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

Ward and Schiller, Prev Chron Dis 2013
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

Jong et al, Circulation 2003
Why Specialists, Continued

- Lower mortality for stroke patients

Mortality Rate for Heart Failure

- 90-Day Mortality
  - Neurologists: 16.1%
  - General Internists: 23.3%
  - Family Practitioners: 25.3%
  - Combination: 19.4%

- Discharge Home
  - Neurologists: 55.9%
  - General Internists: 50.9%
  - Family Practitioners: 47.4%
  - Combination: 48.7%

Mitchell et al, Stroke 1996
Greatest benefit is in highest-risk patients
Why Not Specialists?

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

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.
Barriers: Communication

Pham et al, NEJM 2010
Electronic Health Records

![Graph showing the percent of any EHR system and basic EHR system over the years 2010 to 2012.](Hsiao et al, Health Affairs 2013)
EHRs: Specialty Care

Patel et al, JGIM 2013
What is the Right Model?

- Care coordinator linked directly to patient
What is the Right Model?

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What is the Right Model?

- Care coordinator centered with PCP
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What is the Right Model?

- Care coordinators linked to specialists

Pham et al, NEJM 2010
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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?

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