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The Promise of Care Coordination

Certain Models of Care Coordination Can Reduce Hospitalization And Health Care Expenditures among Medicare Beneficiaries, Improve Quality of Care

New Report Offers Evidence-Base as a Foundation to Build Urgently Needed Reforms in Primary Care for Older Americans

LAS VEGAS, NV – A major new report finds that care coordination programs can reduce hospitalizations and Medicare costs and improve the quality of care for chronically ill older adults--provided the programs: promote direct engagement of teams of primary care physicians, nurses and social workers; create close communication among all providers involved in a patient's care; and empower patients to help manage their own care. Released at the 2009 Annual Conference of the American Society on Aging and the National Council on Aging, "The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses" can help policy-makers craft national health care reforms that will better serve older adults and their caregivers.

The New York Academy of Medicine commissioned the report in conjunction with the National Coalition on Care Coordination (N3C). It was authored by Dr. Randall Brown of Mathematica Policy Research, Inc. Brown was the lead researcher for a recent government study of 15 care coordination programs nationwide that serve older patients. The Brown report issued Tuesday takes a deeper look at the programs that were most successful at yielding quality improvements and cost savings, to identify commonalities and determine whether there is sufficient evidence to pursue care coordination as part of a national health care reform plan.

"While better care coordination is not the sole solution to the entire health care problem, it is achievable now and can improve the quality of life for millions of older Americans including the most frail and vulnerable," the report concludes. "It is important to move forward with what the best evidence suggests has the most promise."

By analyzing programs that demonstrated the best results and comparing them to those that were not effective, Brown has identified the components that should be included in care coordination intervention provisions to most effectively deliver quality care, generate savings and reduce hospitalizations. They include:

- **A multidisciplinary team approach to care** that assigns a nurse as care coordinator, directly engages the primary care physician, addresses hospital transitions, and includes social workers to coordinate and help arrange community services for patients who need them.
- **Interventions targeted to patients who will most benefit from them.** Not all patients with chronic illness are alike or need the same level of intervention. Patients most likely to experience the greatest benefits from the care coordination model described in this report are those who are at substantial risk of hospitalization and are able to participate in managing their ongoing health needs.
- **In person (“high touch”) contact between the patient and the care coordinator,** rather than telephone interactions.

The report emphasizes the importance of coordinating care across different settings, as patients transition from hospitals to home, to ensure that patients have the information and skills to manage at home as well as the follow up health care and the social services they need. Additionally, the report highlights the need for new approaches for financing care coordination across Medicaid, Medicare and private insurance, which are currently designed to reward volume instead of value.

The report offers specific recommendations for implementing the new Medicare “medical home” demonstration, based on lessons from earlier care coordination demonstrations. They include careful definition of: the target population; the services to be provided; and the manner in which they are provided. Experts view the medical home as a potential vehicle to provide team-based coordinated care through a primary health care provider.

“This report gives a ‘thumbs up’ to care coordination, provided it is done right. It provides powerful evidence that can be a critical element in getting doctors, hospitals, community care providers, patients, and caregivers working together to improve the health and well being of older adults with chronic illness, and to reduce excessive, avoidable health care costs,” said Pat Volland, Director of The New York Academy of Medicine’s Social Work Leadership Institute and a co-convenor of N3C, which also plans to examine the degree to which existing care coordination services offer support for family caregivers.

“We’re looking forward to working with President Obama and members of Congress to make improved care coordination a key pillar of national health care reform efforts.”

About The National Coalition on Care Coordination

N3C was formed in 2008 with support from The Atlantic Philanthropies to promote better-coordinated health and social services for older adults with multiple chronic conditions. Membership includes leading experts from aging, social, healthcare, family caregiver and professional organizations.

N3C defines care coordination as a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which a care coordinator manages and monitors an individual's needs and preferences based on a comprehensive care plan.

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