Six Keys to Effective Longitudinal Care Plans

Building Blocks to Improve Care Coordination and Patient Engagement

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INTRODUCTION

Consequences of Fragmented Care

Fragmented care has a direct influence on the patient experience and care quality. Consider the multi-faceted cost and quality impact of fragmentation:

- 75% increase in overall healthcare costs [i]
- 2x as many primary care visits and 6x as many specialist encounters [ii]
- 7% greater likelihood that care deviates from best practices [iii]

The care fragmentation experienced by today's patients is often caused by ineffective transitions of care due to a siloed patient story, lack of a longitudinal care plan, and suboptimal use of technology.

Care coordination overcomes care fragmentation

Given the complexity of today's healthcare system, many providers face challenges in actualizing a sustainable care coordination strategy. Yet, there is ample opportunity to overcome these challenges and deliver better care across the patient's journey by embracing best practices for care coordination.

The most effective longitudinal care coordination models are patient-centered, designed for optimal information sharing between clinical teams, and include six key elements as defined in the following pages.

75% INCREASE

in overall healthcare costs [i]

ELEMENT ONE

Patient and Family Engagement

The patient story forms the foundation of care coordination. This narrative is built from strong partnerships between clinicians, patients, and their families, and reflects a deep understanding of care preferences, values, and goals.

Once established, the patient story provides the basis for "whole person" care planning. This approach considers both medical needs and social determinants of health (SDOH) – as these non-clinical social, economic, and environmental factors impact health by as much as 50%.

Your care team can bring the patient story together and foster a patient commitment to self-care by:

- Focusing on what matters most to the patient and family
- Engaging the patient as an active partner
- Understanding and aligning interventions with patient goals
- Identifying and addressing SDOH
- Communicating consistent information
- Leveraging technology for meaningful information-sharing through preferred channels

Per the Advisory Board, food insecurity alone carries annual health-related costs of $155 billion. [iv]

ELEMENT TWO

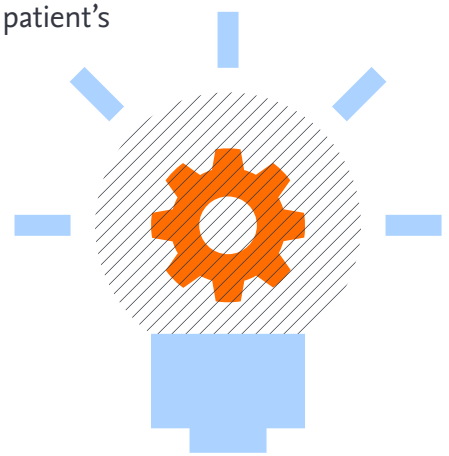
Longitudinal Care Plan

Conceptually, a longitudinal care plan (LCP) provides a one-stop central hub for accessing the full patient story and all information needed to support optimal care transitions. A longitudinal care plan is a holistic, dynamic, and integrated plan that documents important disease prevention and treatment goals and plans. An LCP is patient-centered, reflecting a patient's values and preferences, and is dependent upon bidirectional communications.[v] The LCP aligns the care team around the patient's goals and preferences.

The LCP benefits the patient and the care team. Patients are reassured that their care teams understand their unique needs and will approach care with a personalized plan. Confidence in their care providers can help motivate them to follow their care plan. And clinicians benefit from the shared expertise of the entire interprofessional team contributing to the care plan.

For maximum impact, ensure your patient's longitudinal care plan is:

- Driven by the patient's goals
- Focused on wellness and disease self-management
- Supportive of team-based care and communication



ELEMENT THREE

Integrated Care Team

An integrated approach to care coordination is paramount and relies on strong teamwork. To support optimal care transitions, patients and families must rely on timely and smooth handoff of information from each care team member to others.

Effective integrated care teams are characterized by:

- Shared interprofessional goals across disciplines that align with patient goals
- Understanding each member's scope of practice and valuing each discipline's contributions
- Creating care eco-systems that allow each discipline to practice at the top of their license

For example, pharmacists can deliver tremendous value to care delivery and outcomes when they expand their services beyond medication dispensing to include chronic disease management, patient education, and medication therapy management.

