# Guide to Improving Care Coordination

This guide provides an overview of quality improvement processes, strategies, and objectives to help improve care coordination. Identifying the drivers contributing to unnecessary emergency department (ED) visits, hospital utilization, and readmissions can help improve patient safety, enhance quality of care, and lower healthcare spending.

There are many factors that may contribute to ineffective care coordination. However, this resource will focus on the following drivers:

- Unreliable handoff processes
- Poor information transfer
- Insufficient support for patient and family self-management
- Discontinuous care after discharge
- Poor information transfer due to insufficient availability of health information
- Lack of standard, known processes

To help you get started, we have provided a care coordination worksheet that will guide you through the quality improvement process. This tool can be used to address any of the drivers identified using the steps below:

1. Determine the drivers of avoidable ED visits, hospital utilization, and readmission.
2. Use the guide to select an intervention strategy based on the identified driver.
3. Use the SMART (strategic/specific, measurable, attainable, realistic, and time) Goal Worksheet to develop a goal for the intervention.
4. Use the PDSA (plan, do, study, act) worksheet to steer the implementation strategy using PDSA cycles to measure effectiveness and adjust as appropriate.

Each driver, associated intervention strategies and their descriptions, objectives, and supportive resources can be found in the following tables:

| Unreliable Handoff Process | | |
|---|---|---|
| **Strategy** | **Strategy Description** | **Objective** |
| Enhanced Information Transfer at Discharge | Improvements in timely transfer of medical information from the acute-care setting to post-discharge healthcare providers. | Ensure that current and accurate health information is accessible by receiving providers. |
| Follow-Up Care Established at Discharge | Arrangements (made prior to leaving the acute-care setting) for the patient to receive appropriate follow-up care. | Ensure that patients receive proper post-acute follow-up care. |

| Unreliable Handoff Process | | |
|---|---|---|
| **Strategy** | **Strategy Description** | **Objective** |
| Medication Management | Activities to improve effectiveness of pharmacotherapy; including support of patient understanding of appropriate medication use and adverse events. | Reduce medication errors leading to adverse events and readmission. |
| **Resources** | | |
| • Handoff \| AHA TeamSTEPPS Video Toolkit \| AHA<br>• Tool: Handoff \| AHRQ<br>• Tool: I-PASS \| AHRQ<br>• Warm Handoff: Intervention \| AHRQ<br>• Resources and Tools To Improve Discharge and Transitions of Care and Reduce Readmissions \| AHRQ<br>• Medication Management Strategy: Intervention \| AHRQ | | |

| Poor Information Transfer | | |
|---|---|---|
| **Strategy** | **Strategy Description** | **Objective** |
| Enhanced Information Transfer at Discharge | Improvements in timely transfer of medical information from the acute-care setting to post-discharge healthcare providers. | Ensure that current and accurate health information is accessible by receiving providers. |
| Medication Management | Activities to improve effectiveness of pharmacotherapy; including support of patient understanding of appropriate medication use and adverse events. | Reduce medication errors leading to adverse events and readmission. |
| Plan of Care | Collaborative development of a complete, accurate strategy for post-discharge care, including history, situation, likely progression, and patient/family preferences for end-of-life issues. | Consistent vision of medical and health support needs among caregivers, including the patient as self-caregivers. |

| Poor Information Transfer | | |
|---|---|---|
| **Strategy** | **Strategy Description** | **Objective** |
| Electronic Health Record / Electronic Medical Record | Databases and data access/reporting systems to standardize patient information available to providers across care settings. | Prevent medical errors by minimizing incomplete, inaccurate, and conflicting information across care settings. |
| Enhanced Palliative Care Consultation and Support | Improved assessment of palliative care needs and end-of-life preferences, including appropriate palliative and hospice care referrals. | Ensure common understanding of preferred medical treatments to reduce reliance on acute care services.<br><br>Consistent vision of medical and health support needs among caregivers, including the patient as self-caregivers. |
| Personal Health Record | Organizational tool for patients to track health care goals/concerns, medications, sign and symptom red flags, provider contact information, and any other information relevant to healthcare self-management. | Provide reliable resource for patients to document key medical information and track health support needs. |

**Resources**

- Resources and Tools To Improve Discharge and Transitions of Care and Reduce Readmissions | AHRQ
- Medication Management Strategy: Intervention | AHRQ
- Improve Care Coordination | HealthIT.gov
- Indiana's Post Form
- Respecting Choices | Person-Centered Care
- HITECH_Fact_Sheet_PHR_Providers_v2.indd (healthit.gov)
- The Guide to Getting and Using Your Health Records - HealthIT.gov

