Creating Medical Home Communities

Systems of Care/Patient Centered Medical Home Initiative

Last Updated: February 6, 2011

Coordination and Continuity of Care
Policy and Protocol

Westminster Medical Clinic (WMC) provides external care coordination and ensures continuity of care in collaboration with outside facilities and organizations. Continuity of care protocols outline comprehensive and safe care for patients who receive inpatient and/or outpatient care between WMC and facilities such as hospitals, nursing homes, specialty care, disease management services and others.

WMC provides internal care coordination by identifying high acuity patients, as well as those treated in outpatient and inpatient settings and contacting these patients after discharge to provide and/or coordinate follow up care.

WMC maintains processes for evaluating, prioritizing and coordinating care for patients who receive in-house care management and provides coordination for patients who receive care from other physicians.

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External Care Protocol
Hospitals and Skilled Nursing Home Facilities

Identifies patients who receive care in hospital, ED and/or skilled nursing home facilities:

A. The Care Coordinator at WMC reviews and tracks admissions and discharges, transfers, inpatient lists via fax, email, telephone, and hospital electronic portals for external care facilities each day to identify established patients who have already accessed care in the outside medical facility.
    1. The Care Coordinator reviews communication documents daily to cross-check WMC patients with health information technology or outside medical facility new admissions, discharges, transfers, patient medications, laboratory results, and patient summaries. To cross-check with external medical facilities, follow the process below:
        a. Access the current inpatient list at Centura Health Systems.
            1. Open Internet Explorer
            2. Log into www.myvirtualworkplace.org
            3. Enter user name and password (user name and passwords are assigned by Centura Hospital systems, contact physician liaison for forms)
                i. The Centura Hospital portal opens.
            4. Click on “Work Tools”, Clinical Tools, Meditech
            5. Citrix Client loads and opens
            6. Press “enter” when the HCIS CEU.Live window opens.
            7. Enter PIN number (assigned by Centura with user name and password) and press enter
            8. Click on Rounds Report, Simple Rounds report.
            9. Click on desired facility
                i. Ex. St. Anthony Hospital North
                ii. The previous steps need to be done for each hospital individually.
            10. In pop up window type in provider’s mnemonics,
            11. Tab to each successive field and type “Y” for yes
            12. In the “Penrose Pavilion” leave field blank
            13. On Right hand side of pop up window click the check mark.
            14. A list of patients for each provider will be generated.
            15. Press Print
        b. Access the list of patients who have been in the emergency room at Centura Health Systems.
            1. Open Internet Explorer
            2. Log into www.myvirtualworkplace.org

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3. Enter user name and password (user name and passwords are assigned by Centura Hospital systems, contact physician liaison for forms)
    i. The Centura Hospital portal opens.
4. Click on “Work Tools”, Clinical Tools, Meditech
5. Citrix Client loads and opens
6. Press “enter” when the HCIS CEU.Live window opens.
7. Enter PIN number (assigned by Centura with user name and password) and press enter
8. Click on “Outpatient/ER visits report” icon. A “Lookup” window opens.
9. Highlight desired facility and press “enter”.
    i. Ex. St. Anthony Hospital North
    ii. The previous steps need to be done for each hospital individually.
10. In the pop up window enter all providers’ mnemonics
11. In Provider section enter WESTME
12. Add “Y” for admitting, attending, referring, primary care, and consulting.
13. In the “From” and “Thru Date” fields add dates being searched.
14. Press enter or click on the green check mark on the top right of the window.
15. A list will be generated of patients who are/were in the ED or had an outpatient procedure (mammogram, CT scan, ultrasound etc) within the dates selected.

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Systematically sends clinical information to facilities with patients as soon as possible:

A. In response to new patient admission notification from the external medical facility, the Care Coordinator communicates pertinent medical information to the specified contact at each external medical facility, to include all information in the patient’s *PCP Transition of Care Record*. The *PCP Transition of Care Record* is communicated by the PCMH Care Coordinator within 30 minutes but no later than 2 hours after admittance notification, limited to normal business hours, 8am-5pm.