ELEMENT FOUR

Evidence-Based Practice

When best practices are followed consistently throughout a patient's care journey, the opportunity to positively impact outcomes and costs is significant. Yet clinicians and patients alike can be misguided when relying on unknown, disparate or dubious information sources. You can support optimal evidence-based care across your organization through:

- A trustworthy source of high quality, current, consistent and unbiased clinical knowledge
- Assurance that the recommendations are based on the latest evidence and appropriate for each patient and clinical scenario
- Actionable decision support tools offered at the right moment within the clinical workflow
- Efforts to minimize unwarranted care variations between clinicians or care settings

Unwarranted care variation represents a $20M–$30M (per $1B in revenue) actionable savings opportunity for a typical provider organization. [vi]

ELEMENT FIVE

Enabling Technology

Health information technology (IT) is a critical enabler of high quality, safe, and effective care coordination. Absent an infrastructure that supports the easy flow of information, care teams are limited in their ability to optimize care transitions. Effective digital information exchange can improve communication and deliver consistent evidence-based clinical decision support to all care teams.

Health IT solutions can support your team in care coordination activities such as:

- Sharing the patient story and care plan across care settings
- Enabling team communication
- Applying decision support tools to foster best practices and reduce the cognitive burden on clinicians
- Promoting patient engagement with portals, apps, and telehealth that support patient assessment, education, self-monitoring, and health reminders
- Analyzing data to understand clinical decisions and outcomes of care delivery

While great progress has been made on the health technology front, more opportunities abound to achieve the goals of a true longitudinal care plan. When clinical decision support tools work well, high adherence to recommendations can support improved outcomes.

ELEMENT SIX

Measuring Outcomes

Health systems should be intentional in measuring the outcomes of care coordination at the patient, clinician, and organization level. The impact of well-coordinated care is significant, with documented benefits including:

- 16% reduction in Medicare costs [vii]
- 50% reduction in inpatient admissions
- 28% reduction in ED visits
- 71% increase in operating margins [viii]
- 2.3 percentage point increase in average HCAHPS ratings [ix]

By evaluating the impact of your care coordination efforts on similar metrics for your health system, you can inform future goal setting and process improvements – opening the door to ever more positive results in patient experience, clinician satisfaction, and clinical and financial outcomes.

POINT OF CARE TOOLS

Care Planning and PatientPass

Elsevier's Care Planning promotes team-based, patient-centered care throughout the patient's entire journey, driving more standardized and safer care. **elsevier.com/care-planning**

Elsevier's PatientPass delivers current, evidence-based patient education, personalized for each patient's delivery preferences, health literacy and health status. **elsevier.com/patientpass**

With Elsevier's Care Planning and PatientPass comprehensive patient care and education solutions, you can promote team-based collaboration that contributes to more consistent care and a better patient experience, enable clinicians to find and refer the right education to keep the patient engaged in their treatment plan, and derive insights into what your organization can do differently to deliver better care to your community.

i Artiga, S. A., & Hinton, E. H. (2018, May). *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*. KFF. https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

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iii Dykes, P. C., Samal, L., Donahue, M., Greenberg, J. O., Hurley, A. C., Hasan, O., O'Malley, T. A., Venkatesh, A. K., Volk, L. A., & Bates, D. W. (2014). A patient-centered longitudinal care plan: vision versus reality. *Journal of the American Medical Informatics Association, 21*(6), 1082–1090. https://doi.org/10.1136/amiajnl-2013-002454

iv Artiga, S. A., & Hinton, E. H. (2018, May). *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*. KFF. https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity

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viii Freeman, R. F. (2017, May 8). *What Does The Comprehensive Shared Care Plan Mean For Nursing?* Health IT Buzz. https://www.healthit.gov/buzz-blog/interoperability/comprehensive-shared-care-plan-nursing

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