When a Care Map is Not a True Predictor of Clinical Outcomes

C are maps are widely used in health care throughout the world. There are multiple synonyms for the term care map, such as process map, guidelines, and clinical pathways (De Bleser et al., 2006). Not having a single agreed upon definition of care map leads to confusion in health care organizations. Experts have tried to use different terms for care maps and clinical pathway. However, care maps and clinical pathways are still used interchangeably because both terms are designed to support clinical decision management, organize care processes, and enhance effective communication across different disciplines on health care teams (Schrijvers, van Hoorn, & Huiskes, 2012).

Typically, care maps focus on managing a single disease, which is less helpful in the care of older adults who frequently present with multiple comorbidities.

IS THE CARE MAP A TRUE PREDICTOR OF HEALTH OUTCOMES?

The world’s population is aging; hence, the ultimate challenges in gerontological care are providing quality and equity of care for older adults. How to measure the quality of care in a tangible way is an important question. The majority of health care organizations consider that the care map plays an important role as an indicator predicting health outcomes, such as quality of care, patient safety, patient satisfaction, and clinical outcomes (Rotter et al., 2010). It remains ambiguous whether the care map is a true predictor of older adults’ health outcomes (Boyd et al., 2005; Mutasingwa, Ge, & Upshur, 2011).

Evidence shows that care maps improve health outcomes, such as promoting clinical effectiveness, improving multidisciplinary communication, providing well-defined care, reducing unnecessary variations in patient care management, lessening clinical complications, enhancing patient satisfaction, and reducing costs of care by shortening hospital lengths of stay (Auyong et al., in press; Hardt et al., 2013). Moreover, advanced management of chronic illnesses results in longer life expectancy in older adults.
Health care organizations integrate the care map with the trajectory of illness. Many studies have exhibited lower hospital readmissions and lengths of stay, leading to improvement in quality, safety, communication, and efficiency (Dubuc et al., 2013). Although use of care maps results in positive health outcomes, the effectiveness of care maps in older adults remains controversial (American Geriatrics Society [AGS] Expert Panel on the Care of Older Adults With Multimorbidity, 2012; Mutasingwa et al., 2011).

Care maps may have some drawbacks. Care maps are most effective in predictable conditions, but in complex conditions, they may lead to poor care. For instance, polypharmacy results in a significant risk of an adverse drug reaction, such as gastrointestinal bleeding, fractures, and delirium (AGS 2012 Beers Criteria Update Expert Panel, 2012; Peron, Gray, & Hanlon, 2011), which may have greater consequences in older adults with multiple comorbidities (Peron et al., 2011). Therefore, following the care map for one specific disease may worsen other coexisting conditions and deteriorate health outcomes in older adults. The view that all patients with the same conditions are the same is not only incorrect, but contrary to a patient-centered approach.

Care maps specify care for a specific period for a specific treatment. Therefore, health outcomes improvements that result in the short term probably do not represent accurate outcomes in the long term. Early discharge planning may have a negative effect on both mortality and functional outcomes in older adults (Ayoung-Chee et al., 2014; Fox et al., 2013). Care maps mainly focus on specific disease management, which impedes the use of care maps for older adults with multiple comorbidities (Schrijvers et al., 2012) and different interpretations of well-being. In addition, the differences in patients’ values, cultural beliefs, expectations, and experiences across their lifespans influence quality of life. Hence, using only the care map may be problematic to predict older adults’ health outcomes (Schrijvers et al., 2012; Scott, Mathias, & Kneebone, 2015).

All improvements are associated with change, but not all changes will result in improvements, particularly in gerontological care. Older adults with chronic conditions need sophisticated care associated with unpredictable consequences, which may require more health care resources (Ayoung-Chee et al., 2014). Focusing on the reduction of errors may cause more limited access to care because the care map restricts individualized clinical judgments (Geleris & Boudoulas, 2011). Relying solely on a care map, health care may unintentionally be dehumanized and lead to increased patient apathy.

WHAT SHOULD WE DO TO IMPROVE QUALITY OF CARE?

The best approach to comprehensive care of older adults with multiple comorbidities remains controversial. Older adults are more likely to have more than one chronic condition, which can affect their risks and treatments. Moreover, some effective clinical trial interventions recommended in a care map may not be practical for a particular patient setting. Hospitals’ policy makers’ decisions are based on consideration of the feasibility, costs, and benefits of potentially effective interventions. Although health care providers understand well the quality of care, a care map based on reimbursement limits may either constrain what they can provide or reduce patients’ choices. Moreover, the ethical dilemma of one’s inability to pay for health care services may be a factor. For example, older adults with no health insurance coverage may have inequitable access to health care services. Therefore, health care organizations need to improve the quality of care yet do so with limited resources.

Health care organizations wish that care maps could be an accurate predictor in improving older adults’ health outcomes; however, determining what constitutes a true predictor in health outcomes is problematic. Approximately 50% of care maps are based on the opinions of members of a specific health care organization (Geleris & Boudoulas, 2011). The current authors believe multiple approaches to person-centered care are necessary. One thousand care maps are useless, unless they are implemented to care properly.

Professional nurses are involved in the coordination of patient care and as such are in an ideal position to provide quality care (Rosstad, Garasen, Steinsbekk, Sletvold, & Grimsmo, 2013). Nurses have a
genuine understanding and belief in person-centered care. Furthermore, advanced practice nurses with clinical experiences can help bridge the gap between continuing care and enhanced quality of care in older adults. Care maps seem to be powerful tools, but they cannot be applied to all situations or patients. Therefore, the quality of gerontological care requires nursing teams to understand the goals (and limitations) of care maps and to use them wisely. Henry Ford, one of America’s foremost industrialists, said “Coming together is a beginning; keeping together is progress; working together is a success.”

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