1. If patient admission occurs after normal business hours, the Care Coordinator will respond the following business day, by 9:30 AM providing notification of patient admittance was received by 9am from the external medical facility or from the on-call provider
2. During weekends or after-hours, MAs and providers will send:
    a. Telephone Encounter (TE) to care coordinator.
    b. After the Care Coordinator sends the TCR to the facility, the care coordinator sends the TE back to the patient’s PCP for review.

3. If a patient admission and facsimile communication occurs between the PCMH Care Coordinator and the external medical facility Care Coordinator and/or additional personnel, the PCMH Care Coordinator:
    a. Enters the following into the EMR in New Telephone Encounter
        1. Documents ER, hospital admit or discharge' in the Reason field and facility, admitting provider, diagnosis, etc in the comment box.
    b. Collects pertinent information about the patient from the patient chart and/or EMR, faxes the pertinent information back to the external medical facility within 30 minutes but no later than 2 hours after initial notification.
    c. Documents in the EMR, the time, date, location and to whom the medical records were faxed.
        1. See *Appendix A* for the *PCP Transition of Care Record*, which details the pertinent information the PCMH Care Coordinator transmits in response to new admittance of a PCP patient.
4. If a patient admission and telephone encounter occurs between the PCP Care Coordinator and the respective external medical facility Care Coordinator and/or additional personnel, the PCP Care Coordinator:
    a. Records the conversation in EMR in New TE, including name of facility, admitting provider, diagnosis.
    b. Assigns the telephone encounter to the PCP at the PCMH facility for their review.
5. Current contact information for hospitals is seen below.
    a. The list of hospital information is updated yearly.

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Hospital System	Hospital Name	Main #	Contact Person	Contact Person #	Contact Fax #
Centura Health	St Anthony's North	303.426.2151	Jenny Kosovich, RN	303.501.2198	303.430.2611
	St. Anthony's Central		Kim Taylor Ktaylor@soundphysicians.com	303.509.9322 Pager	
HealthOne	North Suburban Medical Center	303.451.7800	Andy Baker Abaker@soundphysicians.com	303.201.2626	303.453.2203
Exempla	Lutheran Medical Center Good Samaritan Medical Center	303.425.4500	Ryan Soliz Rsoliz@soundphysicians.com	303.509.4247	

Last Update: 10/28/10

6. Current contact information for skilled nursing homes is seen below.

Skilled Nursing Home	Main #	Contact Person	Contact Person #
Alpin Living Center	303.452.6101	Leah Rogers, MSW	303.829.4429
Bear Creek Nursing Center	303.697.8181	Shannon Smith, BSW	720.300.2810
Broomfield Care Center	303.785.5800	Leah Rogers, MSW	303.829.4429
Cambridge Care Center	303.232.4405	Leah Rogers, MSW	303.829.4429
Cherrelyn Care Center	303.798.8686	Shannon Smith, BSW	720.300.2810
Cherry Hill Care Center	303.789,2265	Shannon Smith, BSW	720.300.2810
Clear Creek Care Center	303.427.7101	Leah Rogers, MSW	303.829.4429
Elms Haven Care Center	303.450.2700	Pat Faughnan, RN	303.910.4496
Greenwood Village Care Center	303.773.1000	Pat Faughnan, RN	303.910.4496
Life Care of Westminster	303.412.9121		
Malley Care Center	303.452.4700	Leah Rogers, MSW	303.829.4429
Villa at Sunny Acres	303.255.4181		
Wheat Ridge Manor	303.238.0481	Leah Rogers, MSW	303.829.4429

Last update: 9/12/10

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Reviews information from care facilities and communicates pertinent information to the patient's provider:

A. At the end of each business day, the PCMH Care Coordinator updates patient admissions and discharges by detailing patient name, facility name, attending provider, diagnosis, and updates. The Care Coordinator enters the external medical facility database login portal (if available) periodically to access new information regarding the patient and/or makes follow-up phone calls to the external medical

facility Care Coordinator to gather updates on patient progress and new information. The Care Coordinator electronically or manually posts the information in a designated area at the end of the day for review by the care team and/or sends the information if new or relevant to the provider/care team.

