Coordination of Care Tip Sheet

What is coordination of care?

- The deliberate exchange of communication of care activities between two or more participants involved in the member's care to achieve optimal treatment delivery and outcomes.
  - Collaboration should always include the member.
- Care coordination aligns treatment plans and wellness goals creating treatment fidelity across settings and persons.
- The goal of care coordination is to meet the member's needs and deliver high-quality care through the exchange of information among treatment providers responsible for different aspects of care.

Coordination of care benefits:

- Improve outcomes for members and families
- Help facilitate more comprehensive treatment planning
- Provide a holistic approach to care
- Ensure appropriate dosage of prescribed services
- Offer a comprehensive view of services for treating providers
- Prevent potentially conflicting treatments and multiple treatment plans
- Align resources to member's needs

Who should coordinate care:

Care coordination may include a variety of individuals on the treatment team based on the member's unique needs. Clearly defined roles and an understanding of these roles can help all members of the care team communicate effectively and efficiently. This collaboration allows for a holistic view of treatment enabling the ability to identify potential barriers towards treatment success.

Individuals include:

- Behavioral health providers (e.g., counselors, social workers, therapists, psychiatrists)
- Physical health providers (e.g., primary care provider, pharmacist, neurologist)
- Specialty care services (e.g., dentist, optometrist, ENT, dietician)
- Therapy services (e.g., physical therapists, occupational therapists, speech therapy)
- Educational and community supports (e.g., teachers, school psychologists, caregivers)
- Family members

Considerations

- Release of information must be signed by the member or their guardian prior to any outreach
- Method of care coordination that is most appropriate based on member's need (e.g., phone, fax, meeting)
- Request and review records from previous or current providers to align care and member's needs
- Notify member and/or guardian about coordination occurring

References: McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination). Rockville (MD): Agency for Healthcare Research and Quality (US); 2007 Jun. (Technical Reviews, No. 9.7.) 3, Definitions of Care Coordination and Related Terms. Available from: https://www.ncbi.nlm.nih.gov/books/NBK44012/; Care Coordination. Content last reviewed August 2018. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/ncepcr/care/coordination.html;Friedman, A., Howard, J., Shaw, E. K., Cohen, D. J., Shahidi, L., & Ferrante, J. M. (2016). Facilitators and Barriers to Care Coordination in Patient-centered Medical Homes (PCMHs) from Coordinators' Perspectives. *Journal of the American Board of Family Medicine : JABFM*, *29*(1), 90–101. https://doi.org/10.3122/jabfm.2016.01.150175