Coordination

The main goal of care coordination is to meet patient’s needs and preferences in the delivery of high-quality care. Care coordination involves managing and integrating care across levels of the system and across time in order to ensure patient information is communicated at the right time and to the right people to facilitate the delivery safe, appropriate and effective care. Every patient will need episodic care coordination at some point in their care experience. Care management, however, involves a more specific subset of care coordination - it involves longitudinal, proactive outreach to manage and coordinate care for a defined group of often higher risk individuals. The Safety Net Medical Home Initiative outlines six core functions of care coordination (one of which involves providing care management services) useful for understanding how to coordinate high-quality services to meet the needs and preferences of patients.
Coordination is a core function of High-Quality Primary Health Care

Social Determinants & Context (Political, Social, Demographic & Socioeconomic)
Coordination is a core function of High-Quality Primary Health Care

High-Quality Primary Health Care
- First-Contact Accessibility
- Continuity
- Comprehensiveness
- Coordination
- Person-Centered

First Contact Accessibility
- Continuity
- Comprehensiveness

Coordination
- Person-Centered
What is Coordination?

**What it is:** Learn more about the core principles and goals of Coordination and its role in PHC improvement.

How do I assess my performance?

**What it is:** Learn more about some indications that improvements might be relevant in your context and what you can achieve by focusing improvements on Coordination.

**Vital Signs Profile:** Use the information in your Vital Signs Profile to help determine relevant areas for improvement.

How do I get started?

**What others have done:** Learn from implementation approaches and challenges in other country contexts.

**How to succeed:** Consider your country context, what elements are not functioning properly, and what needs to be in place to support effective improvements.

**What to ask:** Use guiding questions to help determine how you might begin to plan and enact reforms in your country context.

Guided by the above considerations and relevant resources, start to build out an improvement plan with your CE lead and/or focal point.
What can my country achieve by focusing on Coordination?

Goals & Outcomes

✓ Meet needs and preferences of the patient, fostering trust in the health care system.

✓ Facilitate appropriate treatment and follow-up and have resultant reductions in unnecessary care and readmissions.

✓ Create linkages between health and non-health sectors to effectively meet the complex needs of patients.

✓ Optimized value and clinical outcomes within the system through horizontal and vertical integration of care.

✓ Greater efficiency and cost effectiveness in health service delivery through facilitation of appropriate treatment and follow-up.
Coordination

How do I assess my performance?

Learn more about whether you should focus on Coordination in the Vital Signs Profile.
How do I assess my performance?

Use the information in the Vital Signs Profile to help determine relevant areas of improvement.

Completion of a Vital Signs Profile gives countries a holistic understanding of PHC strengths and weaknesses, a critical first step in the measurement for improvement pathway.
What are other indications that Coordination might be an appropriate area of focus?

**Other Indications**

- **Poor patient experience**
  Patients do not have continuous relationships with care providers who know their care history or facilitated connections to community resources.

- **System fragmentation**
  Systematic misalignment of incentives and intersectoral organizations that lead to inefficiencies that disrupt care and can harm patients.

- **Lack of support for providers**
  Providers or organizations receive little to no incentives, trainings, or operational support for supporting coordinated care.

- **Low or mismatched care-seeking behavior**
  Lack of integrated system results in over-utilization of higher levels of care for needs that can be addressed in at the PHC level.

- **Lack of governance and accountability**
  No formal policy structure to promote collaboration or disincentivize market structures that compensate providers for multiple point-of-care interactions.

- **Informational inefficiency**
  Lack of robust information systems to coordinate communication and track and support patients.
Coordination – What is it?

Learn more about the core principles of Coordination and what you can achieve by focusing improvements in the **What it is** section.
What is Coordination?

Care coordination is the coordination of patient care throughout the course of treatment and across various sites of care to ensure appropriate follow-up treatment, minimize the risk of error, and prevent complications. Coordination of care happens across levels of care and over time, and often requiring proactive outreach on the part of health care teams and informational continuity.

Coordination is a critical component of achieving High-Quality Primary Health Care
What is Coordination?

Coordination connects treatment and across various sites of care to ensure appropriate follow-up treatment, minimize the risk of error, and prevent complications. Coordination of care happens across levels of care and over time, often requiring proactive outreach on the part of health care teams and informational continuity.

Why it’s important

- **Integrates care to facilitate efficiency**
  Creates linkages between the health and non-health sectors and networks within and among levels of care (i.e. horizontal and vertical integration) that support PHC in effectively meeting the varied needs of patients throughout their life course.

- **Supports patient-centered care**
  By improving system performance from the perspective of the user, coordination catalyzes use of care and supports the comprehensive needs of the individual.

