Finding ways to care for chronically ill Americans is quickly becoming one of the singular most critical healthcare challenges of our nation. Nearly 1 of 2 Americans has diabetes, heart disease, or another chronic disease.1 Millions more are at risk, and this generation of youngsters may be the first in history to have poorer health at an earlier age and lower levels of longevity than their parents.2

Government initiatives, as well as programs from private payers, are championing more collaborative approaches to care. Although they show promise, such programs will require more than legislation, increased payment to providers, and good intentions to be successful; they will demand a concerted effort from all participants along the healthcare continuum to work together toward a common goal to control costs and improve the health of all Americans.3 -8

The Promise of Collaborative Care

The new emphasis on collaborative approaches to care holds the promise to:

• Enable care providers to function as an effective, coordinated team to access and manage patient information across dispersed organizations and settings, ensuring that patients receive recommended, evidence-based care
• Improve health outcomes through aligned efforts that harness the physician–patient relationship and achieve shared clinical goals
• Support physicians who seek to practice efficient, team-based clinical care and the realization of patient-centered medical homes.

To reach their potential, collaborative care programs must ensure connectivity between all parties, the use of decision support, the alignment of goals and financial incentives, and a focus on finding innovative ways to better engage and involve patients in their own care.

The Obstacles to Coordinated Care

In the past several years, private and public health plans, large employers, and coalitions have created small yet promising programs designed to achieve better care. These programs, however, are currently the exception, not the rule. Overall, the nation’s chronic care system is fragmented, poorly coordinated, and often of inferior quality and value.6,9

Most troubling is that even patients with access to healthcare often receive poor care.10 For example, patients with chronic diseases frequently receive treatments from multiple primary and specialty care physicians across various sites of care, and rarely are all treating providers able to readily access relevant patient information. Even providers utilizing electronic medical records (EMRs) often struggle with electronic forms in structured and unstructured formats, making accessing and sharing information difficult.11

Such an environment leads to substandard care and makes it difficult to ascertain the scope of impact for chronic diseases and to aggregate critical health information on a patient- or population-specific basis. In addition, this lack of coordination makes it challenging to provide more proactive care, as well as meaningful analysis and healthcare decision support based on evidence-based care guidelines.

Need for New Payment Structures

Although multiple factors contribute to poor adoption of the technology and processes necessary to create a more united care environment, it is clear that the current fee-for-service payment structure does not encourage cooperation or collaboration among payers and providers.12 But change is coming. The Patient Protection and Affordable Care Act (PPACA) and the American Recovery and Reinvestment Act, along with the Health Information Technology for Economic and Clinical Health Act that came with it, together are helping to establish a basis for greater collaborative care. Demonstration pilots for accountable care organizations (ACOs) made possible under the PPACA are gathering considerable attention. ACOs are defined as provider groups that accept responsibility for the cost and quality of care delivered to a specific population of patients cared for by the groups’ clinicians. The US Department of Health and Human Services’ efforts to

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relax antitrust provisions (eg, the Stark law) are expected to help foster greater physician and hospital collaboration. Another key feature of ACOs—bundled payments for episodes of care, including acute and 30-day postdischarge—could also encourage hospitals and community physicians to work more closely together.

Healthcare advocates and executives also believe that the government’s push for adoption of technology, particularly through electronic health records, will create more opportunities for collaborative care.

Strong incentives—up to $44,000 per physician with a large Medicare patient population and $64,000 for physicians serving predominantly Medicaid patients—as well as hefty fines for nonadoption beginning in 2015, may be an important impetus required to finally move physicians toward greater use of technology.

Collaborative care initiatives strive to establish more personalized and proactive care at convenient sites of care, while providing more efficient care and optimized healthcare resource use.

Roots of Collaborative Care

If the tenets of collaborative care sound familiar, it is for a good reason. Historically, what is now referred to as collaborative care was once considered more of a healthcare philosophy or movement. Over time, the concept had many names, including integrated care, primary care behavioral health, and shared care.

Today’s approach to collaborative care is much broader than its predecessors, because there is collaboration across and among:

- Sites of care, including ambulatory care clinics, urgent care, retail clinics, worksite clinics, hospitals, surgery centers, pharmacies, home, online and other virtual care (disease management vendors), alternative care, and fitness centers
- Care providers, specifically primary care, specialists, pharmacists, nutritionists, health coaches, case managers, caregivers, social workers, and therapists
- Data repositories at clinics (eg, paper, EMRs), hospitals (eg, laboratory information systems, hospital information systems), pharmacies and pharmacy benefit managers, reference laboratories (eg, LabCorp), imaging centers, personal health records, health plans, and associated care management vendors

Collaborative care initiatives also strive to establish more personalized and proactive care at convenient sites of care (eg, home, work, retail), while providing more efficient care and optimized healthcare resource use.

