The Barriers to Care Coordination

Study Probes Why Emergency Physicians and Primary Care Physicians Don't Talk to One Another

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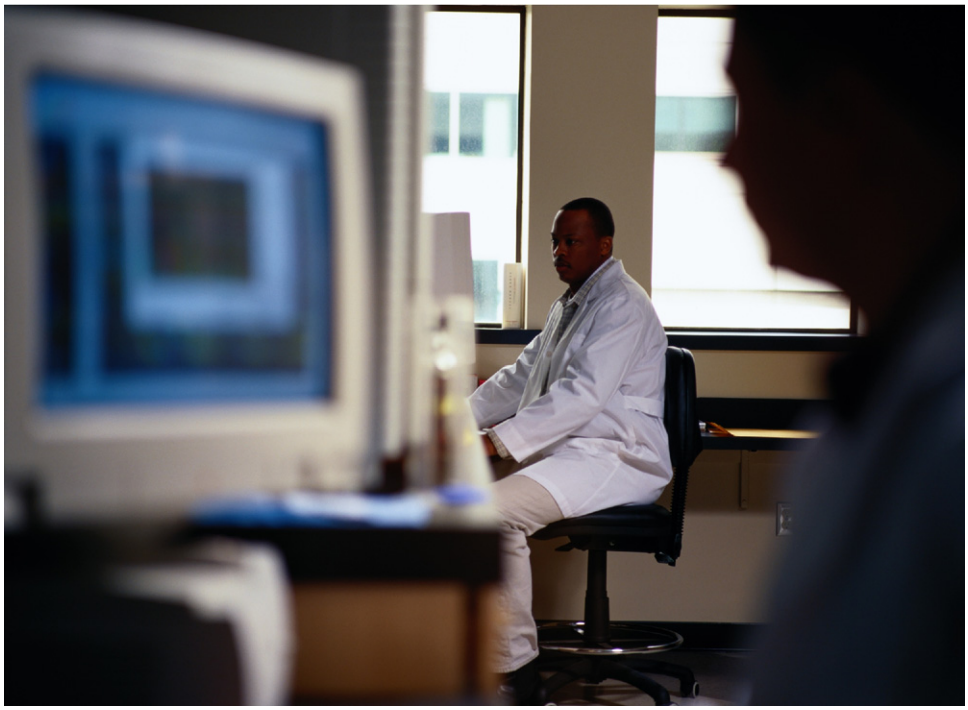
Call any physician's office outside of business hours and the recorded message will probably state, "If this is a medical emergency, go to your nearest emergency department [ED] or call 911." And yet, emergency and primary care physicians (PCPs) don't have much chance to compare notes, leading to duplicated tests and scrambling to locate information about past visits.

This communication gulf has been studied surprisingly little, given the effect it has on costs and quality of care. A recent study by the National Institute for Health Care Reform[1] found that despite their best intentions, emergency physicians and PCPs face any number of barriers to communicating well about their patients.

The researchers, led by emergency physician Emily Carrier, MD, spoke with 21 pairs of emergency physicians and PCPs in 12 communities around the United States. The study was motivated by a problem that seemed obvious to her.

"There hasn't been much attention given to what happens when a patient who has a primary care physician goes into the emergency department," says Dr. Carrier. "Everyone who practices in the ED knows it doesn't always go smoothly."

The sources of information for emergency physicians include patients themselves and their families, who often leave out crucial bits of data in a crisis. They may not recall the names of medications or whether tests already have been performed. Emergency physicians also rely on reaching a PCP by telephone, but many PCPs share call responsibilities with colleagues who don't know their patients. Electronic medical records are also a source of information, but their adoption is spotty in many communities, and information sharing remains a challenge.



One trend that has reduced the frequency of communication between emergency physicians and PCPs is the increasing use of hospitalists to admit patients. PCPs now rarely follow their patients to the ED or decide on admission. Roland Goertz, MD, president of the American Academy of Family Physicians, recalls the days when he would go to the ED with a patient, swinging by the office to pick up their paper chart.

