



Coordination of Care

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Coordination of Care

Overview: The purpose of the initiative is to improve patient care by implementing processes that will help providers coordinate treatment, communicate with one another, manage health care setting transitions, communicate care options to the patient, and track patient activity.

These Blue Cross Blue Shield of Michigan criteria pertain to the coordination of care initiative:

Criteria

Met 

- 13.1 For every patient with chronic condition 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 PCMH physician has admitting privileges or other ongoing relationships
- 13.2 Process is in place for exchanging necessary medical records and discussing continued care arrangements with other providers including facilities for all patients with chronic condition selected for initial focus
- 13.3 Approach is in place to systematically track care coordination activities for each patient with *chronic condition selected for initial focus*
- 13.4 Process is in place to systematically flag for immediate attention any issue that indicates a potentially time-sensitive issue for all patients with chronic condition selected for initial focus
- 13.5 Process is in place to ensure that written transition plans are developed in collaboration with patient and their caregivers where appropriate for patients with chronic condition 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)
- 13.6 Process is in place to coordinate care with payor case manager for patients with complex or catastrophic conditions
- 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 those processes
- 13.8 Care coordination capabilities are extended to all patients with chronic conditions that need care coordination assistance
- 13.9 Care coordination capabilities are extended to all patients that need care coordination assistance

13.0 Coordination of Care

13.1

For every patient with chronic condition 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 PCMH physician has admitting privileges or other ongoing relationships

Guidelines:

- Standards for information exchange have been established among participating organizations to enable timely follow-up with patients.
- Requirements pertaining to specialists are addressed in Specialist Referral Process initiative.
- Facilities may include hospitals, 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 all patients with chronic condition selected for initial focus

Guidelines:

- 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)
- 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 each patient with chronic condition selected for initial focus.

Guidelines:

- Processes are structured to allow care coordination across other settings of care, and may include:
 - o Facility name
 - o Admit date
 - o Origin of admit (ED, referring physician, etc.)
 - o Attending physician (if someone other than PCP)
 - o Discharge date
 - o Diagnostic findings
 - o Pending tests
 - o Treatment plans
 - o 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 all patients with chronic condition selected for initial focus

Guidelines:

- 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 with chronic condition 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).

Guidelines:

- A written procedure is in place outlining the process
- Caregivers may include nurse, social workers, or other individuals involved in the patient's care
- Practice units are responsible for ensuring that written transition plan is provided in a timely manner so that patient can receive needed care
- 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

Guidelines:

- Process may be directed by PO or practice unit
- Process should include ability to respond to and coordinate with payor case managers when the patient is enrolled in formal case management program
- 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

Guidelines:



- Written procedures and/or guidelines on care coordination processes may be developed by the PO or practice
- Training/education of members of care team may be conducted by the PO or practice

13.8

Care coordination capabilities as defined in 13.1-13.7 are extended to all patients with chronic conditions that need care coordination assistance

Guidelines:

- 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



Remember Home - Your Medical Home that is!

Did you get a flu shot at the pharmacy or grocery store?

Have you had tests or services performed at a health fair?

Have you received other health care services (pelvic exam, Pap test, retinal eye exam, diabetic foot exam)?

Tell the staff or doctor so we can keep your records up to date.

Name: _____

I had: _____ Date: _____



Remember Home - Your Medical Home that is!

Did you get a flu shot at the pharmacy or grocery store?

Have you had tests or services performed at a health fair?

Have you received other health care services (pelvic exam, Pap test, retinal eye exam, diabetic foot exam)?

Tell the staff or doctor so we can keep your records up to date.

Name: _____

I had: _____ Date: _____



MQIC HEALTH PLANS' DISEASE MANAGEMENT PROGRAM INFORMATION

To learn more about your health plan's disease/health management programs, please refer to your plan's contact numbers below

