COLEMAN
ASSOCIATES

Dramatic Performance Improvement™

Care Coordination

Care Network Development Guide

Introduction:

One of the primary goals of care coordination services is to decrease the amount of care fragmentation. Making progress to reduce fragmentation in a silo is challenging at best, making the development of care networks a critical component in an effective care coordination program. As the shift from volume to value-based care continues to move forward, communities and organizations must view care from a global perspective, working collaboratively to improve the quality of care that patients receive. Developing relationships between Primary Care Providers (PCPs) and specialists and/or hospital staff can result in more effective care coordination through the elimination of unnecessary referrals, reduction in duplicated assessments, and timely, effective transitions of care.

Network Development:

Broad knowledge of the services and resources available within the care community, development of working relationships and agreements with other members in the care community, and maintenance of a directory of resources are all critical components of a successful care coordination program.

Community Resources Directory: Building a community directory will help assist care coordinators and care coordination service programs in their area with patient care delivery and alignment of services. The first step in care network development is to *develop a database*. Identify resources within the community and create a system to store them in a central location. We recommend that your database be electronically based (paper directories are hard to share among teams and more challenging to maintain in real time). Your directory should include basic information such as name, location, contact

information, etc., but should also include relevant information like services offered, referral requirements, insurances accepted and availability.

Creating a comprehensive list of community resources can seem like a daunting task. Here are some tips on places to start:

- ✓ Outgoing referrals: Review data from past referrals to gain insight into services utilized most frequently.
- ✓ Internal Departments: Understand that each department has a unique perspective on the patient care experience. The billing department will know a great deal about coverage for services and financial resources and assistance programs. Social workers will have better insight into social service resources, etc.
- ✓ Government Agencies: Contact your local health department; they will have good insight into local services.

Creating Agreements and Building Relationships: Agreements between PCPs, specialists, hospitals, and other entities within the care community have proven to decrease costs and increase the quality of care. It is important that care entities within the community work together to create an understanding of the role each party plays in patient care. The American College of Physicians recommends that care communities engage within a framework called Patient Centered Medical Home Neighbor (PCMH-N). This framework offers a set of principles that guide the creation of agreements between members of community care networks.These principles can be found on the American College of Physicians website. (Brizzia make this a link)
https://www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/pcmh_neighbors.pdf

Sources

https://www.acponline.org/acp_policy/policies/ethics_patient_centered_medical_home_2012.pdf

http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Care-Coordination.pdf

https://www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/pcmh_neighbors.pdf

http://www.improvingchroniccare.org/downloads/_11_primary_care__specialty_care_compact.pdf