- **Improved health and clinical outcomes**
  Systems that achieve strong coordination of care facilitate appropriate treatment and follow-up and have resultant reductions in unnecessary care and readmissions.
What is Coordination?

Coordination connects treatment and across various sites of care to ensure appropriate follow-up treatment, minimize the risk of error, and prevent complications. Coordination of care happens across levels of care and over time, often requiring proactive outreach on the part of health care teams and informational continuity.

Key steps and considerations

- **Reorienting care delivery** with PHC as the foundation by shifting toward a community-based, collaborative model of care designed to support the complex needs of the patient at the frontline, including sensitivity to social and cultural needs + preferences.

- **Horizontal integration** with collaboration across sectors, linking to resources to meet the comprehensive needs of the population.

- **Vertical integration** to define interactions between primary, secondary and tertiary facilities - including two-way referrals and robust communication networks with the broader health system and/or other sectors.

- **Private sector engagement** and policy directives to ensure linkages between private providers and the public sector.

- **Creating an enabling environment** by bringing all stakeholders together to transform these strategies into an operational reality – including approaches such as incentives to promote and facilitate coordinated care.
Visual aid: Coordination

HIGH-QUALITY PRIMARY HEALTH CARE IS

Coordinated

High-quality primary health care is coordinated around a person’s needs and preferences throughout treatment and across various care sites. Coordination ensures appropriate follow-up treatment, minimizes the risk of error, and prevents complications.

Coordination of care often requires both health care teams and information systems to reach out proactively.
<table>
<thead>
<tr>
<th>Function</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Link</td>
<td>Link patients with community resources to facilitate referrals and respond to social service needs</td>
</tr>
<tr>
<td>Integrate</td>
<td>Integrate behavioral health and specialty care into care delivery through co-location or referral arrangements</td>
</tr>
<tr>
<td>Track and support</td>
<td>Track and support patients when they obtain services outside the practice</td>
</tr>
<tr>
<td>Follow-up</td>
<td>Follow-up with patients within a few days of an emergency room visit or hospital discharge</td>
</tr>
<tr>
<td>Communicate</td>
<td>Communicate test results and care plans to patients and families</td>
</tr>
<tr>
<td>Provide</td>
<td>Provide care management services for high risk patients</td>
</tr>
</tbody>
</table>
Deeper dive: Structures Supporting the Core Functions of Coordination

Coordination of care relies on proactive outreach on the part of health care teams and robust information and communication systems within and across levels of care. This relies on systematic alignment within and across systems through:

**Vertical Integration**
Involves redefining the role and interactions among primary, secondary, and tertiary facilities to promote coordination and service delivery across levels of care.

**Horizontal Integration**
Involves collaboration across sectors to promote the delivery of comprehensive primary care.
## Deeper dive: Structures Supporting the Core Functions of Coordination

The following structures are some examples of how to support Vertical and Horizontal Integration:

<table>
<thead>
<tr>
<th>Interoperable Information Systems</th>
<th>Workforce Training</th>
<th>Referral Management Systems</th>
<th>Management of political + economic interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Coordination relies on the ability of information systems to connect, in a coordinated manner, a wide range of data sources across different settings of care and sectors and reliably communicate this information at the right time and to the right people.</td>
<td>• Skill building and technical training opportunities may help to improve the quality of care and competency of providers in facilities, establish interfacility relationships, and promote communication networks across levels of care, as well as promote provider motivation and engagement</td>
<td>• To reduce care fragmentation and improve the quality of transitions. Establishing a two-way referral system supports effective communication between physicians within the same and at different levels of the health system.</td>
<td>• At the system-level, policymakers must recognize the potential for interfering interests and restructure market incentives and partnerships to promote collaboration. Governing policies should be protected from turnovers in political leadership and conflicts of interest</td>
</tr>
</tbody>
</table>
Coordination

How do I get started?

Derive information from what others have done, what to ask and how to succeed to help determine where and how you might begin to plan and enact forms in your country context.
Planning for improvement in your context

The guidance and recommendations described within the Coordination module are not intended to provide a one-size-fits all solution.

The considerations involved in planning and implementing strategies will depend on your local context.

Sample activities

- **Consider** implementation challenges and approaches in other country contexts
- **Consider how the features of your health system**, such as how decisions get made and the role of the private sector, will impact your improvement plans
- **Identify** key elements that need to be in place to support improvements
- **Use the guiding questions in the Improvement Strategies** to spur thinking about Coordination in your country context and stimulate ideas for improvement
- **Start to develop** an improvement plan
Planning for improvement in your context

While the specific considerations involved in planning and implementing strategies will depend on your context, you might consider...

