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Short Commentary

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Bringing the Elusive Goal of Care Coordination Within Reach

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Medical errors lead to great suffering and to thousands of death every year in the United States. About one third of those errors are directly attributable to poor coordination of care. Despite these grim statistics, effective care coordination remains an elusive goal in the American health care system.

Today, it is not unusual for a patient to be under the care of two or three specialists in addition to the Primary Care Physician (PCP). For the elderly, care is even more fragmented: one study found that 30% of Medicare beneficiaries are under treatment by five or more physicians [1]. Yet communication between providers remains limited, especially in the outpatient arena. PCPs typically do not manage their patients in the hospital, and their paths no longer crosses that of specialists to discuss a case or get a "curbside consult". The specialists, on the other hand lack access to the one physician with the most comprehensive knowledge of the patient.

Electronic Medical Record (EMR) systems have yet to deliver on their promise of open and seamless communication among providers. Different EMR systems, developed and sold by market competitors, do not inter-operate. Many specialist reports are sent to the PCP in paper form and must first be scanned into the EMR system. And even within the same EMR system, the structure of the electronic note makes it difficult to extract useful information.

In a 2019 survey, 22% of PCPs reported that they used the EMR system to send clinical information to a specialist "sometimes" or "seldom or never" and 35% reported that only "sometimes" or "seldom or never" do they receive information back from the specialist [2]. The study author posited that the true percentages are likely higher "because physicians participating in the survey are a highly motivated subset and are in practices with relatively more sophisticated EHR use."

Widespread adoption of the following four practical approaches would make effective care coordination a reality: eConsults, collaborative care, complex-case conferences, and a referral prioritization system.

In the interprofessional consultation, or eConsult, the PCP and the specialist communicate directly; the patient is not involved. This allows the specialist to get more relevant and accurate information, while the PCP gets a chance to ask clarifying questions[3]. Unsurprisingly, the eConsult has been shown to improve access to specialist care and to enhance communication between providers. eConsults also decrease wait time, and they are inherently "triaged" because the PCP will only seek an eConsult for those patients with more urgent needs.

Despite these benefits, eConsults remain vastly underused. The lack of insurance reimbursement is often cited as a barrier to widespread use of eConsults. Yet reimbursement policies have changed markedly in recent years. Medicare began paying for eConsults in 2019, CMS now allows eConsult reimbursement under Medicaid/CHIP, and some private insurers have begun to follow suit. Although reimbursement rates for eConsults are low, this simply reflects their reduced time burden. While the traditional patient consultation may last 30 - 40 minutes, the average eConsult lasts only Eleven (11) minutes [4]. So, in the same time as a traditional patient consultation, a specialist can provide three or four eConsults.

Broader adoption of the collaborative care model, which has been successfully used in the management of mental illness, would be enormously beneficial. Under this model, a patient is referred to a specialist with a specific question or goal, such as optimizing the insulin regimen for Type II diabetes. Once the question is answered and the treatment is optimized, the patient can return to the PCP for continuing care. The specialist and PCP meet periodically to discuss care for the cohort of patients being managed in that model. Collaborative care would free up the specialists' schedules, providing other patients with timely access to specialist care. Regular interaction with specialists would provide the PCP with a deeper understanding of the illness under management.

Discussing complex cases in a structured meeting is a common practice in specialties, as in oncology; tumor boards and cardiology; catheterization cases. This should become common practice in primary care. Doing so can vastly improve the outcomes in patients with multiple chronic diseases: these patients are typically managed by multiple specialists who at times give irreconcilable treatment recommendations. A PCP can invite the treating specialists as well additional experts in the relevant specialties to discuss such a complex case. Doing so would allow them to find alternatives to contradictory recommendations and collectively to reach a consensus on the best course of treatment.

Triaging specialist referrals remains a challenge. Patients with urgent needs are often not seen by the specialist in a timely manner. A prioritization system needs to be developed for each specialty and the referral specialist/ case managers need to be trained on how to use the system. In a recent study, a panel of rheumatologists and PCPs created a Priority Referral Score (PRS) for rheumatologic disease that showed strong reliability [5]. It is possible to create similar systems in other specialties. Indeed, some are actively looking into using Artificial Intelligence (AI) to create referral priority systems.

As the population in the US gets older and medicine becomes more specialized, care coordination becomes a crucial part of meaningful patient care. The solutions I propose can bring us closer to achieving effective care coordination with only few changes and without disrupting our workflow.

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