Health Plan	Diabetes	Asthma	Depression	Cardiovascular	Tobacco Control	Substance Use Disorders
Blue Cross Blue Shield of MI (Traditional & PPO)	For all programs call BlueHealthConnection 1-800-775-BLUE					N/A
Blue Care Network	1-800-392-4247	1-800-392-4247	1-800-392-4247	1-800-392-4247	1-800-811-1764	
Blue Choice POS	1-800-392-4247	1-800-392-4247				
Great Lakes Health Plan	Linda Noble 1-800-903-5253 Ext 4349	Lucille Tomei 1-800-903-5253 Ext 4355	CompCare 1-800-435-5348	Linda Noble 1-800-903-5253 Ext 4349	Lucille Tomei 1-800-903-5253 Ext 4355	
Health Alliance Plan	1-800-288-2902	1-800-288-2902	1-800-444-5755	1-800-288-2902	1-800-288-2902 (request transfer to ext. 648556)	1-800-444-5755
HealthPlus of MI HealthPlus (Commercial) HealthPartners (Medicaid)	1-800-345-9956 Ext 1943 Option 5	1-800-345-9956 Ext 1943 Opt 4	Adult 1-800-332-9161	1-800-345-9956 Ext 1943 Option 6	1-800-345-9956 Ext 1943 Option 2 Email: hquest@healthplus.com	1-800-216-2716 www.healthplus.org Health & Wellness – Confidential Screening
Midwest Health Plan	1-888-654-2200 Ext 6065 or 313-586-6065	1-888-654-2200 Ext 6065 or 313-586-6065	1-888-654-2200 Ext 6065 or 313-586-6065	1-888-654-2200 Ext 6058 or 313-586-6065	1-888-654-2200 Ext 6071 or 313-586-6071	N/A
Molina Healthcare of Michigan	1-866-449-6828 EXT 155323	1-866-449-6828 EXT 155323				
OmniCare	For all programs call toll free: <ul style="list-style-type: none"> Customer Services 1-866-316-3784 or Nursing Disease and Case Management Department 1-866-782-8507, Ext 1536 www.omnicarehealthplan.com 					N/A; Call Customer Services for Community Referrals
Physicians Health Plan of Mid-Michigan	1-877-803-2551 Option 1	1-877-803-2551 Option 3	1-800-832-9186	1-877-803-2551 Option 5	1-877-803-2551 Option 6	1-800-832-9186
Priority Health						
Total Health Care, Inc.	1-800-826-2862 Ext. 817	1-800-826-2862 Ext. 844	Psych Care 1-800-221-5487	1-800-826-2862 Ext. 817	1-800-480-7848	



Health Plan	Heart Failure	Chronic Kidney Disease	Low Back Pain	Weight Management		
Blue Cross Blue Shield of MI (Traditional & PPO)	Call BlueHealthConnection 1-800-775-BLUE	N/A	N/A	N/A		
Blue Care Network	1-800-392-4247	1-800-392-4247	1-800-392-4247	1-866-MITEAMS Email: www.miteam.org		
Blue Choice POS	1-800-392-4247	1-800-392-4247		1-866-MITEAMS Email: www.miteam.org		
Great Lakes Health Plan	Linda Noble 1-800-903-5253 Ext 4349	Linda Noble 1-800-903-5253 Ext 4349		Lucille Tomei 1-800-903-5253 Ext 4355		
Health Alliance Plan						
HealthPlus of MI HealthPlus (Commercial) HealthPartners (Medicaid)	1-800-345-9956 Ext 1943 Option 6			1-800-345-9956 Ext.1943 Option 3 Email: hquest@healthplus.com		
Midwest Health Plan	1-888-654-2200 Ext 6065 or 313-586-6065	1-888-654-2200 Ext 6065 or 313-586-6065	N/A	1-888-654-2200 or 313-586-6071		
Molina Healthcare of Michigan						
OmniCare	For all programs call toll free: <ul style="list-style-type: none"> Customer Services 1-866-316-3784 or Nursing Disease and Case Management Department 1-866-782-8507, Ext 1536 www.omnicarehealthplan.com 			N/A; Call Customer Services for Community Referrals (including referrals to WIC)		
Physicians Health Plan of Mid-Michigan	1-877-803-2551 Option 5	1-800-832-9186	1-877-803-2551 Option 2	1-800-832-9186		
Priority Health						
Total Health Care, Inc.				1-800-826-2862 Ext. 858		

LETTER of INTENT

Date

<Facility Name>
123 Main Street
Anytown, MI 49000

Dear Dr. Jones:

<Practice Name> is a Patient-Centered Medical Home that coordinates our patient's treatment among providers and manages any health care setting transitions. As the primary medical provider, we believe we can enhance our patient's care and safety. We are pleased that <Facility Name> has agreed to assist us in that regard.

