

Keeping Health Care Costs from Going Awry: Care Coordination is a Key



Bruce Chernof, MD
President and CEO

Sadly for most vulnerable older Californians, their first interaction with long-term services and supports (LTSS) begins in the emergency room. A recent report from California's Medicaid Research Institute (CAMRI) shows that this perspective is particularly true for individuals covered by Medicare and Medi-Cal. Most people who used Medi-Cal-funded LTSS started these services after an emergency room visit, hospital admission, or rehabilitation stay. Older adults entering these institutions may experience additional health complications, be discharged with less

Bruce Chernof, MD, is President and CEO of The SCAN Foundation, dedicated to creating a society where older adults can access health and supportive services of their choosing to meet their needs. The SCAN Foundation Perspectives Series serves as a venue for opinions and observations about transforming the way in which we age.

function than when they entered, and find their support system at home less prepared to meet their needs. While not surprising given the significant health and functional needs of this population as a whole, this finding raises a fundamental question about how to restructure the interactions between institutional care and community-based services so that a person's quality of health and life don't suffer needlessly.

In 2009, The SCAN Foundation in partnership with the state Department of Health Care Services brought together all sources of payment data for Californians eligible for both Medicare and Medi-Cal. The goals were to understand the needs and service use of this population better to know what works and what doesn't in care delivery. This [new report](#) gives a much clearer understanding of the system inefficiencies and more importantly, missed care delivery opportunities. The findings point toward opportunities to use the state's limited resources in different ways that might better support this population's health and daily living needs.

Details of this comprehensive analysis shine a bright light on the merry-go-round of acute, post-acute, and long-term care services that most families experience. Let's look at a few more key findings:

- LTSS use is always preceded by a rapid and substantial increase in use of health care services over many months.

- Every individual with Medicare and Medi-Cal who entered a nursing home for a prolonged stay had an emergency room visit, hospital admission, or rehabilitation stay in the month prior to admission.
- Most long-stay nursing home residents had no home- and community-based services in the months prior to their admission.
- For those with high utilization as described above, initiating LTSS was associated with reductions in the rate of health care spending.
- LTSS programs that explicitly provide care coordination showed reduced health care spending six months after starting these services.

The messages of these findings are stark and simple – we are not identifying people with needs at the right time and we are not providing the right set of coordinated services that can help these vulnerable individuals regain their footing as people, not patients, back in their homes and communities. Additionally, we are using our scarce health care resources in ways that are both inefficient and ineffective. What is the prescription to fix this broken system?

Now is the time to focus resources from inside the health care delivery system to meaningful, robust, and targeted care coordination, as this is the cornerstone to improving care while lowering costs. This means having the staff and operational models to properly screen for potential high-health care use, and identify those who have a need for further evaluation in real time and not just at the convenience of providers. Targeting services means that individuals need to be re-evaluated from

time to time, as not all services need to be continued at the same level in perpetuity. This is a critical process to intervene in ways that improve quality of life and health, use health care resources more efficiently, and forestall nursing home admissions unless absolutely necessary.

Second, services must be harmonized in a way that meets the person's overall needs, not just focused on the capabilities of any individual provider. Doing this well means that care coordination must be driven by the results of a uniform assessment tuned to appropriately target services to people's distinct needs. California has started the difficult task of developing a uniform assessment, and seeing this body of work to completion is critical.

Third, it is time to place older Californians and their families at the forefront when creating systems of care. We must reset the default in the health care system to return people to their homes with appropriate supports and not simply discharge them to the next lower level of care. These data clearly show that a profound and subtle bias toward institutional care and away from community-based services remains at the time of hospital discharge. It may be more expeditious to simply transfer someone to another facility, but that doesn't make it the right decision.

Improving quality of life and health while reducing costs demands that we systematically identify those individuals at highest risk and target our scarce resources to help all older Californians remain safely in the communities of their choice. In human terms, this means allowing vulnerable elders to return to their lives as people, and not live as perpetual patients.