Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.htm>

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**Care Coordination**

Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.

Care coordination in the primary care practice involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.

The main goal of care coordination is to meet patients' needs and preferences in the delivery of high-quality, high-value health care. This means that the patient's needs and preferences are known and communicated at the right time to the right people, and that this information is used to guide the delivery of safe, appropriate, and effective care.

There are two ways of achieving coordinated care: using broad approaches that are commonly used to improve health care delivery and using specific care coordination activities.

Examples of broad care coordination approaches include:

* Teamwork.
* Care management.
* Medication management.
* Health information technology.
* Patient-centered medical home.

Examples of specific care coordination activities include:

* Establishing accountability and agreeing on responsibility.
* Communicating/sharing knowledge.
* Helping with transitions of care.
* Assessing patient needs and goals.
* Creating a proactive care plan.
* Monitoring and followup, including responding to changes in patients' needs.
* Supporting patients' self-management goals.
* Linking to community resources.
* Working to align resources with patient and population needs.

Why Is Care Coordination Important?

Care coordination is identified by the [Institute of Medicine](http://iom.edu/Reports/2003/Priority-Areas-for-National-Action-Transforming-Health-Care-Quality.aspx) [Link to Exit Disclaimer](https://www.ahrq.gov/externaldisclaimer.html) as a key strategy that has the potential to improve the effectiveness, safety, and efficiency of the American health care system. Well-designed, targeted care coordination that is delivered to the right people can improve outcomes for everyone: patients, providers, and payers.

Although the need for care coordination is clear, there are obstacles within the American health care system that must be overcome to provide this type of care. Redesigning a health care system in order to better coordinate patients' care is important for the following reasons:

* Current health care systems are often disjointed, and processes vary among and between primary care sites and specialty sites.
* Patients are often unclear about why they are being referred from primary care to a specialist, how to make appointments, and what to do after seeing a specialist.
* Specialists do not consistently receive clear reasons for the referral or adequate information on tests that have already been done. Primary care physicians do not often receive information about what happened in a referral visit.
* Referral staff deal with many different processes and lost information, which means that care is less efficient.

How Can Care Coordination Be Put Into Action?

Applying changes in the general approach and everyday routines of a medical practice can be overwhelming, even when it is obvious that the changes will improve patient care and provider efficiency. Fortunately, there are resources available for those who are interested in learning how to take a coordinated care approach to primary care practice.

The [Care Coordination Quality Measure for Primary Care (CCQM-PC)](https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/ccqmpc/index.html) builds on previous AHRQ work to develop a conceptual framework for care coordination. The CCQM-PC is intended to fill a gap in the care coordination measurement field by assessing the care coordination experiences of adults in primary care settings. It was developed, cognitively tested, and piloted with patients from a diverse set of 13 primary care practices to comprehensively assess patient perceptions of the quality of their care coordination experiences. The CCQM-PC is designed to be used in primary care research and evaluation, with potential applications to primary care quality improvement. Guidance regarding the fielding of the survey is provided in addition to the full survey, which is in the public domain and may be customized and used without additional permission.

[Care Coordination Measures Atlas—June 2014 Update](https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/index.html). Since publication of the original *Atlas* in 2011, many new care coordination measures have been developed. *Appendix IVa* ( PDF file [PDF version](https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/prevention-chronic-care/improve/coordination/atlas2014/appendix4a.pdf) - 8.56 MB ) in this *Update* presents many new measures emphasizing primary care. Twenty-six new EHR-based measures are identified that can help professionals meet Medicaid and Medicare EHR Incentive Programs criteria. The measures are mapped to the conceptual framework introduced in the original Atlas and included in the *Update*. A new section on emerging trends in the field also has been added to the *Update*.

[Care Management: Implications for Medical Practice, Health Policy, and Health Services Research. Care Management Issue Brief](https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/caremanagement/index.html). This issue brief highlights key strategies to enhance existing or emerging care management programs and summarizes recommendations for decisionmakers in practice and policy, as well as for future research.

AHRQ has assembled additional resources to help clinicians, clinical teams, and health care administrators measure care coordination and learn more about how to incorporate care coordination into routine primary care practice. Visit the [PCMH Resource Center](http://pcmh.ahrq.gov/page/papers-briefs-and-resources) to view the following papers, briefs, and other resources:

* Care Coordination Accountability Measures for Primary Care Practice
* The Roles of Patient-Centered Medical Homes and Accountable Care Organizations in Coordinating Patient Care
* Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms
* Coordinating Care for Adults With Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions
* Prospects for Care Coordination Measurement Using Electronic Data Sources

The following AHRQ Annual Conference presentations on care coordination are also available:

**Care Transitions: Navigating the Health Care System—2011**

* [The Transitional Care Model: Translating Research Into Practice and Policy](https://www.ahrq.gov/news/events/conference/2011/naylor/index.html) ( Microsoft PowerPoint file [Microsoft PowerPoint version](https://www.ahrq.gov/sites/default/files/wysiwyg/news/events/conference/2011/naylor/naylor.pptx) - 3.38 MB )  
  *Mary Naylor, University of Pennsylvania School of Nursing*
* [Project RED: The ReEngineered Discharge](https://www.ahrq.gov/news/events/conference/2011/jack/index.html) ( Microsoft PowerPoint file [Microsoft PowerPoint version](https://www.ahrq.gov/sites/default/files/wysiwyg/news/events/conference/2011/jack/jack.pptx) - 10.21 MB )  
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