HealthManagement
Promoting Management and Leadership

Volume 16 - Issue 1, 2016 - Cover Story

Cardiology in the Care Continuum

The case for coordination of cardiology services across the care continuum would seem to be compelling, given the complex needs of cardiac patients. Siloing cardiac care can lead to fragmented treatment, increased costs and lowering of quality. However, in practice this collaboration and coordination can be difficult to implement.

Barriers to care coordination are explored in a report from the Advisory Board Company, *Mastering the Cardiovascular Care Continuum: Strategies for Bridging Divides Among Providers and Across Time* (Advisory Board Company 2012), who write: “disease complexity, diverse specialist involvement, and multiple treatment options leave no choice but for programmes to work cohesively.” their 14 strategies for bridging divides among providers and across time are grouped into 5 areas:

1. Building the collaborative care infrastructure

This includes setting up the infrastructure that promotes collaboration, such as multidisciplinary boards and committees, encouraging communication, implementing team-based care and including all stakeholders, such as health it specialists and radiologists.

2. Deploying cooperative patient care

Team members need to work in concert to deliver ultimate benefit to the patient. The report offers guidance on the optimal use of the various health providers.

3. Executing successful patient transitions

Improving patient transitions has been proven to reduce readmissions. Such programmes have core elements that include patient education, medication reconciliation and follow-up care.

4. Enhancing longitudinal patient care

Patient care after discharge can include use of risk stratification, transitional coaches, and better relationships with post acute providers.

5. Encouraging patient loyalty – improves patient compliance, and develop and enhance disease management offerings.

The report emphasises key elements for success:

- Risk stratification.
- Patient engagement remains relevant across the care continuum. Patient comprehension of instructions, adhering to a care plan and making necessary visits to physicians are absolutely critical to ensuring consistency.
- Healthcare IT: patient information needs to be available when and where it is required.

Such a transformation would see seamless care for the cardiovascular patient:

"*The mastered continuum will begin upon admission, where a patient will be treated by an order set developed by an entire committee of providers and rounded on by a multidisciplinary team. A transitional coach will ensure all aspects of discharge, including education, medication reconciliation, and exchange of patient information to the next site of care is completed. Upon discharge, the patient is able to return home and, fully aware and engaged, continues to adhere to the prescribed care regimen, with periodic visits to a personal physician and perhaps a disease management clinic"* (Advisory Board Company 2012).

The American College of Cardiology’s health policy statement on cardiovascular team-based care is a welcome addition to the literature. It offers extensive guidance on implementing a care-based model to improve care coordination, and particularly addresses the contribution of advanced practice practitioners, such as nurse practitioners, physician assistants and pharmacists. (Brush et al. 2015).

The document’s creators explain: "*this document will increase awareness of the important components of cardiovascular team-based care and create an opportunity for more discussion about the most creative and effective means of implementing it.*" the policy statement also explores training and qualifications of team members, leadership and accountability, barriers to CV team-based care, examples of effective team based care and opportunities for improvement.

Kaiser Permanente Collaborative Cardiac Care Service

A well-established initiative that uses team-based care across the continuum is the Collaborative Cardiac Care service at Kaiser Permanente in Colorado, USA. The services comprise a nursing team and a pharmacy team that work collaboratively with patients, primary care doctors, cardiologists and others to coordinate proven cardiac risk reduction strategies for patients with coronary artery disese. The service is supported

by an electronic medical record and patient-tracking software. The software records all patient interactions, keeps track of appointments and stores data that can be used for evaluation and analysis. in a study published in 2008 (Sandhoff et al. 2008), the results showed a reduction in all-cause mortality associated with CAD by 76% in patients followed by the service.

Cardiovascular Care Transformation In Utah

A service redesign at the University of Utah health system has transformed cardiovascular care. By organising services to follow the care continuum, both patient satisfaction and market share have increased.

The transformation is highlighted in a case study that describes the changes that took place to redevelop a service with low market share, low patient satisfaction and specialists existing in silos in their departments (Algorithms for Innovation 2014).

“The entire structure was redesigned to provide seamless, efficient and coordinated care for patients,” says outpatient cardiovascular service Line director Steven Tew, MHA, MBA. Medical assistants, previously hired by individual physicians, now took an integral role in patient navigation. The medical assistants staff a centralised phone line that offers patients a single information gateway. As many cardiovascular patients have complex treatment plans and need to see different specialists, the medical assistants can offer efficient assistance, for example changing appointments, scheduling multiple appointments with different physicians on one day through to greeting patients when they arrive.

Published on : Sat, 27 Feb 2016