A framework for evidence-based, patient-centered collaboration

Coordinated care delivery has become a priority quest to improve performance across today’s hospitals and health networks. For more than a decade, the industry has made efforts to advance interprofessional collaboration central to its mission to extract greater value from a system long characterized by care fragmentation and unsustainable costs.

From a policy perspective, stakeholders have identified care coordination as an important catalyst for advancing quality improvement goals related to improved clinical outcomes, better management of chronic disease, reduced medical errors and the cost of care. It’s one reason the industry continues to invest in forward-thinking care models such as patient-centered medical homes (PCMH) and accountable care organizations (ACOs).

Time is of the essence as care fragmentation—characterized by communication gaps that occur when patients with complex conditions see multiple providers—is expected to be compounded by the introduction of more acute, complex medical problems and an aging population characterized by more chronic disease. Exacerbating the problem is a provider community that lacks the resources to effectively manage increased acuity without greater collaboration and support.

A growing body of evidence supports the efficacy of coordinated care, including one study that pointed to a 13 percent greater likelihood of patients with one or two chronic conditions landing in the emergency department within a framework of highly-fragmented care. Another study found coordinated care reduced costs for patients by nearly 50 percent when compared to those receiving more fragmented care across the continuum.
The value proposition for improving care coordination across settings and throughout the continuum is an easy one to make. Yet, today’s health systems need effective ways of advancing these strategies. While a critical step forward, the industry’s quest to implement a patient-centered longitudinal plan of care is only one part of the solution. Advancing to the next level of optimal care coordination requires that healthcare organizations also deploy strategies that create a shift in culture and drive adoption of interprofessional evidence-based practice in a sustainable way.

In addition, the patient must become an active participant in the care process, collaborating regularly with the interprofessional team. Clinicians must engage patients in the self-management of their condition by empowering them to create goals and action steps based on their individual preferences and values. For example, a patient-friendly goal for a diabetic patient may include exercising three times a week.

Patient education that covers information regarding a condition, medication adherence and self-management is also critical to better engagement. Providers need access to relevant, evidence-based education materials to share with patients to support proper care of a condition. This knowledge supports patients in improving their health outcomes while increasing their confidence and engagement in health goals.

From leadership to members of the interprofessional team, healthcare organizations must understand the philosophy behind the tools to optimize and sustain enhanced professional practice. Understanding the framework not only promotes the adoption of interprofessional collaboration, but also supports top-of-license practice.

Coordinated care: A framework for better outcomes, lower costs

The concept of care coordination encompasses many elements, and definitions across the industry vary. While one study found 40 distinct definitions, industry consensus does exist around the following themes necessary to support effective collaboration.

Participant interdependence

Healthcare stakeholders include patients, family caregivers, physicians, nurses, pharmacists, social workers, payers and other allied professionals. All these players have a distinct role in optimal outcomes. As care needs become more complex, they increasingly rely on each other for information to design and carry out the best interventions.

Communication

The most effective care coordination is supported by the timely, accurate and complete exchange of patient information between the interprofessional team. Notably, a strong body of evidence points to adverse consequences for patient care when infrequent and non-standardized exchange of information exists between referring clinicians and specialists.

Knowledge

All stakeholders involved in care coordination must have adequate knowledge of their own role, others’ roles and available resources. In addition, they must have an awareness of the experience, skills, plans, relationships, and preferences of all participants to design the most impactful approach to care. Research suggests that failure to properly identify roles and responsibilities can lead to discrepancies in the coordination of care, ultimately impacting the patient’s health outcomes.


**Patient-centric**
The overarching goal of effective care coordination is to facilitate the appropriate delivery of care for enhanced patient health outcomes. Achieving this goal requires that patients sit in the center of care coordination and are empowered in their care decisions. It necessitates the provision of proactive, individualized care that is coordinated across the continuum based on patient preferences. Pairing patient-friendly goals and action steps with relevant, evidence-based education materials empowers patients with the knowledge to properly care for their condition.

**Defining care coordination**
The deliberate organization of patient care activities between two or more participants, including the patient, involved in a patient’s care to facilitate the appropriate delivery of healthcare services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.

