

# Care Coordination Agreements: Barriers, Facilitators, and Lessons Learned

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**Background:** With growing pressure to improve the quality and coordination of care, physicians feel a need to streamline their relationships with other practitioners around shared care for patients. Some physicians have developed written agreements that articulate the respective responsibilities of 2 or more parties for coordination of patient care, ie, care coordination agreements (CCAs).

**Objectives:** To describe how CCAs are formed and explore facilitators and barriers to adoption of effective CCAs, the extent to which CCAs may be replicable in different market contexts, and the implications for policies and programs that aim to improve the coordination of care.

**Study Design:** Qualitative study of primary care physicians participating in CCAs and representatives of their specialist, hospital, or community-based partners.

**Methods:** Semi-structured interviews with participating providers and national thought leaders in care coordination were reviewed to develop key themes.

**Results:** Agreements that address referral and access processes were considered useful by all practices that had implemented them. Practices that implemented agreements including guidance on shared management of specific clinical conditions (comanagement) also found them useful. CCAs were most successful in settings where both parties to the agreement already had stable communication pathways (such as an electronic health record [EHR], designated staff) and strong working relationships.

**Conclusions:** Policy changes (such as shifts in reimbursement to favor collaborative care or clarification of laws governing such collaborations) can help to support the development and implementation of CCAs, and can address factors that currently make some markets less supportive of coordination.

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For author information and disclosures, see end of text.

Physicians face significant challenges in coordinating care. Patients (particularly those with chronic illnesses) often see many providers; 1 study found that the typical fee-for-service Medicare beneficiary sees 7 different physicians in 4 different practices during 1 year.<sup>1</sup> Poor coordination may result in patients receiving conflicting advice from different providers (including conflicting medication prescriptions), and in lack of follow-up for new diagnoses, tests, or procedures posing risks to patients' health.<sup>2</sup> The burden of care coordination may be particularly high for primary care providers (PCPs), who are charged with serving as the hub for communication and decision making between patients and all of their providers.<sup>3</sup>

While there is no single recipe for effective coordination, one promising strategy is the use of "service agreements" or "care coordination agreements." Care coordination agreements (CCAs), written agreements that articulate the respective responsibility of 2 or more parties for ensuring coordination of patient care, can be helpful tools that allow PCPs to define the level of care expected from themselves and other providers, and to set out specific tasks for which each partner will be responsible. Similar care coordination efforts organized by insurers have been associated with decreased costs and, in some cases, increased quality of care.<sup>4</sup> The American College of Physicians has endorsed further exploration of these agreements, particularly in the context of the patient-centered medical home,<sup>5</sup> and has developed a set of model agreements.<sup>6</sup> The National Committee for Quality Assurance's 2011 standards and guidelines for the Patient-Centered Medical Home allow the development of service agreements between PCPs and specialists to count toward accreditation.<sup>7</sup>

CCAs have been adopted by a diverse group of primary care practices and in varied market contexts. A limited literature<sup>8-10</sup> suggests that CCAs can improve care coordination in certain tasks. There is also anecdotal evidence to suggest that CCAs are more common than they appear to be in the formal literature.<sup>11</sup> However, little research has been done to describe the circumstances under which CCAs are most likely to develop, to discuss common features, and to weigh the implications of having these agreements in place.

## Design

Care coordination agreement cases are defined for the purpose of this study as dyads of a PCP and a partner (specialty prac-

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tice, hospital, long-term care provider, urgent or emergent care provider, or community-based organization) that have agreed for at least 6 months to coordinate the care of shared patients. Further, CCAs must involve, if not focus on, delineating responsibilities of each party in the agreement so as to better coordinate patient care between a PCP and the other provider. The agreements should be in the form of a written document, or else have generated written supporting materials such as standardized referral forms, guidelines, protocols, or electronic medical record (EMR) support.

### Participants and Methods

Under these criteria, practices were identified across the United States through iterative networking via contacts and e-mail listservs for Patient-Centered Medical Home initiatives as well as national primary care, specialty care, urgent care, and pharmacy societies. We purposively selected practices/organizations to include a range of characteristics in terms of size (small, medium, and large practices), ownership type, geography, and rural/urban and suburban settings. During a screening call, we identified practices/organizations that had a CCA supported by written agreements that the partners were willing to make available to the research team.

In all, 37 telephone interviews were conducted from July 2010 to April 2011 with 6 national experts who have published extensively in the peer-reviewed literature on care coordination and related issues or are leaders of national organizations at the forefront of policy related to care coordination, and 31 healthcare providers representing 15 partnerships. (One PCP was interviewed regarding 2 separate partnerships.) Respondents included independent practitioners, hospital-employed physicians, and physicians working in not-for-profit, academic, safety-net, and Veterans Affairs settings. Urban, suburban, and rural respondents were represented. No participants refused to be interviewed.

