Care Collaboration as a Key to Continuous Situational Awareness

A collaborative, team approach for creating the "blueprint" to guide care should reflect the "synthesis and reconciliation" of multiple plans of expert care so as to leverage the power of the clinical team. It should be driven by a unified understanding and commitment to a goal that might dynamically change, constantly informed by continuous communication and situational awareness, with proactive plans to stay coordinated as needs change and is a **fantastic vision**….but do any such plans actually exist?

The need is clear: Current health care systems are often disjointed, and processes vary among and between primary care sites and specialty/sub-specialty sites. Diverse providers operate independently, do not typically "synthesize" or "reconcile" care plans with other providers. (At best they may reconcile medications.)

Moreover, care is rarely "dynamically coordinated" between PCPs, specialists, other providers, and the patient. Today's "care teams of diverse providers" commonly operate without a clear unifying goal, without influential leadership, without accountability….in fact without true "teamwork".

Is "true" team-based care that includes dynamically adaptive plans for synergistic team-based care coordination/delivery possible in the current US healthcare delivery environment?

The nature of the envisioned team effort requires that team members **understand team member roles under a clear set of goals** and accept coordination guidance from a team leader. Beyond the challenges associated with industry adoption of care delivery models that encourages/rewards team-based care, dynamic care planning involves **unpredictable interactions** between

providers, patient, family, and support staff. This can only be realized by business practices that include constant communication between participants who may change the state of individual actions at any time, and enable integrated, adjusted sequencing of workflows that adapt to meet patient need in an unpredictable manner.

At least in ambulatory care, today's care delivery business processes do not even approximate this level of teamwork. Consequently, in today's care environment, care coordination, if any, is performed mainly by patients with limited knowledge. Transformational concepts such as Patient Centered Medical Homes[1], and/or Integrated Practice Units[2] aim to address this issue, but broad adoption is slow.

Beyond adoption of team-based business processes, how can information systems support these challenges?

The ability to maintain **continuous situational awareness** and perform dynamic care planning that adaptively targets effective synthesized services, and maintains coordination of care over time, across multiple clinicians and sites of service, designed to meet the changing needs of the patient is essential to addressing consequences of fragmented, sub-optimal care[3].

[1] https://pcmh.ahrq.gov/

[2] https://hbr.org/2013/10/the-strategy-that-will-fix-health-care

[3] https://ihe.net/uploadedFiles/Documents/PCC/IHE_PCC_Suppl_DCP_Rev1.0_PC_2016-05_26.pdf