BCBSM
Physician Group Incentive Program

Patient-Centered Medical Home and Patient-Centered Medical Home-Neighbor Domains of Function

Interpretive Guidelines

2015-2016
V1.0

13.0 Coordination of Care

Goal: Patient transitions are well-managed and patient care is coordinated across health care settings through a process of active communication and collaboration among providers, patients and their caregivers

Applicable to PCPs. When patient is co-managed by PCP and specialist, roles must be clearly defined regarding which provider is responsible for leading care coordination activities. Applicable to specialists for patients for whom the specialist has lead care management responsibility or when the admission is relevant to the condition being managed by specialist.

13.1

For patient population selected for initial focus, mechanism is established for being notified of each patient admit and discharge or other type of encounter, at facilities with which the physician has admitting privileges or other ongoing relationships

PCP and Specialist Guidelines:

a. Standards for information exchange have been established among participating organizations to enable timely follow-up with patients.
b. Facilities must include hospitals, and may include long-term care facilities, home health care, and other ancillary providers.

13.2

Process is in place for exchanging necessary medical records and discussing continued care arrangements with other providers, including facilities, for patient population selected for initial focus

PCP Guidelines:

a. Patients are encouraged to request that their practice unit be notified of any encounter they may have with other health care facilities and providers (for example, SNFs, rehab facilities, non-primary hospitals)
b. Practice units are responsible for ensuring that other providers have relevant medical information in a timely manner necessary to make care decisions

Specialist Guidelines:

a. Specialists systematically request that patients provide name of PCP
b. Patients are encouraged to request that their PCP be notified of any encounter they may have with other health care facilities and providers (for example, SNFs, rehab facilities, non-primary hospitals)
c. Practice units are responsible for ensuring that other providers have relevant medical information in a timely manner necessary to make care decisions

13.3

Approach is in place to systematically track care coordination activities for patient population selected for initial focus.

PCP and Specialist Guidelines:

a. Processes are structured to allow care coordination across other settings of care, and may include:
    i. Facility name
    ii. Admit date
    iii. Origin of admit (ED, referring physician, etc.)
    iv. Attending physician (if someone other than PCP)
    v. Discharge date
    vi. Diagnostic findings
    vii. Pending tests
    viii. Treatment plans
    ix. Complications at discharge

13.4

Process is in place to systematically flag for immediate attention any patient issue that indicates a potentially time-sensitive health issue for patient population selected for initial focus

PCP and Specialist Guidelines:

a. For example, home monitoring of CHF patient indicates weight gain, or diabetes patient is treated for cellulitis in ER, or a CHF patient has a change in mental health status

13.5

Process is in place to ensure that written transition plans are developed, in collaboration with patient and caregivers, where appropriate, for patients in patient population selected for initial focus who are leaving the practice (i.e., because they are moving, going into a long-term care facility, or choosing to leave the practice).

PCP and Specialist Guidelines:

a. Caregivers may include nurse, social workers, or other individuals involved in the patient's care
b. Practice units are responsible for ensuring that written transition plan is provided in a timely manner so that patient can receive needed care
c. Transition plan must consist of either a written summary or clear, concise excerpts from the medical record containing diagnoses, procedures, current medications, and other information relevant during the transition period (e.g., upcoming needed services, prescription refills)
d. A copy of the transition plan must be provided to the patient
e. Inability to develop collaborative plan due to voluntary, precipitous departure of patient from the practice, or unwillingness of the patient to participate, would not constitute failure to meet the requirements of 13.5

13.6

Process is in place to coordinate care with payer case manager for patients with complex or catastrophic conditions

PCP and Specialist Guidelines:

a. Process may be directed by PO or practice unit
b. Process should include ability to respond to and coordinate with payer case managers when the patient is enrolled in formal case management program
c. Process should include ability to contact health plan case managers when, in the clinician's judgment, unusual circumstances may warrant the coverage of non-covered services, particularly to avoid inpatient admissions or use of other higher-cost services

13.7

Practice has written procedures and/or guidelines on care coordination processes, and appropriate members of care team are trained on care coordination processes and have clearly defined roles within that process

PCP and Specialist Guidelines:

a. Written procedures and/or guidelines are developed for each phase of the care coordination process
b. The procedures or guidelines are developed by either the PO or practice unit
c. Training/education of members of care team are conducted by either the PO or practice

13.8

Care coordination capabilities as defined in 13.1-13.7 are extended to multiple patient populations that need care coordination assistance

PCP Guidelines:

a. Applicable to all patients with chronic conditions
b. Written procedures and/or guidelines on care coordination processes may be developed by the PO or practice

Specialist Guidelines:

a. Applicable to multiple patient populations relevant to the practice
b. Written procedures and/or guidelines on care coordination processes may be developed by the PO or practice

13.9

Coordination capabilities as defined in 13.1-13.7 are extended to all patients that need care coordination assistance

PCP and Specialist Guidelines:

a. Written procedures and/or guidelines on care coordination processes may be developed by the PO or practice

13.10

Following hospital discharge, a tracking method is in place to apply the practice's defined hospital discharge follow-up criteria, and those patients who are eligible receive individualized transition of care phone call or face-to-face visit within 24-48 hours

PCP and Specialist Guidelines:

a. PCP and specialists should coordinate to determine which physician(s) is/are most appropriate for follow-up
b. Hospital discharge follow-up criteria is defined by the practice

13.11

Practice is actively participating in the Michigan Admission, Discharge, and Transfer (ADT) Initiative

PCP and Specialist Guidelines:

a. Practice maintains an all-patient list that has been sent to MiHIN's Active Care Relationship File in accordance with all MiHIN's specifications
b. The practice maintains an active and compliant status with the statewide health information exchange (HIE) system.
c. The practice has a process for managing protected health information in compliance with applicable standards for privacy and security.
d. The practice connects information received through the HIE process with clinical processes, such as transition of care management following hospitalization.

13.12

Practice is actively participating in the Michigan Admission, Discharge, and Transfer (ADT) Medication Reconciliation Use Case

PCP and Specialist Guidelines:

a. The practice connects medication reconciliation information received through the HIE process with clinical processes, such as transition of care management following hospitalization, and a process exists for updating patient medical records