

PLANK 8

All Specialties Intervene with Patients Not in Control

All specialty departments should routinely take blood pressures on all adult patients and refer patients who are not at goal to primary care (or the patient's cardiologist, if the patient is already seeing a cardiologist). When possible, a primary care appointment should be made before the patient leaves the specialty appointment.

Care Coordination

The Agency for Healthcare Research and Quality has defined care coordination as “the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of healthcare services.” The lack of coordination can be unsafe, even fatal, when abnormal test results are not communicated correctly, prescriptions from multiple doctors conflict with each other, or primary care physicians do not receive critical information about their patients. Coordination of care is especially critical for patients with a chronic disease like hypertension, who are often expected to navigate a complex healthcare system. Having all specialists involved in coordination of hypertension care addresses potential gaps in care by taking advantage of all opportunities to intervene when blood pressure control is not at goal.

The National Quality Forum has endorsed a framework for care coordination with five domains:

- Healthcare “Home”: Serves as the patient’s main point of contact for health care and a clearinghouse for all information about a patient’s health status
- Proactive Plan of Care and Follow-up: The plan of care is jointly created and managed by the patient/family and the entire healthcare team
- Communication: All care team members are aware of tests and services coordinated within the plan of care, and results are readily available to all
- Information Systems: Standardized, integrated electronic information systems with functionality to support care coordination
- Transitions or Handoffs: Transitions between settings or providers of care are critical; mishaps often occur that can make care unsafe

Tips for Involving Specialists in Blood Pressure Control

1. Discuss and clarify group philosophy toward population health. Begin dialogue on shared accountability, patient-centered approach for individuals with chronic care needs.
2. Make the case. Involve specialty leaders in the conversation about the importance of BP control for the population and their vital role in care coordination.
3. Create policies, procedures, and accountabilities to support effective collaborations between primary care and specialist providers.
4. Train specialty care staff in proper BP measurement (see Plank 1).
5. Create and disseminate a guideline (see Plank 2) that indicates “handoff” expectations for specific ranges of BP.



Supporting Literature and Resources

1. National Quality Forum, Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination:

www.qualityforum.org/Publications/2010/10/Preferred_Practices_and_Performance_Measures_for_Measuring_and_Reporting_Care_Coordination.aspx

Extensive document on preferred practices and consensus standards in the key domains of care coordination.

2. Patient-Centered Primary Care Collaborative. Core Value, Community Connections: Care Coordination in the Medical Home:

www.pcpcc.net/sites/default/files/media/carecoordination_pcpcc.pdf

Case examples of programs to promote coordination of care in a variety of practice settings.

