Closing Health Care Gaps through Care Coordination
An InfoMC Brief
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The quality and cost of health care services are currently impaired by the gaps that exist between providers and clinical systems of care. Recent efforts in system design and technology resources have strived to bridge these gaps with variable success. A new approach is needed that recognizes gaps in care as medical errors. New approaches for system redesign and technology resources must be adopted to close these gaps. This is achieved through population based approaches to care that are supported by technology that fosters care coordination among providers, and new value based reimbursement models.

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Introduction

In 2001 the Institute of Medicine (IOM) issued a review of the American healthcare system which it described as broken; and, not as a result of poor intent or a lack of hard work. Rather, healthcare systems are broken because of their fundamental design principles and their inability to be patient/person focused. In the report “Crossing the Quality Chasm” the IOM outlined a series of six principles for improving health care including the notion that health services should be safe, effective, efficient, timely, equitable, and patient centered. In the 15 years since this report, much of the American healthcare system has accepted this challenge and tried to improve the quality of care. The triple aim for health care has also emerged with a focus on improving the patient’s experience of care including quality and satisfactions, improving the health of populations, and reducing the per capita cost of health care.

Frequently, attempts to improve the American healthcare system have focused on bridging the gaps in the quality of services and outcomes. This includes trying to accommodate different provider record systems, co-locating providers in larger systems of care to better integrate services, and changes in financing that attempt to improve value purchasing of care. Some of these efforts have in fact helped to bridge the gaps between providers and improve the patient’s experiences of care. Yet the quality and service chasm still remains, and most health care is still fragmented with little coordination of care. The adoption of a patient centered care approach has failed to adequately link the physical, behavioral, and social determinates of health. Attempts to bridge the gaps in care have perpetuated siloes that exist between providers, and have generally ignored the psychosocial elements of healthy behavior change.

Given that the attempts to bridge the gaps in health care have largely failed, there is a pressing need for a fundamental new approach aimed at closing the health care gaps.

*In order to achieve this, a new focus must be adopted that views gaps in health care as medical errors, and no longer acceptable in clinical practice.*

This approach challenges all health care systems with the question of, “*How to close health care gaps?*”
Closing the Gap

The answer to the question of how to close health care gaps is not as complex as some may espouse, yet it does require some very fundamental changes in how health systems are designed and priorities are set. There are four aspects of health care that must change in order to close these health care gaps.

These include:

- New approaches for understanding patients, and diagnosing their health conditions;
- New technologies are needed to achieve the coordination of care among all health care providers include social and community supports and resources;
- Redefining payment and reimbursement models that promote a shift from rewarding the volume of services provided to the outcomes of care produced; and
- Promoting new patient focused empowerment that fosters informed health decisions and healthy behavior change.

Each of these dimensions is outlined below:

New approaches for understanding patients, and diagnosing their health conditions

In order to fully understand any person and evaluate their health status, three aspects of their lives must be considered. These include their physical health, behavioral health, and social wellbeing. All illness regardless of the diagnosis impacts the whole person, their families, and social networks. Failing to recognize, consider, and understand the impact of a health condition on the social and psychological wellbeing of an individual perpetuates the gaps in health care. Providers who do not recognize this whole person approach, and fail to integrate care for all aspects of an individual’s well-being, initiate a cascading impact on the quality and outcomes of care.
In the modern era of health care, most providers have adopted electronic health records (EHR) that document the services provided. These are effective tools for recording historical information that was once charted on paper, and most EHRs can offer directions and reminders that may help bridge gaps in care. However, these systems are ill suited for closing the health care gaps among providers and fully supporting the coordination of care across all health and social services. As informed health systems recognize the integration of the physical; behavioral; and social determinants of health, new technology solutions must be adopted to support care among providers and community supports. Moving from care that occurs between providers to health services among providers closes the health care gap. This requires the integration of care coordination Health Information Technologies (HIT) that supports this new approach. These solutions are available in care coordination and population health technologies that recognize and support the fully integrated care team and close health care gaps.

Redefining payment and reimbursement models that promote a shift from rewarding the volume of services provided to the outcomes of care produced

Gaps in health care have been perpetuated by reimbursement and payment models that reward the amount of services provided, rather than the outcomes produced. Value based purchasing supports the coordination of care and the integration of services for the populations served. These new models of financing require new technologies that are not based on billing and collections. Rather, they are population based contracts that reward integrated and coordinated care. Technology solutions must be able to track and adjudicate new service models and support value based reimbursement mechanisms across systems of care.
Patient centered care is responsive and respectful of individuals and supports their informed and activated engagement in care. This is accomplished when approaches to care are built on the whole person and include their physical, behavioral, and social determinants of health. Empowerment is achieved when the entire care team is able to work together to improve and individual’s activation for improved health and sustained wellbeing. This is achieved through understanding and promotion of a person’s health literacy, their engagement in health care, and their activation for healthy behavior change and self-care. Gaps in care are created when these are not well integrated and breakdowns occur in the coordination among providers.

**Final Word**

It is increasingly evident that simply trying to bridge the gaps that exist in health care is no longer an acceptable approach to health reform and improvement. Health services must shift from an approach that currently supports care between providers to a new practice that occurs among all providers and systems of care. This includes a recognition of the fundamental aspects of an individual’s wellbeing that incorporates their physical and behavioral health, and the social environments in which they live. Reimbursement approaches must recognize and reward successful outcomes in care. Technology resources should cease to foster provider silos, and must promote care coordination among integrated health teams and community resources, and include the patient’s full participation. These technologies exist and must be adopted to fully and finally close all health care gaps.
About InfoMC

InfoMC Inc. is a leading provider of cloud-based healthcare management and care coordination software designed to help close gaps in health care systems. InfoMC offers a suite of rules-based workflow, data exchange, and analytics products to health plans, managed care organizations (MCOs), health systems, and state, county and community health centers and programs. The InfoMC Coordinated Care Solution provides tools for optimal care coordination of complex or chronic physical and behavioral health conditions and populations, resulting in improved quality and cost of care outcomes. The solution is designed to enable care teams – across multiple providers and stakeholders – to play an active role in the patients’ plan of care. With InfoMC solutions, our customers receive comprehensive, sophisticated functionality that eliminates costly administrative and clinical process inefficiencies while promoting improved quality and cost outcomes.

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