1. During normal or after hours, the Care Coordinator opens a Telephone Encounter or New Action to log the patient admission. The Telephone Encounter is left open until the patient is discharged from the external medical facility and has completed a follow-up appointment at the PCMH facility.
2. The Care Coordinator follows up with the patient after discharge within 2 normal business days via phone call.

Systematically facilitates transfer of clinical information to and from specialty facilities:

A. The Referral Coordinator at WMC reviews referral requests via fax, email, and telephone (up to primary care facility discretion) from PCMH facilities each day to identify patients who will have any care or who have already received care in the specialty care facility.
    1. The Referral Coordinator notifies the selected PCMH-N Specialist facility of any new patient referrals within 1 business day of referral request. Referrals are sent to specialty care facilities either same-day or next-day.
        a. A complete *PCP Transition of Care Record* and any additional pertinent information regarding the patient is sent to the PCMH-N facility with the initial referral notification to the Specialist
        b. In the event that insurance eligibility is denied, the Referral Coordinator will contact the Care Coordinator to consider revising the patient care plan or confirmation to proceed with the referral appointment with the patient.

See below for a list of PCMH-N Specialists. (to be updated every 6 months).

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Specialty	Specialty Care Office	Provider Names	Office Main #	Contact Person	Contact Person #	Contact Fax #
Cardiology	*Rocky Mountain Cardiovascular Associates*	Donald Thompson Martin Yussman Claudia Benedict	303.426.5154	**Christie Kiefer**	303.428.2207	303.426.0318
Dermatology	*Denver Dermatology Consultants*	Robert Wright		**Tym Johnson**	303.426.4525	

Gastro PENDING	*Rocky Mountain Gastroenterology*	Paul Deneault Bruce Walker Gareth Weiner		**Stephanie**	303.255.6777	303.255.2190
Gastro PENDING	*Gastro of the Rockies*			**Todd LeVeigne**	720.932.7724	
Heme-Oncology	*Rocky Mountain Cancer Centers*	Alvin Otsuka Praveena Solipuram Russell Tolley Ziari		**Duane Hoxie**	303.775.0529	
Neurology	*Neurospecialty Associates*	Scott London		**Sylvia Pastrana**	303.629.5600	
Ophthalmology	*Eye Surgery Center of CO*	William Self	303.426.4810	**Jackie McAdams**	303.426.4810 ext. 112	
Orthopedic-Spine	*Center for Spinal Disorders*	Michael Janssen George Leimbach Joseph Morreale Monroe Levine Donald Calley Ruth Beckham Alicia McCown	303.287.3800	**Debbie Lucero**	303.328.2490	303.287.7357
Orthopedic-Spine	*Panorama Westminster Office*	Amit Agarwala Christopher Brian Premjit Deol Bharat Desai Douglas Foulk Tom Friermood James Johnson Karen Knight Lonnie Loutzenhiser Nimesh Patel Mitchel Robinson		**Eric Worthan, CEO** **Brandi Ramirez** **Pat Viduya**	303.274.7324	
Surgery PENDING	*Front Range Surgical Associates*	Ciccoletti(sp?) James Garlitz David Long Kyle Nickel		**Elaine**	303.428.0004	
Surgery-Hand, Plastics		Mitch Fremling	303.466.3261	**Eunice Diaz**	303.466.3261	
Urology	*Foothills Urology*	David Cahn	303.985.2550	**Debbie Krieder**	303.985.2550	

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Last Update: 10/28/10

Communicates with patients who cancel or fail to attend visit to specialist or testing facility (no-show):