| Insufficient Support for Patient and Family Self-Management | | |
|---|---|---|
| **Strategy** | **Strategy Description** | **Objective** |
| Medication Management | Activities to improve effectiveness of pharmacotherapy; including support of patient understanding of appropriate medication use and adverse events. | Reduce medication errors leading to adverse events and readmission. |
| Plan of Care | Collaborative development of a complete, accurate strategy for post-discharge care, including history, situation, likely progression, and patient/family preferences for end-of-life issues. | Consistent vision of medical and health support needs among caregivers, including the patient as self-caregivers. |
| Telephone Follow-Up | Telephone calls made to the patient shortly after discharge from the acute care setting to provide information, health education, symptom management, early monitoring of complications, reassurance, and quality post-discharge care. | Address problems arising in the first few weeks following hospital discharge.<br><br>Address patients' post-discharge questions and care needs. |
| Multidisciplinary Team, Multifaceted Interventions | Collaboration among a multidisciplinary team, facilitating community treatment, collaborative care, and shared primary specialty care. | Improve care coordination to reduce readmissions.<br><br>Integration of patients' medical, pharmaceutical, psychosocial, and spiritual needs at the time of discharge. |
| Enhanced Palliative Care Consultation and Support | Improved assessment of palliative care needs and end-of-life preferences, including appropriate palliative and hospice care referrals. | Ensure common understanding of preferred medical treatments to reduce reliance on acute care services.<br><br>Consistent vision of medical and health support needs among caregivers, including the patient as self-caregivers. |

| Insufficient Support for Patient and Family Self-Management | | |
|---|---|---|
| **Strategy** | **Strategy Description** | **Objective** |
| Education | Teaching and materials targeted toward patients, family members, and other informal caregivers on topics of disease self-management, treatment options, expectations, and available resources. | Enable patients to avoid unnecessary utilization of health services through accurate understanding of health medical care needs.<br><br>Improve quality of self-care and management. |
| Coaching | Non-medical support for home-based self-management capability. | Improve competence in achieving personal health goals.<br><br>Avoid inappropriate and unwanted medical interventions. |
| Personal Health Record | Organizational tool for patients to track healthcare goals/concerns, medications, sign and symptom red flags, provider contact information, and any other information relevant to healthcare self-management. | Provide reliable resource for patients to document key medical information and track health support needs. |
| Community Support | Connecting patients and family members to non-medical community health support agencies and other entities within the community. | Eliminate everyday barriers to self-management (e.g., lack of transportation). |
| **Resources** | | |

- Medication Management Strategy: Intervention
- Resources and Tools To Improve Discharge and Transitions of Care
- TeamSTEPPS 3.0 | AHRQ
- PREPARE (prepareforyourcare.org)
- Respecting Choices | Person-Centered Care
- Health Literacy Universal Precautions Toolkit, 3rd Edition
- Culturally and Linguistically Appropriate Services
- Community Health – Qsource QIO Resources
- Nursing Homes – Qsource QIO Resources
- The Guide to Getting and Using Your Health Records - HealthIT.gov
- Call 211 for Essential Community Services | United Way 211

| Discontinuous Care After Discharge, After Information Transfer Due to Insufficient Availability of Health Information | | |
|---|---|---|
| **Strategy** | **Strategy Description** | **Objective** |
| Telemedicine | Remote monitoring and care delivery via telemonitoring (electronic or telephonic transfer of physiological data from home to healthcare provider) or regular telephone-based medical management. | Continued medical management following discharge. |
| Telephone Follow-Up | Telephone calls made to the patient shortly after discharge from the acute care setting to provide information, health education, symptom management, early monitoring of complications, reassurance, and quality post-discharge care. | Address problems arising in the first few weeks following hospital discharge.<br><br>Address patients' post-discharge questions and care needs. |
| **Resources** | | |
| • Telehealth for Providers: What You Need to Know (cms.gov)<br>• General Telemedicine Toolkit (cms.gov)<br>• Long-Term Care Nursing Homes Telehealth and Telemedicine Toolkits (cms.gov) | | |

| Lack of Standard and Known Processes | | |
|---|---|---|
| **Strategy** | **Strategy Description** | **Objective** |
| Multidisciplinary Team, Multifaceted Interventions | Collaboration among a multidisciplinary team, facilitating community treatment, collaborative care, and shared primary specialty care. | Improve care coordination to reduce readmissions.<br><br>Integration of patients' medical, pharmaceutical, psychosocial and spiritual needs at the time of discharge. |
| Clinical Protocols, Best Practices, and Regional Guidelines | Establishment of congruence in practice standards within and across settings. | Ensure that in-setting care will be consistent with care in other settings. |

| Lack of Standard and Known Processes | | |
|---|---|---|
| **Strategy** | **Strategy Description** | **Objective** |
| Enhanced Palliative Care Consultation and Support | Improved assessment of palliative care needs and end-of-life preferences, including appropriate palliative and hospice care referrals. | Ensure common understanding of preferred medical treatments to reduce reliance on acute care services.<br><br>Consistent vision of medical and health support needs among caregivers, including the patient as self-caregivers. |
| **Resources** | | |
| • TeamSTEPPS 3.0 \| AHRQ<br>• ACO Public Toolkit on Care Coordination (cms.gov)<br>• Indiana's Post Form<br>• Hospice Led Palliative Care Toolkit \| Center to Advance Palliative Care (capc.org)<br>• PREPARE (prepareforyourcare.org)<br>• Respecting Choices \| Person-Centered Care | | |

# Intervention Strategies to Improve Care Coordination Worksheet

**Step 1: Determine drivers of high ED utilization, hospital utilization, or readmissions. You can use the "Five Why's" Worksheet" or the "Fishbone Worksheet" to find potential drivers.**

**Step 2: Use the "Guide to Improving Care Coordination" to select an intervention strategy.**

**Step 3: Use the "SMART Goal Worksheet" to develop a goal for the intervention.**

**Step 4: Use the "PDSA Worksheet" to guide implementation strategy using PDSA cycles to measure effectiveness and make adjustments.**



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