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Center for Rural Health Policy Analysis

Rural Health Value UNDERSTANDING AND FACILITATING RURAL HEALTH TRANSFORMATION.

StratisHealth

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Resources for Care Coordination in the Rural Setting

Coordination of care across multiple settings is one of the foundations of providing value-based services. 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]. Improving Chronic Illness Care (ICIC) is a national organization dedicated to improving the health of patients who are chronically ill. ICIC provides evidence-based care coordination resources for practitioners and health systems. Care coordination is a proven approach that can assist not only chronically ill patients, but all patients. ICIC's toolkit "Reducing Care Fragmentation: A Toolkit for Coordinating Care" is a robust set of resources and tools that can help practices and systems implement or improve care coordination. Although the toolkit was created to support care coordination for patient-centered medical homes (PCMH), it is a useful resource even for those not pursuing PCMH certification. According to the ICIC model, key improvement care coordination areas include:

- Accountability
- Patient Support
- Relationships & Agreements
- Connectivity

The Executive Summary of the ICIC toolkit is available here. To access the full ICIC toolkit in pdf format at no cost, click here. See below for further resources for rural health providers and systems.

[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

Care Coordination Model

Learn more about the care coordination model and how it works in an easy-to-interpret diagram and two case studies:

- Diagram: http://www.improvingchroniccare.org/index.php?p=Care_Coordination_Model&s=353
- Case Study – Ms. G: http://www.improvingchroniccare.org/index.php?p=Background&s=350
- Case Study- Ms. H: http://www.improvingchroniccare.org/index.php?p=Care_Coordination_Model&s=353

Case Studies

Read these two case studies about rural providers who have successfully used care coordination:

- Humboldt Independent Practice Association in Northern California, which developed and implemented a process for tracking referrals through an electronic system
  - http://www.improvingchroniccare.org/index.php?p=Humboldt_County&s=346
- Oklahoma School of Community Medicine, which developed and implemented a process that allows for tracking and making e-consultations.
  - http://www.improvingchroniccare.org/index.php?p=Oklahoma_School_of_Community_Medicine&s=348

Implementing Change

The ICIC model change package identifies care coordination key changes, activities, and resources:

- http://www.improvingchroniccare.org/index.php?p=Change_Package&s=354

Additional ICIC Tools and Resources for implementing changes are available here. Some items particularly useful to rural leaders include:

- **Referral Coordinator Job Description**: helpful if you might like to hire a coordinator
- **Referral Coordinator Curriculum**: helpful if you'd like to train existing staff to perform care coordination duties
- **Referral Tracking Guide**: includes sample forms as well as instructions for electronic use
- **Colorado Primary Care–Specialty Care Compact**: an outline of potential provider-specialist-patient relationships. Also includes sample agreements to assist in developing partnerships and creating expectations for care coordination and referrals

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