A. Prior to the end of each business day, the PCMH Care Coordinator or PCMH Referral Coordinator updates the Referral Requests log to ensure follow-up care with the patient.
    1. If notified by a specialist, patient or medical facility that a referred patient did not attend the appointment (no-show or cancellation), the Referral Coordinator at the PCMH-N will attempt to contact the patient to either confirm rescheduling of the appointment or address the barriers and/or challenges the patient has regarding the referral. If the PCMH-N attempts to reschedule the patient twice within a 4 week period of appointments and the patient no-shows twice, then the Referral Coordinator or appropriate personnel at the PCMH-N contacts the specified Care Coordinator at the PCMH. The Care Coordinator will attempt to contact the patient to either confirm rescheduling of the appointment or address the barriers and/or challenges the patient has regarding the referral. The Care Coordinator then records any patient responses in General Notes under Notes tab in the Referral Section.
        a. In the event that the patient agrees to reschedule the referral to the PCMH-N, the Referral Coordinator engages the patient a second time and confirms the referral appointment has been scheduled. The Care Coordinator additionally notifies the PCMH-N facility of the contact and re-appointment.
        b. If the patient declines to re-appoint for the visit, the reason is noted General Notes under Notes tab in the Referral Section and sent to the provider for review.

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Internal Care Coordination Protocol
PCMH Westminster Medical Clinic

Contacts patients after hospital or ER discharge for further care coordination and identifies and contacts patients who are at risk for adverse outcomes following discharge:

A. The Care Coordinator reviews information from facilities to identify patients who require proactive contact outside of patient-initiated visits or who are at risk for adverse outcomes.
    1. Based upon clinical orders from clinician (patient needs contact after review of discharge log/report), the Care Coordinator contacts each discharged patient within 2 business days to:
        a. Schedule follow-up appointments with the patient's PCP or specialist.
        b. Complete the *Personal Care Assessment and Plan* form for each discharged patient and place the form in corresponding patient record or designated file
            1. See *Appendix B* for an example of the *Personal Care Assessment and Plan.*
        c. Reconcile medication from hospital/SNF to PCMH office at time of phone contact.
    2. The Care Coordinator enters the patients who have been hospitalized or admitted to the ER ≥ 3 in the past 1 year into a high-risk patient registry indicating the following: patient name, hospital admission/discharge, diagnosis, and any noteworthy information. A care plan is developed with input from the patient's medical provider.
    3. If the data is available, the Care Coordinator tracks ER discharges, to include the following information.
        a. See *Appendix C* for an example of the *ER Visits Tracker*.

Total Visits
Avoidable Visits
Percentage Avoidable
Chronic
Acute
Mode of Weekday
Mode of Time
Mode of Location
Age: 0-30
Age: 31-64
Age: 65 +
Calls WMC Clinic prior
Percentage Calls Prior
ER Co-Pay

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Reviews information from specialty care facilities to ensure appropriate follow-up care:

A. The medical provider reviews the following within 4 business days of receiving the information from the PCMH-N facility:
    1. *Specialist Transition of Care Record*
        a. See *Appendix D* for an example what will be included in the *Specialist Transition of Care Record.*
    2. Specialist care plan summaries
    3. Completed medical testing results
    4. Secondary referrals outside of the PCMH-N agreement
    5. Recommendations for further patient medical testing and follow-up to the PCP.
B. The PCP provider determines the appropriate follow-up and provides instructions to the Medical Assistant or Care Coordinator to complete the new care plan.

The PCMH facilitates communication between the patient, PCMH, and PCMH-N facility for well-coordinated transfer of care:

A. For patients referred to other care, the PCP, if appropriate, develops a written transition care plan through shared decision making with the patient and family.
    1. If the PCP initiates a referral, the PCP provides a written explanation of the recommendations in understandable language to the patient.
        a. See *Appendix E* for the *Patient Referral Rx*.
        b. See *Appendix A* for an example of the patient's *PCP Transition of Care Record* for written care plan location.
    2. The PCP sends the referral to the Referral Coordinator and the Referral Coordinator confirms the PCMH-N specialist contact information with the patient.