Specifically, you have agreed to:

1. Notify us within 48 hours by phone (xxx) xxx-xxxx or fax (xxx) xxx-xxxx when one of our patients is admitted, discharged or otherwise receives services at your facility.
2. Notice will include the following information:
 - a. Facility name
 - b. Admit date
 - c. Origin of admit (Emergency Dept., referring physician, etc.)
 - d. Attending physician (if someone other than the PCP)
 - e. Discharge date
 - f. Diagnostic findings
 - g. Pending tests
 - h. Treatment plan including prescriptions, and recommendation for follow-up care to be coordinated by < Practice Name>
 - i. Complications at discharge
3. Notify us immediately if your hours change or you are unable to meet the expectations outlined in this letter.

All patients of <Practice Name> expect us to facilitate and coordinate medical care at other medical institutions.

We appreciate your cooperation in this regard and look forward to working with you. Please sign below indicating your understanding of our agreement and return a copy of this letter to me.

Sincerely,

Sam Smith, MD

Agreed to by <Facility Name>

**<Facility Name> – <Practice Name>
Coordination of Care Record**

Fax to <Practice Name> at (xxx)-xxx-xxxx within 48 hours of visit

Name of patient / telephone number
Date and time of visit /Admit Date
Origin of admit (Emergency Dept., referring physician, etc.)
Chief complaint
Attending physician (if someone other than the PCP)
Diagnostic services provided / results 1. 2.
Discharge date / Final diagnosis / Any pending tests
Treatment plan 1. 2.
Prescriptions 1. 2.
Recommendations for follow-up care

Coordinating your patient's care

Staff Education

Tool 13-4

Coordination of Care Initiative



Presentation objectives

- Understand how to best coordinate treatment in a Patient-Centered Medical Home (PCMH)
- Learn how to set up communication processes with patients, facilities and referred-to providers
- Learn how to manage health care transitions
- Learn methods to track patient activity



Why is care coordination important?

- Referrals and consultations are an important part of patient care
- Too many physicians caring for one patient can result in:
 - Confusion
 - Duplication of services
 - Serious medical errors
- 40% of Americans aged 50 to 69 see more than one physician and 25% of this group doesn't know who is managing their care

How to best coordinate treatment

- The key to successful referrals is making sure that the right people do the right thing at the right time for the right patient
- Use a consultation/referral form that standardizes key information for both the patient and the referred to provider
- Clarify roles and boundaries for consults and referrals with phone calls and forms



Your consult/referral form should streamline the process

- Indicates specific action you want from the consult or referral
- Spells out the urgency for the service
- Infers limits on what services to do
- Contains feedback to streamline the process
 - An option to call if tests/data are needed
 - A request to fax back their findings



Sample consult/referral form

Ensures patient can contact referral quickly and easily

Spells out urgency of visit, who to call if they need more information and what they are expected to do

Gives patient history and lets them know how, when and in what form to give feedback to primary care

Asks for brief findings by fax

NO
NORTHERN
PHYSICIANS
ORGANIZATION

Form 1-1
Revised 10/14/03

7000 Executive Drive | 28118

Consultation or Referral Request Form

To: Consultant, Specialist
Name: _____
Address: _____
Phone: _____
Office Hours: _____

From: Primary physician
Name: _____
Address: _____
Phone: _____

SECTION 1 - REQUESTED ACTION

See patient within ___ days or ___ weeks.
 Am I giving you what you need to see this patient? If not, call us at _____

Consultation
 (Please send the patient back for follow-up and treatment.)
 Confirm diagnosis
 Advise as to diagnosis
 Suggest medication or treatment

Referral
 (Please provide primary physician with summary of subsequent visits, lab and test results)
 Assume management for this particular problem, return patient after conclusion of care
 Assume future management of patient within your area of expertise

SECTION 2 - PATIENT INFORMATION

Name: _____
 Address: _____
 Phone: _____ Date of birth: _____
 Previous diagnosis: _____

Pertinent History, medications, laboratory findings, and special clinical considerations:

See additional information attached.
 Please call me when you have seen the patient.
 I would like to receive periodic status reports on this patient.
 Please send a thorough written report when the consultation is complete.

Signature: _____
 Primary physician

SECTION 3 - CONSULTANT/SPECIALIST FINDINGS and RECOMMENDATIONS

I would like to receive periodic status reports on this patient
 When complete fax to _____

Signature: _____
 Consultant

Adapted from The American Academy of Family Physicians. Available at <http://www.aafp.org>

1 of 1 281102



Clarify roles and boundaries

- Develop a referral policy and procedure that maps out your process and assigns roles
- Create referral agreements for your most frequent referrals defining:
 - Which patients are appropriate for referral
 - How quickly the patient will be seen
 - Method and timeliness of feedback to you
- Call consults/referrals and let them know what you need from them, have them sign an agreement

Don't forget the patient

Remind patients regularly to let you know when they have gotten services outside of your office



**Remember Home
- Your Medical Home
that is!**

Did you get a flu shot at the pharmacy or grocery store?

