Care Coordination in Primary Care Practice

CAIPER Interprofessional By Design® eLearning Module Instructional Companion Guide

COURSE OVERVIEW

Care Coordination in Primary Care Practice, an interactive, self-paced eLearning module, provides an introduction to care coordination and common tools and strategies for care coordination in primary care and offers practical ways to work with care coordination professionals and to evaluate success. It is the fourth in a series of eLearning modules that emphasize team-based decisions and skills required for current and evolving primary care practice and continuum-based care.

Each of the modules is appropriate for both undergraduate and graduate students in health professions programs. Content and objectives in each module are aligned with the Interprofessional Education Collaborative (IPEC®) Core Competencies for Interprofessional Collaborative Practice. The Companion Guide offers suggestions for ways to enable learners to achieve the core learning objectives and practice goals.

CORE LEARNING OBJECTIVES

1. Define care coordination as a team-based process.
2. Examine tools and strategies that support effective care coordination in primary care practice.
3. Identify care coordination needs and resources for patients with complex care needs.

Practice Goals for Undergraduate and Graduate Students

UNDERGRADUATE STUDENTS	GRADUATE STUDENTS
Understand the experience of patients and families as they work with different members of the health care team.	Recognize the importance and impact of coordinating care across providers and settings for patients with complex care needs and their families.
Describe the role and responsibilities of each team member in coordinating care across members of the health care team and across health care settings.	Lead care coordination efforts in practice to assure patient and family needs and preferences are met across providers and settings.
Assist patients, families and team members participate in shared decision-making and development of an integrated care plan that addresses patient and family needs and preferences.	Demonstrate competence in conducting assessments and interventions integral to effective care coordination such as risk assessment, development, and implementation of an integrated care plan.
Participate in evaluation of care coordination interventions including their impact on patient and family experience and quality outcomes.	Lead quality improvement initiatives to improve care coordination processes and outcomes.

Supplemental Learning Activities and Instructor Resources

Supplemental Learning Activities provide examples of ways to augment the module content through classroom and clinical activities and practice scenarios. Selected resources are offered as useful background for instructors to prepare and implement course activities to achieve the core learning objectives and practice goals.

Supplemental Learning Activities

UNDERGRADUATE STUDENTS	GRADUATE STUDENTS
Have students shadow a patient as they see different providers or prepare to transition to another setting, e.g. at discharge from hospital and share their observations about communication and coordination.	Have students talk about the ways care is coordinated in their current practice settings and identify strengths and opportunities for improvement.

UNDERGRADUATE STUDENTS	GRADUATE STUDENTS
As a small group exercise, have students develop a case study of a patient with multiple health and social needs and propose how they would work with this patient to make sure that their care is coordinated effectively across providers and settings.	Have students research the type of risk assessment tools commonly used in their practice setting and discuss how and when they are used and their effectiveness.
Have students research the role and responsibilities of specialized care coordination positions in their practice settings, such as patient navigators, care coordinators and case managers.	As a small group exercise, have students share practice examples of patients and families with complex care needs and their observations of the challenges in coordinating care across providers and settings.
Have students conduct a team meeting in which the goal is to develop an integrated care plan that includes patient, family, and team member goals. Have them discuss what they found easy and what they found difficult in constructing a single integrated care plan.	Have students develop a mock quality improvement exercise to improve handoffs between providers and transitions across practice settings.
Have students develop an educational tool or referral form for patients to use when they are referred to another team member or specialist or move from one setting to another. Have them try it out and refine it in practice.	Have students discuss information they would include in referral and consultation forms in their practice settings. Challenge them to achieve consensus on what they consider essential information.

Instructor Resources

Value Transformation Framework Action Guide - Care Management
Value Transformation Framework Action Guide for Care Management is part of a 10 Action Guides series released by the National Association of Community Health Centers (NACHC) in 2019. It succinctly explains why care management should be used and what it looks like in practice and outlines 10 essential steps and associated action items required to build a care management program for high-risk patients.
National Association of Community Health Centers (NACHC). (2019). Value Transformation Framework Action Guide. (Link)

Engaging Patients and Families - Care Coordination Resources
Value Transformation Framework Action Guide for Care Management is part of a 10 Action Guides series released by the National Association of Community Health Centers (NACHC) in 2019. It succinctly explains why care management should be used and what it looks like in practice and outlines 10 essential steps and associated action items required to build a care management program for high-risk patients.
American Academy of Pediatrics. (2020). Engaging Patients and Families. Care Coordination Resources. (Link)

The Care Coordination in Interprofessional Primary Care Practice eLearning module and Companion Guide are CAIPER Interprofessional By Design® educational materials produced by ASU's Center for Advancing Interprofessional Practice, Education and Research. Our thanks to Dr. Karen Saewert for her contribution to the Companion Guide.