The PCMH staff fosters well-coordinated care by engaging and informing patients of the PCMH benefits:

A. The Medical Assistants at the PCMH distributes *PCMH ID Cards* to the patients, explains what a PCMH is, and explains rationale for having a *PCMH ID Card*.
    1. When a new patient attends an appointment for the first time, the Medical Assistant delivers a short, pre-determined script that details what is a patient-centered medical home and gives the new patient an ID Card that lists the PCMH providers and contact information, as well as, PCMH educational material.
        a. See *Appendix F* for an example of the *PCMH ID Card*.
        b. An example of the script is as follows:

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"Hi [insert patient name] . . . I just wanted to give you an ID Card from WMC[us]."

"Always show this ID Card at any other office or hospital. You can even show this card to the receptionist with your insurance card."

"This ID Card says you are a patient at a 'medical home'. That means we are your home base for your [health]care."

"So remember, always show this to every specialist or hospital you go to so that they know whom to contact if they need more information and to allow us to stay involved with your care."

B. WMC as a whole promotes the PCMH model through printed materials.
    1. Practice brochures, cards, and posters
        a. General PCMH "What is it?" information
        b. Extended office hours/open access
        c. Medical Neighborhood information
        d. Website and web patient portal
            a. www.westmedprimarycare.com
        e. Group office visits
            a. Healthier Living CO
                1. See *Appendix G* for an example of a *RX: Healthier Living CO*
            b. Diabetes
    2. Patient health education information regarding chronic diseases.

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Continuous Quality Improvement
PCMH Westminster Medical Clinic

Facilitates quality improvement preparation, implementation, and evaluation methods to maintain continuity of care

A. The Care Coordinator participates in strategizing ways with the medical provider(s) to stay connected with external medical facilities such as specialty offices, skilled nursing homes, and hospitals.
    1. The Care Coordinator will communicate with the medical provider(s) in a bi-weekly meeting to discuss updates on coordination of patient care issues and maintain continuity.
        a. The Care Coordinator participates in patient care team meetings.
        b. The Care Coordinator sends eCW messages to providers on issues of patient care.
    2. To engage a specialty office, skilled nursing home, or hospital to improve bi-directional communication with the PCMH, the Care Coordinator follows the steps below:
        a. Send the specific organization a *Medical Neighborhood Invitation* letter written by a medical provider.
            1. See *Appendix H* for an example of the *Medical Neighborhood Invitation*.
            2. When Specialty offices and/or providers initiate communication with the PCMH to improve bi-directional communication with the PCMH <u>before</u> receiving a *Medical Neighborhood Invitation*, the Care Coordinator sends the *Medical Neighborhood Guide* (a packet of information detailing how to become a Medical Neighbor) to the specific organization or refers them to the appropriate State organization .
                i. See *Appendix I* for an example of the *Medical Neighborhood Guide*.
            3. Log the date when the *Medical Neighborhood Invitation* was sent in the *Medical Neighborhood Tracker* and Specialist Supplemental Tracker.
                i. See *Appendix J* for an example of the *Medical Neighborhood Tracker*.
                ii. See *Appendix K* for an example of the *Specialist Supplemental Tracker*.
        b. Schedule a meeting with the external medical facility at the PCMH and/or refer to the State facilitator or Webinar.
            1. Before the meeting, send a copy of the *Medical Neighborhood Guide* to the specific organization.

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2. Set a date with the specific organization as to when a decision can be expected to formally agree on improving bi-directional communication via the Systems of Care/PCMH Initiative Compact.
3. Log the date of the meeting in the *Medical Neighborhood Tracker*.