"The world has changed along an axis of ever-increasing specialization," he says. "The new model did not reward the coordination of care delivery."

There are no set standards for communication between emergency physicians and PCPs, Dr. Carrier's article observes, so they are left to their own devices. "It's not a system," one PCP is quoted as telling the researchers. "It depends on the goodwill and training of the individual on the other side."

The article goes on to quote an emergency physician with a colorful take on the problem of variation:

"There are some people that will call every primary—that is just their personal style, and some will never call a primary even if you held a loaded gun to their head."

In the study, emergency physicians said they frequently did not receive information on patients referred from a primary care office. Either no information is sent or it gets lost in transit.

Once patients are being evaluated, emergency physicians reported that they "only rarely contact primary care providers to clarify key points in the patient's history or gather additional information."

One PCP was quoted as being frustrated that, when he was contacted by emergency physicians, it was often after a plan of care had already been initiated. "I always offer feedback, but often it is past the point where my feedback is worth anything when it comes to admissions or testing because often they have already done it."

Both sides agreed that more communication would lead to better care for patients with serious problems or the need for follow-up. And they also agreed that faxes and calls about nonemergency complaints would not be particularly helpful and could be a waste of time.

The 2 specialties also reported problems with various communication methods, observing that trading telephone calls can be time consuming and frustrating on both sides. Interrupting the care of one patient to take a call about another can greatly reduce efficiency, the researchers wrote. Faxes can avoid this problem but don't allow for conversation about the problem. As for electronic messaging, some physicians worried that there was no way to know whether the recipient has even seen a text or e-mail. Access to a complete, up-to-date medical record with a simple log-in and a summary of the most important patient information would be ideal, many physicians believed. But most systems in use today fall far short, the physicians reported.

Many of the physicians also worried about spending additional time on communication that they would not be compensated for.

NO SIMPLE SOLUTIONS

There is no single solution to the communication problem, Dr. Carrier's group concluded. Well-designed, easily shared electronic medical records could help. Payment reforms that compensate physicians for managing use could indirectly reward good communication, the authors suggest.

New payment and PCP models, such as the patient-centered medical home, could improve coordination with the ED, the authors say, but only if that goal is clearly stated; current care coordination standards for medical homes do not specifically call for notification of ED visits.

Solutions will need to be tailored to the complexities of both ED and primary care work, Dr. Carrier says. "In the ED, we have a broad range of situations that come up," she says. "When there are multiple doctors involved it can get very complicated."

Meanwhile, the current momentum behind coordinating care in primary care, specialty, and inpatient settings needs to include the ED, Dr. Carrier says. That's because some of the mechanisms for organizing care better involve how medical services are paid for.

"A lot of this is coming down the pike toward emergency providers, and it's good to think about it," she says. "Emergency physicians need to think about how it may affect them and deal with it in a way that benefits their patients and doesn't make their jobs more difficult."

Jesse Pines, MD, MBA, an emergency physician who heads the Center for Health Care Quality at George Washington University, contends that the ED could actually be the center of care coordination for high-risk patients.

"We have this system that is open 24 hours a day, 7 days a week, and high-risk people have exacerbations of their illnesses day and night and on weekends," he says. "How can we better integrate what happens in the emergency department into the overall spectrum of care coordination?"

Dr. Pines' center is putting the finishing touches on a systematic review of ED care coordination programs.

"What we've found is that care coordination interventions are variably effective," Dr. Pines says. "Some work and some don't, and it seems to depend on the local setting." These include making primary care appointments for follow-up care before patients leave the ED or giving patients cab vouchers to get to a physician's office. "The more intensive interventions work better than the less intensive interventions," Dr. Pines says, but of course the more intensive ones are more expensive.

