Ask the Expert: Kim Radel

Beyond the Silos: Transforming Coordinated Care Across Healthcare Systems

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Coordinated healthcare is vital to delivering a high-quality patient experience, yet it has been difficult to systematize across all healthcare settings. Although it has largely been concentrated within disease-specific programs or a small percentage of high-risk patients in primary care, that's starting to change. With 90 million people expected to be in value-based care arrangements by 2027, care coordination is a top priority for provider organizations.

The Centers for Medicare & Medicaid Services (CMS) is driving much of this shift with the goal to have 100% of traditional Medicare beneficiaries in accountable care relationships by 2030. New bundled payment programs like Medicare's mandatory Transforming Episode Accountability Model (TEAM) were created to encourage stronger care coordination between primary and specialty care. In addition, more than 50% of Medicare beneficiaries are enrolled in Medicare Advantage plans aimed at reducing utilization and improving quality across all settings.

Kimberly Radel, associate principal on Vizient's value transformation and payer-provider alignment team, shares how care coordination is evolving and what the most forward-thinking organizations are doing to overcome challenges and succeed.

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What factors are driving changes in care coordination?

Care coordination is increasingly critical to providers in both fee-for-service and alternative payment models (APMs) because they need to lower costs and improve quality to benefit financially. Rising Medicare Advantage penetration and market disruptors — such as private equity-backed start-ups, tech companies, and "payviders" — are also pushing traditional providers to improve patient care coordination across multiple settings. In response, some providers are embedding care coordination functions across broader patient populations and leveraging improved tools to share patient data.

What are the biggest barriers to achieving seamless coordination?

Healthcare is rapidly innovating, but it is also still fragmented across the board. Patients now have more options to seek care outside of traditional settings and have greater access to specialty care. However, this has led to an influx of technology and care solutions, each trying to find their niche in the healthcare continuum. There is also an increase in the use of specialists and rising competition among health systems. These factors are creating significant obstacles to sharing patient information across platforms.

Additionally, health systems are not aligned internally. They tend to have separate care coordination efforts within disease-specific programs, each targeting narrow patient segments and not contributing to one common care plan. An RN care manager might help patients manage congestive heart failure symptoms by providing resources to avoid hospitalization or readmissions, but this remains largely siloed care. This lack of coordinated healthcare leads to conflicting care plans, medication overuse or underuse, and patients bouncing between specialists, driving up the cost of care.

Why is it important to partner more closely with post-acute care providers?

There are significant gaps in post-acute care, particularly

the lack of coordinated patient handoffs between hospitals, skilled nursing facilities (SNFs), home health agencies, and back into primary care. As post-acute utilization grows, we must pay more attention to patient care transitions. One key issue is the disconnect between hospital discharge plans, which focus on the patient's immediate needs, and the longer-term ambulatory care plan once discharged from post-acute care. This mismatch often results in isolated care plans and costly, duplicative efforts.

Earlier and clearer communication between primary care and post-acute care is crucial. Trusted members of the care team, including primary care providers, should initiate advanced care planning conversations with their patients. Newer technologies that improve data sharing across post-acute care and the broader continuum of

care can also ensure critical details regarding a patient's goals follow them wherever they go. Additionally, ACOs and other organizations should continue to monitor patients closely with care coordinator check-ins and collaborative discharge planning.

What are some best practices for optimizing care coordination?

The most successful provider organizations focus on system-wide care coordination by establishing dedicated, centralized care coordination roles and embedding coordination functions into existing patient care teams within clinics and hospitals. They apply patient population risk stratification using value-based care analytics, linking a single data repository to the EHR for a better view of patient needs. They then segment patients into risk categories, offering self-management tools and check-ins using AI and SMS messaging for the lowest-risk patients. For rising-risk patients, centralized staff provide check-in calls and robust discharge planning processes to prevent avoidable readmissions. The highest-risk, complex patients receive more intensive resources, such as home-based care programs.

These organizations also reduce their point solutions and tap into the full potential of existing EHR systems. Finding the right vendor partner is key to making this work. Finally, they learn from market disruptors excelling at patient engagement, using sophisticated digital interfaces, text messaging, and predictive analytics.

How can providers continue to prioritize care coordination?

Care coordination should build from a strong relationship with the primary care physician, who, with care coordination staff, lays the foundation for the patient's clinical story, improving the experience and reducing duplication. Developing the ROI for value-based care, particularly care coordination, is essential. Staffing and technology investments are the biggest expenses, so organizations must build a funding structure tied to their APM contract performance. Financial models should include expenses while tying care coordination resources to the appropriate forecasted revenue and long-term savings. By factoring in rewards, penalties, care management fees, and performance metrics like lower readmissions, organizations can justify their investment in care coordination.