Have you had tests or services performed at a health fair?

Have you received other health care services?

Tell the staff or doctor so we can keep your records up to date.

Name: _____

I had: _____ Date: _____

How to manage a transition

- When a patient will be transferred to another physician for long-term care or permanently be aware that:
 - Transfer can trigger grief, guilt, anger, anxiety and fear in the patient
 - Patients may avoid closeness with physician
- Plan a structured good bye
- Write a transition letter

How the structured good bye works

- Ideally done in person - use active, positive language to explain the change
- Reflect on patient's progress/strengths
- Express learning/gratitude
- Identify new physician
- Discuss possible 'cultural' changes

What's a transition letter?

- To be carried by the patient
- Write it with the patient
- List the chronic conditions and medications
- List key literature references for rare conditions
- Highlight major red flags from history i.e. medication reactions

Transition timing

- Balance advance notice for the patient and premature separation of physician and patient when determining the timing
- Formal notice is 3 to 8 months in advance
- Maintain a future-focused orientation and foster the patient's responsibility for care throughout the relationship

Tracking patient activity

- Knowing if and when your patients have followed up on your suggestions or referrals, impacts the care you provide
- Add tracking ability to your practice management software or electronic medical record
- Or create a simple database in Access or Excel

Sample Excel tracking log

- Keep track of patients who are referred to smoking cessation, diabetic education, other specialists or any type of community resource with this simple log



Sample specialist/other services referral log

Tool 14-2

Initiatives 14.3, 14.7, 10.7

FCMH Resource Binder | 2010

Tracking Log for Open Referrals

- List information for any patients referred to specialist or for other services (diabetic education, counseling, nutrition etc.)
- Send all relevant clinical and financial information to specialist. Request to receive results.
- Put follow-up dates in RED font for priority appointments
- Check the list weekly to follow-up on outstanding referrals
- Log completed referrals and add initials to log
- Add information to medical record, chart etc.
- Copy completed referrals to sheet 2, delete from sheet 1

Date	Patient name	Reason for Referral	Specialist name or program type	Specialist referred to or subspecialist	Follow-up date	Completed Y/N	Notes: Saw specialist or reason did not seek care	Initials



Care coordination gets easier

- Care coordination gets easier when these basic steps have been taken:
 - Policies and procedures drafted with staff roles defined
 - Roles and boundaries clarified for care
 - Agreements drafted for frequent referrals
 - A tracking mechanism in place for patient activity



On office letterhead

Transition Letter

<Date>

Dear Dr. <Name>,

I have had the pleasure of being <patient's name> doctor for the last <number> of years. We decided it was important that I communicate some information to you regarding <his/her> health as <patient's name> is transitioning to your care.

His/her only diagnosis at the conclusion of my care is type II diabetes, which is well managed with 5 units of Humalog before each meal. <Patient's name> has been working very hard to change some things about his life to help his diabetes in the long run, including increasing the amount of exercise he/she gets. At this time his/her HbA1c level has been averaging about 7 over the past year.

In terms of <patient's name> medical history, we felt it was particularly important for you to know that he/she underwent extensive testing for a rash of unknown origin. It was only after a period of time that we realized <patient's name> is allergic to <drug>.

Thank you for assuming the care of <patient's name>. I especially enjoyed being his doctor because of his sunny outlook on life. I trust you will have a similarly positive experience with <patient's name>.

Thank you,

<Doctor name>

<Practice name>



Smoking & Asthma

Eye Exam Report

Eye care specialist

1. Complete this form
2. Sign
3. Fax to Primary care office

Primary care specialist

Name: _____

Fax No. _____

Address: _____

Date: _____

Name of eye care specialist: _____

Name of patient: _____

This patient was seen today for:

- A dilated eye exam
- Fundus photography
- Other _____

Results:

	Left	Right
<input type="checkbox"/> Normal	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diabetic retinopathy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Macular edema	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>

Eye care Doctor's signature

Date of exam

Comments: _____

Primary care office – add this fax to patient's record to document completion of eye exam.