Some of the most promising care initiatives involve corporate and community partnerships, in which employers focus on what happens with employees at home as well as on the job. Additional characteristics of collaborative care programs include:

- Avoidance of duplicative care
- Emphasis on error reduction
- Promotion of more comprehensive services, including mental health
- Establishing a clearly defined team with roles and responsibilities for each person
- Focus on improved quality and reduced costs

Example of Collaborative Care: Optimal Prescription Therapy, Medication Adherence

Although considerable emphasis is placed on technology within collaborative care programs, technology alone is not the solution. To more readily see how collaborative care works in the real world of healthcare today, consider what happens during the seemingly simple process of prescribing a new medication, beginning with the simple question—Is there strong evidence for prescribing a specific medication for a patient? Under collaborative care, answering this question begins with evidence-based guidelines—specifically class A evidence—and continues with issues such as the impact of direct-to-consumer and physician marketing.

Once a medication is prescribed, providers must consider a range of additional issues, including polypharmacy, potential drug–drug interactions, contraindications, and the patient-specific formulary and benefit design, because affordability is a leading cause of low medication adherence.

Next, consider what happens once the patient begins taking the medication. Is it taken as prescribed? How can we confirm persistency and adherence? Options for answering these questions include patient-reported data, pill counts, devices, caregiver statements, and refill analysis. If the medication is not taken as reported, providers must then determine the reason, which can range from affordability and side effects to the patient’s own perception of medication effectiveness.

Medication use must also be monitored over time for efficacy, and titrated as necessary to meet patients’ needs (eg, age, weight). All this information must be recorded in a practice management and/or e-prescribing system for optimal provider communication and overall coordination of care. Without every element involved, providers and payers have insufficient knowledge and data, and ultimately, costs and outcomes could be negatively impacted.
Key Attributes Needed for Optimal Outcomes in Collaborative Care

Collaborative care initiatives cannot exist in a vacuum. All healthcare stakeholders must take responsibility for decisions as well as health outcomes. There must also be clear insight and transparency across the care continuum, as well as role definition and clarity among care sites and providers. As Sevin and colleagues suggest, the following attributes are necessary for the success of collaborative care:

**Empowered primary care physicians.** The primary care physician must have the tools and authority to act as the care team leader, coordinating and working with practice staff, specialists, and other care providers. Providers must always recognize that patient needs, values, and the context of their lives must dictate all healthcare decisions.

**Appropriate structure.** Operational issues must also be addressed. For example, it is important to address organizing principles, including business models and payment reforms, to ensure coordination and cooperation. Such models are exemplified by emerging ACOs and patient-centered medical homes, which encompass tactics such as bundled payments, quality-based payments, and care coordination fees. Care collaboration is also enhanced by gainsharing agreements and risk-adjusted capitation.

**Effective technology.** Data exchange, interoperability, and aggregation are ultimately controlled by connected patient EMRs/health information technology. EMRs often represent data silos; current EMRs are good at storage, not communication and connectivity (think “meaningful use”). Robust data integration aggregated across silos and transformed into computable data for more automated analysis and timely decision support at the point of care are important considerations.

**Connection between providers, payers, and patients.** Although steps are being made to better connect providers, effective collaborative models must extend that connectivity to payers, and most important, to patients. Engaging patient portals that provide relevant and tailored information, personalized health support available via cell phones and the internet, and expansion of communication to smartphones are all necessary to a successful care model.

**Care architecture.** Connectivity and technology are important, but the next step in the process must be the necessary architecture to take patient data and conduct analysis and research. Such findings can then be used to help in care management, evidence-based decision support, and population management. Of equal importance, the data and insights contained would be of significant interest and value to payers and providers through reports and analyses that confirm guideline compliance, highlight quality achievements, and provide other valuable insights for measuring and improving care.

**A Model for Our Future**

Although factors ranging from new models of care to technology will help collaborative care programs become a reality, ultimately such programs will not work unless steps are taken to educate, engage, and fully involve patients in their own health. The onus is on providers, as well as plan sponsors, to develop the education, technology, and outreach to help foster more engaged patients who take an active role in the collaborative care process.

The coming years will remain challenging for the healthcare industry—providers and payers alike. Without a commitment to change, the best intentions of current healthcare reform efforts will fail. Collaborative care programs represent an innovative approach that can address these challenges with pragmatic solutions. When we, as an industry, embrace such approaches, we can begin to lead our nation toward necessary, meaningful, and lasting changes in our healthcare system.

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**Disclosure Statement**

Dr Gordon has nothing to disclose.

**References**