- **Factors that impact vertical integration:**
  - Gatekeeping structures and bidirectional referrals that successfully maintain primary care as the first point of contact
  - Defined facility roles within the network
  - Established relationships among providers
  - Formalized facility networks based on the 3-in-1 principle

- **Factors that impact horizontal integration:**
  - Long term, system-wide commitment to collaboration
  - Resource availability (including strong information technology networks and workforce training programs) to create and sustain the system

- **Factors that impact multisectoral collaboration:**
  - Policy formulation and political will
  - Resources and coordination
  - Clear responsibilities and mutual accountability across stakeholders
  - Shared benefit for all involved sectors
Learn from what others have done

**Role Delineation Policy | Solomon Islands**
Increasing care accessibility and quality for rural populations by defining service delivery packages at each level of health facility.

**EBAIS Model | Costa Rica**
Integrated Primary Health Care Teams provide holistic care to a specific, geographically ordered group of citizens (empaneled patients).
Solomon Islands: At-a-glance context

- East Asia & Pacific
- Lower-Middle Income
- Conflict-affected and fragile state
## Solomon Islands: At-a-glance context

<table>
<thead>
<tr>
<th>GDP per capita ($PPP)</th>
<th>Human Development Index</th>
<th>Life expectancy at birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,422</td>
<td>0.55</td>
<td>71</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of population living in rural areas</th>
<th>Percentage of population living under $1.90 per day</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>77%</td>
<td>25%</td>
<td>611.3K</td>
</tr>
</tbody>
</table>
Why reforms were needed

• 80% of population live in rural areas, while a disproportionate concentration of resources and qualified staff are in the urban capital, Honiara.

• > 70% of rural health centers required repairs – and there are no consistent standards for health facilities

• Much of the population travels to the National Hospital for primary health services, bypassing of sub-hospital facilities

• All of these issues cause significant barriers to the delivery of timely, coordinated, and geographically accessible care

Approach

In 2011, the Ministry of Health and Medical Services commenced the development of a role delineation policy, defining service delivery packages for each level of health facility. In 2016, the packages were simplified based on experiences from early piloting. The levels of care are:

• Rural Health Centres (abolishing the previous category of Nurse Aide Posts)
• Area Health Centres levels 1 and 2
• Urban Health Centres
• General Hospitals

The Service Delivery Packages outline what is required at each level for staffing, infrastructure, equipment, essential registers, manuals, guidelines and forms, and essential medicines.

These packages are the basis of role delineation that informs policy, change planning, and expectations of services to be delivered.
Strengths

- **Promotes coordination of care and efficiency:** all levels of the system though clarity of services that are expected to be delivered at each facility.

- **Engages patients and communities:** informs care seeking behaviors, helping local communities know what services they can expect.

- **Facilitates policy and political commitment:** the National Development Plan now specifies “Access to quality health care is a universal aim of all Solomon Islanders”; and the National Health Strategy includes healthy happy productive people as the vision, Universal Health Coverage as the goal, and Role Delineation Policy as the central driver of required changes.
Learn from what others have done: Solomon Islands

- **Simple, clear Service Delivery Packages**: created through early piloting and an iterative, consultative process.

- **Clarity in expectations**: clear job descriptions and reporting lines, requirements for infrastructure, equipment, essential registers, manuals, guidelines and forms, and essential medicines.

- **Incentives for rural postings**: to encourage medical staff to work in populations outside the capital.

- **Documents for driving change**: Service Delivery Packages are used by policy makers to guide resource allocation, by provincial health planners to guide changes, by local communities to identify what range of services they can expect, and by local staff to assess what services they should be delivering.
Costa Rica: At-a-glance context

- Latin America & Caribbean
- Upper-Middle Income
- Spanish-speaking country
## Costa Rica: At-a-glance context

<table>
<thead>
<tr>
<th>GDP per capita ($PPP)</th>
<th>Human Development Index</th>
<th>Life expectancy at birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>$17K</td>
<td>0.79</td>
<td>80</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of population living in rural areas</th>
<th>Percentage of population living under $1.90 per day</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>21%</td>
<td>1%</td>
<td>4.91M</td>
</tr>
</tbody>
</table>
Learn from what others have done: Costa Rica

Why reforms were needed

- Despite long-time national commitment to UHC and value of overall well-being, budgetary turmoil in the 1980s overshadowed health policy concerns
- High levels of dissatisfaction with PHC and declining utilization
- Loud calls for privatization and the scaling back of the health care system from the international donor community.
- Result was a primary health care system desperately in need of reform to improve service delivery and better meet the needs of the population in a fiscally sustainable manner

Approach

- EBAIS – or Integrated Primary Health Care Teams – model was established in Costa Rica. These teams provide holistic care to a specific, geographically ordered group of citizens (empaneled patients).
- EBAIS design enables multidisciplinary teams to deliver comprehensive preventive, acute, and chronic disease management to Costa Ricans throughout the course of their lives.
- Proactive outreach and informational continuity facilitate appropriate treatment and coordination across the continuum of care.
- The EBAIS has two coordination policies that promote primary care as the main system for service provision: gatekeeping and dual referrals.
Learn from what others have done: Costa Rica

- **Promotes coordination of care** across the health system through cross-disciplinary proactive outreach teams who follow up with at-risk individuals.