c. Follow-up with the external medical facility on the date set at the previous meeting. Ask if the specific organization and/or any providers individually would like to proceed with the Compact agreement.
d. If the external medical facility or any providers decide to agree to the Compact, ask the office manager to check the boxes in the Compact that are applicable to all providers in the office who agreed to the Compact. If time allows or circumstances dictate, a meeting may be scheduled to facilitate the process.
e. Assist the external medical facility personnel to facilitate the Compact, ie.
    1. How will the office personnel alert themselves that the PCMH has referred a patient,
    2. How will the provider know the patient is from the PCMH, and
    3. How the Transition of Care Record process will occur.
f. Send the *Medical Neighborhood Toolkit* to the office manager and additional personnel.
    1. See *Appendix L* for an example of the *Medical Neighborhood Toolkit*.
    2. Share information and processes that the other Medical Neighbors are doing to improve bi-directional communication.
g. Ask the external medical facility specific questions to help fill out the *Medical Neighbor Specialist Practice Profile*.
    1. See *Appendix M* for an example of the *Medical Neighbor Specialist Practice Profile*.
h. Make a copy of the Compact that already has boxes checked off by the office manager, which represents what the office providers agree to in the Compact.
i. Write down all providers that wish to participate in the Medical Neighborhood on the top of the copied Compact
j. Complete the *Medical Neighbor Specialist Practice Profile* and journal the dialog and conversation at the external medical facility at the end of the *Assessment*.
    1. Log the date of the completed work, the external medical facility name, and the associated providers in the *Medical Neighborhood Tracker*.

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k. Send the medical provider(s) the *Medical Neighbor Specialist Practice Profile* for approval to accept the external medical facility in the Medical Neighborhood.
l. Update the list of Medical Neighbors in the following documents:
    1. *Care Coordination Policy and Protocol*
    2. *Westmed Primary Care website*
    3. *Medical Neighborhood Tracker*
    4. *Specialist Supplemental Tracker*
    5. *List of Medical* Neighbors for PCMH providers
        i. Send an updated list to the PCMH providers.

B. The Care Coordinator participates in PCMH practice redesign and systems improvement.
    1. The Care Coordinator participates in data collection through a registry and conducts clinical audits.
        a. Queries registry on monthly basis to monitor patients with chronic disease according to protocol.
            1. Performs or supervises population management of at least 3 chronic diseases.
        b. Provides a report to the providers to determine a monthly action plan.
        c. Facilitates outreach and coordinates the action plan with appropriate personnel.
        d. Sends provider and practice level performance data to providers
        e. Under direction of medical director, monitors other levels of performance, such as, cost utilization, data on vulnerable populations and overuse of services or treatment.
        f. Directs collection of patient satisfaction surveys
    2. Each quarter, the Care Coordinator conducts a clinical audit for all PCMH providers regarding the *PCP Transition of Care Record*.
        a. Audit each provider separately using the *PCP Transition of Care Record Checklist* to determine what percentage of the *PCP Transition of Care Record* is being captured in any outbound referral to a PCMH-N hospital, skilled nursing home, and/or specialty care facility.
            1. See *Appendix N* for the *PCP Transition of Care Record Checklist* to reference as to what needs to be recorded and where each element is located in the EMR.
        b. Enter the results in the *PCP-TCR Tracker* from the PCMH Audit just performed.
            1. See *Appendix O* for the *PCP-TCR Tracker* tool to conduct the audit, record the results, create updated graphic representation of the results for each PCMH provider, and aggregate the data for the PCMH clinic.
        c. Prepare clinical reports and provider reports regarding the Transition of Care Record quarterly using the *PCP-TCR Tracker*

SAMPLE

tool. Send an electronic copy or hand a hard copy to each provider.