Notes were transcribed verbatim and jointly reviewed by both the lead interviewer and the research assistant for quality and validation purposes. The interview responses were coded and analyzed using Atlas.ti, a qualitative data management and analysis software tool.

Participants were required to submit a copy of each CCA or its supporting material to analyze its content and verify respondents' assertions. A database of selected CCA agreements is available upon request to the authors.

### Take-Away Points

Primary care providers seeking to improve their patients' access to and coordinate care with specialists, hospitals, and community-based organizations may struggle to build and maintain relationships with these entities. Care coordination agreements are written agreements that delineate the way primary care practices will share care responsibilities with these partners.

- Practices that have piloted this approach report improved access and quality of care, but note several pitfalls that can limit their utility.
- Changes in policy and care reimbursement can encourage further development of these agreements.

## RESULTS

We identified 15 CCAs. Five of the partnerships were with specialist practices, 6 were with hospitals, 5 involved community-based organizations such as behavioral health providers, and 1 involved an emergency care provider. (In some cases, agreements involved more than 2 participants.) Six agreements exclusively involved practices and organizations working with children; the remainder involved practices treating adults or all ages. Six were staffed by 5 or fewer physicians, and an additional 5 were staffed by 6 to 10 physicians; the remainder were larger practices. Through these CCAs, providers divide up the work of patient care, using some combination of broad strokes aimed at defining the relationship between 2 practices and specific details that help to standardize joint management of particular conditions. These agreements are generally developed at the practice or Independent Practice Association level rather than by individual physicians within practices. The following section describes attributes of CCAs in greater depth (see **Table 1** for the frequencies with which various elements appear in CCAs).

### Types of Care Coordination Agreements

Based on themes raised in respondents' descriptions of their agreements, we identified 2 principal types of CCA. The first, which at times has been called a *master service agreement*, includes broad agreements as to how providers should generally conduct referrals and transitions of care. An example of one such agreement between primary care providers and specialists requires participants to "define responsibilities between PCP, specialist, and patient" and "maintain competency and skills within scope of work and standard of care." The second type are *comanagement agreements*, which delineate specific understandings regarding division of tasks for comanagement of particular conditions (for example, a detailed algorithm outlining the process by which children with pediatric voiding dysfunction will be first evaluated by their pediatrician and then, if necessary, referred to a pediatric urologist). Many CCAs include elements of both types (for example, a master service agreement setting

■ **Table 1.** Frequency of CCA Characteristics Based on Qualitative Interviews

Category	Frequency
<b>Total CCA cases/total number of providers (interviewed)</b>	<b>15/31</b>
<b>Specificity of the agreement</b>	
Agreement only outlines general principles (MSA)	4
Agreement only addresses comanagement of specific disease(s)	4
Combinations of the above (for example, MSA + specific comanagement agreements)	7
<b>Coordination activities addressed by CCA</b>	
Access to care/referral process	13
Communication	10
Comanagement	8
Quality	3
Prohibition against secondary specialist referrals	2
Colocation	5
Specific clauses to alleviate anti-kickback concerns	3
<b>Supporting documentation</b>	
Standard referral form	5
Comanagement protocols/patient flow algorithms	5
Follow-up/consult form	4
Documents available online/EMR	4
Patient education material	2
On-call lists/contact information sheets	2
Provider educational material (either related to care coordination, or comanagement of a disease)	2

CCA indicates care coordination agreement; EMR, electronic medical record; MSA, master service agreement.

general expectations for interactions between participants as well as specific comanagement agreements for conditions of particular interest). (See Table 1, listing CCA characteristics among the practices evaluated for this study.)

**Most Useful Features of Active CCAs**

Coordination tasks most commonly addressed by existing CCAs include ensuring timely access for patients and standardizing the content in information transfer, as well as ensuring timeliness of information transfer and clear division of clinical comanagement responsibilities.

**Referral and Access**

Nearly every agreement addresses the mechanics of how referrals are requested and conducted. Respondents reported that limited access to referrals was often the strongest motivation to initiate the agreement in the first place. In general, the more standardized the referral process described in a CCA, the more consistently partners tended to apply the agreement and the more partner practices praised their utility.

**Comanagement**

Elements detailing the shared management of specific

conditions were found in roughly half of the agreements we reviewed, and were described by all respondents who had developed them as a useful feature. For example, a comanagement agreement between a PCP and a pharmacist stipulates that for diabetic patients the pharmacist can order specific tests under the physician’s license and can adjust medications according to an agreed-upon protocol based on the test results.