- **Informational continuity** through strong integrated electronic health records, including data on some environmental determinants of health captured from annual home visits.

- **Multidisciplinary team-based approach** to health that considers the important role of the patient’s wider community in their wellbeing and connects them to resources.
Learn from what others have done: Costa Rica

- **Geographic Empanelment** of population to EBAIS teams. Each EBAIS team provides comprehensive preventive, promotive, and curative care to approximately 4,00—5,000 population.

- **Gatekeeping and dual referrals** to maintain primary care as the first and primary source of care – serving as care managers and the first point of contact
What elements should be in place to support effective improvements in Coordination?
Policy directives that promote coordination across all levels of health care and between health and non-health sectors require robust regulatory and supervisory mechanisms. In order to translate policy into action, the implementation of policy recommendations and initiatives must be supported across all levels of governance and networks within the health system and across sectors.
As patients transition across levels and sites of care within and beyond the health sector, it is important for quality management infrastructure to be in place to enable care coordination. To facilitate the coordination of high-quality primary health care across providers, facilities, and sectors a national quality improvement plan that integrates standardized care plans, diagnostic protocols, training programs, and accreditation systems should be in place.
What elements should be in place to support effective improvements in Coordination?

Coordination relies on information systems with broad capacities to track and manage the health of a patient. Information systems should produce reliable, complete, and timely information that ensures interoperability from a wide range of data sources and continuity of patient information.
What elements should be in place to support effective improvements in Coordination?

The effective use of information systems empowers and engages patients and improves communication among team members to promote coordination. **Interoperability** of data management systems is an essential function to ensure that information systems can effectively collect, analyze, and share critical information to all relevant providers and care teams.
What elements should be in place to support effective improvements in Coordination?

Strong leaders must have or develop competencies and personality traits to effectively manage and engage the workforce to motivate a culture of collaboration. Managers should be properly equipped with the tools, systems, and skills to productively assess the health workforce within a facility and provide supportive supervision.
The specific considerations involved in planning and implementing strategies will depend on your local context.

The questions listed may be a useful starting place to determine how you might begin to plan and enact reforms in your context.

What should be considered to begin improvements?

- What systems are in place for horizontal and vertical integration?
Questions to ask to help you get started

The specific considerations involved in planning and implementing strategies will depend on your local context.

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What should be considered to begin improvements?

- What systems are in place for horizontal and vertical integration?
- In what ways are providers supported to encourage coordination of care? For instance, do they receive adequate remuneration and professional development opportunities and are there information systems in place to streamline communication?
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☐ What incentives are or are not in place to promote collaboration between key actors (including insurers, providers, and health authorities)?

☐ Is a significant amount of primary care delivered by the private sector? If so, how are they involved in the coordination of care?
Recap: Coordination

**System**
- Governance & Leadership
  - Primary Health Care Policies
  - Quality Management Infrastructure
  - Social Accountability
- Health Financing
  - Payment Systems
  - Spending on Primary Health Care
  - Financial Coverage
- Adjustment to Population Health Needs
  - Surveillance
  - Priority Setting
  - Innovation & Learning

**Inputs**
- Drugs & Supplies
- Facility Infrastructure
- Information Systems
- Workforce
- Funds

**Population Health Management**
- Local Priority Setting
- Community Engagement
- Empowerment
- Proactive Population Outreach

**Facility Organization & Management**
- Team-based Care Organization
- Facility Management
- Capability & Leadership
- Information Systems Use
- Performance Measurement & Management Outreach

**Service Delivery**
- Access
  - Financial
  - Geographic
  - Timeliness
- Continuity
- Comprehensiveness

**High Quality Primary Health Care**
- First Contact Accessibility

**Availability of Effective PHC Services**
- Provider Availability
- Provider Competence
- Provider Motivation
- Patient-provider Respect & Trust
- Safety

**Outputs**
- Effective Service Coverage
  - Health Promotion
  - Disease Prevention
  - RMNCH
  - Childhood Illness
  - Infectious Disease
  - NCDs & Mental Health
  - Palliative Care

**Outcomes**
- Health Status
- Responsiveness to People
- Equity
- Efficiency
- Resilience of Health Systems

Social Determinants & Context (Political, Social, Demographic & Socioeconomic)
Recap: Coordination

HIGH-QUALITY PRIMARY HEALTH CARE IS

Coordinated

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