**Barriers to optimal care coordination**
While the good news is that the industry has made progress in advancing the concept of coordinated care, the reality is that health systems and their partners in care still face notable barriers to achieving an optimal framework. Identifying stakeholders and their roles is achievable, but ongoing issues related to interoperability and data silos still plague effective and timely information sharing. Organizational boundaries and the diversity of EHR systems across health networks present significant barriers for accessing patient information by the interprofessional team. This can be true even when the clinicians belong to the same health care system; for example, when the ambulatory care side of the system uses one EHR and the acute care side uses a different EHR.

Input and feedback from patients, their families and community partners can be critical to understanding patient dynamics and optimizing outcomes. Without systems in place to aggregate and analyze important input related to social determinants of health and caregiver insights, the impact of care coordination is limited. Notably, this kind of feedback can be particularly important during care transitions—a focal point of industry efforts to improve quality outcomes as the risk of fragmented care is highest when patients move from setting to another.

The ability to create and share a longitudinal patient record in real-time is a critical step towards optimal care coordination, but it is not the holy grail. Even when systems are in place to support greater information sharing and communication across participants, optimal interprofessional collaboration necessitates that professionals follow the same standards of care and utilize the most current evidence.
Advancing care coordination strategies for optimal outcomes

The evolution of health IT has been an important enabler of the high-level initiatives that are positively impacting population health, patient experience and the cost of care. Care coordination supported by the right technology framework, including integrated clinical systems, clinical decision support and other collaborative platforms, has been proven to produce better outcomes—especially for patients with complex chronic needs. 

A comprehensive needs assessment and individualized plan of care is foundational to coordinated care, requiring input from all participants along the continuum and clarifying a patient’s preferences related to their goals. Yet, as one PCMH found, this process is much bigger than most healthcare organizations presently have the training or resources to perform on their own.

It is in this area where tools like Elsevier Care Planning can have a notable impact in both the acute care and ambulatory care settings. As the industry’s only longitudinal care planning tool, the solution promotes communication and collaboration across care settings and disciplines, combining the complete patient story with more than 600 evidence-based care plan guides and standardized assessments. The solution enables design of patient-friendly goals and action steps, establishing a framework of transparency to promote greater self-management of a condition. The Professional Practice Services team complements and expands on this foundation by working with healthcare organizations to transform siloed clinical workflows into a team-based model of care to advance evidence-based practice and achieve sustainable success.
On-demand connectivity and collaboration between patients and the care team is necessary to support patient-centric care coordination. Clinical teams must have access to tools that enable easy communication with patients who are increasingly digital and expect proactive engagement from healthcare providers. Solutions like Elsevier Interactive Patient Education advance these goals by improving connectivity between clinical teams and patients.

Interactive, integrated education resources are provided in the format that patients prefer, including language and literacy level. Care coordinators can better engage patients by sending them the right resources at just the right time, using the format they learn best. Thousands of education topics covering conditions, tests, and treatments are available, simplifying health information so patients can understand their conditions and make decisions to be healthier and improve their quality of life.

The full potential of coordinated care can only be reached when clinicians guide patients to the best decisions. Resources such as Elsevier Clinical Skills help round out care coordination strategies by promoting standardized, evidence-based practice. A comprehensive online solution accessible in the EHR or on any mobile device, Elsevier Clinical Skills enables organizations to standardize education and manage competency among their nurses, therapists and other health professionals.

The solution combines more than 1,600 evidence-based skills and procedures with competency management functionality, ensuring care teams in a variety of healthcare settings—including ambulatory—can access a base of knowledge that reflects the latest clinical guidelines anywhere, anytime.
Taking quality performance to the next level

Achieving systemic financial sustainability and clinical performance expectations in the age of value-based care is nearly impossible without effective care coordination. Forward-looking hospitals and health systems are wise to lay the right foundation to support greater collaboration across the continuum and patient-centered care.


x What Causes Care Coordination Problems? A Case for Microanalysis: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4975569/

xi What Causes Care Coordination Problems? A Case for Microanalysis: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4975569/

xii Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions. https://pcmh.ahrq.gov/page/coordinating-care-adults-complex-care-needs-patient-centered-medical-home-challenges-and