Introduction
The problems associated with a fragmented healthcare system are well documented and acknowledged as barriers to the delivery of quality, cost-effective care; compliance with regulatory and legal mandates; and appropriate reimbursement under value-based care.

To overcome these barriers, a call to action has been raised to focus on improving care coordination through the implementation of longitudinal, patient-centered care. Despite the obvious benefits of coordinated care, however, many healthcare organizations remain mired in the traditional model, which focuses on acute-care needs and treatment of chronic disease in an episodic manner.

Today’s Realities: The Current Patient Experience
Healthcare is an extremely complex and fast-paced environment, and streamlining and simplification are essential if we are to improve patient outcomes and overall costs of health, especially for our most vulnerable populations.

As the need to manage medically complex patients grows and value-based reimbursement tightens, organizations must evaluate the impact of effective longitudinal care coordination.

Today, patients can transition through multiple and disparate care “system silos” each time they have a medical need. In such a provider-centric, impersonal and episodic process, their paths to recovery and wellness can be jeopardized by errors, duplications and omissions.

In addition, studies have shown that what is being done is not working; communication among providers and traditional discharge processes and summaries are ineffective. This leaves patients and their families to navigate a complicated health system and engage community resources independently – despite personal challenges such as lack of knowledge regarding disease process and next steps; health literacy; and the impact of non-medical determinants of health.

This is exacerbated by the fact that, today, 40 percent of patients discharged from the hospital have pending lab results and follow-up care required.¹

Obviously, this state of complexity will not heal itself, given an already stressed healthcare system and increasing numbers of patients presenting with comorbidities and complex disease states that require multi-faceted and complicated care.
Chronic Illness and Patient Behavior

The CDC reports that 51 percent of the U.S. population has been diagnosed with one or more chronic illnesses, and this population accounts for 86 percent of total healthcare costs.\(^3\)

It also has been shown that 60 percent of health outcomes are associated with the patient’s non-medical determinants, yet this information is rarely accounted for in developing the patient’s plan of care.\(^4\)

This juxtaposition of facts is important, as chronic illness is particularly impacted by patient choice/behavior, including smoking, substance abuse, healthy eating and exercise. In turn, these behaviors are influenced by socio-economic factors such as where a person lives, financial stress and education level, but the current infrastructure rarely enables the inclusion of that information in the patient’s plan. Thus, knowing the facts and deliberately coordinating care that includes both medical and non-medical determinants of health is vital in helping the chronically ill patient population achieve the best possible outcome.

Coordination by Definition

We know that effective coordination of a patient’s healthcare services is key to healthcare transformation. But what exactly does that mean and what does this coordination entail?

“Planned Care”

The Agency for Healthcare Research and Quality defines care coordination as 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.\(^5\)

“Longitudinal Care Planning”

A longitudinal care plan is a holistic, dynamic, and integrated plan that documents important disease prevention and treatment goals and plans. A longitudinal plan is patient-centered, reflecting a patient’s values and preferences, and is dependent upon bidirectional communications.\(^6\)

Electronic systems can pull together the various elements for the relevant provider and/or patient/family member and provide actionable information to identify and achieve the individual’s health and wellness goals along the spectrum of care.

Failures in effective patient-centered care coordination lead to higher readmission and a $25 billion - $45 billion increase in annual health care spend.\(^7\)
A Framework-Driven Approach

When it comes to creating a care-delivery system that precludes fragmentation of care, there is no “quick fix.” Such a monumental change requires a calculated, systematic approach to doing things differently, transforming an organization’s culture and practice and maintaining commitment to change.

This need prompted Elsevier to create a Clinical Practice Model Framework, which provides a scalable structure to guide sustainable healthcare transformation and propel organizations into a new era of healthcare delivery.

The Framework is supported by core beliefs, principles, theories and healthcare best practices that have been synthesized into concise models to effect change that leads to positive outcomes for patients and their families, caregivers and the healthcare community at large.

The six inter-related models of care are intentionally designed, evidence-based, action-oriented and outcome-focused. They also are team-focused, technology-enabled, scalable and capacity building for a solid foundation for change. For detailed information on these models, see our Webcast, “Leveraging Longitudinal Care Plans to Improve Outcomes.”

Sustainable healthcare improvement begins with cultural change.

The Right Information Technology

Health information technology (HIT) the launchpad for many activities necessary for coordinated care, that is:

- Gathering the story and enabling it to be shared and accessible to all stakeholders across settings
- Fostering team communication
- Applying CDS to ease the cognitive burden clinicians face with today’s information glut
- Promoting patient engagement, with portals, tablets and apps that help patients learn about their ailments and self-maintenance
- Housing databases that enable practitioners to share information for research and clinical improvement activities
- Employing analytics for greater insight

The list continues – and continues to grow – with tools for risk assessment and stratification, registries, care management workflow and technology that fuels telehealth just some of the data infrastructure supporting healthcare today.
When embarking on the journey to longitudinal care planning, a key consideration is ease of integration of care planning tools into an organization’s EHR. From there, the ideal solution is one that is pre-built, speeding the transformation by combining the patient story with practice guidelines that inform decision making at point of care with the most accurate, up-to-date content available. Such a solution also should support standardization in a way that allows individualization and reflects the scope of practice accountability in the prevention and management of potential problems.

A solution also should enable standardized assessments for one plan across venues and disciplines. This is critical to the identification of patient priorities/potential problems and, when based on best practices, leads to care consistency. In addition, the vendor chosen should provide a proven framework to transform culture and practice, with workflow integration that elevates health information technology from data gathering to organization and interpretation that translates into knowledge and wisdom that empowers healthcare today.

### Impact of Effective Care Coordination

- Improved process efficiency – resulting in improved staff engagement
- More efficient transitions of care
- Reduces errors, unnecessary tests and procedures, omissions of care
- Improved patient engagement
- Reduced readmissions
- Improved overall patient experience due to better care, more efficient process and personal connection with healthcare providers
- Satisfying work life culture

### Conclusion

Longitudinal care coordination must move from an aspiration by healthcare organizations to an imperative. Like most transformations, this one may not be easy, but the rewards are many. And like all transformations, it begins with acceptance. In this case, that means recognition that longitudinal care planning is a critical tool in assuring patient-centered care, meeting the demands of value-based initiatives and creating a strong foundation for the future.

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References


2. Ibid.


