

Reducing Care Fragmentation *Executive Summary*

A TOOLKIT
FOR COORDINATING CARE



Executive Summary

Reducing Care Fragmentation: A Toolkit for Coordinating Care is for clinics, practices, and health systems who want to improve care coordination by transforming the way they manage patient referrals and transitions. Providing coordinated care is an essential feature of any patient-centered medical home (PCMH)—but one that can be challenging to implement. The toolkit was designed to make it easier.

This executive summary briefly introduces the concepts covered in detail in the toolkit and provides an overview of its contents.

AN INTRODUCTION TO CARE COORDINATION AND WHY IT'S SO DIFFICULT

Care coordination is “the deliberate organization of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of health care services.”¹ In other words, all providers who work with a particular patient share important clinical information and have clear, shared expectations about their roles. Equally important, they work together to keep patients and their families informed and to ensure effective referrals and transitions take place.

Across U.S. health care, fragmented systems and communication breakdowns contribute to widespread failures in care coordination that have devastating consequences for patients. Several factors combine to make care coordination extremely challenging:

- Because accountability for the process is shared, it’s not clear who is responsible for making it work well.
- Many primary care practices (PCPs) no longer have the personal relationships with consultants and hospitals that make communication easier.
- The time and effort needed to carry out effective referrals and transitions is usually not reimbursed.
- Most PCPs do not have adequate personnel or information infrastructure (such as electronic records) dedicated to care coordination.

TOOLKIT OVERVIEW

The toolkit contains practical strategies and clinical resources to help you implement specific practice changes that will make care coordination easier.

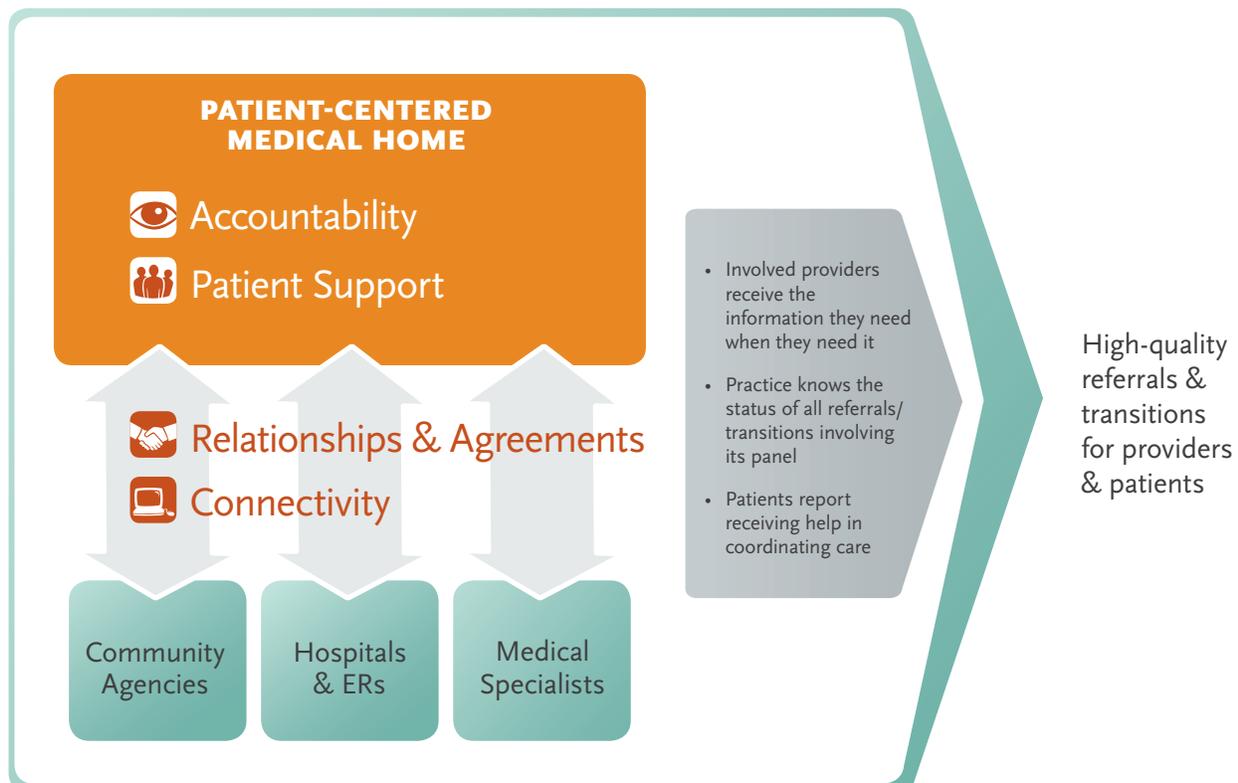
- First, two patient cases illustrate what care coordination means and why achieving it is so important—and so challenging.
- Next, the toolkit introduces a Care Coordination Model based on key concepts that contribute to successful referrals and care transitions.
- The toolkit then describes four key changes that support the model and identifies tools and resources available to facilitate each change.
- To illustrate real-world examples of improved care coordination, the toolkit follows with five case studies from diverse settings—including a small family care network, a safety net public hospital, and a regionally integrated health system delivering comprehensive care.