Comanagement agreement elements include:

- Specifications for proper referral preparation for selected conditions, including transfer of records, workup, and education of the patient prior to specialist evaluation
- Evidence-based care protocols
- Continuing medical education for PCPs on comanagement of certain conditions

Providers generally developed generic comanagement plans for certain health problems in advance (for example, listing in advance the tests and therapies that a primary care provider would provide for a patient before arranging a consultation with a specialist), rather than customizing plans for each individual patient; in some cases, this meant that a patient could experience care that reflected a specialist’s input without ever leaving the PCP. A urologist who worked

■ **Table 2.** Facilitators and Barriers to the Establishment of CCAs

Phase	Facilitators	Barriers
<b>Early planning</b>	<ul style="list-style-type: none"> <li>Startup funds</li> <li>Early administrative support</li> <li>Shared organizational sense of mission/identity among collaborators</li> <li>Strong preexisting relationship/trust between partners</li> <li>Presence of high-level champion</li> <li>“Win-win” (financial, efficiency, and productivity) for both parties</li> <li>PCP market leverage</li> <li>Market demographics (eg, rural/urban/suburban or provider supply, socioeconomic makeup of patient population)</li> </ul>	<ul style="list-style-type: none"> <li>Organizational disinterest or significant bureaucracy</li> <li>Partner concerns about being “boxed in”</li> <li>Provider concerns about legal implications of CCAs</li> <li>Market conditions that make a potential partner dependent on income they would lose under a CCA</li> <li>Provider fragmentation</li> </ul>
<b>Initial implementation</b>	<ul style="list-style-type: none"> <li>Dedicated staff members</li> <li>Partners comfortable with skill set necessary for comanagement</li> </ul>	<ul style="list-style-type: none"> <li>Partners in different stages of readiness</li> <li>Maintaining trust as agreement expands to include more providers (both in the initiating practices and with an increase in number of CCAs that a practice engages in)</li> </ul>
<b>Sustainability</b>	<ul style="list-style-type: none"> <li>Interoperable HIT</li> <li>Colocation</li> </ul>	<ul style="list-style-type: none"> <li>Difficulty accessing agreements/guidelines at point of care</li> <li>Continuous training/orientation for sites with high staff turnover</li> </ul>

CCA indicates care coordination agreement; HIT, health information technology; PCP, primary care physician.

in a market with limited specialist availability reported his PCP colleagues would initiate a jointly developed process of evaluation and treatment, which frequently resolved patients’ symptoms before they were able to schedule a specialist visit. The CCA allowed him to spend more time operating and his practice to offer faster access to new patients.

**Colocation**

In some agreements, 1 partner had a representative provider who was embedded or co-located within the other partner’s practice; most frequently this was a behavioral health collaborator in a primary care practice. Participants reported that they benefited from what they described as the “osmosis” learning that takes place when providers share space and have the opportunity for frequent casual interactions.

**Supporting Materials**

Practices often developed supporting documents to aid them in their tasks and improve consistency of care coordination (see Table 1 for frequencies of common supporting documents). See [Appendix](#) for details.

**Barriers and Facilitators to CCA Establishment**

In the early planning phases of developing a CCA, many respondents reported having an outside stimulus to motivate providers (see [Table 2](#)). This might take the form of outside funding for time to develop the agreement, additional

administrative support, or funding for additional patient care activities required as part of the agreement that might not otherwise be reimbursed, such as patient education or outreach.

Respondents also cited an organization’s intrinsic sense of mission, willingness to transform, and sense of identity as a leader in its local professional community as drivers of CCA development. Leaders of small independent practices described working with larger institutions as a longer, more cumbersome process. In some situations, champions within large organizations felt they were negotiating not just with their partner organization but also with their own leadership.

Nearly all respondents emphasized the role of strong pre-existing relationships and trust. “In the end, it doesn’t matter what is on paper; it’s how you work together,” one respondent said. In fact, many adopters said that the act of discussing and negotiating the CCA was more fruitful than the actual terms of the agreement, which they described as “icing.”

Respondents also emphasized that CCAs had to offer what they called a “win-win”; that is, all partners had to benefit in concrete ways. For example, agreements that codify comanagement responsibilities between specialists and PCPs most often focus on conditions specialists are willing to give up (ie, they can backfill their time with more lucrative or more specialty-specific work) and PCPs are willing to handle (ie, they

can be reimbursed appropriately for the costs of providing the care, sometimes at enhanced rates).

