



The Medical Neighborhood: What, Why, and How

Introduction: What you will Find in This Module

The concept of a medical neighborhood is not always well understood. Within TCPi, the term refers to the many services and professionals that can contribute to the health and well-being of the patients and families you serve. It includes more than just the principal focus of care and the care team that takes responsibility for each patient; the concept of a medical neighborhood acknowledges that at times the medical home cannot serve all patient needs and desires. A broader support system is sometimes necessary.

The medical neighborhood ideally includes all the caregivers and services interacting with each patient. Unfortunately, an expansion in the number and types of caregivers often increases the likelihood of breakdowns in communication and coordination, resulting in a negative impact on the patient in the form of confusion, duplication of unnecessary services, and even medical harm. A transformed practice working within a medical neighborhood sets up systems to ensure seamless communication and coordination of care.

Care Coordination is another term used more and more often, frequently with unclear definitions. In this module, you will see that TCPi defines care coordination as the work the practice does to ensure the patient/client and their family members receive the care they need from other providers in the medical neighborhood – both within and outside health care – and that the practice has systems in place to reliably “close the loop,” obtaining information about the value of services received.

Several change concepts from the TCPi Change Package relate to the medical neighborhood and care coordination. The resources provide guidance on things both primary and specialty providers can do to make the medical neighborhood a welcome place that serves all, or nearly all, of each patient’s needs.

Practicing in a Medical Neighborhood

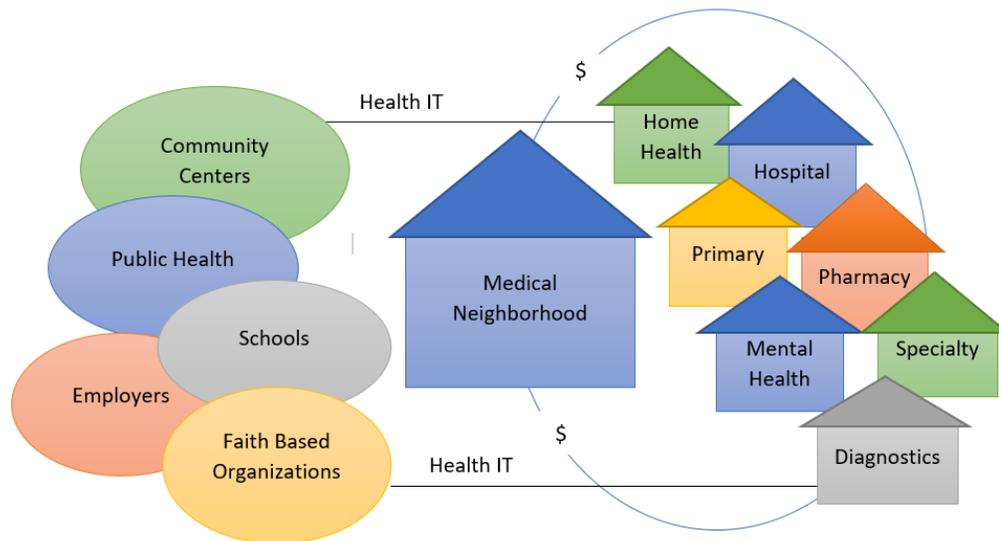
From the TCPi Change Package:

1.5.3 Coordinate care. Provide effective care coordination across the medical neighborhood.

1.5.4 Ensure quality referrals. Engage members of the medical neighborhood to ensure a high level of service and quality.

1.4.4 Use community resources. Inventory available community resources and refer patients as appropriate to access services not available in the practice.

1.6.1 Consider the whole person when planning care.



You must first define the medical neighborhood your practice works within as the starting point for implementing these change concepts. If you are a primary care practice or a practice that cares for people with chronic conditions, your practice likely serves as the hub of the medical neighborhood. If you are a specialist, your practice may partner with one or more primary care medical home “hubs” for most patients and/or serve as the medical home hub for selected patients/clients. Regardless of your practice type, you will want to answer the following questions:

- Who are the other providers/care givers to whom you refer and who refer patients to you?
- Which are the hospitals, nursing homes, therapy services, surgical and other facilities that you and your patients use?
- What are the resources available to address behavioral health and social health needs?
- What community resources are available to serve other needs of your patients, including housing, employment, justice, education, and other sectors?

By answering these questions and taking an inventory of these potential points of service, you are defining your patients’ medical neighborhood. But you cannot stop there.

Effective Care Coordination

Effective care coordination ensures each caregiver has the information they need about care rendered, services provided, and information collected during previous encounters with other providers or in other settings. This includes information on transitions to or from hospitals or nursing homes, as well as referrals made from one provider to another.

Medications, lab results, diagnostic tests, or clinical observations should not require duplication just because of lack of information. Providing effective care coordination requires a systems approach. This includes establishing and documenting expectations on both sides of each referral regarding information provided, timing, and responsibility for the patient over time.

Care Coordination Includes:

- Setting up systems for communication between facilities and physician offices about admissions and discharges.
- Assigning responsibility for care coordination, patient outreach, and closing the loop on referrals to both clinical providers and community service agencies (See [Managing Referrals](#) module for additional guidance of referrals).
- Creating well-defined workflows that have a high degree of reliability so that the patient remains engaged and neither they nor their information “falls through the cracks”.

Resources

Many available tools and resources can assist those working in a medical neighborhood, including:

- [ACP High Value Care Coordination \(HVCC\) Toolkit](#)
- [Safety Net Medical Home Initiative Care Coordination](#)
- [Rural Health Information Hub Rural Care Coordination Toolkit](#)
- [4 Pillars of Successful Referral Management](#)