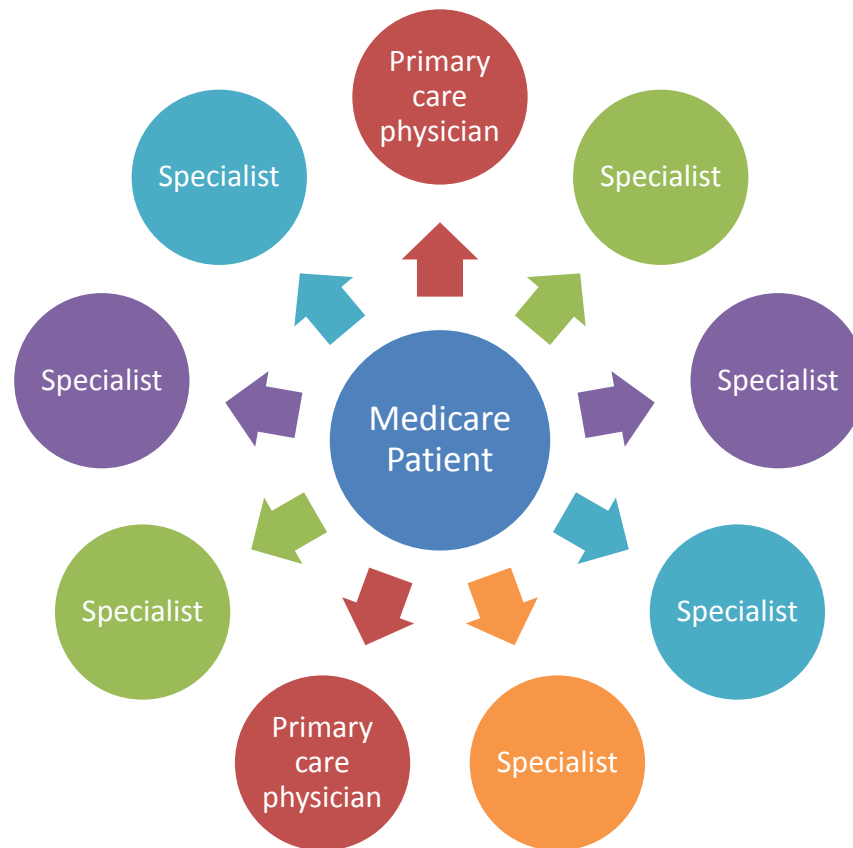
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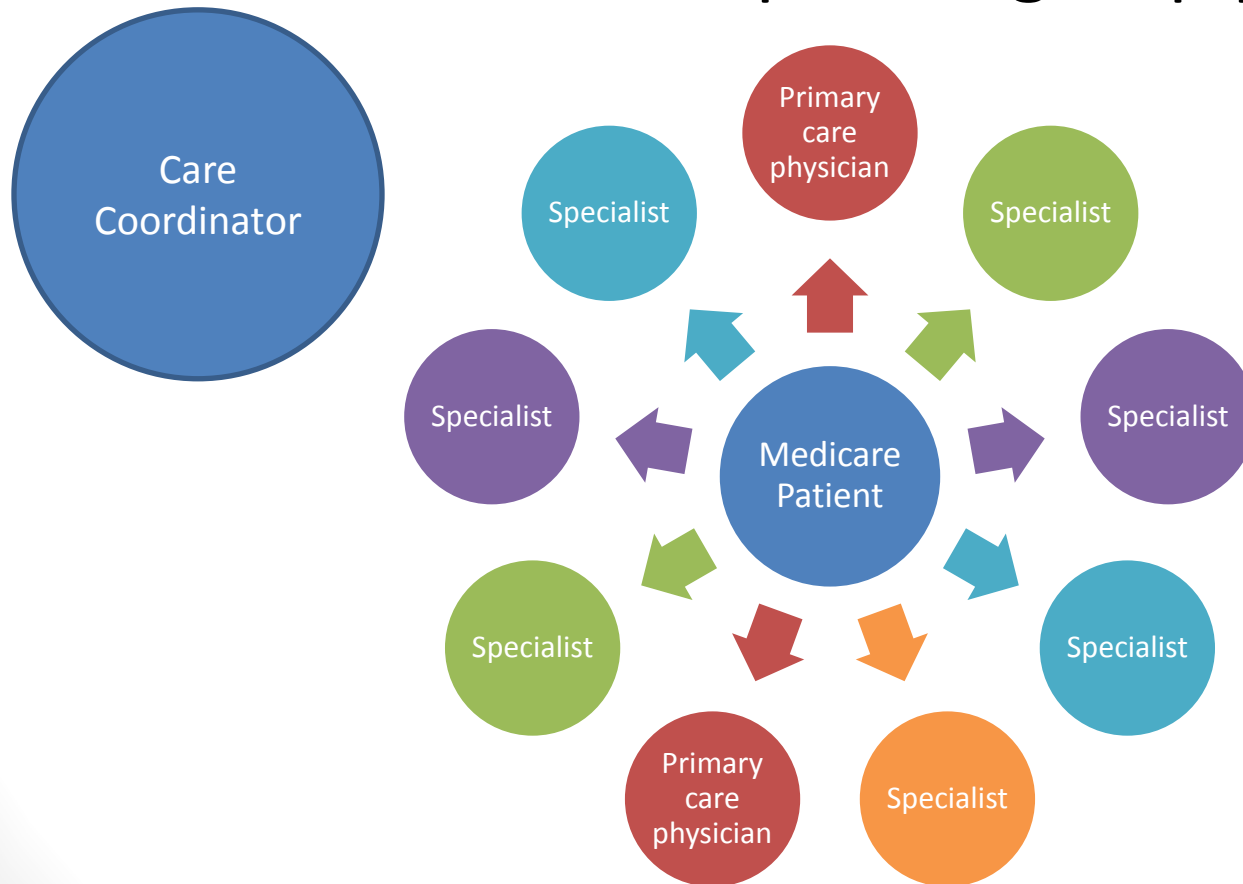
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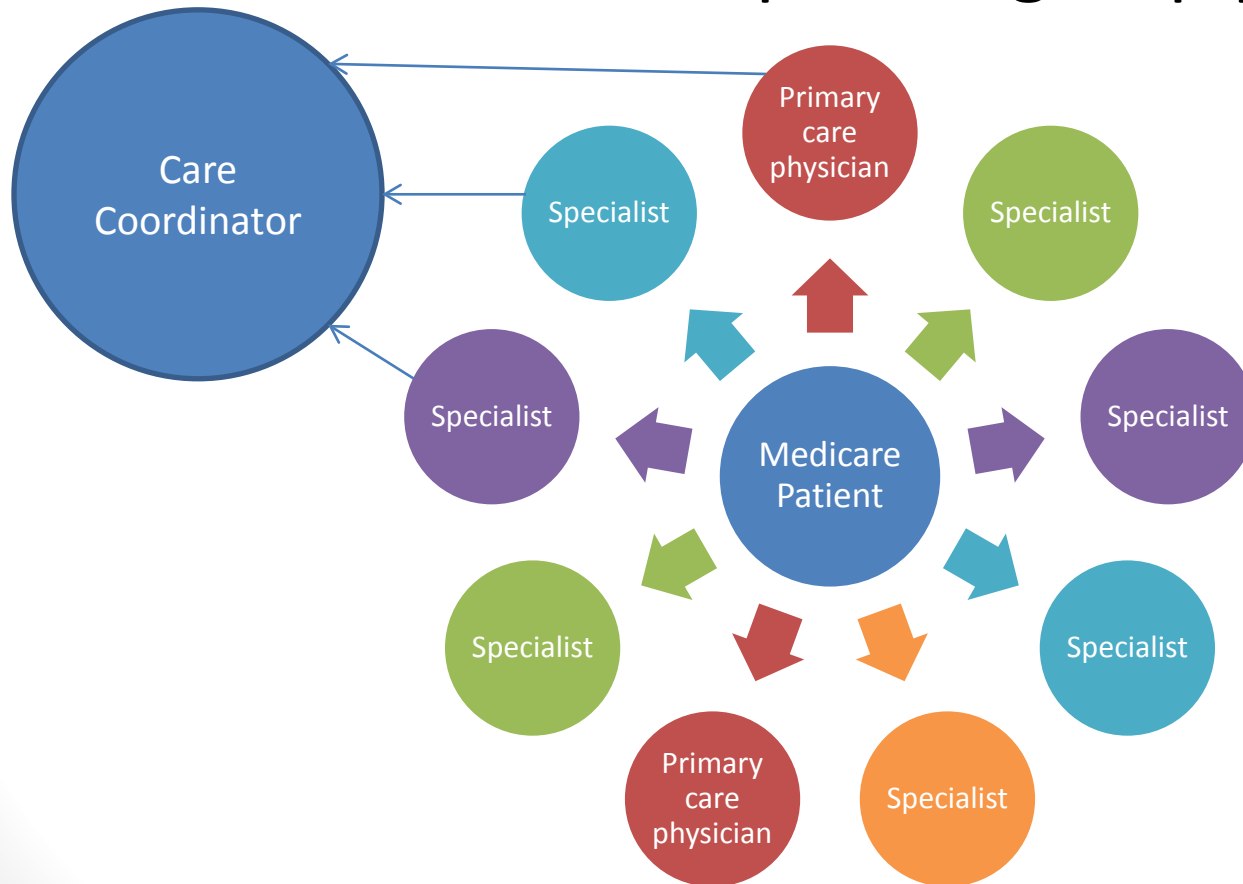
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Conclusions

- The prevalence of complex patients is high and rising
- Specialists are an important part of the health care team
 - Can improve outcomes for selected patients
- We don't know how care should be shared
 - Likely many models, depending on needs
- Major barriers are communication and lack of “tradition” and clear roles



Recommendations

- A team needs to form around the patient
 - Best centered with lead decisionmaker
- We need shared information
 - Electronic health records, personal records
- More evidence should be generated
 - How should we organize the system?
 - Local laboratories
 - Learning health care systems



Thank You!

- Questions?
- Contact me: kjoynt@hsph.harvard.edu