***Barriers and Facilitators to Initial Implementation of CCAs***

Respondents noted several elements that were helpful in initiating CCAs. In particular, staff members (from collaborating practices or a central organization) dedicated entirely or in part to monitoring the progress of the CCA, or facilitating communication between participants, were considered beneficial.

Master service agreements and comanagement agreements each faced unique implementation challenges. For more general master service agreements, parties sometimes found themselves struggling to maintain consensus on “appropriate” follow-up, availability, and cost of services to patients or insurers. Practices were sometimes surprised to learn the extent to which their values were truly shared—not just among their CCA collaborators, but within their own practices. In one case, a PCP champion who had negotiated a stringent agreement with specialist practices reported with chagrin that some of her own primary care colleagues proved to be a barrier during the implementation process: they were uninterested in sharing care and preferred to delegate certain responsibilities entirely to specialists.

***Barriers and Facilitators to Long-Term Sustainability of CCAs***

Compatible health information technology was the most commonly mentioned facilitator to the long-term sustainability of CCAs. A seemingly trivial barrier to rapid access to CCA details could prove significant over multiple patient encounters: one provider said that simply having agreements maintained on a separate website, rather than integrated directly into its EMR, had diminished compliance.

Except in the case of integrated delivery systems, patients whose care was governed by a CCA generally represented only a fraction of a partner organization’s business. Partners reported that CCAs were difficult to maintain when they did not have an easy, reliable way of knowing which of their patients fell under the agreement. A few PCPs wistfully expressed their hope that partner organizations would resolve this problem by simply adopting the principles of the CCA for all of their patients, but no partner organization we interviewed had elected to do so.

a diverse group of providers. This exploratory analysis describes these agreements and their effects on providers, with the caveat that these tools are still developing and further research will be necessary to fully characterize their impact once more data are available. Below are preliminary lessons learned from the early experiences of providers who have developed CCAs.

**Specific Policy Changes Could Facilitate the Development of CCAs**

Most providers interviewed stated that CCAs had increased their efficiency and improved the quality of care; this was true even for those respondents who were hard pressed to describe specific ways in which their day-to-day practice had changed. Rather, their perception of benefit often seemed to be rooted in their experience of developing the agreement, with its ongoing existence viewed as a testament to the strength of their relationship with their partners. Respondents with specific comanagement agreements were more likely to point to specific efficiencies or practice improvements. These perceptions of value may reflect greater provider satisfaction, an important potential benefit. Our qualitative analysis found that some communities’ characteristics (such as stable practices with long-standing relationships, the presence of shared information technology, and outside support for the initiation of agreements) were more amenable to CCAs than others. To date, most CCAs are relatively new and there are no published data on the impact of CCAs on healthcare utilization and costs.

While respondents could offer little concrete evidence of benefit from their early use of these agreements, their frequently voiced conviction that these agreements did improve the quality of their care suggests that further exploration of their potential to improve coordination would be helpful. Relatively low-cost policy changes could support providers in developing additional agreements and undertaking formal study of their effects.

Specialty societies can work together to develop joint guidelines for the comanagement of selected conditions, which were described by respondents as among the most useful elements of CCAs. This task may be politically difficult, however, as specialist supply is not uniform and specialists in some markets will be more willing to share patient care duties than others.

Clarifying existing federal laws that govern collaborations between independent practices, particularly with respect to concerns that their agreement could be construed as a kick-back or a self-referral, can help to reassure providers. Again,

**DISCUSSION**

The CCAs discussed in this study represent emerging efforts at an innovative approach to care coordination among

we encountered no examples of providers experiencing legal trouble, but did see several cases where providers were reluctant to enter into agreements because of concerns that they would run afoul of these laws.

Policies affecting reimbursement could have a profound effect on CCAs. For example, policy changes that encourage a shift away from fee-for-service reimbursement and toward capitation, encouraging PCPs and specialty practices or other organizations to participate in ACOs, share accountability for the quality of patient care, and receive bundled payments, could, among many other effects, change the current dynamic that makes specialists in some markets less willing to give up reimbursement for treating conditions that might also be amenable to comanagement, or make providers more willing to communicate with one another about shared care for patients.

Policy makers who help set priorities for funding of research and pilot programs can support further (quantitative) research to determine whether certain types of CCAs are more effective than others in improving the quality, efficiency, and patient-centeredness of care. In particular, providers we interviewed had not yet measured patient satisfaction with overall coordination of care; this is an important part of understanding their use in patient-centered care.