3. Quarterly or bi-annually, the Care Coordinator works with the Referral Coordinator to conduct an audit for the organizations which are members of the Medical Neighborhood.
    a. Produce a report of patients referred to each Medical Neighborhood office over the previous 3 months.
    b. Randomly select 4 patients from each Medical Neighborhood office listed on the report and conduct a phone survey or use e-messaging through the Patient Portal using 4 pre-determined questions listed in the *Medical Neighborhood Phone Survey Tracker*.
        1. The Care Coordinator documents responses to the phone or electronic survey in the *Medical Neighborhood Phone Survey Tracker*.
            a. See *Appendix P* for an example of the *Medical Neighborhood Phone Survey Tracker*.
        2. If the Care Coordinator does not speak with the patient on the phone, a message is left.
            a. The Care Coordinator attempts one more time to contact the patient for the phone survey.
        3. Audit each Medical Neighborhood office or organization separately using the *Specialist Transition of Care Record Checklist* to determine what percentage of the Transition of Care Record is being captured in any inbound notes back to a PCMH.
            a. See *Appendix Q* for an example of the *Specialist Transition of Care Record Checklist*.
        4. Enter the Transition of Care Record results into the *Score Care Template*: *TCR Worksheet*.
            a. See *Appendix R* for an example of the *Score Card Spreadsheet.*
    c. Send the *Score Card Spreadsheet* to all PCMH providers and the Referral Coordinator to complete the Provider Worksheets and Referral Worksheets respectively within 1 week.
    d. Once the *Score Card Spreadsheet* is received back from all PCMH providers and the Referral Coordinator, manually enter averaged scores into the *Score Card Spreadsheet: Final* for each Medical Neighbor office. Then copy + paste the *Score Card Spreadsheet: Final* into the *Score Card Template*, a Microsoft Word document.
        1. Save the *Score Card Template* document as [officename.month] into a file folder named [monthScoreCards].
            a. See *Appendix S* for an example of the *Score Care Template* to copy+paste the *Final Spreadsheet* in.

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2. Publish the document as an Adobe PDF for each Medical Neighborhood office.
3. Send the Adobe PDF document to providers and e-mail to the Medical Neighborhood offices using the contact information in the *Medical Neighborhood Tracker* or Care Coordination Policy and Protocol lists.

4. Sends PCP score card to specialists to complete and return. Collates information.
5. Quarterly or bi-annually, updates the Medical Neighborhood Newsletter with a letter from the Care Coordinator, Referral Coordinator, PCMH Project Manager, or a PCMH medical provider and send to the Medical Neighborhood offices via email.
6. Facilitates communication between the PCMH providers and the Medical Neighborhood offices and/or providers regarding any concerns or questions from either party.
7. Under supervision of the medical provider, the Care Coordinator evaluates clinical care and utilization of resources and assists in development of new clinical tools/forms/procedures.
8. The Care Coordinator arranges, supervises or conducts group visits amongst any member of the Medical Neighborhood and the PCMH and/or if any member requests so.

SAMPLE

CARE PLANNING
PCMH Westminster Medical Clinic

Identifies patients at high-risk for poor outcomes (multi-morbidity conditions or high utilization of ED services) or those who require help in coordination of services:

A. The Care Coordinator maintains a patient registry by entering selected patients who have ≥ 3 chronic diseases, ≥ 3 hospital or ED visits in the past year, patients on long-term anticoagulation (ex. warfarin), or identified by their clinician as being non-engaged/non-adherent with care recommendations or requiring help in care coordination/case management into the Care Management registry to include:
    1. Patient contact information
    2. Patient hospitalizations
    3. Personal Care Plan
        a. Evaluates and prioritizes patient's medical, social, psychological needs and assists in solving barriers to their health care and recovery
        b. Helps patient set goals and provide education informational to help care for illness
        c. Advocates for patient and family and link the patient to the appropriate community resources
            1. Community Resource Book
        d. Promotes adherence to care plan with support in self-management skills and facilitate healthy behavior changes
        e. Regularly communicates with patient/family
            1. Provides written summary
            2. Provides written care plan
        f. Adjusts medications or changes treatment per practice standing orders or clinician's directions

B. The Care Coordinator should take the following other steps when identifying high-risk patients and/or coordinating services:
    1. Notifies patient's medical provider of progress, barriers or important issues effecting the care plan
        a. Conducts biweekly care management meetings with the provider(s).
    2. Monitors tickler file and ensures timely intervention
        a. Lab and referral tracking
        b. Specific patient alerts
    3. Communicates with external disease management or case management organizations
        a. Maintains list of contacts
        b. Establishes a timeframe for communication with the agency regarding the specific patient
        c. Agrees on a mutual care plan for each patient
        d. Enters appropriate patient information into high-risk patient registry

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4. Facilitates transfer of care
    a. If known, recommends a PCP or specialist in the area the patient is relocating.
    b. Arranges for medical records to be sent to the new provider after obtains signed release in compliance with HIPAA regulations.

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References

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