COORDINATION AND COMMUNICATION

Dr. Pines's review found that the interventions with the most evidence for their value involve ED coordinators who make plans for patients on

their discharge from emergency care, such as setting primary care appointments. Programs that ease direct communication between emergency physicians and primary care may also be useful, but Dr. Pines says they have not been well studied.

ED care coordination programs are often focused on specific populations, such as the elderly, children, or frequent users of emergency services. Joint guidelines issued by the American Academy of Pediatrics, American College of Emergency Physicians, and the Emergency Nurses Association, for instance, recommend the addition of a physician coordinator and nurse coordinator in the ED to follow the care of children in the ED.[2] And research at a Quebec hospital found that a coordinator for frail elderly patients reduced the number of ED visits and improved their transition to the home environment.[3]

One ED coordination program in Washington State has improved care for about 500 frequent ED users, most of whom have mental health or substance abuse problems. The Emergency Department Consistent Care Program has reduced ED visits by about half for high-volume users; much of that was accomplished by cutting off the supply of narcotics to drug-seeking patients, explains Kara Elliott, RN, the program's administrative coordinator.

Patients are identified by ED staff or sometimes pharmacies, and a nurse coordinator reviews the case for inclusion in the program. Once enrolled, patients receive a plan of care that sets out where and when medical visits should take place, whether it is in the ED or a PCP office.

The consistent care program is run out of the nonprofit CHOICE Regional Health Network, which carries out regional coordination and quality initiatives. The program, in place since 2003, is sustained by a contract with the Medicaid insurer that covers most of the patients involved and saves money on reduced ED visits.

Program leaders are looking forward to a new electronic ED visit tracking system that will automatically fax notification of an ED visit to the primary care provider and make a summary plan of care available to emergency physicians. "It may not eliminate the need for a phone call to gather more information" for patients with complicated histories, says Ms. Elliott, but the basic information will be available.

RESEARCH, QUALITY AND THE ACO

Coordination of care in the ED is likely to get more attention from researchers in the next 5 to 10 years, Dr. Pines says, particularly because quality measures focus on hospital readmissions and appropriate use of the ED.

Over time, the ED has increasingly become where many Americans receive their acute care. Just 45% of the acute care visits Americans made between 2001 and 2007 were to personal physicians. More than half were to other sites, the most common being to the ED, which accounted for 28% of visits. That means that emergency physicians, who compose just 4% of physicians in the United States, handle more than a quarter of all acute care encounters and nearly all after-hours and weekend care.[4]

And yet the ED largely has been left out of the current national discussion about better coordination of care, with much of the focus on the way PCPs follow their patients and how they fare as hospital inpatients. But that is destined to change if coordinated care models such as accountable care organizations become widespread, as called for by the federal health care reform law. The whole idea of coordinated care is to ensure that patients are treated in the most appropriate setting, minimizing waste and maximizing quality of care. Although much of the focus has been on designing medical practices that are patient centered and on managing hospitalizations and specialist referrals, accountable care organizations should also address the management of ED visits, says Dr. Goertz.

"A highly organized ACO needs to be able to coordinate information about patients," Dr. Goertz says. "The cost pressures ever mounting around the system will force us to give a lot more credence to that coordination."

Emergency physicians are also anxious to have a seat at the table as Medicare payment policies are designed. In a letter to CMS in December, the American College of Emergency Physicians and the Emergency Department Practice Management Association observed that ED visits are likely to continue to grow, even as more of the uninsured receive coverage under health care reform.

"We believe there is a significant, and often overlooked, role for emergency physicians in new delivery systems models that will greatly contribute to improve-

ments in quality and coordination of patient care," the letter stated.

Specifically, they remark, emergency physicians can help monitor and control readmissions to the hospital within 30 days of discharge. It would also help if PCPs educated their patients about appropriate use of the ED. The organizations recommend that overall "[t]he ACO . . . provide a framework to engage all physicians in coordinating the patient's care."

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