### Limitations

This study describes the experiences of a relatively diverse but self-selected group of providers about their experiences with care coordination agreements. As such, it may not provide a representative picture of all providers who have attempted such agreements. Qualitative projects such as this one have both strengths and limitations; while our methodology allowed us to capture respondents' views both broadly and in depth, we were restricted to a small sample size, and cannot generate meaningfully precise estimates of, for example, the benefits of various CCA elements. In describing their experiences, most respondents did not provide utilization or financial data to verify their accounts, so we may not have accurately captured the effect care coordination agreements had on their practices. Finally, many of the agreements we evaluated were only a few years old, meaning that some of the benefits and challenges may not have been fully realized yet.

### CONCLUSIONS

In general, providers who have developed CCAs say they have improved the coordination and quality of care their pa-

tients receive. The use of CCAs will likely continue to grow in selected markets and clinical settings, but without reimbursement or policy changes they may not be disseminated more broadly. As CCAs evolve, further study can clarify their effects on clinical practice.

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■ **Appendix.** Infrastructure and Supporting Documentation Developed and Used by Practices to Facilitate Co-management of Patients

Comanagement resources include care protocols, educational materials, and consent forms.

**Care protocols** cover comanagement and referral tasks and offer many opportunities for emphasizing the use of evidence-based guidelines and streamlining transfers and workups. Respondents were often pleased with the results of their protocols. Care protocols can be organized as a list of duties, as an algorithm, or as patient flow charts. The documents themselves, however, can require detailed and lengthy negotiation, as participants attempt to create a concise, useful document that can encompass the complexity of disease presentation: “The hardest part of algorithms is the tendency to want to change them. Algorithms should be simple. On the other hand, if it is too simple it becomes ‘What about this?’ Then it’s too complicated. If it’s too onerous, people won’t use it. We struggle with that [balance of simplicity versus inclusiveness] continually,” said one specialist involved in developing such agreements. Respondents also often emphasized that these protocols were only guidelines, and did not diminish the importance of individual physician judgment or amount to “cookbook medicine.” Even for practices that had successfully created such documents, application could be difficult if protocols were not readily on hand at the point of care (for example, integrated into an electronic medical record).

**Educational materials** for both physicians and patients are another comanagement resource. In developing these materials, respondents often drew on existing documents and encouraged patient education earlier in the patient diagnosis pathway (for example, specialists are pushing educational materials out to PCPs so that they can begin workup and treatment during their initial evaluation and educate patients for subsequent specialist visits). “Branding” of these documents assures patients that their care is approved by the specialist they would otherwise eventually see. The end result is a patient who is more prepared for and takes more away from a specialist visit, respondents agreed.

If a **protocol** targets a disease that specialists have largely handled in the past, PCPs may require additional education. One practice has developed CME courses to meet this need. This education can also ruffle feathers, however: “The thing is if I went to 15 different PCPs with these algorithms [and educational materials], some might be insulted, like ‘Gosh, I [already] know that,’ while others don’t feel comfortable with the [particular disease so they welcome the education],” one specialist noted.

**Consent forms** that allow PCP and behavioral health partners to share information and arrange appointments for patients appear unique to this area of care, and legally necessary. Implementing standardized forms in the PCP’s office ensures that they are signed before the behavioral health visit, streamlining care and reducing data-sharing challenges related to patient confidentiality.

**Infrastructure and Supporting Documentation—Referral/Communication and Other Resources**

To improve referral and communication processes, respondents created **standardized referral forms**, **consultation forms**, and **partner lists** as the products of negotiations around expected communication patterns (ie, what information needs to be transmitted at what point in the patient’s care).

Respondents noted that **standardized referral forms** were perhaps the most useful tools outside of EHRs for coordination, saving provider time, and easing administrative staff burden. Some practices also designed these forms to dovetail with specific comanagement protocols.

**Standardized consultation forms** for communication from other specialists back to PCPs attempt to address PCPs’ concerns about the completeness, clarity, and conciseness of consultant communication regarding clinical decision making and follow-up care plans. These forms were identified as an area for improvement by many, as they tend to remain vague, mostly “suggested” principles rather than a standardized form as seen for referrals.

Surprisingly, few practices used lists of physicians or other providers participating in the CCA in a way that distinguished these participants from other providers to whom the practices routinely referred care. Such lists are designed to address the difficulty providers face, especially during after-hours care, in contacting and referring to the appropriate physician. Lists that distinguish CCA participants from their peers who do not participate can be a resource for physicians seeking to identify others who share their values in coordinated care.

**Other Resources**

One practice developed membership cards which identify patients as part of a practice/medical home to address both communication and referral goals. They are unique among supporting documents in that they rely on patients’ participation (patients are requested to present them as they move among different physicians, clinics, and hospitals).