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.

    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

SAMPLE

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.

SAMPLE

References

"Complete Physician Practice Connections-Patient Centered Medical Home Companion Guide." *A Companion Guide to NCQA's PCP-PCMH Standards*. National Committee of Quality Assurance / Pfizer Inc., 2008. Web. 25 Feb. 2010. <http://www.ncqa.org/tabid/629/Default.aspx>.

Hammond, Scott, MD. "Primary Care – Specialist Physician Compact." Colorado Systems of Care/Patient-Centered Medical Home Initiative. (2009).

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