- In the final section, you'll find an index of all the tools and resources recommended in the toolkit, along with copies of the tools themselves or information about where to find them online.

THE CARE COORDINATION MODEL AT A GLANCE: Key concepts, changes, and resources

The Care Coordination Model looks at care coordination from the perspective of a PCMH—considering the range of providers and organizations they work with, including medical specialists, community agencies, and hospital and emergency facilities. The model is based on four key concepts related to patient referrals and care transitions: accountability, patient support, relationships and agreements, and connectivity. These four concepts are general ideas that drive care coordination.

To make them more useful, the toolkit translates four specific practice changes accompanied by supporting activities, tools, and resources. Here is a brief summary:





ACCOUNTABILITY

Why it's important:

When multiple practices or clinics are involved in a patient's care, all must collaborate—but one must assume overall responsibility for organizing the care. Establishing conditions and infrastructure to assure effective referrals and transitions is a core responsibility of the PCMH. Referrals are more likely to be successful when all providers understand each other's expectations and preferences—and when adequate staff and information infrastructure exist to help patients and their information get where they need to go.

Key changes:

1. Decide as a primary care clinic to improve care coordination.
2. Develop a tracking system for referrals.

Activities:

- Develop a quality improvement (QI) plan to implement changes and measure progress.
- Design the clinic's information infrastructure to internally track and manage referrals/transitions including specialist consults, hospitalizations, ER visits, and community agency referrals.

Tools and resources:

- NCQA Care Coordination Process Measures – In the toolkit
- Care Coordination Questions from Validated Instruments – In the toolkit
- Referral Tracking Guide – In the toolkit



PATIENT SUPPORT

Why it's important:

Referrals and transitions challenge patients and families. They raise questions that need to be answered, generate appointments that need to be made, and produce logistical challenges and anxiety that need to be addressed. Practices that dedicate staff time to meeting these patient needs are more likely to have successful referrals and transitions.

Key change:

3. Organize a practice team to support patients and families.

Activities:

- Delegate/hire and train staff to coordinate referrals and transitions of care, and train them in patient-centered communication, such as motivational interviewing or problem solving.
- Assess patient's clinical, insurance, and logistical needs.
- Identify patients with barriers to referrals/transitions and help patient address them.
- Provide follow-up post referral or transition.

Tools and resources:

- Referral Coordinator Job Description – In the toolkit
- Referral Coordinator Curriculum – In the toolkit
- Patient Referral Checklist – In the toolkit
- The Care Transitions ProgramSM – Online at www.caretransitions.org
- Patient Activation Assessment Form – In the toolkit
- The Post-Hospital Follow-Up Visit: A Physician Checklist to Reduce Readmissions– Online at www.chcf.org/publications/2010/10/the-post-hospital-follow-up-visit-a-physician-checklist



RELATIONSHIPS & AGREEMENTS

Why it's important:

Referrals and transitions work best when all parties—patients, primary care providers, and consultants—agree on the purpose and importance of the referral, and on the roles that each will play in providing care. As close, personal relationships between PCPs and specialists or hospital staff become less common, PCMHs should start conversations with their key specialist consultants or hospitals to discuss each other's preferences and expectations.

Key change:

4. Identify, develop, and maintain relationships with key specialist groups, hospitals, and community agencies.
5. Develop agreements with these key groups, hospitals, and agencies.

Activities:

- Complete internal needs assessment to identify key specialist groups and community agencies with which to partner.
- Initiate conversations with key consultants and community resources.
- Develop verbal or written agreements that include guidelines and expectations for referral and transition processes.

Tools and resources:

- Coordinating care in the medical neighborhood: Critical components and available mechanisms – Online at www.pcmh.ahrq.gov
- Colorado Systems of Care/Patient Centered Medical Home Initiative: Colorado Primary Care-Specialty Care Compact – In the toolkit
- Promising Approaches for Strengthening the Interface between Primary and Specialty Pediatric Care, from the Federal Expert Workgroup on Pediatric Subspecialty Capacity – In the toolkit



CONNECTIVITY

Why it's important:

To support successful referrals and transitions, all providers involved must have the information they need to optimize care and a trustworthy way of communicating. An electronic referral system can help assure that critical information flow occurs in a timely way and can incorporate agreed upon guidelines for referrals and transitions. These goals can also be accomplished with pencil and paper standardization of referral requests and consultation notes, and using fax machines or phone calls to communicate.

Key change:

6. Develop and implement an information transfer system.

Activities:

- Use a shared electronic health record or web-based referral system, or set up another standardized information flow process.

Tools and resources:

- Enhancing continuity of information: essential components of a referral document – Abstract online at <http://www.ncbi.nlm.nih.gov/pubmed/18854473>
- Enhancing continuity of information: essential components of consultation reports – Abstract online at <http://www.ncbi.nlm.nih.gov/pubmed/19509210>
- Optimizing referrals & consults with a standardized process – Abstract online at <http://www.ncbi.nlm.nih.gov/pubmed/18046956>
- Bridging the Care Gap: Using Web Technology for Patient Referrals – In the toolkit
- Are electronic medical records helpful for care coordination? Experiences of physician practices – Abstract online at <http://www.ncbi.nlm.nih.gov/pubmed/20033621>

1. McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; June 2007.